FEATURE ARTICLES:

• Opioid Addiction: One of our Most Treatable Diseases
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• The Global Experience with Supervised Injection Facilities: A Clinical Review
• Two Views: The Conflict of Treating Pain and Addiction

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The young life and nascent career of Dr. Tracy Tam ended abruptly and violently on Friday, June 30 when she was inexplicably murdered while caring for patients at Bronx Lebanon Hospital in New York City. Dr. Tam was a family physician and member of the Academy. We know little about the man who murdered Tracy or the motive for his senseless act of violence which also inflicted serious wounds on five other people; three medical students and two other physicians.

Dr. Tam is a co-author of an article which appears in this issue: Collaboration to Achieve Quality Improvement.

News of Dr. Tam’s death was shocking. She had only recently completed her training and was in her first job as a family physician. She was described by a friend and colleague who worked closely with her as “sincere and kindhearted with a lightness of spirit guided by her laser focus to serve and help others.”

We have heard from others who knew and worked with Dr. Tam. Their praise and admiration for her is consistent and uniform. She was, by all accounts, a wonderful young woman, a competent and compassionate physician and a vibrant young life. What a horrible loss for her family, her friends, her colleagues, her patients and the communities wherein she lived, practiced and shared her passion for family medicine.

We have become accustomed to reports of violence in the news media and the propagation thereof by social media. Dr. Tam’s murder is a shattering blow to the Academy and family medicine. She was young, and we treasure youth. She was enthusiastic about her job, and we admire passion. She was dedicated to her patients, and we aspire to be of value. She was contributing to her community and her profession, and we cherish purpose. We could discern in Dr. Tam the profile of what we know family physicians aspire to be and what we hope our commitment to the specialty and to the patients family physicians serve will produce. Her death is more than a tragedy. It is a reminder that there is so much more we must do to eradicate violence from society. That challenge is compounded by the steady erosion of will perpetrated by continuing violence and the anger which so regularly precedes and follows such senseless acts. In the aftermath of such tragedy we are often confronted with the doubt and frustration of dealing with such dark and incomprehensible human behavior. Ironically, the will and character to do so are forged in the crucible of anguish which such violence creates. As Helen Keller said:

“Character cannot be developed in ease and quiet. Only through experience of trial and suffering can the soul be strengthened, ambition inspired, and success achieved.”

We mourn the death of Dr. Tam and the serious injuries of others wounded in the attack. We pray that the families and loved ones of the victims will recover. And we look ahead, again, to the challenge of making the world a gentler place.
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Greetings! I humbly introduce myself as the 70th president of our New York State Academy of Family Physicians.

My earliest roles in our Academy were as a resident member of our commissions and by my third year of residency as delegate to my first NYSAFP Congress of Delegates (COD). At that first COD I realized I had found a group of similarly passionate family physicians with whom I wanted to work to strengthen our collective voice. It was clear that participation in the NYSAFP meant we could be a part of what family docs stood for in New York State — and also that we could help guide that policy.

In my first year out of residency I served as the NYSAFP Delegate to the National Conference of Constituency Leaders (NCCL). NCCL is the AAFP leadership training stomping grounds that develops women, minorities, new physicians, international medical graduates, and lesbian, gay bisexual, transgender (LGBT) family physicians to prepare to step forward as leaders on both the state and national levels. The following year I began my term as a NYSAFP Director and returned to NCCL to be elected to serve as LGBT Co-Convener, Alternate Delegate and then Delegate from NCCL to the national COD for the following two years. By 2014, I would return to NCCL in the role of Convener, running NCCL under the guidance of our amazing AAFP staff. Each of these roles brought me annually to the AAFP COD, which I have attended every year since. Last year I was given the unique opportunity to serve as a Social Media Ambassador for the Family Medicine Experience (FMX), our national continuing medical education event that occurs right after the AAFP COD.

Each time, I return to NYSAFP as my touchstone. I am continually impressed with our members, never more so than when I get to join a group of family physicians, residents, and students to speak with our legislators on lobby day, or execute the vision of our board through the work of our commissions. For the last 7 years I have served on the AAFP Commission for Membership and Member Services - this past year as Chair of that AAFP Commission.

In my day job I work as medical director of a small FQHC in the South Bronx that is part of a larger network of FQHCs run by the Institute for Family Health with locations throughout Manhattan, the Bronx and the mid-Hudson region. I also serve as chief medical information officer and help run our two student run free clinics.

I feel very lucky to work for an organization that is dedicated to providing care to the underserved, and knows medicine is a social justice issue; focuses on building health centers and training programs in areas of high need and works to eliminate healthcare disparities related to income, race, ethnicity and country of origin. And which allows me the opportunity to connect my work at the Institute to the good work we do here at the NYSAFP.

Together we now speak with the unified voice of over 6,000 members. At no greater time in our nearly 70-year history have we been called upon to serve in defense of the health of our patients. It is our privilege as family physicians to serve our patients in an exam room that falls outside partisan politics, always prioritizing the unique needs of the individuals and families before us. The year ahead will challenge us to pursue single payer as the solution for our state, and health care for all as the unwavering priority for our country. NYSAFP has been and will continue to provide consistent and uncompromising advocacy in the public policy arena for our members, their patients and communities.

There is no greater privilege than to be called to the service of others. As leaders we are further called upon to share this passion with the next generation of family physicians. I charge each of you as you engage the new third year clerks, joining you in your practice or hitting the floor of your education centers this month, to be the family physicians you met, or wish you had met, as that third year clerk. Our Academy will continue to support your good work with leadership development, mentorship, and structured learning opportunities for you, for our residents and for our students.

In the coming year your NYSAFP will step forward to lead by example in physician wellness. Throughout the year we will highlight wellness practices embraced by our Academy and our members. Your NYSAFP commits to serving as your touchstone for resiliency, inspiration and the resources that will further your joy of family medicine.

Finally, I am honored to be a part of this legacy and the good work of our academy. I extend my thanks to each of you in serving your patients, families and communities through your membership in the New York State Academy of Family Physicians and look forward to the year ahead.

Sarah C. Nosal, MD, FAAFP
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Right in New York City’s backyard, Long Island is an in-demand location to live and work—near several major airports, home to the world-famous Hamptons beaches, over 60 vineyards, endless leisure activities, and some of the highest performing school districts in the country.
Both houses of the NYS Legislature adjourned the 2017 session late in the evening on Wednesday, June 21st. They left Albany without an agreement to extend mayoral control of New York City’s schools, which expires on June 30 and without renewing county sales taxes and New York City’s personal income tax, which will expire in the fall. It is possible that the Legislature will return to Albany at some point for a special session if an agreement is reached, or to pass extenders on these outstanding issues.

The state’s opioid/heroin epidemic continues to be top of mind in Albany. In an early spring press release the Governor stated that, “The number of opioid deaths in 2015 doubled compared to the number in 2010 and the number of heroin involved deaths in 2015 was five times of that in 2010. In addition, there has been a bigger increase in opioid deaths between 2010 and 2015 outside of New York City, with sharper increase in heroin related deaths outside of NYC.”

Recently, the NYS Health Department announced a new webpage dedicated specifically to county and statewide statistics and resources related to the epidemic. The page can be found: https://www.health.ny.gov/statistics/opioid/

The final state budget this year also invested $213 million to address the heroin and opioid crisis in New York, representing an increase of over 100 percent from 2011. The investments include:

- $145 million for community-based providers
- $65 million for 8,000 residential treatment beds
- $9 million for housing units
- $41 million for opioid treatment programs
- $21 million for outpatient services
- $9 million for crisis/detox programs
- $27 million for state-operated addiction treatment centers
- $6 million for Naloxone kits and training
- $25 million for expanded programs, including family support navigators, peer engagement and 24/7 urgent access centers

Late in the session, a number of proposals were put forward as we have summarized below, however few bills on this topic were actually passed by both houses.

**Governor Cuomo’s Opioid Proposal:**
In early June, the Governor quietly released a draft bill to the Senate and Assembly with proposals in a number of areas focused on addressing the growing opioid crisis. His proposal included the following initiatives:

- **Insurance Law Changes**
  Amendments are made to the Insurance Law to:
  - Prohibit insurers from requiring preauthorization for treatment and medications, imposing prior authorization, conducting concurrent review, and retrospectively denying coverage in certain circumstances.
  - Limit mandated coverage of treatment to providers that are part of the insurer’s provider network.
  - Require providers to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurance company and designated by the Office of Alcohol and Substance Abuse Services (OASAS).
  - Limit patient cost-sharing.
  - Require coverage of certain medications.

- **Addiction Professional**
  The draft bill requires hospitals to have an “addiction professional” available in the emergency department on-site or by tele-health to consult with the attending physician about services provided to a patient who has or is at risk of having a substance use disorder. An addiction professional is a professional whose scope of practice under the State Education Law includes substance abuse and prevention services or a Credentialed Alcoholism and Substance Abuse Counselor credentialed by OASAS.

- **Drug Schedules, Public Health Law**
  We understand that the bill reschedules certain drugs to Schedules I and II.

- **Voluntary Non-Opioid Directive**
  The bill provides for a voluntary non-opioid directive by a patient in a written form indicating that the patient does not want to be prescribed, offered or administered an opioid.

- **Prescription Monitoring Program (PMP Registry)**
  The bill eliminates a provision in the 2012 I-STOP law that exempts physicians in hospital emergency departments from the requirement to consult the PMP registry if they prescribe a controlled substance for a patient that does not exceed five days.

No formal proposal by the Governor in this area was introduced when the session ended on June 21st. If both houses are called back to Albany later this year to address other outstanding issues, it is possible that the Governor will again try to get this and other proposals related to the opioid crisis enacted.

**Senate’s Opioid Package:**
On June 13th, the NYS Senate Majority and its Task Force on the Opioid/Heroin Epidemic held a press conference announcing a package of bills as the next steps to combating drug abuse. The package of bills (as
summarized below) relate to strengthening enforcement, increasing penalties, prohibiting dangerous synthetic drugs and additional steps around prevention and treatment. The Senate quickly passed the package of bills and called on the Assembly to also act. However, many of these bills lack Assembly sponsors and when the session ended none of these measures were passed by both houses.

**Strengthening Enforcement**

Enacting “Larcen’s Law” – Holding Drug Dealers Accountable: Bill S2761, sponsored by Senator Amedore, establishes the crime of homicide by sale of an opiate controlled substance. Currently, a person who provides an illicit drug that results in the death of a user can typically only be charged with criminal sale of a controlled substance.

Creating Drug Free Zones Around Drug or Alcohol Treatment Centers: Bill S1127, sponsored by Senator Akshar, would criminalize the sale of a controlled substance on the grounds of a drug or alcohol treatment center, or within 1,000 feet of such facilities.

Establishing New Penalties for Heroin Sales: Bill S880, sponsored by Senator Robert Ort (R-C-I, North Tonawanda), would create level penalties as it relates to heroin sales, taking into account the lighter weight of heroin.

Making it Easier to Prosecute Heroin Dealers: Bill S638, sponsored by Senator Phil Boyle (R-C-I, Bay Shore), would assist in the prosecution of heroin dealers by creating a presumption that the possession of 50 or more individual packages containing heroin and/or having an aggregate value of $300 is possession with intent to sell.

Cracking Down on Black Market Prescription Drugs: Bill S2814, sponsored by Senator Kemp Hannon (R, Nassau), would establish the offense of fraudulent prescription, dispensing and procurement of non-controlled substance prescription medications and devices, and establish the offense of unlawful possession of non-controlled substance prescription medications and devices.

Increasing the Penalties for Heroin and Polydrug Offenses: Bill S2744, sponsored by Senator Martin Golden (R-C-I, Brooklyn), would increase the penalties for selling heroin, compounds that include heroin, and “polydrug” compounds that include heroin and another narcotic.

**Prohibiting Dangerous Synthetic Drugs**

Improving the Regulation of Fentanyl: Bill S5884, sponsored by Senator Jacobs, adds six new derivatives of fentanyl to the controlled substance schedule regulated by the state Department of Health. Fentanyl and fentanyl-combined drugs are a major driver of the many recent overdoses that have occurred across New York State.

Cracking Down on The Sale of Carfentanil: Bill S623, sponsored by Senator Boyle, would make the sale of 2 milligrams or more of Carfentanil a Class A-II felony and the sale of 10 milligrams or more of Carfentanil a Class A-I felony. Carfentanil is synthetic opioid and a schedule II controlled substance, which is 100 times deadlier than fentanyl, and 10,000 times stronger than morphine.

Conforming State Controlled Substances with Federal Schedules: Bill S5357, sponsored by Senator Hannon, updates the state controlled substances schedules, promoting consistency with the federal schedules and promoting health and safety.

Protecting Children from Drug Abuse

Toughening Penalties for Sale of a Controlled Substance to Minors: Bill S3845, sponsored by Senator Kathy Marchione (R-C-I-Reform, Halfmoon), would make the sale of a controlled substance by an adult to a minor under the age of 14 a class A-II felony.

