



Friday, November 19, 2021

8:30am–8:35am

Welcome and Introduction

Jay Schechtman, MD, MBA

Chief Clinical Officer, Healthfirst

Susan J. Beane, MD

Executive Medical Director, Healthfirst

Keynote

8:35am–9:05am

Building the Future We Wish to See: Partnerships for Optimal Medical Outcomes in 2021 and Beyond

Sujana S. Chandrasekhar, MD, FACS

Partner, ENT and Allergy Associates, LLP; Secretary-Treasurer, American Otological Society; Clinical Professor, Zucker School of Medicine at Hofstra/Northwell; Clinical Associate Professor, Icahn School of Medicine at Mount Sinai; Consulting Editor, Otolaryngologic Clinics of North America

9:05am–9:20am

Question and Answer Session

Panel 1

Effects of Medicaid Health Homes Among People with Substance Use Disorder and Another Chronic Condition on Health Care Utilization and Spending: Lessons from New York State

Charles J. Neighbors, PhD, MBA

Director, Health Evaluation and Analytics Lab (HEAL); Associate Professor, Department of Population Health, NYU Grossman School of Medicine; Research Professor, NYU Wagner Graduate School of Public Service

9:20am–10:00am

Delivering HOPE: Humanizing and Addressing Substance Use via Partnerships

Sandeep Kapoor, MD, MS-HPPL

Assistant Professor of Medicine, Emergency Medicine, & Science Education, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell; Adjunct Assistant Professor of Nursing, Hofstra Northwell School of Nursing and Physician Assistant Studies; Assistant Vice President, Addiction Services, Emergency Medicine Service Line, Northwell Health; Director, Screening, Brief Intervention, and Referral to Treatment (SBIRT), Northwell Health

10:00am–10:25am

Question and Answer Session

10:25am–10:35am

Break

Panel 2

Disparities in the Screening and Treatment of Cardiovascular Diseases in Patients with Mental Health Disorders

Christoph U. Correll, MD

Professor of Psychiatry at The Zucker School of Medicine at Hofstra/Northwell; Professor and Chair of the Department of Child and Adolescent Psychiatry, Charité University Medicine

Culturally Responsive Interventions for Posttraumatic Stress Disorder

Nicole H. Weiss, PhD

Assistant Professor of Psychology at the University of Rhode Island

The Clubhouse Model: Role of Psychosocial Rehabilitation in Addressing Social Determinants of Health

Joshua Seidman, PhD

Chief Research and Knowledge Officer, Fountain House

10:35am–11:35am

11:35am–12:00pm

Question and Answer Session

12:00pm

Final Remarks and Adjournment

Dismiss Session

Jay Schechtman, MD, MBA



Chief Clinical Officer, Healthfirst

Jay Schechtman, MD, has been with Healthfirst since 1999 and is responsible for all aspects of members' care and quality, encompassing medical and care management, clinical performance outcomes, and pharmacy.

Dr. Schechtman is an industry expert in population health, accountable care, high-risk populations, and integrated products. Dr. Schechtman also serves as the Assistant Clinical Professor in Community and Preventive Medicine at the Icahn School of Medicine at Mount Sinai.

Prior to working at Healthfirst, Dr. Schechtman was a National Medical Director for Magellan Specialty Health and a full-time academic physician at the Mount Sinai Medical Center in New York. He obtained a medical degree from Mount Sinai School of Medicine and an MBA from the combined healthcare management program of Mount Sinai and Baruch College.

Dr. Schechtman is board-certified in rehabilitation medicine and was chief resident at Mount Sinai.



Susan J. Beane, MD



Executive Medical Director, Healthfirst

Dr. Susan Beane joined Healthfirst in 2009, bringing with her extensive professional experience in managed care. As Executive Medical Director at Healthfirst, Dr. Beane leads a team that collaborates with major healthcare delivery systems and with local and national policy experts on the design, implementation, and dissemination of innovative, outcomes-focused models of care. Her research contributions span the health of caregivers, obesity, community health collaboration, chronic care management, and maternal health. In particular, Dr. Beane is an expert in the benefits and challenges of the use of health insurance data to define populations and health outcomes.

Dr. Beane, a dedicated proponent of primary care and a board-certified internist, promotes true partnership with providers and communities with the aim of evolving to an effective, efficient, equitable delivery system that can provide satisfying access for all.

Prior to joining Healthfirst, Dr. Beane served as Chief Medical Officer for Affinity Health Plan for five years—during which time she helped Affinity’s plan become a top performer in quality and member satisfaction. Before that, she worked at AmeriChoice and HIP USA, as Medical Director.

Dr. Beane is a graduate of Princeton University and Columbia University College of Physicians and Surgeons.



Sujana S. Chandrasekhar, MD, FACS



Partner, ENT and Allergy Associates, LLP; Secretary-Treasurer, American Otological Society; Clinical Professor, Zucker School of Medicine at Hofstra/Northwell; Clinical Associate Professor, Icahn School of Medicine at Mount Sinai; Consulting Editor, Otolaryngologic Clinics of North America

Dr. Sujana Chandrasekhar is an otolaryngologist (ear-nose-throat surgeon) with a subspecialty in otology/neurotology, involved in patient care, teaching, humanitarian work, and mentoring. She is a partner at ENT and Allergy Associates, practicing in Manhattan, New York, and Wayne, New Jersey. She has academic appointments at Zucker and Icahn Schools of Medicine. She is co-Executive Producer and co-host of a popular video livestream show, 'She's On Call,' which has several thousand weekly views (@ShesOnCall) and is carried as a podcast as well on WBAI.org. She is Consulting Editor of Otolaryngologic Clinics of North America, for which she also records podcasts of each issue, including one on the Special Article Series 'Deliberately Shaping the Future of Otolaryngology'.

She was President of the 13,000-member American Academy of Otolaryngology-Head and Neck Surgery in 2015–2016 and prior Chair of its Board of Governors. She is Secretary-Treasurer of American Otological Society and Vice President-Elect of the Eastern Section of the Triological Society.

Her residency training was at NYU Medical Center in New York and her clinical fellowship was at House Ear Institute in Los Angeles. She is widely published, including a textbook, *Temporal Bone Histology and Radiology Atlas*, which she co-edited with her father, Dr. H.K. Chandrasekhar, and several Clinical Practice Guidelines. Her research on intranasal surfactant and gender issues has garnered several awards. She is considered an expert on sudden hearing loss. She has spoken around the world on Otolaryngology, Otology/Neurotology, and Gender/Bias topics.

Honors of which she is particularly proud include: HBK Trailblazer Award from AAO-HNS WIOS (2012), Triological Society Presidential Citation (2018), Luis Guerrero Memorial Lecturer, University of Santo Tomas, Manila, Philippines (2016), Physician Mentor Recognition Award, AMA Women Physicians Section (2013), and Keynote Speaker, UKWENTS International Womens Day (2021).

Find her on social media @DrSujanaENT on Twitter, @sujanachandrasekhar on Instagram, @DrSujana on YouTube, and @drsujanaent on TikTok, her practice at @ENT_and_Allergy on Twitter and at www.entandallergy.com, her show at @ShesOnCall on Twitter and IG, and the Otolaryngologic Clinics of North America issues and podcasts at www.oto.theclinics.com.

Dr. Chandrasekhar is married, with four children aged 16 to 25.



Charles J. Neighbors, PhD, MBA



Director, Health Evaluation and Analytics Lab (HEAL); Associate Professor, Department of Population Health, NYU Grossman School of Medicine; Research Professor, NYU Wagner Graduate School of Public Service

Twitter: [@CharlieNeighbo1](https://twitter.com/CharlieNeighbo1)

Dr. Charles J. Neighbors, PhD, MBA, is a behavioral scientist who brings together clinical, statistical, and business expertise to understand and inform about healthcare reform and its impact on individuals struggling with addictions and mental health disorders. He serves as an Associate Professor in the Department of Population Health at NYU Langone, and as the Director of the Health Evaluation and Analytics Lab (HEAL), a joint initiative of NYU Langone and NYU Wagner Graduate School of Public Service.

Dr. Neighbors' research focuses on examining quality and efficiency of the current treatment system for Substance Use Disorders (SUDs), studying the impact of system reform efforts, and bringing evidence-based interventions to practice. Part of his research involves analyses of large administrative databases (e.g., Medicaid) to examine characteristics of the SUD treatment as well as the use of quasi-experimental methods to study the impact of system reform interventions. Most of this work has been conducted in New York State, relying on a strong collaborative partnership with state regulatory agencies (notably, the Office of Addiction Services and Supports (OASAS) and the Department of Health (DOH)).



