Short-term outcomes in patients attending a Primary Care–based Addiction Shared Care Program

Lynn Wilson MD, CCFP, FCPC
Meldon Kahan MD, CCFP, FRCP(C)
Department of Family and Community Medicine
University of Toronto
May 29, 2009

Background

- 1998–2004: St. Joseph’s Health Centre (SJHC), Toronto Department of Family and Community Medicine had traditional inpatient/ED addiction consultation service and program for pregnant substance users
- Limited impact (patients lost to follow-up; no contact with their family physicians)
- We decided to pilot a Shared Care Addiction Program, modeled after SJHC Mental Health Shared Care Program

Background (2)

- No published studies of Addiction Shared Care
- Funding received from Primary Health Care Transition Fund (via MoHLTC) for pilot program and evaluation
Rationale for shared care

- Numerous RCTs have shown that primary care interventions for addiction are effective
- Addiction treatment system has limited capacity, and patients prefer primary care
- E.g., population survey, Ontario (n=1084):
  - 36% with alcohol dependence sought help
  - FP 29.7%
  - AA 12.3%
  - Formal addiction treatment 7%

Cunningham JA, 2004

Program description

- St Joseph’s Health Centre (SJHC) – community teaching hospital in Parkdale
  - Inner city neighborhood with high prevalence of addiction and mental illness
- Addiction Medicine Service
- Joint program of Family Medicine and Mental Health
- Staff
  - Full-time nurse clinician
  - Addiction therapist
  - Medical Director and six part-time medical staff (family physicians)
  - Family medicine residents and clinical fellow

Referral process

- Community doctor sends brief written referral
- Therapist assesses patient
- Physician sees patient 1–2 weeks later
- Faxes written note back, +/- phone call
- Educational information also sent to referring MD
  - Alcohol withdrawal
  - Alcohol. opioid dependence
  - Safe prescribing of prescription opioids
- Follow-up and urgent re-assessments are provided
**Services provided**

- Outpatient medical detoxification (alcohol, opioids, etc)
- Pharmacotherapy
  - Methadone, disulfiram, naltrexone, etc
- Short-term counseling
  - Therapist
  - Physician
- Referral
  - Formal addiction treatment, Mental Health, AA, etc

**Evaluation**

- **Design:**
  - Prospective cohort study, conducted between January 2005 and April 2006
- **Participants:**
  - Patients who attended at least one session
    - Patients provided written consent for later contact
    - Referred from family doctors, government agencies, ED, self-referred

**Methods**

- At intake, therapist recorded demographics, substance use past month
- 4 months after initial visit, research assistant conducted structured telephone interview asking:
  - Quantity and frequency of substance use past month
  - Participation in addiction treatment
Results

Total # referrals
- 290: Family physicians - 41%
- MOT and other agencies - 41%
- Staff - 10%
- ED, specialists - 9%

Not eligible: 26
Refused consent: 60
Data lost: 4
Gave consent: 200
Unable to interview at 4 months: 129
Interviewed at 4 months: 71

Successful vs failed follow-up

<table>
<thead>
<tr>
<th>Category</th>
<th>Failed follow-up (n = 129)</th>
<th>Successful follow-up (n = 71)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Men</td>
<td>103 (80%)</td>
<td>48 (68%)</td>
<td>0.054</td>
</tr>
<tr>
<td>Age (years)</td>
<td>40.1</td>
<td>45.9</td>
<td>0.002</td>
</tr>
<tr>
<td>Alcohol problem</td>
<td>121 (94%)</td>
<td>53 (75%)</td>
<td>0.000</td>
</tr>
<tr>
<td>Cocaine problem (other drugs - no differences)</td>
<td>63 (49%)</td>
<td>16 (23%)</td>
<td>0.001</td>
</tr>
<tr>
<td>Mean # appts/patient</td>
<td>4</td>
<td>5</td>
<td>0.104</td>
</tr>
<tr>
<td>Mean # no-shows/patient</td>
<td>1</td>
<td>1</td>
<td>0.738</td>
</tr>
<tr>
<td>Show rate initial MD appt</td>
<td>67%</td>
<td>87%</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Results: Alcohol

<table>
<thead>
<tr>
<th>Category</th>
<th>Baseline</th>
<th>Follow-up</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently a problem</td>
<td>33/71 (47%)</td>
<td>9/71 (13%)</td>
<td>0.000</td>
</tr>
<tr>
<td>Mean drinking days/week</td>
<td>4.97</td>
<td>2.36</td>
<td>0.000</td>
</tr>
<tr>
<td>Mean # drinks/week</td>
<td>32.9</td>
<td>10.2</td>
<td>0.000</td>
</tr>
<tr>
<td>Binge drinking 5/d M, 4/d F</td>
<td>16/33 (49%)</td>
<td>7/33 (21%)</td>
<td>0.02</td>
</tr>
</tbody>
</table>
29 patients reported current problematic prescription opioid use
7 were started on methadone treatment
13 who weren't on methadone had decreased their prescription opioid consumption
  (but 2 continued to view it as a problem)
11 felt use was still problematic (including 2 who had cut down)

Results: Opioids

<table>
<thead>
<tr>
<th>Category</th>
<th>Baseline</th>
<th>Follow-up</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently problem</td>
<td>29/71 (41%)</td>
<td>11/71 (16%)</td>
<td>0.000</td>
</tr>
<tr>
<td>Mean morphine equivalent/day (mg) (n = 13)</td>
<td>168.4</td>
<td>70.9</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Results: Opioids

<table>
<thead>
<tr>
<th>Category</th>
<th>Baseline</th>
<th>Follow-up</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis problem</td>
<td>13 (18%)</td>
<td>8 (11%)</td>
<td>0.32</td>
</tr>
<tr>
<td>Benzodiazepine problem</td>
<td>8 (11%)</td>
<td>1</td>
<td>0.004</td>
</tr>
<tr>
<td>Cocaine problem</td>
<td>16 (22%)</td>
<td>14 (19%)</td>
<td>NS</td>
</tr>
<tr>
<td>Current involvement in AA or formal treatment (all drugs)</td>
<td>-</td>
<td>22 (31%)</td>
<td>NS</td>
</tr>
</tbody>
</table>
Limitations

- Only 41% referred by family physicians
- Incomplete follow-up
- Substance use based on self-report, with no corroboration
- Little information on mood, social functioning
- Results, though preliminary, are promising

Potential advantages of shared-care versus traditional treatment

<table>
<thead>
<tr>
<th>Shared care</th>
<th>Traditional treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family medicine setting acceptable and convenient</td>
<td>Stigmatizing</td>
</tr>
<tr>
<td>Rapid admission, flexible appointments</td>
<td>Long waiting lists, complex and inflexible admission procedures</td>
</tr>
<tr>
<td>Feedback and education for family doctors</td>
<td>&quot;Black box&quot; for family physicians</td>
</tr>
<tr>
<td>Provides pharmacotherapy and medical detoxification</td>
<td>Limited medical services</td>
</tr>
<tr>
<td>Family physicians have ongoing role in counselling and relapse prevention</td>
<td>Family physicians excluded from role in treatment</td>
</tr>
</tbody>
</table>

Crucial success factors

- Leadership support: Departmental Chiefs, hospital administrators
- Permanent funding for key personnel: Nurse clinician, therapist, Medical Director
- Full integration with Department of Family and Community Medicine
Potential for benefit (reduced morbidity, mortality, health care savings) is enormous
Further research needed on effectiveness of addiction shared care
Need for more demonstration projects

*Thank you!*