Limiting Children’s Opioid Exposure: Bill S5949, sponsored by Senator Akshar, requires a health practitioner to receive written consent from a minor’s parent or legal guardian in order to prescribe a medical treatment containing opioids, as well as to discuss the risks of addiction and dangers of overdose associated with the medication. The bill also limits the prescription for a controlled substance containing an opioid to a seven-day duration unless there is a medical emergency that puts the child’s health or safety at risk.

**Preventing Addiction and Facilitating Successful Recoveries**

Requiring Patient Counseling Prior to Issuing a Prescription for a Schedule II Opioid: Bill S5670, sponsored by Senator Akshar, requires health care practitioners to consult with a patient regarding the quantity of an opioid prescription and the patient’s option to have the prescription written for a lower quantity. The physician must also inform the patient of the risks associated with taking an opiate medication, and the reason for issuing the medication must be documented in the patient’s medical record.

Preventing Predatory and Deceptive Substance Abuse Treatment: Bill S6544, sponsored by Senator Akshar, makes it a crime to offer to or accept any kickback from an individual or entity that provides substance abuse services in exchange for patient referral and admission.

Expanding Access to Funding for State Substance Abuse Services: Bill S898, sponsored by Senator Amedore, authorizes the state Office of Alcoholism and Substance Abuse Services (OASAS) to provide funding to substance use disorder and/or compulsive gambling programs operated by for profit agencies.

**Bills Passed by Both Houses Related to Opioids:**

While several hundred bills were passed by both the NYS Senate and Assembly this session, the following bills are directly related to substance abuse prevention and treatment. Neither have been transmitted to Governor Cuomo yet for consideration.

Training for CASACs: Bill A373/S982, sponsored by Assembly Member Rosenthal and Senator Amedore, requires a mandatory one-time continuing education course on medication assisted treatment by Credentialled Alcoholism and Substance Abuse Counselors (CASACs).

Expanded Drug Disposal Options for Unused Controlled Substances: Bill S6750/A387-B, sponsored by Senator Hannon and Assembly Member Gunther requires pharmacies with ten or more stores in a chain to provide drug disposal options to customers for unused controlled substances, in accordance with federal DEA regulations.

We are in the process of creating an end of session summary of all health care-related bills passed by both houses this session, including a number of bills that are NYSAFP priorities. Once completed we will share with the Academy to distribute to the membership. All of us at Reid, McNally & Savage thank NYSAFP staff, leadership and members for all of your support and participation in advocacy efforts this session, and wish you a relaxing and enjoyable summer.
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W e, as family physicians, have been dealing with the difficult dilemma of providing good pain management for our patients while being cognizant of the dangers of prescribing such treatment. Many of the current family physicians were trained to be careful with prescribing narcotic analgesics, because of the dangers of dependency and addiction. The much talked about opioid addiction epidemic has created many issues for our profession and in today's society. Meanwhile our patients suffering from addiction have found it very difficult to find adequate treatment, and their family physicians have encountered many difficulties providing adequate care for their patients with an incurable illness.

As family physicians we deal with uncertainty every day. We are used to making difficult choices all the time, often with limited information regarding the condition our patient presents with. We try to gather objective data and we learn how to interpret subjective complaints before making difficult treatment decisions. We try to keep the objective separate from the subjective to allow us to make a good assessment.

When we were asked to assess each patient for pain at each visit (with the suggestion of using a 5th vital sign to quantify pain) it automatically caused confusion, because we mixed the objective (temperature, pulse, blood pressure and respiratory rate) with the subjective (pain). It is not very surprising then, that this mixing of incompatible groups of data ultimately caused major problems.

We also were asked to reconsider our opinion regarding the use of a class of medications that we were taught possessed a great potential for harm (dependency/addiction). We were told that the newer generation of semi-synthetic opioids were substantially less addictive and could be safely used for the treatment of chronic pain.

Around the same time regulatory agencies decided that physicians were not treating pain adequately. When the pharmaceutical companies understood what was happening (and perhaps they were involved in starting this process) a campaign commenced to convince us that what we had previously learned was incorrect. Many primary care physicians were approached and were told that the newly manufactured narcotic analgesics were excellent to treat pain and had a low potential for dependency. Soon many of us

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VIEW ONE

By Eddo deLang, MD

One

VIEW TWO

By Scott Noren, DDS

Two

acording to the CDC and other sources, the sheer number of pills prescribed in the U.S. is staggering and has steadily increased. “Health care providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills”.¹

When the numbers of pills prescribed is analyzed, about 50% of all opioid pills are prescribed by primary care physicians.² Has this massive increase in the number of pills prescribed resulted in higher rates of overdose and addiction? If so, what can be done to reduce the supply of narcotics to the public?

Prescribing narcotic medication in a surgery practice, such as mine, is generally short term. In rare instances this becomes long term (i.e. more than a week post op) and chronic pain management models then come into play.

Prescribing postoperative pain medication is necessary in surgical practices and results in a variety of patient experiences. Some state that they took as little as one dose of ibuprofen while some used both ibuprofen and acetaminophen/narcotic pain medication until exhausting their prescriptions. Others requested more of either one or both medications. The proper response when requesting more pain medication should always be to have a patient return for a postoperative visit to ascertain why they are having unusual or prolonged discomfort. There are relative norms for the amounts prescribed for given surgical procedures, although each situation is unique. It would be out of the norm for a surgeon to prescribe, say, #50, 600 mg ibuprofen and #50 acetaminophen/hydrocodone pills to a typical postoperative third molar removal patient. This surgeon or patient would definitely be suspected of abuse and or diversion of narcotic pain pills, as well deviating from reasonable standards of care.

While the quantity in my example of deviation would seem odd to most providers and even most patients, I can relate a real scenario in my practice which involved a patient receiving large numbers of narcotics from their primary care provider every month for a condition that had never been referred to a chronic pain provider. By crunching the numbers of pills prescribed over time, this patient would, theoretically, have to take one oxycodone tablet every 2.72 hours of every day of each month. This patient also reported to me that he and his wife were unsure what to do with the leftover pills they did not use.

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became generous in prescribing such medications and the system encouraged this by telling everyone that under-treating pain was considered a form of medical malpractice.

My skepticism for change probably protected me from accepting this new view. I continued to follow my old teachings that narcotic analgesics were innately addictive. Many discussions ensued with my patients that such medications were not needed, unless someone had an acute, very painful condition or was terminally ill. Most patients accepted my explanation and in retrospect I am very grateful that I was able to live by my old beliefs.

Everything became much clearer to me when our son started “experimenting” with drugs. Initially my wife and I did not recognize that he was in danger, but as the years went by we became very aware of the pain of his addiction. I can say out of personal experience that this addiction pain is in many ways worse than the pain of a patient with chronic pain due to spinal stenosis. Our son has suffered terribly and his journey is not something I would ever want to experience. He went through many failed rehab attempts, homelessness, jail and treatment for acquired diseases. We, as parents, were forced to stand by watching his life unravel, powerless and at times hopeless. Wondering if he would still be alive when we did not hear from him for months and dealing with his rage when he was home and had relapsed. If anything, I have gained a great deal of respect for the disease of addiction and I believe that I have become overall more empathetic through his suffering.

Little did the governmental agencies know when they promoted dangerous treatments to be used for pain that was often better treated in a different manner. There was (and still is) little understanding of the pain of addiction. I remember calling the ED physicians in our town explaining to them that 60 tablets of Vicodin were not needed for the pain of a sprained ankle. The responses I received when I made these calls were often shocking.

Now we are dealing with a nationwide addiction problem that will be difficult to treat. I hope that our profession can learn from this terrible experience by becoming more critical of every suggested evaluation and treatment change. We should continue to stand by our old oath: “first do no harm”. We need to find a better way to follow our professional judgement and not follow outside recommendations so easily in the future. Ask questions, be critical and talk with each other about illogical treatment modalities before using these. Mistrust is not always a good guide, but we need to continue to be critical and not accept what is recommended without hesitation. Let us try to avoid being guided by subjective complaints only. It is our duty to try to find measurable and objective ways to quantify pain and determine which methods of treatment have evidence of providing safe and effective pain relief.

Let us learn from this terrible experience and do better in the future. Consider the level of physical pain (after a complete assessment of the patient and not just based on a 5th vital sign number) and compare it with the chronic pain of the incurable illness of addiction and then try to make a wise choice for effective treatment. This is not an easy task, but we owe it to ourselves, our children and our patients.

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Eddo deLang, MD, is a family physician in Cortland and in McGraw, NY, and Residency Director of a rural family medicine track of the University of Buffalo in Olean, NY.
Extensive guidelines for chronic pain management are available from the CDC and the AAFP, internal medicine associations, and others. Yet in spite of this the past years have seen an explosion in the prescribing of controlled substances.

This led to the NYS legislature passing the law limiting opioid prescribing for acute pain. The law limits a provider to a 7-day initial period.1 But for chronic pain there is no limit and the vast numbers of prescription narcotics that have led to overdose, diversion, and as a bridge to heroin and other illicit drug use, is attributed to the post 7-day prescribing practices by providers, especially primary care and family practice medical doctors. A FAQ sheet regarding the law is referenced at the end of this article.

How many narcotic prescribers have read the 13,376 word CDC guidelines? The CDC guideline paper categorically connects the dots between increased sales and prescribing of opioid prescriptions and outcomes of overdose, deaths and opioid use disorder.2 They clearly blame opioid use disorder with decreased function at home, work and school. As the economics of productivity decreases, job loss and increased health care costs surely have a national effect on the GDP. The guidelines suggest referral to chronic pain specialists but in fact, such referrals are fraught with practical problems which limit them. These problems include: 1) only a one year certificate program in chronic pain management and 2) this is currently not a recognized specialty. There is a lack of chronic pain specialists, and lacking recognized specialty status with subsequent reimbursement does not encourage providers to become certified.

These guidelines mention a number of issues but provide very little firm data. They briefly mention bridging to heroin and illicit drugs but provide no statistics on conversion.

I question whether voluntary training in acute and chronic narcotic prescribing by medical societies, associations and government agencies has been effective in lowering the number of pills prescribed nationally. I believe that this reasonable first step is not enough and argue that this issue requires more aggressive actions that may involve more mandatory practice guidelines instead of voluntary guidelines for the management of chronic pain.

The answer in addressing the sea of pills coming out of primary care is based, I believe, on recommendations for a more aggressive line of action. These include:

1. Pharmacists are in part gatekeepers for the process of supplying narcotic pills to patients; they can be provided with software that would compute a time limit on primary care prescribing for chronic pain and requirement to refer to a chronic pain specialist.

2. We need to solve the need for more board certified pain specialists and to ensure they are distributed where needed. Congress should appeal to the American Board of Family Medicine with HHS input to create a board certification for a chronic pain residency program to help increase the national number of chronic pain specialists.

3. Providers, in conjunction with their specialty societies should come up with a grandfathering clause for current chronic pain specialists and the ABFM draft minimum new program requirements for a board specialty.

4. Congress must give incentives for grads to go into this new specialty like we did for rural medicine.

5. In the meantime, primary care providers who prescribe for chronic pain must be required in the first 3 months of prescribing to make mandatory referrals to specialists like orthopedics and neurosurgery or neurology as indicated, and primary care should be restricted from open ended, long term prescribing unless those other modalities have been thoroughly exhausted. A panel should be established of pain specialty providers to be accessed via the web to review cases NOT for punitive reasons but for an outside look at chronic cases that might need new approaches.

6. NY I-STOP has been helpful but it is limited by bordering state data base inaccessibility. We need the initiation of a federal narcotic I-STOP program. This is very popular amongst pharmacists. The drug lobby opposes anything that limits the spread of narcotic prescribing growth and they are allegedly, according to Ithaca Journal reporter John Roby, trying to expand into countries like China.

Additional input is needed by all impacted parties, but until we take the reins regarding chronic pain prescribing via a regulatory fashion, the epidemic will only continue to grow.

Endnotes
1 https://www.cdc.gov/vitalsigns/opioid-prescribing/
2 https://www.cdc.gov/mmwr/volumes/65/rr6501e1.htm

Scott Noren, DDS is an oral & maxillofacial surgeon practicing in Ithaca, NY, concentrating on CT guided implant surgery and bone grafting. He is active politically and has discussed the opioid issues with his congressman and with the office of the Surgeon General.
I became certified to prescribe buprenorphine in 2010, at a time when our office was providing medical services to a local residential drug treatment facility that was seeing a rise in the number of opioid addicts they were treating and saw a need for someone that could prescribe buprenorphine. I was initially reluctant because of concern that once I became certified, my office practice would get calls from folks in the community who were in need, and it was not the patient population I was looking to attract. I did not want my waiting room filling up with junkies and did not want to deal with the numerous no-shows that were expected with this population. At least these were some of the false beliefs I had at the onset. In any case, after learning that I could get certified to prescribe buprenorphine and limit its use to the residential drug treatment setting, I agreed to do it. I took the course and after basically 1 day of CME on the subject I became certified (and learned a lot in the process!).

I initially started prescribing buprenorphine for a small number of patients in the residential drug treatment setting, and limited it to this for a couple of years. During these initial years I had the odd call asking if I would prescribe buprenorphine at my private practice, but kept to my plan of not using it in the office. I turned people away, advising them to seek care for this elsewhere, not having a true understanding of just how difficult it was for people to access good care for their addiction and truly not understanding just how much of a difference buprenorphine could make in people’s lives.