Sandeep Kapoor, MD, MS-HPPL



Assistant Professor of Medicine, Emergency Medicine, & Science Education, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell; Adjunct Assistant Professor of Nursing, Hofstra Northwell School of Nursing and Physician Assistant Studies; Assistant Vice President, Addiction Services, Emergency Medicine Service Line, Northwell Health; Director, Screening, Brief Intervention, and Referral to Treatment (SBIRT), Northwell Health

Twitter: [@KapoorMedEd](https://twitter.com/KapoorMedEd)

Sandeep Kapoor, MD, is an assistant professor of medicine, emergency medicine and science education at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, assistant vice president of addiction services for the Northwell Health Emergency Medicine Service Line, and director of Screening, Brief Intervention, and Referral to Treatment (SBIRT) at Northwell Health. He is the recipient of the 2020 Northwell Health President's Award for Leadership and received the 2020 Outstanding Mentor Award by the American Academy of Child & Adolescent Psychiatry. Dr. Kapoor is passionate about motivating others to humanize and address substance use for the enhancement of patient care and organizational culture.

Utilizing SBIRT as a foundational framework and gateway, Dr. Kapoor and team are the architects of Northwell's Pathways to Recovery portfolio, including six ED-based learning laboratories for Medication Assisted Treatment, offering layers of support and services for patients and employees in need of care for opioid use disorder.

Focused on health professional pedagogy, and to address an evident gap in traditional medical education, his team has developed and integrated a dynamic four-year longitudinal Addressing Substance Use curriculum revolving around early identification/intervention within the Zucker School of Medicine. His team has also established a curricular footprint in six residency training programs within Northwell, including: Internal Medicine, Emergency Medicine, Psychiatry, Pediatrics, Obstetrics, and Family Medicine. Additionally, Dr. Kapoor is a Medical Communications and Quality Improvement faculty member, and a course director for the second 100 weeks curriculum, at Zucker School of Medicine. He also serves as faculty for the Addiction Psychiatry Fellowship at Zucker Hillside Hospital.

As a member of the Northwell Health Opioid Management Steering Committee, which is charged to collate a community of solutions to address the prevalent opioid epidemic, Dr. Kapoor leads interdisciplinary efforts to unify system-wide substance use screening protocols, deliver workforce training, scale NAL-SAT (Naloxone Saturation Campaign), and develop strategies for school, community, and employee engagement.

Dr. Kapoor is an active member of the Northwell Health Institutional Review Board, New York State OASAS SBIRT Policy Advisory Committee, and on a number of NYS Delivery System Reform Incentive Payment (DSRIP) committees.

Passionate about public speaking and writing, Dr. Kapoor delivered a TED-like talk titled "Empathy: Back to Basics for Today's Real World," has authored multiple book chapters, and penned three opinion pieces titled "'Angels in America' again: It's time to humanize addiction", "The Power of Words: An Argument to Remove the Term 'Addict' from Our Vocabulary" and "In the wake of the opioid epidemic, let's not forget about alcohol."



Christoph U. Correll, MD



Professor of Psychiatry at The Zucker School of Medicine at Hofstra/Northwell; Professor and Chair of the Department of Child and Adolescent Psychiatry, Charité University Medicine

Twitter: [@HealthEquityMD](https://twitter.com/HealthEquityMD)

Christoph U. Correll is Professor of Psychiatry at The Zucker School of Medicine at Hofstra/Northwell, New York, USA, and also Professor and Chair of the Department of Child and Adolescent Psychiatry, Charité University Medicine, Berlin, Germany. He completed his medical studies at the Free University of Berlin in Germany, and at Dundee University Medical School in Scotland. He is board certified in general psychiatry and child and adolescent psychiatry, having completed both residencies at The Zucker Hillside Hospital in New York City. Since 1997, he has been working and conducting research in New York, USA, and since 2017 he is also working in Germany again.

Professor Correll's research and clinical work focus on the identification, characterization, and treatment of youth and adults with severe mental illness, including psychotic and mood disorders, spanning all disease stages, from the prodrome to first and multi-episode illness and up to refractory illness. He further focuses on psychopharmacology, epidemiology, clinical trials, comparative effectiveness, meta-analyses, the risk-benefit evaluation of psychotropic medications, and the interface between physical health and mental health.

He has authored or co-authored over 700 journal articles that have been cited over 47,000 times. He served on several expert consensus panels on the use of antipsychotics across a range of psychiatric disorders and received over 40 research awards for his work.

Since 2014, the year of inception of this metric, he has been listed every year by Clarivate/Web of Science as one of the "most influential scientific minds" and "top 1% cited scientists in the area of psychiatry" (<https://hcr.clarivate.com>).

Additionally, he has been holding numerous Expertscape rankings, such as 15 topics ranked as "Expert" (among the top 1% cited scientists), and 24 topics ranked as "World Expert" (among the top 0.1% cited scientists), including in September 2021, for example, ranked as number one among world experts for the following areas:

1. Schizophrenia, out of 91,754 scientists (<http://expertscape.com/ex/schizophrenia>)
2. Schizophrenia Spectrum and Other Psychotic Disorders, out of 95,490 scientists (<http://expertscape.com/ex/schizophrenia+spectrum+and+other+psychotic+disorders>)
3. Psychotropic drugs, out of 130,506 scientists (<http://expertscape.com/ex/psychotropic+drugs>)
4. Antipsychotics, out of 59,384 scientists (<http://expertscape.com/ex/antipsychotics>)
5. Delayed-action preparations, out of 68,476 ranked scientists (<http://expertscape.com/ex/delayed-action+preparations>)
6. Central nervous system depressants, out of 234,254 ranked scientists (<http://expertscape.com/ex/central+nervous+system+depressants>)
7. Tranquilizing agents, out of 69,634 scientists (<http://expertscape.com/ex/tranquilizing+agents>)
8. Weight gain, out of 69,350 scientists (<http://expertscape.com/ex/weight+gain>)



Nicole H. Weiss, PhD



Assistant Professor of Psychology at the University of Rhode Island

Website: <https://web.uri.edu/psychology/research/stress/>

Dr. Nicole Weiss is an Assistant Professor in the Department of Psychology at the University of Rhode Island and is the Founding Director of the STRESS Lab. Dr. Weiss leads research on the co-occurrence of posttraumatic stress disorder and risky, self-destructive, and health-compromising behaviors, most notably substance use disorder. The overarching goal of this research program is to inform the development of culturally responsive interventions to prevent and reduce substance use among people who have experienced psychological trauma. Dr. Weiss's research is funded by several grants from the National Institutes of Health. She has contributed immensely to the research literature, publishing over 140 peer-reviewed articles. Dr. Weiss's work has been recognized by several early career awards, including a Rising Star Award from the Association for Psychological Science and the 2019 University of Rhode Island Early Career Faculty Research and Scholarship Excellence Award in Social Sciences.



Joshua Seidman, PhD



Chief Research and Knowledge Officer, Fountain House

Twitter: [@jjseidman](https://twitter.com/@jjseidman)

Joshua Seidman, PhD, joins Fountain House after more than 30 years working in healthcare at the intersection of research, policy, quality improvement, patient-centered care, health information technology, payment reform, and care delivery innovation. He has trained academically as a health services researcher and strongly believes in complementing that with a human-centered design approach in advancing new models of care. Dr. Seidman has a strong passion for transforming the care and health of people with serious mental illness, including the policy needed to enable that transformation.

Dr. Seidman most recently served as Managing Director in the Avalere Health Center for Healthcare Transformation. He previously launched and led Avalere's Center for Payment and Delivery Innovation. Before joining Avalere, he served as a consultant to the Brookings Institution's ACO Learning Network, supporting physician-led ACOs in making better use of data to manage population health. Dr. Seidman oversaw quality and performance improvement at Evolent Health, which supports the nation's leading providers in their population health and care transformation efforts.

He previously served as Director of Meaningful Use for the U.S. Department of Health and Human Services, where he was responsible for the Office of the National Coordinator for Health IT's policy development around the meaningful use of electronic health records and e-quality measures. Previously, Dr. Seidman was the founding President of the Center for Information Therapy, which advanced the practice and science of using health IT to deliver tailored information to consumers to help them make better health decisions.

Dr. Seidman's quality measurement experience dates back to the 1990s. He served as Director of Measure Development at NCQA, where he helped transition HEDIS from a measurement set primarily comprising preventive and process measures to one that included several chronic-disease and intermediate-outcome measures. He has done research and analysis related to quality and providers at the American College of Cardiology and the Advisory Board Company.

