Improving Treatment Delivery

The Role of Behavioral Health in Primary Care

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Working with communities to address the opioid crisis.

- SAMHSA’s State Targeted Response Technical Assistance (STR-TA) Consortium assists STR grantees and other organizations, by providing the resources and technical assistance needed to address the opioid crisis.

- Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

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Working with communities to address the opioid crisis.

- The STR-TA Consortium provides local expertise to communities and organizations to help address the opioid public health crisis.
- The STR-TA Consortium accepts requests for education and training resources.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS) who is an expert in implementing evidence-based practices.

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Contact the STR-TA Consortium

❖ To ask questions or submit a technical assistance request:

• Visit www.getSTR-TA.org
• Email str-ta@aaap.org
• Call 401-270-5900

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Objectives

✧ Review most common behavioral health issues confronting primary care
✧ Review the impact of these issues on patient care
✧ Discuss approaches for primary care practices to improve access to care and improve outcomes
Common Behavioral Health Issues in Primary Care

- Depression
- Anxiety Disorder
- Stress Reaction
- Substance Use Disorders
Depressive Disorders

- >85% of patients are diagnosed and treated by primary care
- Often an occult presentation mimicking dementia or other metabolic disorders
- Importance of screening - especially in the elderly
- Comorbidities of stress, anxiety, bipolar disorder and SUD often confuse the picture
Depressive Disorders

- Most commonly involves deficits of serotonin and norepinephrine
- Prognosis is excellent with treatment
- SSRI, SNRI, CBT, adjunctive therapy
Why is screening so important?

- The best opportunity to improve outcomes in behavioral health for primary care.
- Proper diagnosis leads to better treatment
- Access to care is only made possible through primary care practices due to workforce shortages in mental health
- Many screening tools i.e. PHQ-9 available
- Medicare Wellness Exam has improved screening
Anxiety/Stress Disorders

- Very common and commonly misdiagnosed and treated
- Over use of benzodiazepines
- Under use of non-pharmacologic therapies
- Under use of CBT
- Treatments of choice are SSRI/SNRI with/without CBT
- Stress management techniques
Substance Use Disorders

- Usually unrecognized until the disease is advanced
- Must recognize it as a disease and treat it as such
- Screening in primary care practices is imperative
- Interventions are frequently effective when done properly by primary care
- Treatment is effective
The Disease Model of Addiction

- Primary disease of the brain-genetics, animal models reproducibility, constellation of symptoms, effective reproducible treatment
- Hijacking of the pleasure-reward center of the meso-limbic system
- Dopamine is most important neurotransmitter
4 C’s of Addiction

- Cravings
- Compulsion to use
- Control—loss of...
- Continued use—despite negative consequences
Dealing with SUD in Primary Care

- Understand the scope and impact of the problem
- Understand the origin of the insane behaviors
- Don’t take things personally—it’s not about us
- Don’t fire patients in active addiction
- Do keep them under your care and steer them to proper treatment including 12 Step Recovery engagement
- SBIRT and be prepared ahead of time for proper referrals
Dealing with SUD in Primary Care

- #1 Nicotine Use Disorder—420,000 deaths per year
- #2 Alcohol Use Disorder—90,000 deaths
- #3 Opioid Use Disorder—72,000 deaths and climbing
Medication Assisted Treatment

- **Nicotine**: varenicline, bupropion, nicotine replacement
- **Alcohol**: naltrexone, acamprosate, disulfiram
- **Opioids**: naltrexone, buprenorphine, methadone
Please Consider...

- Becoming a “waivered” prescriber- < 350 prescribers, < 50 addictionologists-primary care is desperately needed on the front lines
- Become competent in prescribing naltrexone
- Support distribution/education in use of naloxone
- Develop your network for inpatient and outpatient addiction referrals
- Echo Project for support
DATA 2000 Waiver Training

- samhsa.gov
- 8 hrs online for MD/DO
- 24 hrs free for APRN/PAs
Case #1

63 y/o WM with chronic back pain with spinal stenosis was being managed with oxycodone followed by pain mgmt. Was presenting for f/u with repeatedly running out of meds too early and then found to have + cocaine on UDS.
Case #1

- Discharge from the practice for major contract violation
- Report to MBN for suspected diversion
- SBIRT
- Suspect false + cocaine and disregard
Case #2

65 y/o WF with RA and HTN started on chronic opioids for chronic pain related to RA 10 years ago. Had escalation of pain requiring escalation of opioid dosing. 5 years ago, she began escalating her own dosing and was “cut off” by prescribing physician due to concerns she was “developing a problem”. She then began illicit acquisition and use of oxycodone when she was unable to stop on her own. She then progressed to oral hydromorphone, and finally at the age of 63 began injecting hydromorphone intravenously. She is still reporting level 8/10 pain despite IV hydromorphone use.
Question #2
The next best course of treatment is?

✧ A. Stabilize her back on a controlled oral dose of hydromorphone to stop the IV use and prescribe naloxone.

✧ B. Refer for treatment for opioid use disorder and prescribe naloxone

✧ C. Convince her she just needs to decide to stop using

✧ D. Discharge from your practice for violating her controlled medication contract
Review: Best Practices to Improve Treatment Delivery

- Screening is imperative—especially for depression and SUD’s

- Understanding the scope and impact of these issues and how effective primary care practices are in providing effective treatment

- Understand the basic necessity for primary care providers to be competent in the treatment of these common behavioral health issues in order to provide adequate access to care—including MAT for SUD’s
Thank You

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