Then one day a woman who I had been caring for for many years came in and described her battle with opioid addiction to me. She came to it like many people, initially getting prescribed opioids for pain management, then struggling to stop using them because of intense withdrawal symptoms that made it difficult for her to function and because of intense cravings that consumed her. We talked about buprenorphine, and after she made many calls to find a local prescriber without success, I agreed to prescribe it for her myself. And thus began my venture down the slippery slope. Over the next few months I recall having another patient in a similar circumstance, then a patient who was discharged from the residential drug treatment facility we were working with who needed a bridge prescriber until they could get in to see someone who had a waiting list almost 1 year long. I started prescribing buprenorphine for them too. Over time, I saw the difference the medication was making in their lives, recognized the paucity of available resources for buprenorphine in our community, and started to open up my practice to new patients in need of buprenorphine.

The decision to open up my office practice to folks in need of buprenorphine has been one of the most rewarding decisions I have made since I completed my residency over 20 years ago. The impact it has on not just my patients but on their families and friends has been shocking to me. Folks that haven’t worked in many years are keeping jobs and enjoying their day to day lives again. Young children who were taken from their homes and put into foster care because of their parents’ drug use have been reunited with their parents and grandparents. A young man whose addiction started at age 13 when his father handed him some of his pain medication, whose twin brother and best friend died of an opioid overdose over 2 years ago, who spent a couple of years incarcerated and who attended many drug treatment programs only to quickly relapse after leaving the programs, got onto Suboxone while attending outpatient drug treatment and has now been clean over a year and is now thriving as a carpenter. A young woman who was addicted to prescription pain medications she was getting from various ERs to help with her chronic back pain and who eventually took to street use was put on Suboxone and has become one of the top producing employees for the large national company she is working for. Another opioid addict who dropped out of school, lost rights to his kids and was stealing to make ends meet is now on the verge of graduating from college. He is running his own thriving business at the same time, and has been reunited with his children. A woman in her mid-20s who lost her kids because of her opioid addiction, started using buprenorphine about 2 years ago, worked hard to get her children back and now they are living together and doing well as a family. A man in his 30s with terrible social anxiety who sought care knowing I prescribed buprenorphine, was noted as having a worrisome skin lesion on his initial exam, and after getting on buprenorphine agreed to a biopsy that turned out to be melanoma. There is a good chance that if he could not find a buprenorphine prescriber he would not have sought care (his practice of many years), and his melanoma would have advanced and threatened his life. Another man who had overdosed seven times, once ending up with permanent neurological injury, has been put on buprenorphine and is doing great. His mother thanked me for giving her son back to her more times than I can count.

You are probably interested in how this works out for the office in general. While a few patients are challenging for receptionists and nurses, the vast majority are not. Since I am the only one in our group of 4 who is certified to prescribe, I have taken pains to inform patients that they must keep their appointments for evaluations and refills and if a visit is not required that they request a refill with plenty of lead time to allow for weekends and when I am away on vacation. A treatment contract helps ensure understanding. By these measures and by sharing with our office staff the extremely meaningful role buprenorphine plays in these people’s lives, our office team is on the same page in care. Do I discharge some patients for failure to comply? Sure, I have had to do so a few times. But they are the extreme minority.

There are many more positive stories I could share. At this point I have about 80 patients that I am currently prescribing buprenorphine to. The vast majority are pleasant, kind and highly appreciative of what we are doing for them. And I am grateful that they have, as a group, led me down this road.
Addiction is one of the most serious health problems of young and middle aged adults. More die from opioid overdose than MVAs. IV drug addiction can lead to HIV, Hep C, endocarditis and overdose deaths. Addiction to prescription drugs can also lead to overdose deaths, accidents, criminal activity and prostitution to support the addiction. It often leads to destruction of family, loss of job, depression and the list can go on and on. There is a paradox in that this disease has evidence proven treatments, but few people are able to access the treatment. While the medical profession is quick to refer any person with chest pain to a cardiologist, those with opioid addiction are often considered hopeless and not referred or helped.

Effective Interventions

Prior to the advent of buprenorphine there were three basic treatments which could work and are still available. One was long term rehab, halfway houses or residential communities. This was successful if the person wanted to get better and was willing to change their whole social network once they left the treatment center. Many of these treatment centers focused on the 12 step model. Others had a heavy religious flavor. This treatment is still available and useful for people who have multiple drug problems and an unstable social situation. It can be combined with buprenorphine or methadone. Many people will remain in the program and have long term success.

A second form of treatment was oral naltrexone, which worked in highly motivated people who took the medicine. Physician health programs used this successfully. Physicians motivated to keep their license would take the pills daily and not use opioids. Other people, however, would often stop the medicine or miss doses and relapse. Studies did not show significant success with oral naltrexone, but in some highly motivated selected patients who are part of a comprehensive treatment program, it can work. Now there is an extended release IM formulation of naltrexone (Vivatrol) so that people need an injection only once a month. In selected patients this is very successful.

Finally there was methadone. This was very successful for those who attended methadone clinics. The mortality rate for heroin addicts not on methadone was 30%. The biggest problem was and still is the lack of methadone clinics and the fact that patients have to go there every day. Methadone overdose is common, so in the United States methadone can only be given for addiction in a state approved program where people go daily and take the medicine as a liquid. Overdoses are rare in those who attend methadone clinics. The high dose of methadone patients are given blocks the effect of other opioids and eliminates most cravings. When people hear methadone clinic it brings up negative thoughts. In reality, for those who attend these clinics, it is life saving and many get their lives back together. Homeless people go to these clinics, but thousands of professionals also take methadone each day.

Opioid addiction treatment changed dramatically with the advent of buprenorphine in 2000. Unlike methadone, buprenorphine is very safe and can be given to patients to take at home. People can also receive prescriptions from their family doctor. Various studies support the use of this medication. Not only does it prevent overdose, HIV and Hep C, but people's lives are often dramatically changed. Physicians, PAs and NPs need an eight hour course to prescribe buprenorphine, which can be taken on line.
Most Treatable Diseases

A second group is similar to the first group, but they present with uncontrolled pain. Some may have hyperalgesia and may not admit to addiction. Buprenorphine is also an excellent treatment for pain and for hyperalgesia. Once they are off the other opioids and on buprenorphine, they may admit that they really had an addiction.

A third group of patients are similar, but they use other drugs or have a concurrent mental health disorder. They will need additional counseling. Although a certified family physician might be able to induce them quickly after an overdose, they may do better in an outpatient program where they can initially receive both medication and counseling. In some cases, the primary care doctor can provide the medicine and they can receive counseling elsewhere as long as the counseling program communicates with the physician. Two groups of patients who will benefit most from a comprehensive outpatient treatment program are those who have used multiple drugs starting in adolescence and lack basic educational and social skills, and those patients who continue to have positive urine drug screens for opioids, cocaine, marijuana, alcohol or other substances.

A fourth group of patients are those who have major social and mental health problems. They often need inpatient or a halfway house, but once they are in recovery they may do well being prescribed in a primary care office. Just as one talks about step therapy for hypertension or asthma, the same is true for addiction treatment. If a primary care physician misjudges and starts treatment, and the patient continues to use or their emotional and social problems become overwhelming, they can be referred to outpatient counseling and the outpatient program can refer them to an inpatient program and/or halfway house. Any patient you are treating whose urine drug screens remain positive for other drugs or alcohol in spite of your counseling needs referral for additional treatment.

Even if your patient is receiving treatment elsewhere, support them when you see them. Help them realize that they are very special because they were not afraid to get help and enter into recovery. If the patient relapses, get them back into treatment.

Patient Presentations

Patients can present to your office in two ways. Some come asking for help. If you cannot provide the help, arrange a referral from your office as you would with any other condition. Do not just give them a number to call. Initially, your office staff may not know who to call, but with practice it will become easier. Refer them with the same care you might refer a middle aged man with new onset angina and let the patient know you will want to know how they are doing. In some cases you can start the treatment. If they are in withdrawal and if you are certified, you can start buprenorphine. If they just had an overdose, you might elect to start the buprenorphine and then refer them. This is one of the ways that a family physician can save a life.

The second type of presentation is someone who is addicted or abusing drugs, but comes in for some other reason. If the reason is pain, offer buprenorphine as a way to relieve their pain. In all cases, be kind to these patients and see if you can motivate them to seek treatment. In the case of opioids, ask them if they have ever had an overdose, been arrested, or wished that they had not taken any of a certain drug. Ask if they are concerned about the money they spend or if their spouse or children are concerned. After a few of these questions you might ask: “Do you ever wish that you had never started these medicines?” If they give any suggestion that they might be sorry they did, let them know that very effective treatment is available and that you can refer them. If you are a prescriber of buprenorphine, you might even say, “If you want to stop, I can start your buprenorphine tomorrow.” Many drug addicts do not continue drugs because they like them, but because they fear withdrawal and feel there is no hope. In trying to persuade someone to get help, spend more time in providing hope than in telling them how bad it is. Ideally they should be telling you how bad it is and you offer the hope. When they return for some other acute problem, ask them if they are still using, having any problems or want to start medicated assisted treatment.
For Patients not ready to Stop

One very effective intervention is giving a patient a prescription for Narcan or telling them to buy Narcan in the pharmacy. Insurance will pay for the prescription for the patient. If you are talking to a family member, they can be instructed to go to a local pharmacy and buy it. The cost is around one hundred dollars for the nasal spray.

Another option is to refer them to a local outpatient program where they have training and give out free Narcan, or your practice might decide to have a local outpatient program do a training in your office and give out free Narcan to family members of opioids users.

For the opioid user who is not ready for treatment, there is more to prescribing Narcan than just saving their life. You are telling them: “You have a problem, you might die, and even though you are not interested in treatment, I really care about you. I do not want you to die. I hope you will come back and get treatment.” Drug use is contagious from person to person, but so is recovery. They may end up telling their friends that this person really cares and others may come for help someday.

One can also ask the patient if they use clean needles, offer HIV and Hep C testing. Again, this is part of showing you care. Needle exchanges do not increase drug use, but keep people safe. Good exchange programs try to motivate customers to accept treatment.

For practices that are concerned about the current opioid epidemic, there are some simple things that can make a big difference. First, know where there is a nearby outpatient treatment program. If possible, meet the director of the program. Make kind and effective referrals. Also feel free to call the program to get advice.

Second, have one or more physicians, NPs or PAs become certified in prescribing buprenorphine. If the practice does not want to take all comers, at least take patients who are already part of your practice and are struggling with opioids. Work with a treatment program. You may initially refer all patients there while you prescribe the buprenorphine for those who are stable, or you may want to start prescribing and refer patients who need extra help, continue with positive urines or are not doing well in other ways.

If you are not ready to prescribe buprenorphine but want to do something really helpful, sponsor a Narcan clinic. The outpatient program you work with will put it on for you. The practice can advertise it for patients or family members of those who use. The staff will instruct in the use of the medicine and distribute free Narcan kits. More important, they will answer many questions and let users and their families know that your practice and the outpatient program really care. Although there is very effective treatment, we need for users and families to overcome the stigma and feeling of hopelessness so that they can enter into treatment and recovery. There are few things in a family practice that is more satisfying than helping someone overcome an addiction.

Endnotes
1 Schuuckt, Mark K Treatment of Opioid Use Disorders NEJM 2916 375:357-368 July 26, 2016
5 PCSS MAT http://pcssmat.org
6 Weiss RD et al Adjunctive counseling during brief and extended buprenorphine/naloxone treatment for prescription opioid dependence: a 2-hase randomized controlled trial Arch Gen Psychiatry 2011 Dec 68 (12) 1238-40

Helpful Resources
Providers’ Clinical Support System -Medicated Assisted Treatment (PCSS - MAT) http://pcssmat.org. Through this site you can get certification, mentoring, and much helpful information.
Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol Tip series No. 40, Center for Substance Abuse Treatment, Rockville MD. Order print copies from SAMHSA.
*Medicated Assisted Treatment for Opioid Use Disorder” pocket guide available free on SAMHSA website: https://store.samhsa.gov/product/Medication-Assisted-Treatment-of-Opioid-Use-Disorder-Pocket-Guide/SMA16-4892PG

Norman Wetterau, MD is a family physician in Danville and Nunda, New York. He has developed an interest in addiction medicine and has over 150 opioid addicts on buprenorphine. He is past president of the New York Society of Addiction Medicine and past board members of NYSAP and of ASAM. He is Clinical Associate Professor of Family Medicine at the University of Rochester.