Dr. Seidman earned a PhD in health services research, an MHS in health policy and management from Johns Hopkins Bloomberg School of Public Health, and a BA in political science from Brown University. In a volunteer capacity, Dr. Seidman is a Past President of the Society for Participatory Medicine and previously served for five years as President of Micah House, a transitional house for homeless women in recovery from substance abuse. He serves on the advisory committee for Sapien Labs' Mental Health Million Project. When he is not running after his four children, he stays grounded by running marathons, having completed 44 of them.





Building the Future We Wish to See: Partnerships for Optimal Medical Outcomes in 2021 and Beyond



Sujana S. Chandrasekhar, MD, FACS, FAAO-HNS

Physician-Partner, ENT & Allergy Associates, LLP

Past President, American Academy of Otolaryngology-Head
& Neck Surgery

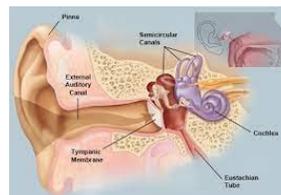
Clinical Faculty, Hofstra and Icahn Schools of Medicine

Consulting Editor, Otolaryngologic Clinics of North America

Co-Exec Producer and Co-Host, She's On Call

Who am I?

- Practicing Otolologist/Neurotologist – subspecialty within ENT (Otolaryngology)
- Physician Partner in the Largest Single-Specialty ENT practice in the US – ENT & Allergy Associates, LLP



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560 White Plains Road, Suite 500
Tarrytown, NY 10591





Who am I? - 2

- Past President of the 13,000 member American Academy of Otolaryngology-HNS
- Consulting Editor, Otolaryngologic Clinics of North America
 - Issues and Podcasts
- Co-Exec Prod and Co-Host, Video Web show @She'sOnCall – & podcasts



AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY®



Healthfirst 2021 Fall Symposium
Building the Future We Wish to See

Foreword

Building the Future We Wish to See



Sujana S. Chandrasekhar, MD, FACS, FAA-HNS
Consulting Editor

Biologics in Otolaryngology



Dr. Jennifer Villwock approached me in December of 2018 with a suggestion for an issue of *Otolaryngologic Clinics of North America* on leadership, mentorship, and professional development. As she, our then-Senior *Otolaryngologic Clinics of North America* Editor Jessica McCook, and I brainstormed as to how to craft this necessary and important series of articles so that they might reach the widest possible audience, we decided to publish them over the course of a year as a Special Article Series on Intentionally Shaping the Future of Otolaryngology, guest edited by Dr. Villwock. The first two articles of the series were published in the August 2020 issue of *Otolaryngologic Clinics of North America*, and the final two articles appear in the August 2021 issue. Taken together, these 12 articles make a comprehensive treasure trove of material that is of value not just to all otolaryngologists but also to anyone who cares to see a more inclusive and fairer world.

The two Special Series articles in the current issue are "Women in Academic Medicine and Leadership" by Dr. Mona M. Abaza and "Balance Versus Integration: Work-Life Considerations" by Drs. Julie L. Wei and Jennifer A. Villwock. These articles explore vitally important subjects and provide an excellent conclusion to the series.

In the United States in 2004, there were four female chairs of otolaryngology (4/104 departments, 3.8%) and in 2018 there were six female chairs of otolaryngology (6/117, 5%).¹ As of December 31, 2020, the American Association of Medical Colleges reports that 4 of 86 (4.7%) US Otolaryngology departments were led by women, 3 of whom are white and 1 of whom is Asian.² The American Academy of Otolaryngology-Head and Neck Surgery has had only four women Presidents to date, the first of whom, Dr. M. Jennifer Derabery, served in 2003-2004, and the second, Dr. Gayle Woodson, served in 2014-2015. The first and only female President of the Triological Society served in 2020-2021. It is not just the highest levels of leadership that are kept from women's grasp; there are numerous barriers to getting near those positions. Even accounting

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for hours worked, patients seen, and academic productivity, women surgeons are promoted less, paid less, and funded less than their male counterparts.³ Dr. Abaza discusses "sticky floors," "glass ceilings," avoiding "falling off the cliff," beating the odds, missing rungs on the ladder to success, building more supportive steps, and accomplishing the future that we envision. She stresses the importance of men and women promoting the advancement of women.

Many of us came of age hearing that we should strive for work-life balance; the impetus now is for work-life integration. Balance seeks to achieve an ideal state where your work and life coexist and thrive separately; integration is about bringing work and life closer together. Drs. Wei and Villwock write about burnout, well-being, wellness, gender-specific challenges for integration, and microaggressions. They provide actionable details on what to consider while starting one's career and practices to follow for emotionally healthy work-life integration. When and how to seek and use counseling, coaching, and peer support concludes this article.

The late actor Christopher Reeve, who played Superman among other characters, and sustained a complete C1-C2 vertebral injury in 1995, leaving him quadriplegic, said in 1996, "So many of our dreams at first seem impossible, then they seem improbable, and then when we summon the will, they soon become inevitable."⁴ I urge the reader to take the time to read these and all 12 articles in the Special Series: Intentionally Shaping the Future of Otolaryngology, guest edited by Dr. Jennifer Villwock and authored by thoughtful leaders in our field. Just like Superman, we can summon the will to make these necessary changes inevitable.

Sujana S. Chandrasekhar, MD, FACS, FAA-HNS
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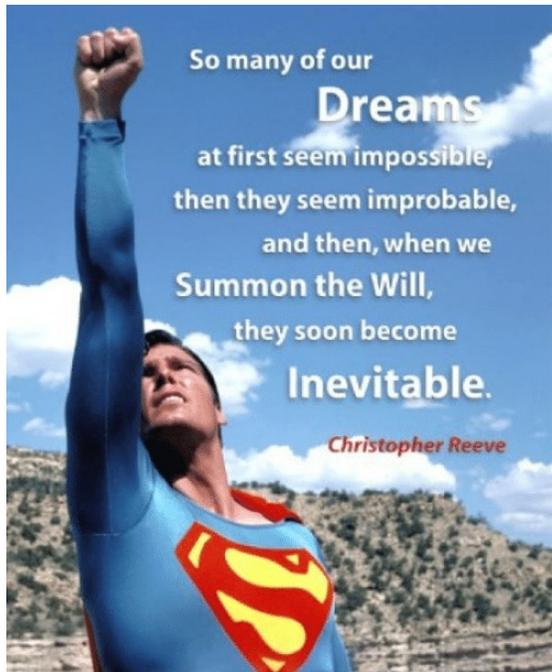
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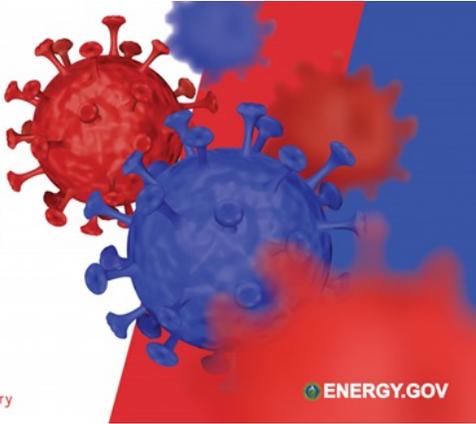


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What Did We Learn During the COVID 19 Pandemic?

“
Periods of social and economic distress often breed innovation. I look forward to seeing the inventions and advances that help us rise to meet the challenges of COVID-19.
”

- Dr. Thomas Mason
Director, Los Alamos National Laboratory



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What Did We Learn During the COVID 19 Pandemic?

SUSTAINABLE DEVELOPMENT GOALS



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<https://www.weforum.org/agenda/2020/04/here-s-what-covid-19-can-teach-us-about-environmental-action/>

What Did We Learn During the COVID 19 Pandemic?

ACCESS TO HEALTHCARE

- “This pandemic is a stark reminder of the divide that exists in countries without universal health care, between those who can afford health care and those who cannot and may be forced into poverty as a result.”

- Dr. Erwin Khoo from the International Medical University in Kuala Lumpur, Malaysia, and Dr. John Lantos from Children’s Mercy Hospital, Kansas City, USA

- <https://www.advancedsciencenews.com/lessons-learned-during-the-covid-19-pandemic/>



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What Did We Learn During the COVID 19 Pandemic?

MENTAL HEALTH

- While mental health is significant and will be a lasting effect of the current pandemic, it is not being given the attention it deserves.
- “I do not think it is given enough priority. Everyone must pay attention to their emotional well-being and the well-being of those we care about. Awareness is important, and we tend to lose sight of it because of its ‘invisibility’ and indistinctness, [especially in these unprecedented times].”