Naloxone Rescue

Most opioid overdoses are witnessed. Naloxone (Narcan) nasal spray can be lifesaving. You can provide this to appropriate people by registering as an Opioid Overdose Prevention Program for New York State. (One person can be a program.) It’s easily done, with a one-page application. You will be provided with kits containing two cartridges, each one containing 2 mg/2 ml. of naloxone for delivery as an intranasal spray. I posted a sign in our waiting room advising anyone who thinks they may ever be in a position to witness an opioid overdose to ask for a kit. I meet with interested individuals, assemble the syringes and instruct in their use. Rescued patients must still be brought to the emergency department as naloxone wears off in an hour, sooner than the opioid they’ve used. You can register by going to the website www.health.ny.gov/overdose or by emailing Clara.DeSanctis@health.ny.gov or mark.hammer@health.ny.gov. Narcan nasal sprays can also be purchased over the counter in N.Y. State (they contain 4 mg naloxone/0.1 ml), but many pharmacies don’t carry them, though they can be ordered. Cost is about $50-$80 but is rising. Medicaid and Medicaid managed care are supposed to cover them.

By Robert Bobrow, MD
The Choosing Wisely campaign, launched by the American Board of Internal Medicine in 2012, represents a multi-specialty, multi-organization movement to encourage the use of evidence-based diagnostics and treatment in medical practice, while recommending physicians not provide interventions found to be ineffective or harmful.\(^1\) Consistent with the theme of this month’s issue of Family Doctor, we will focus on the twelve Choosing Wisely recommendations we identified which deal with controlled substances. The recommendations have three main themes: pain, headache, and behavioral disturbance with one specific recommendation regarding pregnancy care.

The Choosing Wisely lists contain three specific guidelines, which mirror the 2016 updated CDC guidelines for opioid management in chronic pain.\(^2\) Each of the three guidelines we highlight recommend against starting opioids for acute pain or non-cancer chronic pain; two guidelines recommend an adequate trial of pharmacologic and non-pharmacologic alternatives prior to considering opioids.

In contrast to acute pain, opioids are not recommended in the first line treatment of non-cancer chronic pain. For patients with non-cancer chronic pain, behavioral and physical therapy should be attempted before starting any medication. According to the American Society of Anesthesiologists, non-opioid medication would be second line treatment, with opioid therapy as third line if no improvement with first or second line therapy.\(^3\) As with all medications, side effects should be considered. As such, opioids are not recommended for either acute or chronic pain in people who have safety-sensitive jobs (fork-lift operators, motor vehicle drivers, crane operators, etc.).\(^4\)

The American Academy of Physical Medicine and Rehabilitation guideline on acute disabling low back pain notes that providing and/or taking opioids early in treatment is associated with higher surgical rates, longer period of disability, and an increased risk of later opioid use.\(^5\) This guideline stands in contrast to the practice of short-term opioid therapy for acute injuries. We did not identify any current Choosing Wisely guidelines to support or discourage short-term use of opioids in severe pain.

A second theme we found in the Choosing Wisely guidelines was two guidelines that deal with the use of controlled substances in the area of treating sleep and behavioral disturbances. The American Geriatrics Society recommends against the use of benzodiazepines for patients with agitation, delirium, or insomnia.\(^6\) The use of benzodiazepines in these clinical situations increases a patient’s risk of falls, hip fractures, and nearly doubles the hospitalization rate. If sedative medication is necessary due to risk of patient harm, it should be given at the lowest effective dose for the shortest amount of time.

The American Academy of Nursing discourages the use of “PRN” sedative, hypnotic, or antipsychotic medications to prevent or treat delirium without assessing for underlying causes and using non-pharmacologic approaches.\(^7\)

For insomnia, the American Academy of Sleep Medicine (AASM) provides two guidelines regarding the use of medications for sleep. In adults, the AASM discourages hypnotics as primary therapy. Evidence-based treatments such as cognitive-behavioral therapy (CBT), a combination of behavioral modification and cognitive strategies involving stimulus control, sleep restriction, and replacing sleep fears with positive sleep expectations are first line treatments for insomnia. Of note, patients who have been on hypnotics for an extended period of time and been successfully treated may reasonably continue on hypnotics if they are reluctant to stop medication. The AASM guideline for children discourages the use of any medication for childhood insomnia; no current United States Food and Drug Administration approved medications exist for childhood insomnia; treatment should focus on parent-child interactions and behavior change. However, if the child has developmental or cognitive impairment, medication may be necessary as the child may not be capable of behavior change.\(^8\)

Two Choosing Wisely guidelines relate to the use of opioids and butalbital for headaches. The American Headache Society guideline recommends against the use of opioids or butalbital as first-line treatment for recurrent headache disorder increases on the basis of risks for developing addiction syndromes, the risk of developing chronic headache continued next page
disorder, and the risk for hypersensitivity to pain.\(^9\) The American Academy of Neurology guideline states that opioids and butalbital should not be used for migraine headaches, except as a last resort.\(^10\) This guideline points out that treatments such as triptans and NSAIDs are more effective; opioids should be reserved for patients with contraindications to or continue to have symptoms on first line therapies. In addition, use of opioids causes a decreased alertness.

A final Choosing Wisely guideline we identified dealing with controlled medications was issued by the American Academy of Nursing. This guideline cautions against the use of opioids during pregnancy, without a full consideration of side effects, risks to the woman and her fetus, and possible benefits.\(^11\) Possible side effects of opioids on a fetus include neonatal abstinence syndrome and developmental deficits and on the pregnant woman include increased rates of depression, anxiety, increased risk of preterm labor, poor fetal growth, and stillbirth. It has also been noted also that women using opioids during pregnancy had longer post-partum hospital stays.

Currently, there are ten guidelines by eight societies featured in the Choosing Wisely campaign discussing controlled medications in the setting of acute and chronic pain, headache, and behavioral disturbances. All eight societies represented by these guidelines consistently recommend against unnecessary opioid use in specified settings. These guidelines should be of use to family physicians in their outpatient, inpatient, and maternity work; these guidelines mirror those of the 2016 CDC guidelines on the prescribing of opioids in chronic pain as well as good clinical practice.

### Endnotes

## Pain

<table>
<thead>
<tr>
<th>Recommending Body</th>
<th>Guideline</th>
<th>Description &amp; Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Society of Anesthesiologists-Pain Medicine</td>
<td>Don’t prescribe opioid analgesics as first-line therapy to treat chronic</td>
<td>Consider multimodal therapy: behavioral and physical therapies prior to pharmacological intervention.</td>
</tr>
<tr>
<td></td>
<td>non-cancer pain.</td>
<td>If drug therapy appears indicated, non-opioid medication (e.g., NSAIDs, anticonvulsants, etc.) should be trialed prior to commencing opioids.</td>
</tr>
<tr>
<td>American Academy of Physical Medicine and Rehabilitation</td>
<td>Don’t prescribe opiates in acute disabling low back pain before evaluation</td>
<td>Early opiate prescriptions in acute disabling low back pain are associated with longer disability, increased surgical rates, and a greater risk of later</td>
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<td>and a trial of other alternatives is considered.</td>
<td>opioid use. Opiates should be prescribed only after a physician evaluation by a licensed health care provider and after other alternatives are trialed.</td>
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<td><a href="http://www.choosingwisely.org/clinician-lists/aapmr-opiates-for-low-back-pain/">http://www.choosingwisely.org/clinician-lists/aapmr-opiates-for-low-back-pain/</a></td>
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<tr>
<td>American College of Occupational and Environmental Medicine</td>
<td>Don’t prescribe opioids for treatment of chronic or acute pain for workers who perform safety-sensitive jobs such as operating motor vehicles, forklifts, cranes or other heavy equipment.</td>
<td>The use opioids has been consistently associated with increased risk of motor vehicle crashes. Evidence suggests higher risk with acute opioid use, but risk remains elevated throughout treatment with any opioid and reverses on cessation. Workers who operate motor vehicles/heavy equipment should be precluded from performing these or other safety-sensitive job functions while under treatment with opioids.</td>
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## Insomnia

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<tr>
<th>Recommending Body</th>
<th>Guideline</th>
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<tr>
<td>American Geriatrics Society</td>
<td>Don’t use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.</td>
<td>Large scale studies consistently show a doubling in the risk of motor vehicle accidents, falls and hip fractures leading to hospitalization and death in older adults taking benzodiazepines and other sedative-hypnotics. Use of benzodiazepines should be reserved for alcohol withdrawal symptoms/delirium tremens or severe generalized anxiety disorder unresponsive to other therapies.</td>
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<td>American Academy of Nursing</td>
<td>Don’t administer “prn” (i.e., as needed) sedative, antipsychotic or hypnotic medications to prevent and/or treat delirium without first assessing for, removing and treating the underlying causes of delirium and using nonpharmacologic delirium prevention and treatment approaches.</td>
<td>The most important step in treating delirium is identifying, removing and treating the underlying cause(s). Because numerous medications are associated with the development of delirium (e.g., benzodiazepines, anticholinergics, diphenhydramine, sedative-hypnotics), their administration on a prn basis should be avoided if possible. These medications should be administered only at the lowest effective dose, for the shortest amount of time, in patients who are severely agitated and/or at risk for harming themselves and/or others.</td>
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<td><a href="http://www.choosingwisely.org/clinician-lists/nursing-medications-to-prevent-or-treat-delirium/">http://www.choosingwisely.org/clinician-lists/nursing-medications-to-prevent-or-treat-delirium/</a></td>
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<td>American Academy of Sleep Medicine</td>
<td>Avoid use of hypnotics as primary therapy for chronic insomnia in adults; instead offer cognitive-behavioral therapy, and reserve medication for adjunctive treatment when necessary.</td>
<td>Cognitive-behavioral therapy (CBT) for chronic insomnia involves a combination of behavioral modification, such as stimulus control and sleep restriction, and cognitive strategies, such as replacement of unrealistic fears about sleep with more positive expectations. In clinical trials, CBT is generally as effective as or more effective than hypnotics. Some patients may benefit from a limited course of hypnotics while CBT for chronic insomnia is initiated. Patients who have successfully used hypnotics for extended periods and are reluctant to discontinue their current treatment regimen may be reasonable candidates for continued pharmacologic treatment.</td>
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<td>American Academy of Sleep Medicine</td>
<td>Don’t prescribe medication to treat childhood insomnia, which usually arises from parent-child interactions and responds to behavioral intervention.</td>
<td>No medications are approved by the US Food and Drug Administration for the treatment of pediatric insomnia. As childhood insomnia usually arises due to parent-child interactions, treatment should be behavioral interventions. When necessary, hypnotics should be used short term, with caution and close monitoring for efficacy and side effects. Some children with significant developmental delay or cognitive impairment may not respond to behavioral management and may benefit from judicious use of hypnotics.</td>
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<td>American Academy of Neurology</td>
<td>Don’t use opioid or butalbital treatment for migraine except as a last resort.</td>
<td>Opioid and butalbital treatment for migraine should be avoided because more effective, migraine-specific treatments are available. Frequent use of opioid and butalbital treatment can worsen headaches. Opioids should be reserved for those with medical conditions precluding the use of migraine-specific treatments or for those who fail these treatments.</td>
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<td>American Headache Society</td>
<td>Don’t prescribe opioid or butalbital-containing medications as first-line treatment for recurrent headache disorders.</td>
<td>These medications impair alertness and may produce dependence or addiction syndromes. They increase the risk that episodic headache disorders such as migraine will become chronic, and may produce heightened sensitivity to pain. Use may be appropriate when other treatments fail or are contraindicated. Such patients should be monitored for the development of chronic headache.</td>
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<tr>
<td>American Academy of Nursing</td>
<td>Don’t prescribe opioid pain medication in pregnancy without discussing and fully weighing the risks to the woman and her fetus.</td>
<td>In utero exposure to opioids can lead to risks for the infant, including neonatal abstinence syndrome (NAS) and/or developmental deficits affecting behavior and cognition. Women using opioids during pregnancy were shown to have higher rates of depression, anxiety and chronic medical conditions as well as increased risks for preterm labor, poor fetal growth and stillbirth. Women who used opioids during pregnancy were four times as likely to have a prolonged hospital stay compared to nonusers and incurred significantly more per-hospitalization cost.</td>
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The Opioid Crisis: A Call for Cross-Sector Collaboration in New York State

By Jocelyn Young, DO, MS and Michael Mendoza, MD, MPH, MS, FAAFP

National and local attention to the opioid epidemic is at an all-time high, and it remains so as most measures show the toll continuing to climb. According to the Centers for Disease Control and Prevention (CDC) more people died from drug overdoses in 2015 than in any other year on record. Additionally, the majority of those deaths continue to involve an opioid, a trend which has not changed. As of 2016, nearly half of all documented opioid overdose deaths involved a prescription opioid, namely natural and semisynthetic opioids and synthetic opioids other than methadone, though this data did not differentiate deaths that involved multiple opioids.

From 2014 to 2015 New York State experienced a 135% increase in death rates involving synthetic opioids, the largest percentage in the country. This increase includes synthetics such as tramadol and fentanyl but excludes methadone. Even more concerning is the trend of fentanyl being mixed with heroin along with other street and prescription drugs including methamphetamines, cocaine, quetiapine, and tramadol. As efforts are made to curb overprescribing of controlled substances, such as the Prescription Drug Monitoring Program (PDMP), we are unfortunately seeing patients with addiction turning to heroin among other drugs. In NYS, deaths from heroin use rose to an all-time high in 2014, and it climbed more than 25% from 2013. Alarmingly, half of all New Yorkers who died from a heroin overdose in 2013 were under the age of 35 years old.

The impact of opioids extends beyond their direct effect on health. A 2011 study estimated the total annual societal cost of prescription opioid abuse alone at $55.7 billion with those costs divided almost equally between workplace costs and healthcare costs, along with a smaller proportion attributable to criminal justice costs. A subsequent study went on to estimate the cost of lost productivity solely from nonfatal prescription opioid overdoses at $20 billion, a figure which included lost productive hours and productivity lost to incarceration. In total, drug abuse is estimated to cost $120 billion in lost productivity. Worse, these numbers fail to account for the ravaging effects of addiction on the patients themselves and their families. As of 2014, an estimated 7.9 million American adults suffered from a substance use disorder combined with a co-morbid mental illness making treatment even more complicated. The U.S. Department of Health and Human Services estimates that one in 10 children in the United States lives with at least one adult who suffers from a substance use disorder, and the majority of these children are younger than age five.

This complex epidemic cannot be tackled using any single approach. In order to curb this evolving epidemic, we will require a comprehensive and sustained response across multiple sectors in our communities and across the state. Because those with addiction often abuse prescription opioids, we have seen greater emphasis across the state to monitor opioid prescribing. The state-wide prescription drug monitoring program, (i.e., I-STOP), in New York State led to a 90% decrease in patients visiting multiple practitioners and pharmacies to obtain controlled substances by the end of 2015. New York State has also created a method to share PDMP information with New Jersey to begin to combat patients crossing state lines to obtain prescriptions. Along with these efforts, New York has increased funding to the Office of Alcoholism and Substance Abuse Services to provide more patient beds at many levels of care for those struggling with addiction.

In March 2016, the CDC released guidelines for prescribing opioids and New York State has gone further to require all prescribers carrying a DEA license to complete 3 hours of training in opioid prescribing by July 2017 and to repeat it every 3 years thereafter. Additionally, recent efforts at the national level seek to increase access to medication assisted therapy, specifically with buprenorphine. Physicians were initially capped on the number of patients they could prescribe buprenorphine to. Multiple advocacy efforts have led to increases in the number of patients each physician can prescribe buprenorphine to and beginning in 2017 there is a pathway for advanced practice providers to begin prescribing and monitoring patients.

Prescription opioids are only one aspect of the problem. Because most drug overdoses do not occur in healthcare settings, we must also pursue efforts to prevent unnecessary deaths from overdose by expanding access to naloxone (e.g., Narcan), especially within at-risk communities and settings. As of 2006, in New York State it has been is legal for non-medical persons to administer naloxone to another individual to prevent an opioid/heroin overdose from becoming fatal. Programs can apply to become

continued next page
registered to train members of the public on how to use naloxone obtained from the state to reverse a possible overdose. Thanks to these efforts naloxone was administered during 11,992 emergency medical services (EMS) calls in 2014, a 57 percent increase from the previous year (7,649 in 2013), and these numbers are probably an underestimate.2

However, expanding access to naloxone is only one step to address overdose. We must also address the underlying disease of addiction that places individuals at risk. On-demand treatment opportunities, particularly for those who are seen in the emergency departments for overdose, will decrease the chances that some will relapse. Efforts across the state are underway to create pathways for these patients to be seen by a buprenorphine provider within 24 hours of their presentation to the emergency department. Further steps to increase access to medication assistance therapy along with adequate counseling and follow up are needed in New York and across the country.

Finally, there is much work to be done to reduce the stigma associated with addiction. Only by viewing and treating addiction as a chronic disease can we change the perceptions. This will allow us to perform better screening, to treat with evidenced based practices through the initial stages and throughout the lifetime, to lead to recovery.

Endnotes
7 New York State Department of Health Bureau of Narcotic Enforcement (2016)

Jocelyn Young, DO, MS is a family medicine resident at the University of Rochester with a special interest in addiction medicine.

Michael Mendoza, MD, MPH, FAAP is a family physician and Commissioner of Public Health for the Monroe County Health Department. He is also Associate Professor of Family Medicine, Public Health Sciences and Nursing at the University of Rochester Medical School.
Overdose deaths, the spike in the incidence of addiction nationally, and the spread of hepatitis and HIV related to the use of opioids are a national health crisis. Overdose is now the leading cause of death for people under fifty. For over one hundred years the government has chosen to treat this crisis as an issue for law enforcement. Historically, millions of people have been incarcerated for drug offenses; billions of dollars have been spent on unsuccessful efforts to close borders to black market trafficking and take down distribution rings domestically, and allocation of resources to treatment programs were derided as being soft on crime.

During the 1800’s opiates and cocaine were mostly unregulated and were available to consumers from stores, pharmacies, mail order catalogues and physicians. In 1898, the Bayer pharmaceutical company began offering its formulation of heroin for medicinal use. Heroin was represented as being non-addicting, and therefore an efficacious treatment for morphine addiction, which was an affliction of Civil War veterans who used it for the chronic pain of war wounds. Bronchitis and tuberculosis were also treated with heroin. It was marketed for children to lessen the pain of teething, and for middle class women as a remedy for “female troubles”. Some estimates say that iatrogenic addiction made up two thirds of the addicted population in the late 19th century. In 1906, the American Medical Association approved heroin for general use, and recommended that it be used in place of morphine.

At that time, public policy and opinion was lenient and sympathetic to people who became dependent on opiates. They did not cause societal problems, and they received medication-based treatment from their physicians when their use became problematic. However, the dawn of the 20th century saw in the increasing numbers of immigrants an emerging population of addicts who sought out heroin solely for its euphoric effects. This group was younger, mostly male and very poor. These people obtained opiates from black market sources and committed crimes to pay for them. The stereotype of the opiate addict changed from geriatric war veterans and middle class housewives to foreign street criminals. This significant shift in public perception, along with the societal problems generated by crime, contributed to a shift away from the sympathetic view of addicts in the 19th century to a call for intervention by law enforcement.

In 1914 Congress passed the Harrison Narcotics Tax Act (also known as the Harrison Anti-Narcotics Act). This act was presented and passed as a method of regulating the production and distribution of opiate-containing substances. Later the act was interpreted by the US Supreme Court to criminalize the practice of prescribing opiates to addicts. Maintenance treatment using opiates on an outpatient basis was the commonly accepted protocol for the treatment of opiate addiction. This action marked the first legal move toward the eventual dominance of the viewpoint that drug addiction is a criminal condition over the view that it is a medical condition, and should be punished rather than treated. Although the Court later overturned the decision prohibiting the use of opiates in the treatment of addiction, neither public opinion nor policy has moved away from the view that addiction is a moral failing of individuals with criminal tendencies. That position has its roots in racism, xenophobia, ignorance, and the political strategies of state and federal officials.

In 1971 President Richard Nixon declared war on drugs. He characterized the abuse of illicit substances as “public enemy number one in the United States”. Under Nixon, the U.S. Congress passed the Controlled Substances Act of 1970. This legislation is the foundation of the modern drug war. In *The New Jim Crow*, Michelle Alexander writes that Nixon approved campaign ads that used “code” words like “criminal” or “protester” to stand for Blacks and Puerto Ricans. The “law and order” campaigns of both Nixon and George Wallace were subliminally aimed at targeting Blacks as being responsible for crime. This was the “Southern Strategy” aimed at creating a racially polarized electorate, and bringing the working class over to the position of conservatives.

In 1986 the Anti-Drug Abuse Act was passed by Congress. It changed the system of federal supervised release from a rehabilitative system into a punitive system. The bill enacted new mandatory minimum sentences for drugs, including marijuana. This act mandated a minimum sentence of 5 years without parole for possession of 5 grams of crack cocaine while it mandated the same for possession of 500 grams of powder cocaine. The Fair Sentencing Act of 2010 reduced this 100:1 disparity to 18:1. The 18:1 disparity is still in place. The 1994 Crime Bill, signed into law by President Clinton, introduced the infamous “three strikes and you’re out,” authorizing life sentences for drug sellers – regardless of the amount of drugs sold.

The upshot of the War on Drugs as waged over the past one hundred years is the mass incarceration of non-violent, low-level drug offenders. Sentences have been meted out with appalling racial disparity: Blacks make up approximately 13 percent of the population, yet they represent approximately 40 percent of the incarcerated population convicted of drug offenses. We are, today, precisely at the logical outcome of the War on Drugs “law and order” strategy. The policies of prosecution and incarceration were never meant to rehabilitate or treat people suffering from the disease of addiction. Despite arguments from experts who urged the adoption of a medical approach to the crisis, our highest officials have persisted in an unsuccessful, expensive and inhumane approach that has been an epic failure.

**Endnotes**

2 FN 2 Center for Substance Abuse Treatment, Medication-Assisted Treatment in Opioid Treatment Programs. Treatment Improvement Protocol Series, No. 43, DHHS Publication No. (SMA) 12-4214; Rockville, MD: Substance Abuse and Mental Health Services.

**References**


Gwen Wilkinson was a prosecutor in Ithaca, New York for over twenty years. She was elected to three terms as the Tompkins County District Attorney. Under her leadership, the DA’s office became a supporting participant in the local Treatment Courts. In 2014 she was named Co-Chair of the Municipal Drug Policy Committee, and co-curated “The Ithaca Plan.” She is currently the Interim Drug Policy Coordinator for Ithaca.
Many physicians, addiction professionals, politicians and the public have been perplexed about supervised injection facilities (SIFs). When this concept arose in the city of Ithaca proposal in 2015 to take a new and medically centered approach, I, too, was caught without any information to put SIFs into perspective.

This article will share research data and experiences gathered from around the globe over the past 37 plus years grouped into categories that family physicians are likely to find most important.

There are 97 SIFs globally in 66 cities in 11 countries (but none as of this writing in the United States) and only 2 in North America (both in Vancouver, BC). The New York State Academy of Family Physicians (NYSAFP) has written the New York State Department of Health announcing its support for pilot facilities in NYS. Reasons for this step can be gleaned from this article.

What is a SIF?
SIFs are sanctioned, supervised places for the self-injection/inhalation of client pre-obtained drugs (heroin, other opioids, other controlled substances) where trained personnel in a non-judgmental environment are present to take action in case of an overdose and create a long term relationship with users with the intent of: reducing their risk of infectious disease, assisting with their movement from use to recovery as their motivation allows, providing medical treatment for injection related illness (e.g. abscesses) and STDs, and providing sterile injection equipment (syringe exchange, clean works) to limit the spread of disease.

Drugs are not sold or provided within the facility and steps are taken to prevent opioid use from starting there. Chronic users are the clients. Given that users are a diverse population, SIFs will not meet the needs of all socioeconomic demographics but are an important access point for an important group of users. SIFs target clients are generally underserved and marginalized people, generally male between the ages of 20 and 50.

As a public health harm reduction intervention, SIFs operate as part of a wider, coordinated network of services, and also address the community impact of drug use. They help resolve health inequities, and public health and safety tensions related to public injection.

How does a SIF facilitate the medical model of treatment?
First, SIFs provide a location where an overdose can be immediately addressed. “Among tens of millions of supervised injections, only one fatality has been reported in any SIF - in Germany in 2002, attributed to anaphylactic shock.” In some instances the SIF’s effect on fatalities seems to have a “halo” effect. Insite, a SIF in Vancouver, BC, Canada was responsible for a 35% reduction in fatal overdoses in the area around the program compared to only 9% in the rest of Vancouver.

Second, SIFs provide a portal where the subset of users ready to take the next step to recovery can be referred to Suboxone/methadone treatment, a detox center, counseling and support/ rehab services. For the subset not ready to make a change, the SIF builds a long term trusting relationship that stands ready to assist the user to change when they are ready, but recognizes that some users will not be able to change. For these, the SIF reduces harm by preventing death and reducing the spread of disease.

Thirdly, SIFs have been “posited to reduce costs associated with this public health crisis by reducing needle re-use and sharing and, therefore, incidences of HIV/HCV/HEPB and soft tissue infections; reducing the costs to society of addictions and overdose deaths....”

In Vancouver, BC “Studies ... have estimated that the program incurs negative net
costs, reflecting both savings in cost and expected increases in life expectancy, and... annual savings of CAD $500,000 per HIV death and USD $660,000 per overdose death prevented..."15 People who inject drugs are estimated to comprise 56 percent and 11 percent of all new HIV and HCV infections in the United States (respectively)."16

A study estimating costs for a SIF in San Francisco modeled on Insite in Vancouver, BC concluded that, "a SIF in San Francisco would be an extremely cost-effective intervention, saving approximately $2.33 for each dollar spent."17

For SIF participants hospitalized for injection related infections the length of stay dropped from 12 days [IQR: 5-33] to 4 days [IQR: 2-7].8

Do SIFs encourage recovering addicts to relapse?
"SIFs do not increase drug use in the area, nor do they encourage young people to initiate drug use."9

What about abstinence-based treatment?
"Initially (in Vancouver, BC) there was strong opposition to the facility from providers of abstinence-based drug treatment, but engagement turned them into allies over time as they recognized [SIFs] role in referring participants to their treatment programs."10

Injecting narcotics is illegal – how have other countries addressed this?
Each location and society has found a way to allow for the operation of their SIF when they had the motivation to do so. Often it has involved a combination of efforts on the part of legislatures at the local, regional and federal level; community partners; public health; and the cooperation of law enforcement.