– Dr. Khoo



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What Did We Learn During the COVID 19 Pandemic?

RACISM/DISCRIMINATION

- People are stereotyped as being disease carriers.
- “Racism and discrimination lead to chronic stress. They are barriers in realizing the principles of equality, a core principle of human rights. The rights to non-discrimination must remain central to all government responses. We must advocate countermeasures to address widespread stigmatization that have adverse public health impact.”

– Khoo and Lantos

Amanda Phingbodhipakkiya
Tw: @alonglastname



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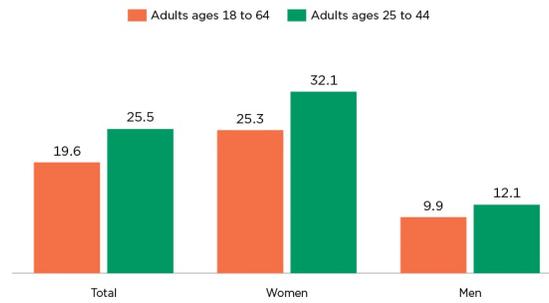




What Did We Learn During the COVID 19 Pandemic? THE ROLE OF WOMEN IN SOCIETY

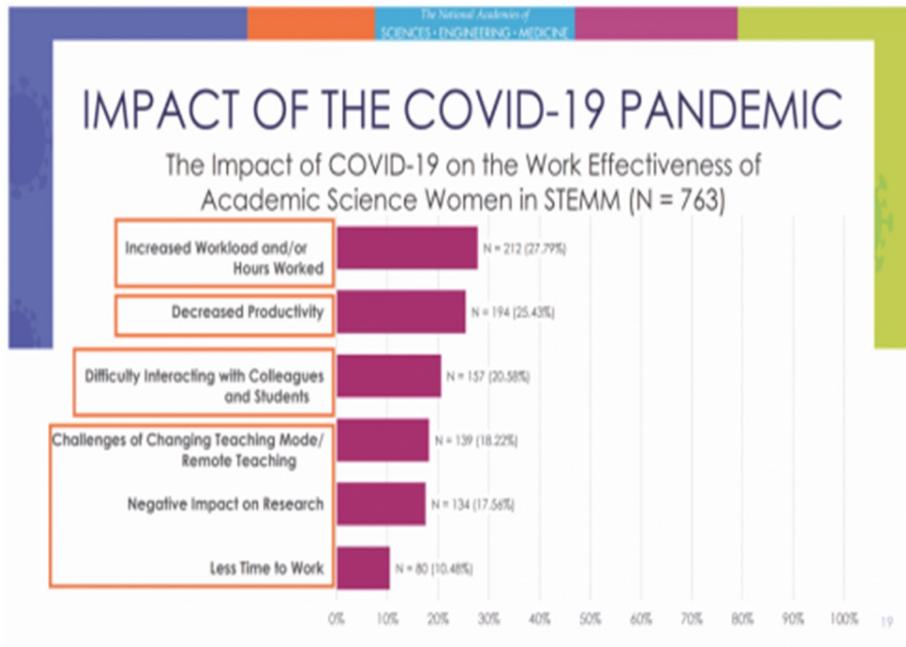


Percent of Adults With Children by Age Group Who Are Not Working Due to COVID-19 Related Child Care Issues



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The percentages reflect nonworking adults with children excluding those who are retired or not interested in working.
Source: U.S. Census Bureau, Household Pulse Survey (Week 12: July 16-July 21, 2020).



#NoMoreManels



Sundays Live
11 am - 12 noon ET
on YouTube, Twitter,
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#askusanything

Mondays 2-3 pm ET
in WBAI 99.5 FM (NYC)
wbai.org



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5 Lessons Learned from Covid 19



<https://magazine.ucsf.edu/five-big-lessons-pandemic>

1. Science doesn't always move slowly.
 - Creativity, collaboration, breaking down silos
2. We are failing the most vulnerable.
3. Supply chains are a weak link.
4. Video Visits are here to stay.
5. Delayed consequences enable bad behavior.



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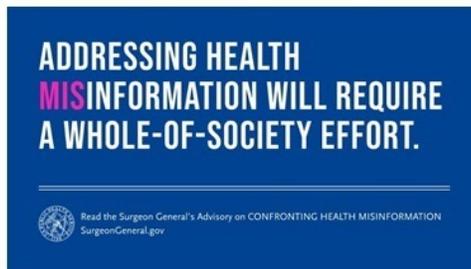


Health Misinformation



Dr. Vivek Murthy, U.S... · 2d

Health misinformation is information that is false, inaccurate, or misleading according to the best available science at the time. During this pandemic, it's divided our friends, families, and communities. It's led to threats against our health workers. And it's cost us lives.

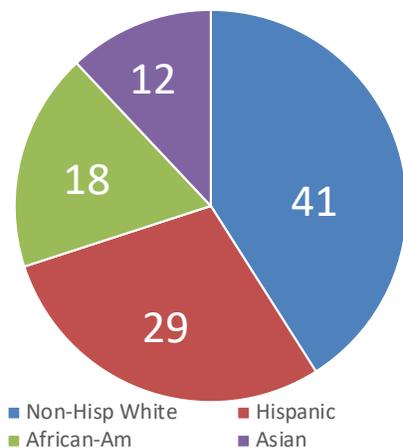


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Racial Representation in Healthcare

US Population



General Medical Workforce

- 5.1% African American
- 4.4% Hispanic

URM Representation in Hospitals:

- 32% of patients
- BUT
- 14% of hospital Board members
- 11% of Executive Leadership
- 19% of Mid-Level and First-Level Managers

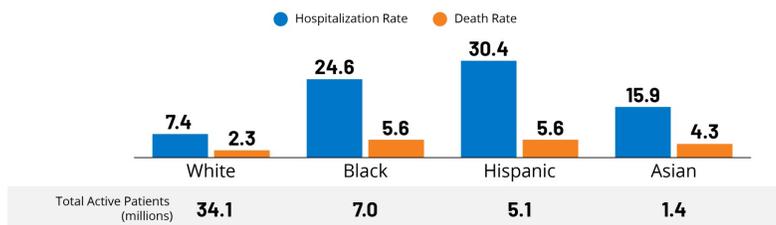
<https://www.insideindianabusiness.com/story/41124811/diversity-increases-quality-outcomes>



Racial outcomes in Covid-19

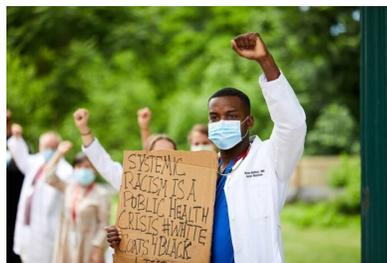
COVID-19 Hospitalization and Death Rates among Active Epic Patients by Race/Ethnicity

Rate per 10,000, as of July 2020



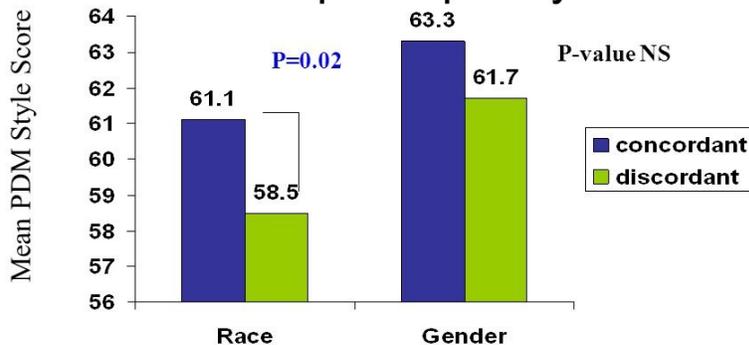
NOTE: Rates for Black, Hispanic, and Asian patients are statistically significantly different from White patients at the $p < 0.05$ level. Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic. Data for other racial groups not shown due to insufficient data.

SOURCE: Epic and KFF analysis of Epic Health Record System COVID-19 related data as of July 2020.



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Patients in race-concordant relationships rate their physicians as more participatory



Adjusted for patients' age, gender, education, marital status, health status, length of the patient-physician relationship, physician gender (race concordant analysis) and physician race (gender concordance analysis). Cooper-Patrick L, JAMA 1999;282:583-589



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Implicit (unconscious) bias (DISCORDANCE) HARMS.