In Vancouver, BC, Canada, the SIF has operated since 2003 on an exemption from drug control laws through a “Section 56” waiver under a research pilot. It is now considered to be a healthcare facility.11 It is annually renewed. In 2011, the Supreme Court of Canada rendered a decision unanimously in favor of its existence partly based on its public health impact.12

In Frankfort, Germany, a SIF has been operating for 23 years and is fully licensed. Legal opinion found that the site was a medical facility, thus, clarifying the role of law enforcement.13

In Sydney, Australia, their facility initially operated under temporary exemptions requiring biannual re-certifications but now operates under a change in state law allowing participants to self-administer drugs and possess controlled substances.14

Why move away from the law enforcement model?
"Research has found that the war on drug’s policing strategies are associated with increases in HIV transmission risk... had a deleterious effect on public health. In addition to fueling some of the highest rates of incarceration worldwide, drug war supply-side strategies such as drug raids and crackdowns have had minimal, short-lasting impact and may lead to the displacement of drug activity zones."15 Injection in unsafe spaces (e.g., public bathrooms, parks, abandoned housing...) prompted by the threat of arrest exacerbates the potential for fatal overdose as well as HIV, HBV and HCV transmission.16 Injection in a hurried, furtive, unclean manner is not compatible with disease transmission prevention.

SIFs reduce public drug use and... demonstrated... significant reductions in the transmission of HIV and HCV, other morbidities such as abscesses, and a reduction of fatal overdose deaths."17

The law enforcement model has failed to effectively move individuals from their addiction to abstinence. It has clogged courts, jails, and prisons with users of a diverse background. Police officers are frustrated with the failure of the status quo and embrace a model that offers hope for the individual, reduces the hazard and nuisance of public injection, and refocuses law enforcement efforts on the truly criminal aspects of drug trafficking.

What has law enforcement said about SIFs?
In King County, Washington; Vancouver, BC; and Sydney Australia, SIFs garnered statements of support from their chief of law enforcement.18 In Vancouver, BC, 17% of SIF participants said the police helped them get to the SIF.19 In Frankfort Germany and Canada high courts have ruled in favor of SIFs. In Sydney, the SIF provides real time drug market monitoring data that can be used by law enforcement.20

What about the community – what do the neighbors say?
In urban settings, the data shows SIFs receive favorable community reviews. “Both the Vancouver and Sydney evaluations found some positive and no negative effects on the surrounding community. In both cities, there was a significant reduction in observed instances of public injection in the neighborhood. The numbers of discarded syringes and the amount of injection-related litter in the vicinity also declined substantially. In neither instance was there an increase in crime or drug dealing in the vicinity (although in Sydney there was a slight increase in the negligible level of loitering around the SIF). A series of surveys in Sydney found that area residents and business owners had experienced a sustained decline in exposure to public injection and discarded syringes following the opening of the SIF. Evaluators sought, but did not find, any evidence that the SIFs had encouraged new drug use or discouraged its cessation."21

What is the opinion of public health/medical societies?
The American and Canadian Public Health Associations and the Canadian Medical Association endorse SIFs saying, for example, they “... are one proven way of meeting the health and safety concerns raised by injection drug use.” The Massachusetts Medical Society and the NYSAFP have endorsed them. The NYSAFP has written the NYSDOH asking it to set up pilot studies in urban and rural settings.22
What about people who won’t use a SIF?
Just as diabetics are a diverse group requiring individualized approaches and care regimens, so are users. Naloxone, and other medically assisted therapy, detox, and rehab, must be available through many portals. Other target groups (such as IDUs who hold down jobs, have families, are professionals) require other approaches to engage them.

Unanswered or incompletely answered questions: Only through pilot SIFs in rural as well as urban settings can important questions be resolved through properly constructed studies. Such questions as:

Many of the SIFs are in urban environments - can SIFs be successfully scaled to smaller communities?

SIF’s cost effectiveness and efficacy are sensitive to the prevalence of the very problems they seek to mitigate. “… These include geographic concentration or dispersion of persons who inject drugs (PWID), prevalence of HIV and HCV, rates of SSTI [skin and soft tissue infections] care-seeking, overdose deaths, and needle-sharing. For example, the wider dispersion of PWID combined with the low HIV incidence rate in Toronto translated to a lower cost-benefit ratio for the introduction of a single SIF than in settings like Ottawa or Vancouver.” At what “break point” is a SIF not reasonable?

Additionally, community acceptance might be quite different in a small town setting compared to an urban one. If the community perceives the problem as intolerable, the arrival of a SIF and the reductions it brings will be well received. If the problem is less dramatic and the community small wherein problem neighborhoods are geographically a block or two rather than sections of an urban city, the community may not see as much relief and may perceive disadvantages.

The success of SIFs has resulted in Vancouver expanding its two sites into other cities and integrating them with other facilities. Montreal has been approved for 3 new SIFs, Seattle has endorsed two sites, into other cities and integrating them with other facilities. Montreal city, the community may not see as much relief and may perceive dramatic and the community small wherein problem neighborhoods it brings will be well received. If the problem is less perceives the problem as intolerable, the arrival of a SIF and the smaller town setting compared to an urban one. If the community

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The success of SIFs has resulted in Vancouver expanding its two sites into other cities and integrating them with other facilities. Montreal has been approved for 3 new SIFs, Seattle has endorsed two sites, and San Francisco and Baltimore are considering sites.

The global success of SIFs led the NYSAFP in June 2016 to ask the NYS Department of Health to create SIF pilots in urban and rural settings throughout the state. If SIFs work as well in rural settings as they do in urban - if they scale to communities of smaller size, then we need to use them to save lives and reduce harm.

The initial skepticism that SIF proposals evoke is reminiscent of our reaction to Syringe Exchange Harm Reduction programs in the 1990s. Syringe exchange has proven to be highly efficacious and brought none of the “normalization of drug use” that its detractors feared. Global data on SIFs also refute detractor’s arguments.

References


William Klepack, MD, practices family medicine with Dryden Family Medicine in Dryden, New York and is Medical Director of the Tompkins County Health Department. The content of this article is not meant to reflect an official position of the Tompkins County Health Department.
Overview

Interprofessional team collaboration as a skillset needs further refinement in education and further analysis regarding outcomes. An interdisciplinary team created to address the issue of patient violence in an ambulatory pain management clinic at Bronx Lebanon in New York City resulted in desirable outcomes in multiple parameters. A sample of 538 retrospective chart reviews showed changes in opiate prescribing practices, decreases in patient violence and improved patient and provider satisfaction.

Introduction

The use of prescription opioids to treat pain in the United States increased 10 times in 20 years between 1989 and 2009.\textsuperscript{5} Locally in New York City, in 2009, one out of four unintentional drug poisoning (overdose) deaths involved prescription opioids, excluding methadone.\textsuperscript{2} In March 2016, the Center for Disease Control published prescribing guidelines for chronic pain to address this analgesic misuse and abuse.\textsuperscript{3,4} These guidelines aligned with existing protocols initiated by the Department of Family Medicine at Bronx Lebanon Hospital Center in 2013. Along with providing effective healthcare and improving the lives of our patients, provider safety and high quality medical care must be assured.\textsuperscript{6} The discord between medications desired by patients and those actually prescribed may increase the risk for violence and conflict in the clinic.\textsuperscript{7}

From 2002-2013, incidents of workplace violence requiring time off for recuperation were four times more common in healthcare than private industry.\textsuperscript{8} Workplace violence has been sub-classified by the World Health Organization (WHO) as either physical or psychological.\textsuperscript{8} Internationally, about 10\% of health care providers report physical violence within the prior year, while more than 70\% report physical violence at some point in their career. In the healthcare industry, 80\% of incidents were caused by interactions with patients. Healthcare workplace violence is widespread, underreported, costly, and preventable. The Occupational Safety and Health Administration (OSHA) recommendations for violence prevention include five key components: 1. Management commitment and worker participation, 2. Safety and health training, 3. Worksite analysis and hazard identification, 4. Recordkeeping and program evaluation, and 5. Hazard prevention and control.\textsuperscript{7} The 2015 OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers characterizes the risk factors for healthcare workplace violence as both patient, client and setting-related, and organizational. Working directly with people who have a history of violence, abuse drugs or alcohol, or are gang members are listed as risk factors. Tapering or discontinuation of opioids is not listed.

Methods

In 2013, a pain management clinic was established in Bronx Lebanon’s Department of Family Medicine. Specific quality improvement goals were to increase patient satisfaction, decrease patient admissions to the hospital and emergency room visits for opiate related overdoses, decrease violent incidents in the clinic, change provider prescribing practices, and increase clinic volume (productivity). An interdisciplinary team was chosen to provide social support, increase the modalities available to patients, and increase the reservoir of creative environmental solutions at each location throughout the clinic from patient entry to exit.\textsuperscript{10-14} Formal meetings for team support and case review were needed to formalize changes in policy, and informal ad hoc communication and learning were encouraged to foster team building and enhance an holistic perspective of patient centered care.

Behavioral health care providers and a physiatrist were available as consults for patients by referral. Initially, providers saw their own pain panel with infrequent referrals for ancillary care.\textsuperscript{15} Currently, providers who are prescribing pain management medications adhere to current standard guidelines, which include a formal pain contract with patients, a review of the Pain Management Registry (PMP), and the “one provider and one pharmacy” rule.\textsuperscript{16,17} Interprofessional education for the team (the clinic manager, five medical doctors (MD), three osteopathic doctors (DO), a doctor of clinical nursing practice, family nurse practitioner and licensed acupuncturist (DNP/FNP/L.Ac), two social workers (LMSW, LCSW), a licensed practical nurse (LPN), a registrar and a patient care technician (PCT)) was conducted on site and at monthly team meetings, during which goals such as revisions of pain contracts and clinic policies were set as agenda items. Pain management team meetings also set aside time to discuss specific cases found to be successful examples or models for improving quality parameters.
Additional monthly team meetings including primary care, behavioral health and pain management were conducted to foster social support and convey hospital-wide updates, and group emails with informal updates shared new evidence or progress on cases. On site daily huddles allowed for informal announcements, and registrars, nurses, medical assistants and the clinic manager frequently collaborated one to one with the integrative providers to ensure enhanced patient care.

The blended informational platforms (both for education and informal learning) were constantly modified according to the learner’s schedule, current learning potential, and specific patient cases. Emails and articles could be read when the learner had spare time and specific cases discussed informally could be escalated to discussion at a formal team meeting.

Results / Findings:

The combination of formal education and informal learning processes changed clinic workflow and structure. Structured meetings and seminars combined with ad hoc communication resulted in highly visible measures of progress. The fusion of education and learning was grounded in problem-based learning through clinical case review, self-directed learning, and knowledge as a team.

Physiatry and behavioral consults are now mandatory for patients. After a full initial evaluation, patients may choose from evidence based management options. Cases are discussed among providers for learning purposes or for assistance. The clinic fosters healthcare provider collaboration with patients to create and evaluate interventions in an ongoing manner.

Prescribing practices have changed significantly, with less than 5% of patients seen at the pain management clinic receiving opiates without an established plan to taper down dosing. In comparison, when this clinic was established, more than 90% of patients were prescribed ongoing opiate medications, with no intention to wean. Frequent communication led to improved adherence to patient screening and to patient outcomes. Preset agendas to update the pain management contracts as well as informal discussion of cases between providers led to desirable outcomes. In 2016, there was a 45% increase (compared to 2013) in signed contracts and (random) urine toxicology screening. Providers now document their review of the PMP 100% of the time, with a reduction in prescription redundancy and diversion. Sharing specific cases in which the PMP reinforced or contradicted a patient’s narrative encourages providers to comply with regular PMP review. These measures are part of the noted changes in prescribing practices.

Clinic volume has increased. The number of clinic patient visits increased by 23% from 2014 to 2015, well exceeding clinic goals.

Patient satisfaction has also increased. Comparing Octobers 2015-2016 to 2014-2015, there was a 50% decrease in formal complaints filed against the clinic by unsatisfied patients.

The number of violent incidents in the clinic has decreased. The clinic manager addressed unacceptable patient behavior approximately 120 minutes per week from October 2014 through October 2015 for an estimated five pain patients. This typically involved de-escalating potentially dangerous situations, often in the presence of an armed security guard. In the past six months, these occurrences have been reduced to approximately 20 minutes of work time spent with a single patient weekly, and rarely involved security personnel. This was an 84% decrease in time that the clinic manager spent with patients de-escalating violence.

Continuing education and learning among the entire clinic staff, from registrars to medical providers, has created a safer and friendlier work environment. Patients are no longer coming to clinic in expectation of an opiate prescription. Instead, they are informed early and often in their visit about the formalized guidelines and protocols that the team follows and practices.

Conclusions:

During the year in which the clinic volume increased, there was an overall decrease in number of opiate prescriptions, morphine equivalents when prescribed, and in violent outbursts or incidents in the clinic. Patient satisfaction and clinic safety improved. A cultural paradigm shifted in expectations of patient, provider, and staff in our ambulatory outpatient clinic as a result of creative responses from team members.