Proceedings of the National Academy of Sciences:

- 1.8 million hospital birth records in Florida between 1992 and 2015
 - Black babies were **three times** more likely to die in the hospital than white newborns when cared for by white doctors.
 - When Black doctors cared for Black babies, the mortality rate was cut in half.
 - The race of the doctor caring for white babies did not make much difference to the likelihood of survival.
 - No statistically significant connection between the risk of maternal mortality and the race of the mother's doctor.
 - **The difference in mortality rates can be attributed to "racial concordance between the physician and newborn patient."**



Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician–patient racial concordance and disparities in birthing mortality for newborns. PNAS August 17, 2020 <https://doi.org/10.1073/pnas.1913405117>

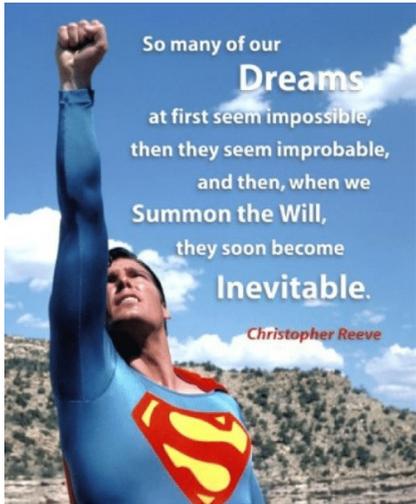
Implicit (unconscious) bias (CONCORDANCE) can do good.



Alsan M, Garrick O, Graziani GC, NBER www.nber.org/papers/w24787

Working Paper 24787, National Bureau of Economic Research, 2018

- >1300 Black men in Oakland, CA were assigned to either a Black male or Non-Black male doctor.
- Prior to meeting their doctor, all patients chose the same preventive screening tests: BP, blood for glucose/cholesterol
- After talking with their doctor:
 - **Black men w/ Black doctor** – more likely to opt for every test than BM w/ NBD
 - BM/BD: 47% more likely to get DM screening and 72% more likely to get cholesterol test
- BM/BD also:
 - More likely to discuss other health problems
 - BD wrote more notes including about personal issues



Value-Based Health Care Benefits

PATIENTS	PROVIDERS	PAYERS	SUPPLIERS	SOCIETY
Lower Costs & better outcomes	Higher Patient Satisfaction Rates & Better Care Efficiencies	Stronger Cost Controls & Reduced Risks	Alignment of Prices with Patient Outcomes	Reduced Healthcare Spending & Better Overall Health

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

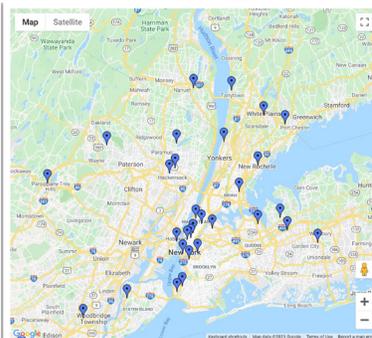
<https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558>





What is Our Healthcare Dream?

- Access
- Quality
- Innovation
- Costs



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What is Our Healthcare Dream?

- Access
- Quality
- Innovation
- Costs



<https://www.entnet.org/quality-practice/reg-ent-clinical-data-registry/>



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What is Our Healthcare Dream?

- Access
- Quality
- Innovation
- Costs



<https://time.com/5710295/top-health-innovations/>
(2019)



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25

What is Our Healthcare Dream?

- Access
- Quality
- Innovation
- Costs

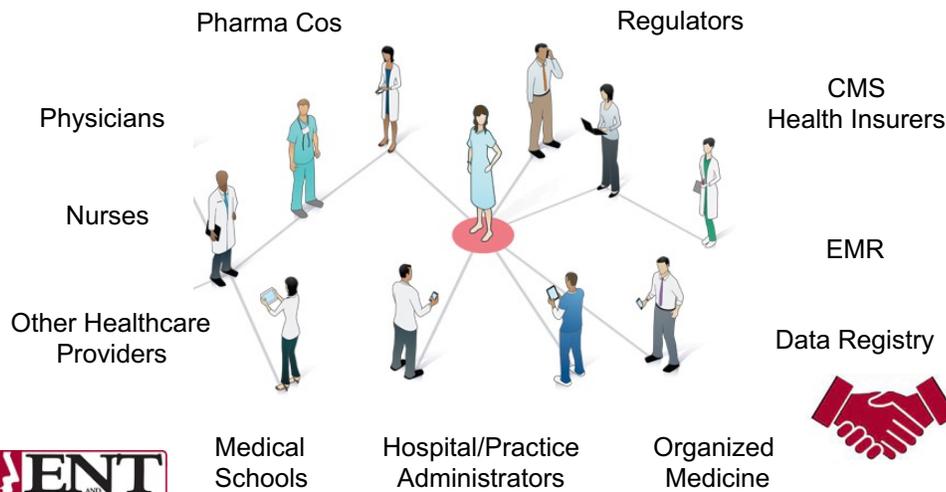


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26

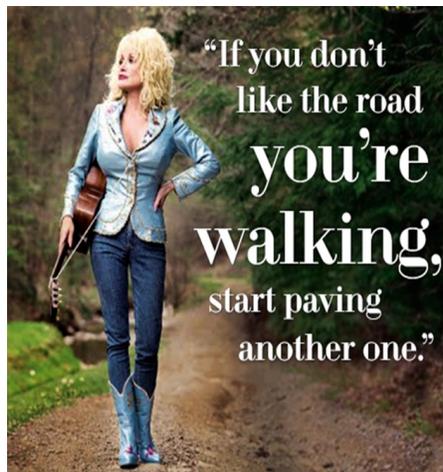


By Partnering with Each Other, We Can Achieve Our Dreams of Equitable, Effective, Affordable, Patient-Centered Healthcare



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Building the Future We Wish To See Takes Bravery and Gumption



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Building the Future We Wish To See

Sujana S. Chandrasekhar, MD, FACS, FAAO-HNS
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Past President, AAO-HNS
Clinical Faculty, Zucker and Icahn SOMs
Consulting Editor, Otolaryngologic Clinics of NA
Co-EP, Co-Host, @ShesOnCall
Tw: @DrSujanaENT
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EFFECTS OF MEDICAID HEALTH HOMES AMONG PEOPLE WITH SUBSTANCE USE DISORDER & ANOTHER CHRONIC CONDITION ON HEALTH CARE UTILIZATION AND SPENDING

Lessons from New York State

Charles Neighbors, PhD, MBA
Director, NYU Health Evaluation & Analytics Lab (HEAL)
Associate Professor, Department of Population Health, NYU Grossman School of Medicine
Research Professor, NYU Wagner Graduate School of Medicine

Agenda

1. NYU Health Evaluation & Analytics Lab (HEAL)
2. Understanding NYS Medicaid
3. Medicaid Health Homes



NYU HEALTH EVALUATION & ANALYTICS LAB



Mission & Vision of HEAL

Mission

Conduct research and evaluations that **assist in the administration of the New York Medicaid program** and contribute to national scholarship on health and healthcare.

Vision

Be a national resource for improving health and well-being of vulnerable communities and individuals.

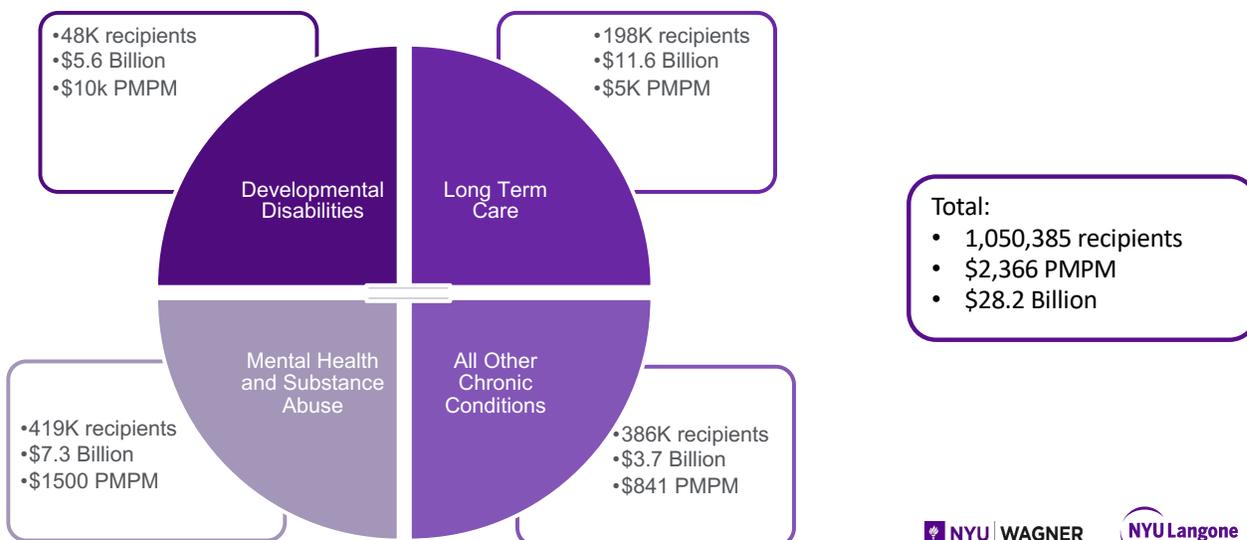


Context

- Affordable Care Act – Medicaid Expansion
 - Large BH Among Newly Covered
 - Chronic Disease Management
 - Patient Centered Medical Home
- New York Health Home Program
 - Concern About Medicaid Cost Management
 - Medicaid Redesign Team
 - HH Tool for System Reform
- Integrating Care → Better & Efficient Care

7

NYS High Cost Medicaid Enrollees 2011



8



New York Medicaid Health Home (HH) Program

- Largest Program in US
 - Approximately 800k Eligible
 - Support for recruitment
- Eligibility
 - HIV/AIDS
 - SMI
 - 2+ Chronic Health Conditions (including SUD)
- Distinguishing Features
 - Breadth of Conditions
 - Attention to Behavioral Health

9

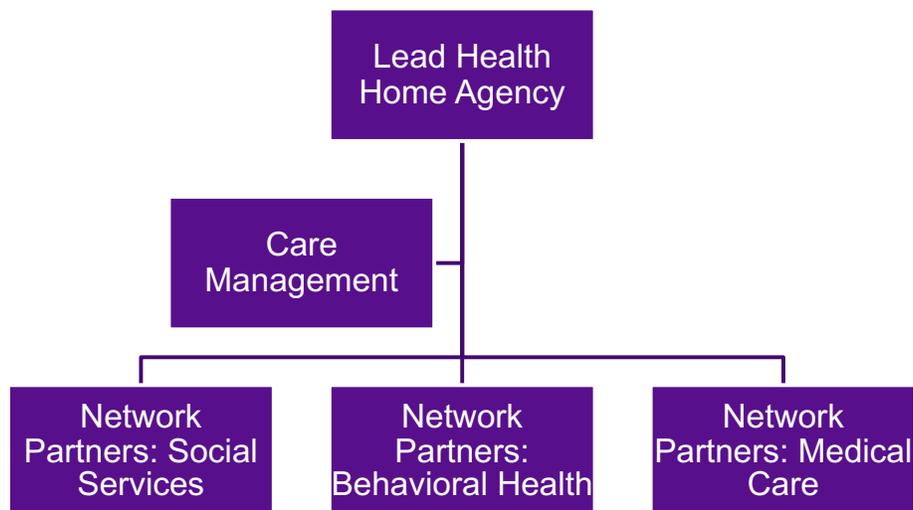
Six Core Health Home Services

- Comprehensive care management
- Care coordination & health promotion
- Comprehensive transitional care from inpatient to other setting and appropriate follow-up
- Support for patients & families
- Referral to community & social services
- Use of health information technology (HIT) to enhance care coordination

10



NYS Health Home Structure



11

NYS HEALTH HOME EFFECTS ON HEALTH CARE UTILIZATION & SPENDING



Approach

Data

- Medicaid data for 2.9M members between 2011-2014 with chronic health conditions
 - Exclude co-insured with Medicare
- 44,229 HH enrolled with SUD
- 39,471 comparison with SUD

Method

- Statistically matched comparison group
- Compare change over time between HH enrollees and comparison groups
- Adjust for many individual characteristics in the analyses
 - Demographics
 - Health conditions
 - Healthcare use history

Health Home Enrolled vs Comparison Demographics - SUD Clients

		Comparison	HH Enrolled
Age (Mean)		43.1	43.6
Gender (%)	Male	57.8	57.3
	Female	42.2	42.7
Race (%)	White	33.1	30.3
	Black	35.1	34.5
	Latino	24.3	25.3
	Other	3.9	5.2
	Unknown	3.7	4.8
NYC vs. ROS (%)	NYC	53.9	55.0



Comparison of Clinical Characteristics

	Comparison	HH Enrolled	
Subpopulation (%)	HIV	18.1	18.3
	OMH	40.9	38.2
Severe MH (%)	Schizophrenia	12.7	15.9
	Bipolar	10.1	12.1
Chronic Medical (%)	Heart Disease	31.8	33.5
	Diabetes	17.2	18.3
	Asthma	9.6	10.8
Other (%)	Intellectual Disability	2.0	2.1

15

Healthcare Utilization Average Over Prior Year – SUD Clients

	Comparison	HH Enrolled
ED (visits/year)	1.8	2.0
Inpatient (admit/year)	0.9	1.1
Outpatient (visits/year)	28.6	32.5
Average Cost	\$26,524	\$26,890

16

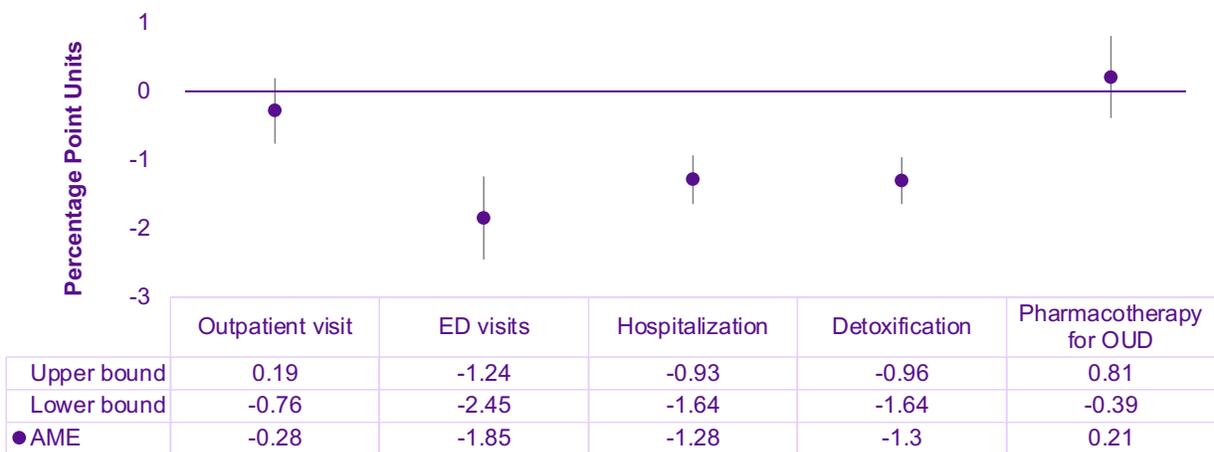


Healthcare Utilization Average Over Prior Year – SUD Specific Claims

	Comparison	HH Enrolled
<i>ED (visits/year)</i>	0.3	0.4
<i>Inpatient (admit/year)</i>	0.2	0.3
<i>Outpatient (visits/year)</i>	19.0	22.0

17

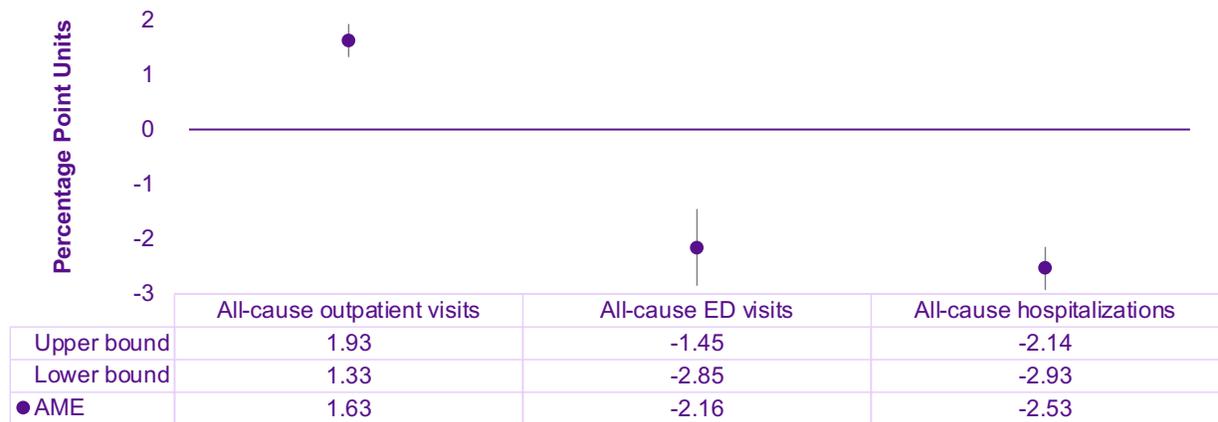
Average Marginal Effects for SUD-Related Health Care Utilization (95% CI)