Discussion:

These initial numbers serve as a foundation for future direction and questions to address. Do patients who attend physical therapy also use other hands on modalities? Do patients who utilize acupuncture have a greater inclination for talk therapy, mindful meditation and osteopathic manipulation? How can we increase the satisfaction and accessibility for modalities to which patients are using?

Would the integrative team and adjunct modalities model transfer to sites in other settings to offer support during the opiate epidemic? Is this model of clinic (and case) based learning, the best way to train future learners? How can solo practitioners incorporate aspects of a group model? In an office with limited providers and in consideration of training and treatment time, acupuncture is often the most time efficient and volume boosting of the options we offer. In a larger site where many people with varying skillsets/interests are working together, many of these options should be teachable.

It is our hope that the strategies and policies of this ambulatory chronic pain management clinic can be further adapted to assist more patients with detoxification from opiate dependency.
Endnotes
9 (OSHA) OSHA. Guidelines for preventing workplace violence for healthcare and social service workers. OSHA. 2015(No 3148-04R).
12 Health NIf. NIH review finds nondrug approaches effective for treatment of common pain conditions. 2016.
20 Jacob JA. As Opioid Prescribing Guidelines Tighten, Mindfulness Meditation Holds Promise for Pain Relief. JAMA. 2016;315(22):2385-2387.

Lisa Morrow, DNP, FNP, L.Ac is very grateful for the generosity, enthusiasm and talent of this amazing team that is also ever ready for reflection and evolution.

Russell Perry, MD has elicited more Hepatitis C cures than any other provider in NY State (at time of publication). As faculty at Bronx Lebanon for decades, he continues to train hundreds of medical students, residents and peers in primary care and infectious disease best practices.

Sri Lakshmi Kadiyala, MD is a compassionate, caring physician trying to improve the quality of health for the patients she serves.

Robert Simon, MD is a Diplomate of the American Board of Physical Medicine and Rehabilitation with subspecialty certification in pain medicine. His main interest is in musculoskeletal medicine as it relates to the health and fitness of his patients.

Tracy Sin-Yee Tam, DO is a person devoted to patients, family, and friends and always striving to look at things in a positive way.

Inyanga Mack Collins, MD thrives in the environment she creates with her students and patients, which is a safe place for healing and learning.

Jose Tiburcio, MD attends to his patients and teaches his residents based on the concept that prevention is better than treatment of disease.

Michael Sledzinski is a coach and teacher at heart, compassionate and empathic, ambitious and curious, and determined to improve the lives of everyone he interacts with.

From the Editor

It is with great sadness that we report the recent death of Dr. Tracy Tam, one of our co-authors featured in this issue of Family Doctor. Dr. Tam was shot and killed on June 30th while covering for an attending on vacation on the family medicine floor at Bronx Lebanon Hospital. Dr. Tam’s friend and co-author, remembers her with these words:

“Dr. Tam was sincere and kindhearted with a lightness of spirit guided by her laser focus to serve and help others. She joined our group 1 year ago and has blessed our clinic with calmness, sureness and a peaceful presence since day one. She was in her early 30’s, and her sudden loss is unspeakable and unfair. She so loved life and all those around her, and looked forward to each day with a grace that spread to those around her. If we can get safety laws in place, and advance healthcare and humanity along the lines I believe she would have encouraged- that will be honoring her life.”

NYSAFP wishes to offer our sincere condolences to Dr. Tam’s family, friends and colleagues who have been impacted by this senseless tragedy.
The news is full of statistics and stories about opiates. The burgeoning numbers of opiate overdoses and the toll opiate dependence is taking on all ages has brought the problem to the national stage, and has forced family physicians to pay attention.

Among those age 15–44 in some counties in New York as many as 41% of all deaths are caused by drug overdoses: in Westchester 25%, Sullivan 41%, Putnam 29%, Orange 36%, and Rockland 29%. Where fentanyl entered the heroin supply, overdose deaths have climbed steeply.1

Use of heroin/fentanyl burgeoned after implementation of policies to reduce availability of prescription opioids coincided with an influx of high-potency, low-priced heroin/fentanyl analogs.2 Deaths attributable to fentanyl and its analogs were 72.2%, to heroin 20.6%, and to prescription opioids 2.6%.3 In the United States, recent fatalities have also been attributed to fentanyl in counterfeit Xanax (alprazolam), Norco (acetaminophen-hydrocodone), and other medications.4

Opiate dependence is a medical condition with ICD-10 code F11.20. Strong scientific evidence unequivocally shows that for opioid use disorder, medication is the essential component of treatment.5 Opiate dependence can be treated effectively with methadone (used since 1970), buprenorphine (developed initially for pain control, prescribed as treatment for opiate dependence in the US since October 2002); and naltrexone (the newest of the three). Buprenorphine is the generic name for the partial mu agonist in brand name compounds including Suboxone, Zubsolv, Bunavail, and Probuphine (an implant). Naloxone is the second ingredient, an antagonist added to prevent attainment of a “high” especially if the powder is injected. Formulations of Suboxone are buprenorphine-naloxone in a 4:1 ratio, and come as sublingual tablets or films. I have had 13 years’ experience as a family physician treating opiate-dependent patients with Suboxone, so in this article I will concentrate mostly on it, called by some, a “miracle” drug. Approximately 42% of patients in treatment with buprenorphine plus naloxone or with methadone remained consistently “low users” of illicit opiates for 55 months after entering a medication trial.6

Suboxone is a Schedule III drug, and in order to prescribe it for opiate dependence, one must take a course and obtain a DATA waiver, which comes with a special DEA number to use on buprenorphine prescriptions. There is a cap of 30 patients initially, which may be increased to 100 or even 275 patients.

According to Patrice Harris, MD, chair of the AMA Opioid Task Force, more than 30,000 physicians have obtained a waiver to treat patients with substance-use disorders with buprenorphine. However, only a small number of physicians treat patients with opioid-use disorders and, of those who do, most do not treat up to their cap. Only 20% of patients who need treatment for opioid-use disorder are receiving it.7 As of 2013, only 4530 family physicians had a DATA waiver to prescribe buprenorphine.8 Why do many family practice doctors decide not to become credentialed as Suboxone doctors? As one doctor wisely suggested, too little recognition is given to how a relatively small number of opiate-dependent patients can dominate and monopolize a doctor’s practice.

Here are some suggestions for fitting the needs of these patients into an otherwise busy primary care practice:

- To save time, one medical assistant/clerical staff member should be the designated person for obtaining prior authorizations.
- Respect the cap on patient numbers; know how many current buprenorphine patients you have. (A Department of Justice rep visited me just once in 13 years, “to touch base.”)
- Firmly require tox screens: No sample, no prescription.
- Prescribe weekly at first, and advance gradually, with good compliance, to monthly.
- Use urine cups with a temperature strip.
- Collect urine samples on Mondays (since weekend drug abuse is more common than weekday). Do oral swabs randomly. Though not as sensitive or comprehensive, their source is indisputable.
- Check the NYSDOH HCS site for each new patient’s controlled drug history and document what you find (include out-of-state prescriptions).
- If patients have taken Suboxone previously, ask what that dose was, and how they felt on it.
- Provide starting patients with 16 mg/day, but tell them to use less, if cravings are satisfied.
- No patient ever needs more than 24 mg/day. Tapering Suboxone requires months; don’t rush.
- If patients come to you on street Xanax, substitute low dose long-acting benzodiazepines (usually 1 mg Klonopin per night) to prevent a withdrawal seizure.
- Discuss risks of high dose benzodiazepines with any opiate.
Find a lab that will fax results to you promptly. These results are necessary to determine the course of treatment. Test for illicit opiates, benzodiazepines, cocaine, and alcohol. Ask for norbuprenorphine/creatinine determination, which should be generally consistent for a patient.

Buprenorphine may be a miracle drug, but it does not work if the patient does not take it; norbuprenorphine (metabolite of buprenorphine) tells you they take it. Some patients will deliberately not take it when they plan to get high. These patients need more counseling, or perhaps an inpatient rehab program. After inpatient treatment or jail, they should be allowed to return to Suboxone treatment as soon as possible.

Addressing the psychosocial aspects of addiction requires counseling. Opiate dependence, more than most medical conditions, unravels a patient’s social structure, regardless of the family’s financial situation at the time opiate dependence began. If you are a family practice doctor who enjoys counseling, opiate-dependent patients will flock to your practice. However, it is difficult balancing counseling these patients with the needs of your other patients. One doctor wrote, “I have yet to meet a family physician who provides this service and is continuing with a traditional family medicine practice.” Well, I was such a physician for 10 years, so it can be done, but is stressful. Now, at age 74, I am working only 19 hours a week, confining my practice to patients who need Suboxone. I work in a clinic that has counselors, mental health workers and a psychologist. For a younger family doctor with a full primary care practice who wants to treat opiate-dependent patients, too, the ideal is to treat with buprenorphine and coordinate psychosocial care with a counseling service, a private psychiatrist, or a social worker.

Suboxone treatment should continue for at least a year, during which time the family doctor can screen for HIV and HCV, do routine immunizations, and attend to dental, ophthalmic, and orthopedic problems that have been neglected. On Suboxone, testosterone and estrogen levels return to normal (having decreased during opiate abuse), and women will need birth control or perhaps obstetrical care. Constipation usually improves rapidly during treatment with buprenorphine, and can be managed with occasional senna, more water and exercise. Many patients will be interested in quitting smoking, and will be glad to receive the usual aids. Insomnia goes away when the patient stops smoking close to bedtime and begins to exercise in the morning. Life improves: One patient proudly confided that he used earnings from his new job to buy back from a pawnbroker jewelry he had stolen from his parents (to support his drug habit), which he returned to his parents.

Many of my opiate-dependent patients who never had a problem with alcohol enjoy the support of AA meetings. A situational depression occurs frequently in patients in their first month of treatment, related to awareness of their environment after months or years of being solely focused on obtaining opiates. It seems to result from comparing their financial circumstances with those of relatives and peers who never abused drugs. This transient depression usually does not require medication for treatment, just reassurance that they will catch up quickly, if they remain compliant and work or attend school. Those patients who have dual diagnoses of substance abuse and psychiatric disorder should be evaluated by a psychiatrist. Among patients with opiate dependence, comorbidity with depression, bipolar disease, and anxiety is more prevalent than in the general population. On the basis of 56,391 total observations from 2009 to 2011, representing an estimated 1.18 billion ambulatory visits at general medicine ambulatory settings by adult patients, anxiety was the most prevalent comorbidity. It was found in 13.4 percent of patients with, and 3.5 percent of patients without, substance use disorder. Anxiety interferes with a patient’s return to normal social function. Buspar, the SSRIs, propranolol, and benzodiazepines can be considered for treating anxiety in the opiate-dependent patient. Buspar and SSRIs have a slow onset of action, and because impatience accompanies anxiety, these two medications are not as desirable as propranolol and benzodiazepines. Propranolol, 10 or 20 mg pm, maximum 40-80 mg per day in patients with no complaints of sexual problems, fatigue, or bradycardia can be helpful, especially during the weeks waiting for SSRIs or Buspar to become effective. Low-dose long-acting benzodiazepines work well, but there is controversy about their use. Richard Saitz, senior editor of the Journal of Addiction Medicine, provided a valuable forum for this debate. Two doctors presented opposing views and Dr. Saitz summarized their arguments with the reassuring statement that, “in the end, their conclusions were not that far apart.”10-12

Dr. DuPont, presenting the con side, stated it is possible for the anxiety of opiate-dependent patients to be treated with counseling (medication is unnecessary). However, he conceded that physicians might occasionally prescribe benzodiazepines to patients with substance use disorders, if this is done cautiously and after educating these patients about the risks. Dr. Park, on the pro side, discussed alternative medications, but prefers benzodiazepines because of their rapid onset of action and proven efficacy; he says they are better tolerated, as long as they are prescribed in a way that minimizes harm. Dr. Saitz commented, “As with most debates worth having, the answers are neither simple nor absolute. If they were, there would be no need for debate. Our patients deserve no less than to have their conditions carefully diagnosed and to have the risks and benefits of treatments carefully considered so that they can get the best individualized care. Such care is unlikely when statements such as ‘we never/always treat with . . .’ are the starting point.”10 Dr. Saitz recognizes that not everything is a black-and-white decision, and in the end, primary consideration needs to be given to the patient’s medical welfare and values.13

OASAS recommends that no benzodiazepine be prescribed to a Suboxone patient. Some of my Suboxone patients, doing well on low dose Klonopin, have been directed by drug court to stop Klonopin or they will be considered in violation of the court and punished. Drug court, an alternative to parole or jail/prison time, offers an opportunity, if treatment is completed, for someone convicted of a non-violent drug-related crime to have their record sealed (which means...
it does not have to be disclosed on employment applications, and eligibility is restored for student loans, certain housing assistance and voting rights). There are over 100 drug courts in New York. Their aim is to provide highly supervised coordination between the legal system and medical treatment providers.