18



Average Marginal Effects for General Health Care Cost and Utilization (95% CI)



19

Average Marginal Effect for Total Medicaid Cost of Care Per Patient

Upper bound	-501.08
Lower bound	-1196.25
AME	-848.67

20



Summary

- Medicaid Health Homes Offer Integrated Care for Individuals with Complex Chronic Health Conditions
- Behavioral Health Conditions are Prevalent Among this Medicaid Sub-Population
- Health Homes Increased Ambulatory Care and Reduced Crisis Acute Care Events for Individuals with Substance Use Disorders
- Paradoxically, Health Homes did not Increase Engagement in Specialty Substance Use Disorder Treatment



Journal of Substance Abuse Treatment
Volume 132, January 2022, 108503



Effects of Medicaid Health Homes among people with substance use disorder and another chronic condition on health care utilization and spending: Lessons from New York State

Charles J. Neighbors^{a,*,2,3,4}, Sugy Choi^{a,5}, Rajeev Yerneni⁶, Sarah Forthal⁷, Jon Morgenstern⁸

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<https://doi.org/10.1016/j.jsat.2021.108503> [Get rights and content](#)

FROM THE STATES

Substance Use Disorders and Diabetes Care
Lessons From New York Health Homes

Sarah Forthal, MPH^a, Sugy Choi, PhD, MS^{a,†}, Rajeev Yerneni, PhD, MBA^a, Zhongjie Zhang, MPH^a, David Stawicki, MD, MPH¹, Natalya Egorova, PhD, MPH², Todor Mijanovich, PhD³, Victoria Mayer, MD, MS^{4,†} and Charles Neighbors, PhD, MBA^{4,8}



Thank You Team!

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THANK YOU

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TOBACCO, ALCOHOL and DRUGS
AFFECT YOUR OVERALL HEALTH

**WE ASK
EVERYONE**

Screening:
Brief Intervention and
Referral to Treatment

Delivering HOPE

Humanizing and Addressing Substance Use via Partnerships



Sandeep Kapoor, MD, MS-HPPL

*Assistant Professor of Medicine, Emergency Medicine, & Science Education
Zucker School of Medicine at Hofstra/Northwell*

*Adjunct Assistant Professor of Nursing
Hofstra Northwell School of Nursing and Physician Assistant Studies*

*AVP, Addiction Services
Emergency Medicine Service Line, Northwell Health*

*Director, SBIRT
Northwell Health*

[@KapoorMedED](https://twitter.com/KapoorMedED)

Addressing Substance Use

@ Northwell
Health

Northwell Health

- Emergency Medicine Service Line
- Division of General Internal Medicine
- Department of Psychiatry & Behavioral Health
- Department of Pediatrics
- Department of Obstetrics and Gynecology
- Opioid Management Steering Committee (OMSC)
- Pharmacy Service Line
- Center for Emergency Medical Services (CEMS)
- Center for Addiction Services and Psychotherapy Interventions Research (CASPIR)

Community Relations

- Legal
- Gov't Affairs
- Public Relations
- Marketing
- CEMS
- HR/Talent
- EHS/EAP
- Wellness



Hofstra/Northwell

*Donald and Barbara Zucker School of Medicine
Donald and Barbara Zucker School of Graduate Nursing*



Center on Addiction



New York State Office of Alcoholism and Substance Abuse Services (OASAS)



Substance Abuse and Mental Health Services Administration (SAMHSA)

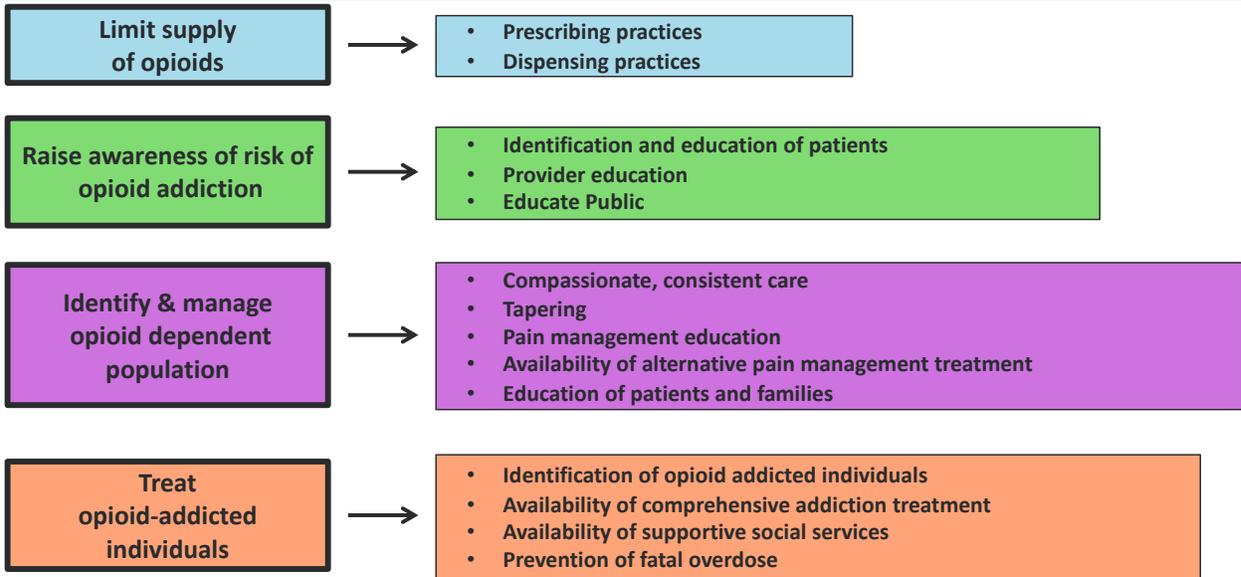




Northwell Health Opioid Management Steering Committee

- Addressing the Opioid Crisis -

Chair: Jay Enden, MD
Exec Sponsor: Mark Jarrett, MD



Institute for Healthcare Improvement



Sandeep Kapoor MD, MS-HPPL
@KapoorMedEd

Successful #partnership is like a bridge

- 2 sides connected
- Bidirectional flow
- Structure & Trust
- Providing passage over obstacles
- Long-standing

#ThrogsNeckBridge

I ❤️ NY -- 📷: my iPhone11

@NorthwellHealth @Northwell_EM @ZuckerSoM
#InThisTogether #MedED #RecoveryMonth



Dr. Chethan Sathya, MD MSCE and 8 others



Sandeep Kapoor MD, MS-HPPL
@KapoorMedEd

Like a bridge, #Partnership requires:

- Balance
- Support structures
- Maintenance/Care
- Repair
- Continued Investment

#WhitestoneBridge

I ❤️ NY -- 📷: my iPhone11

@MichaelJDowling @NorthwellHealth @Northwell_EM
@ZuckerSoM #InThisTogether #MedED
#RecoveryMonth



Nina Vincoff MD and 8 others



acknowledged,
recognized, profes
avowed, approve
acknowledgment
Archaic. recogn
sion: declaration



Appreciate.
Acknowledge.
Affirm.



supported
HEARD
relief
SAFE

connected
trusted

ACCEPTED



Our
Diversified
Personal Approach
will help facilitate successful
System-Level Strategies



re-frame



“Life's most persistent and urgent question is:

“What are you doing for others?” ”

Dr. Martin Luther King Jr.