When Klonopin was stopped by drug court in one case, the patient who had been working and was in a good stable relationship with his girlfriend, couldn’t sleep, argued with his girlfriend and ended up going to jail. Nothing positive was achieved for this patient by taking away the medication that helped him sleep and avoid excessive anxiety. Assuming our court system is beneficent and not just punitive, it reflects a lack of knowledge about varying effects of different drugs and different doses. The American Society of Addiction Medicine is looking into this policy.

There is no doubt that illicit opiates, such as fentanyl, heroin, and oxycodone, combined with street Xanax can kill. It is important to make a distinction between street opiates and the drugs used to treat addiction. In addition, methadone is different from buprenorphine in important ways. Methadone is a full agonist at the mu receptor site and has a longer half-life than buprenorphine. A patient can get “high” on methadone at sufficiently high doses, but not on buprenorphine-naloxone. Methadone can cause respiratory depression. Buprenorphine has the advantage of being only a partial agonist; hence negating the potential for life-threatening respiratory depression. Buprenorphine has the advantage of being only a partial agonist; hence negating the potential for life-threatening respiratory depression in cases of abuse. Thus, the risk of overdose death in patients taking Suboxone is highly overstated.

Benzodiazepines are different from one another, with different half-lives and indications. Xanax is short-acting, habit-forming, and considered the most dangerous of the benzodiazepines. The substitution of Klonopin for Xanax will prevent a benzodiazepine withdrawal seizure, and, if taken as directed, only at nighttime, will promote good sleep without morning grogginess. Klonopin’s effects on anxiety last up to 100 hours. Valium, another long-acting benzodiazepine, in low doses is useful for some patients who suffer from limb tremors related to their anxiety. Patients on low dose benzodiazepines prescribed by physicians have been shown to be compliant with their medications and distinctly different from those termed “problematic users”.

Some patients tell me they had anxiety before opiate addiction, and were never treated for the problem. Most who receive low dose long-acting benzodiazepines to treat insomnia and anxiety never escalate the dose and are fully compliant with both Suboxone and benzodiazepine regimens. In one study, 40% of persons surveyed used a benzodiazepine in the month prior to admission, and 25% of these met criteria for benzodiazepine dependence (DSM IV). Benzodiazepine users averaged 32.0 years of age, 63.6% were male, 85.2% used heroin, and reported, on average, 13.3 (±11.2) days of benzodiazepine use during the past month. Alprazolam (Xanax) was the most commonly used benzodiazepine (52%), and buying it on the street the most common source (48%). The most commonly reported reason for benzodiazepine use was ‘to manage anxiety’ (42.6%), followed by ‘to get or enhance a high’ (27.7%), ‘to help with sleep’ (11.4%), and ‘to decrease opioid withdrawal’ (10.2%). The most common reason for benzodiazepine use was significantly associated (p<.001) with the source, with persons who got their benzodiazepine from a prescriber (23%) more likely to report anxiety as their primary reason for use, while persons who bought it on the street (48%) had the highest likelihood of reporting use to get or enhance a high.

Opiate-dependent patients who are being treated with buprenorphine drugs are extremely grateful. Some need concurrent anxiotylitics. Seeing patients resume normal lives, get good jobs and establish strong family ties is rewarding. It is sad that many are not able to find a family doctor for treatment. Co-morbidity of anxiety and opiate dependence makes management of these patients difficult, but with the usual resourcefulness that made us choose to be family doctors, we can overcome a lot of the problems. Perhaps this article will help more family practice doctors choose to treat opiate-dependent patients, with benefit to all concerned.

Endnotes
1 New York Times 4/14/17, Josh Katz, You Draw It: Just How Bad is the Drug Overdose Epidemic?
8 Information from 2013 Medicare Part D data and the US Drug Enforcement Administration’s DATA waiver roster. Now it is time for all family physicians to consider offering services to at least some of these patients.

Valerie Heemstra, DO, MSc, received her medical degree from the University of New England College of Osteopathic Medicine and her master’s degree from Rhodes University, in South Africa. She is board-certified in family practice and medical director at Innovative Health Systems in North White Plains, NY, where she has approximately 90 Suboxone patients. Prior to 2016 she did full family practice in community health centers in the Boston area and in New York State.
The prevalence of opioid use disorder (OUD) among reproductive-age women is increasing, along with the incidence of neonatal abstinence syndrome (NAS). Medication-assisted treatment (MAT): buprenorphine or methadone maintenance combined with behavioral therapy, is the recommended standard of care for pregnant women with OUD. However, women with OUD who are pregnant and/or parenting small children have multifaceted needs that often include social, emotional, and environmental challenges, and insecurity regarding their parenting knowledge and skills. To improve the care of these patients while acknowledging their complex needs, we developed a voluntary in-office health education and risk reduction group for pregnant and/or parenting women with OUD who are also receiving MAT. Unlike traditional chemical dependency group models, this format emphasizes health education and mutual support, not therapy. Topics are tailored to participant needs and interests, such as NAS, labor and delivery on buprenorphine, hepatitis C, the science of addiction, and encountering stigma. Patients have responded favorably to these groups. This article offers family physicians insights for treating pregnant or parenting patients with OUD, and provides practical guidelines on how women’s health education and risk reduction groups can be incorporated into existing office routines.

Development of Health Education and Risk Reduction Group

A weekly health education and risk reduction group was created for pregnant and/or parenting women prescribed buprenorphine for OUD at an outpatient medical practice in a suburb of Buffalo, New York. These groups were developed in response to research highlighting deficits in parenting knowledge among women in this population. The aim was to increase parenting skills and confidence for women in recovery while providing a “safe space” for them to learn from each other, create healthy, supportive relationships with other mothers, and to foster greater commitment to recovery. The only eligibility criteria was motherhood (pregnant or having children under the age of five years old), active status in treatment, and a willingness to share and learn from other women. Some women were pregnant for the first time, while others had multiple children.
This group is distinct from traditional group models found in chemical dependency and inpatient treatment centers due to its emphasis on health education, risk reduction, and mutual help and support, rather than psychotherapy. Additionally, this group places specific emphasis on women’s issues and the experience of motherhood in the context of recovery. The female-only environment provides a safe space for members who may have experienced previous trauma from men or may not feel comfortable sharing personal experiences with men in the room.

Group curriculum modules include overcoming stigma, hospital and delivery, breastfeeding, taking baby home, parenting tips, social support, responding with sensitivity, nurturing touch, safe sleep, and positive discipline. The group structure is flexible and informal to meet the current needs and interests of the women. Based on patient input, themes have evolved to include topics related to healthy relationships, coping skills, understanding the role of child protective services, neonatal abstinence syndrome, Hepatitis C and pregnancy, depression, and contraception. Members also requested coverage of parenting topics including preparing quick and healthy weeknight meals, potty-training, and co-parenting.

“Ask the Doctor” sessions, led by physicians in the practice, have been incorporated into the group routine as well. These “Ask the Doctor” sessions encourage patients to ask medical questions that they may not have time to ask during regular visits. Topics include the biology of addiction and genetic risks, the difference between buprenorphine and buprenorphine/naloxone, and laboring and delivery on buprenorphine. Guest speakers have also been invited to the groups, including an experienced female patient who shared her personal story of trauma, as well as usual. Pregnant and parenting women recovering from addiction encounter stigma in almost all facets of daily life - from professionals, family members, friends, and the recovery community. Although medication assisted treatment is the recommended best practice for this population, the belief persists that MAT substitutes one drug for another. Patients have shared their experiences of going to the pharmacy to pick up their buprenorphine prescription and receiving a negative response from the pharmacist upon seeing the mother’s pregnant belly. Providing a safe space where women do not feel judged based on their addiction or parenting may offer a unique opportunity for women to gain a sense of empowerment.

These health education and risk reduction groups are a positive adjuvant to treatment as usual. Pregnant and parenting women in treatment for OUD have a wide range of concerns, including financial stressors, comorbid physical and mental health issues, parental stress, drug court obligations, and child custody issues. An in-office health education and risk reduction group offers the ability to meet a greater number of these needs in one setting.

**Recommendations for Working with this Population**

The medical management of OUD, including the physician’s interpersonal response, is a determinant of maternal and fetus stress levels, and, therefore, neonatal health. Embracing a trauma-informed and nonjudgmental perspective can promote rapport with patients. Pregnant women with OUD already have an increased level of psychological stress, which impacts the fetus. Negative interactions with the healthcare system can exacerbate the stress. McCarthy and colleagues suggest adopting an “attitude of unconditional positive regard” toward pregnant and mothering women using opioids. Addiction is not a homogenous disease. Having a general awareness of the challenges facing this patient population, including stigma and shame, dealing with Child Protective Services or the criminal justice system, difficult family relationships and trauma, will assist in establishing rapport and developing a trusting relationship with these patients.

**Conclusion**

A significant clinical need exists for this population. Despite the initial coordination and office uptake required to get groups rolling, facilitation can be emotionally rewarding to both providers and patients.

**Endnotes**


### Table 1. Billing for Services.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>Bundled into standard E&amp;M codes</td>
</tr>
<tr>
<td>99078</td>
<td>Counseling and education provided by a physician to a group</td>
</tr>
<tr>
<td>99411</td>
<td>Physician:* preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure)</td>
</tr>
<tr>
<td>99412</td>
<td>Physician:* preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure)</td>
</tr>
<tr>
<td>98961</td>
<td>Non-physician: education and training for patient self-management by a qualified, health care professional using a standardized curriculum</td>
</tr>
<tr>
<td>98962</td>
<td>Non-physician: education and training for patient self-management by a qualified, health care professional using a standardized curriculum</td>
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</tbody>
</table>

* or other qualified health care professional

### Table 2. Group Implementation Suggestions.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator</td>
<td>A staff member with time, compassion, and empathy.</td>
<td>• Easy to incorporate into existing office routines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If possible, a facilitator other than the patients’ regular provider to encourage open discussion</td>
</tr>
<tr>
<td>Office uptake</td>
<td>Support and communication among office staff.</td>
<td>• Improves scheduling, recruitment, and office space coordination</td>
</tr>
<tr>
<td>Coordination of patient appointments,</td>
<td>Scheduling prescription renewals with group reduces patients’ travel time.</td>
<td>• Promotes attendance</td>
</tr>
<tr>
<td>prescriptions, and group time</td>
<td></td>
<td>• Alleviates dual burdens of transportation and childcare</td>
</tr>
<tr>
<td>Children welcome</td>
<td>Mothers are permitted to bring young children, not yet in school.</td>
<td>• Alleviates burden of childcare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Women pregnant on buprenorphine for the first time can meet other mothers and children and be reassured</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Allows observations of mother-child interactions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prompts mother-to-mother conversation and sharing</td>
</tr>
<tr>
<td>Voluntary attendance</td>
<td>Physicians recommend the group to eligible patients, but it is not a requirement to receive a prescription.</td>
<td>• Because attendance is not mandated, patients enter with a mindset that promotes empowerment</td>
</tr>
</tbody>
</table>

*Kailey Lopian* is a graduate student pursuing a dual Master of Social Work/Master of Public Health degree at the University at Buffalo.

*Linda Kahn, PhD,* is a Research Professor and medical anthropologist in the University at Buffalo Department of Family Medicine. Her research focuses on patients with complex chronic conditions, including opioid use disorder.

*Richard Blondell, MD,* is a Professor at the University at Buffalo Department of Family Medicine. He is a 1978 graduate of the University of Rochester, School of Medicine and Dentistry and 1981 graduate of the University of Louisville Family Practice residency program. His research focuses on patients who have an opioid use disorder with a co-existent chronic pain disorder or pregnancy.
Despite the healthcare community’s best efforts, millions of teens across the country remain under-vaccinated against serious infectious diseases. The immunization rates for teens in New York specifically are a significant public health concern:
- Only half (53%) of teens 13 through 17 years of age received the flu vaccine.
- Only 47% of girls and 38% of boys completed the HPV vaccine series.
- While these rates are in line with national averages, they could be higher.

As family physicians we can play a part in helping change these statistics. The Highlight on VACCINATIONS 4 TEENS program provides the resources and tools to help us make an impact. The NYSAFP was one of 15 AAFP Chapters awarded a grant to bring this important program to members.

Please visit www.aafpfoundation.org/vaccinations4teens to learn about the program and access the Resource Library for the following materials:

**Materials for teen patients and families, including:**
- Reminder communications (postcards, text messages, letters, emails)
- Educational posters
- Personal testimonials
- Content for office websites and social media channels

**Tools for care teams and office staff, including:**
- Educational videos on updates to the 2017 Childhood and Adolescent Immunization Schedule
- Link to AAFP Immunization Information Systems (IIS), a web-based map that displays immunization rates and exemption laws in all 50 states

**Educational Event:**
As part of Highlight on VACCINATIONS 4 TEENS, NYSAFP will host a non-CME educational panel discussion on **Saturday, September 9 at Siena College** featuring immunization champions who will share perspectives on how family physicians can play a part in helping protect more teens from serious infectious disease. You will receive an invitation via email soon with more details and registration information. If you have any questions, please reach out to NYSAFP Chapter Executive Kelly Madden at kelly@nysafp.org.

**This program provided through the AAFP Foundation’s Family Medicine Philanthropic Consortium with support from Sanofi Pasteur.**

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