The Issue

Substance misuse is estimated to cost society:

\$442 BILLION EACH YEAR



HEALTH CARE COST



LOST PRODUCTIVITY COST



CRIMINAL JUSTICE COST

Surgeon General's Report
Retrieved February 20, 2018, from <https://addiction.surgeongeneral.gov/>



HEART DISEASE

\$312B



DIABETES

\$245B



CANCER

\$216B

**= \$773
Billion**

**SUBSTANCE
misuse/addiction
including Tobacco**

**\$706
Billion**





Evident gap in education



< 4hours
Dedicated Curricular Time in average Medical School

62%

Medical Residents **DON'T** feel educationally prepared to treat SUDs

75%

Nurses feel **UNPREPARED** to provide care for people who use illicit drugs

98%

Social Work Master's Programs **DON'T** require a course on substance use

Goplerud, 2017

The REAL Issue

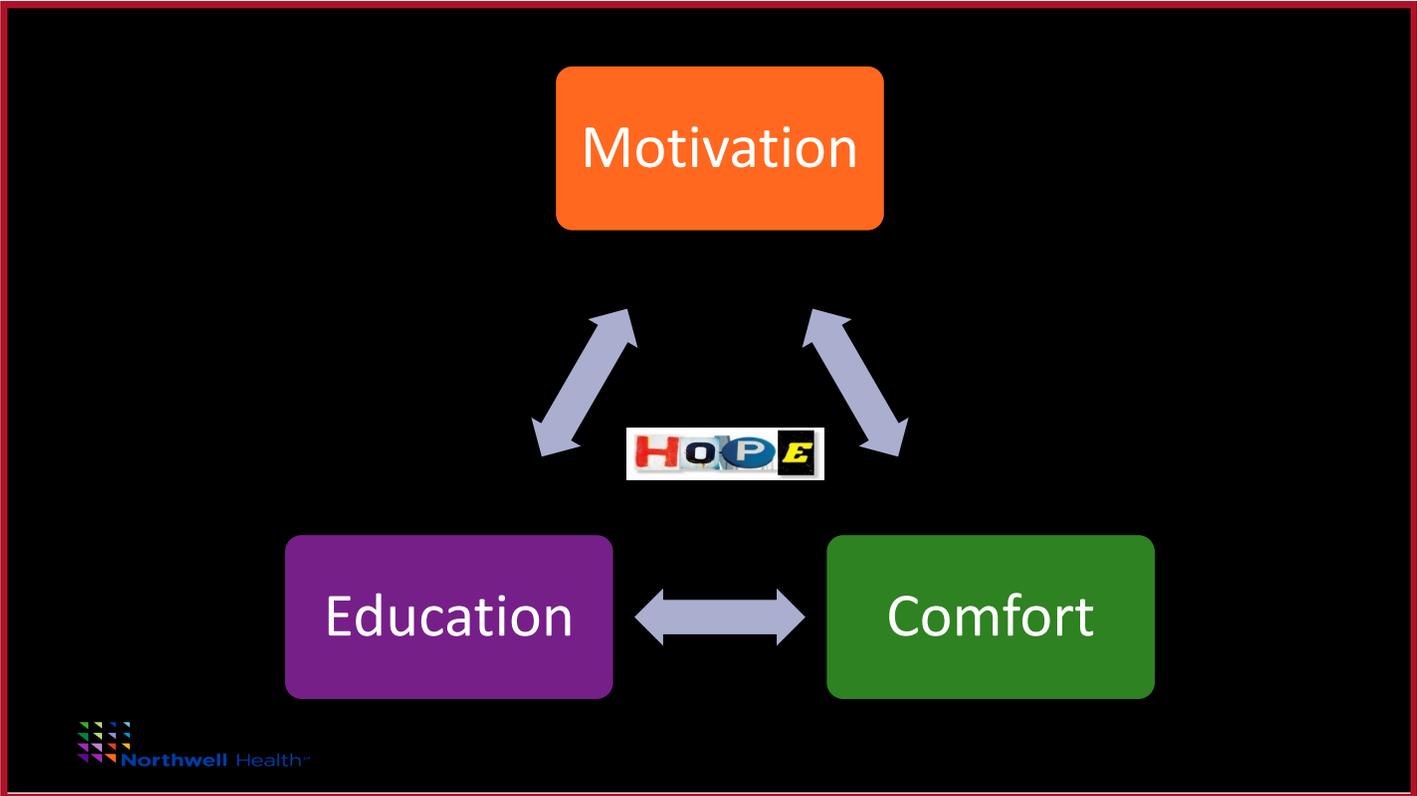
Major source of referrals to treatment are **NOT** healthcare providers, though most people see a doctor at least one time per year

1 IN 10

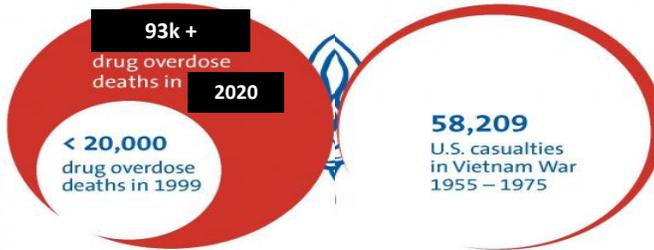
PEOPLE WHO NEED

only 6.6%

WHY?



A State of Addiction: The Substance Use Epidemic



Source: National Institute on Drug Abuse via USA Today

250 deaths per day = 11 deaths per hour



More New Yorkers die from overdose than from *suicides, homicides and motor vehicle crashes combined*

82% of overdoses involve an opioid



Source: Li W, Huynh M, Lee E, Lasner-Frater L, Castro A, Kelley D, Kennedy J, Maduro G, SebekK, Sun Y, Van Wye G. Summary of Vital Statistics, 2014. New York, NY: New York City Department of Health and Mental Hygiene, Office of Vital Statistics, 2016.

Alcohol Related Emergencies and Deaths



- Excessive alcohol use is responsible for more than **95,000 deaths** in the **United States** each year or **261 deaths per day**.
- Alcohol** the **third-leading preventable cause of death** in the US.
- Alcohol** contributes to about **19% of ED visits**





Substance Use and the Pandemic



COVID-19 has brought additional stress, trauma, isolation, and uncertainty.

- More individuals **using substances ALONE**
- **Alcohol sales** increased over **54%** in **2020**
- **Less access** to Naloxone (*Narcan*) the antidote to an opioid overdose
- **Increased amount of Fentanyl** in the drugs including opioids, cocaine, and meth
- **Interruption of treatment** including medications such as Buprenorphine
- Inability to secure devices needed to join Telehealth consults and remote-based therapy
- Food insecurity and safe housing issues.
- Reluctance to seek medical care due to fear of potential exposure to COVID-19



Why do we continue to play the
BLAME GAME?



When do we **stop** watching/playing the **BLAME GAME?**

How the blame game works:

Lack of *accountability* underscores a

Lack of *ownership*, perpetuating a

Lack of *motivation*, fostering the

Lack of *action*



Motivate a Shift in our Culture

Substance Use/Misuse
is truly a ***Healthcare Issue***

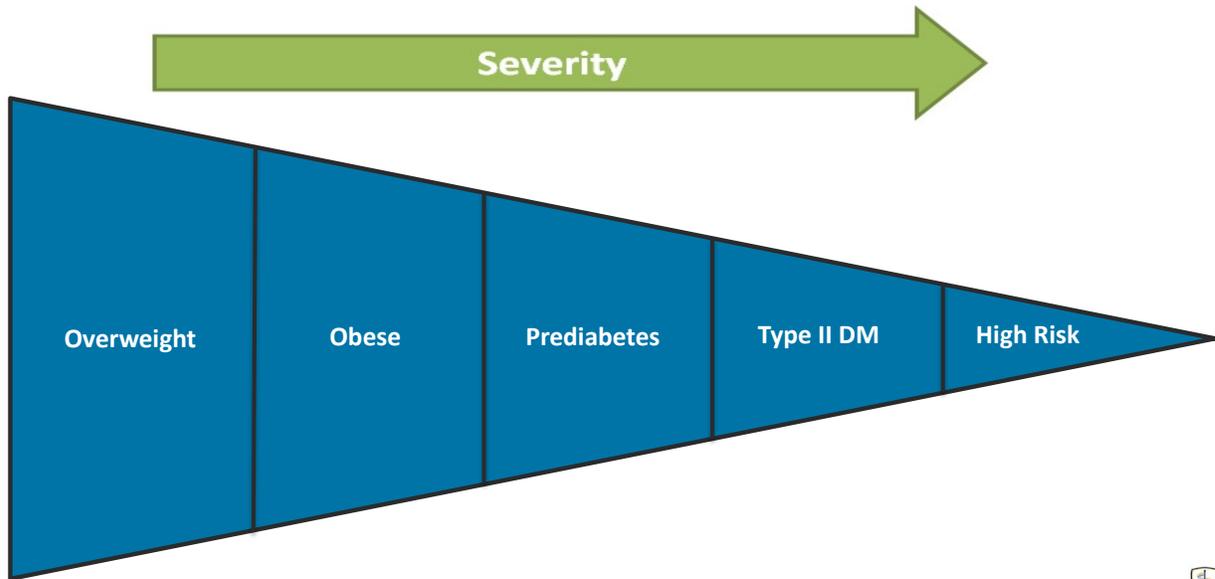
Enhance *Awareness,*

Comfort,* and *Skills

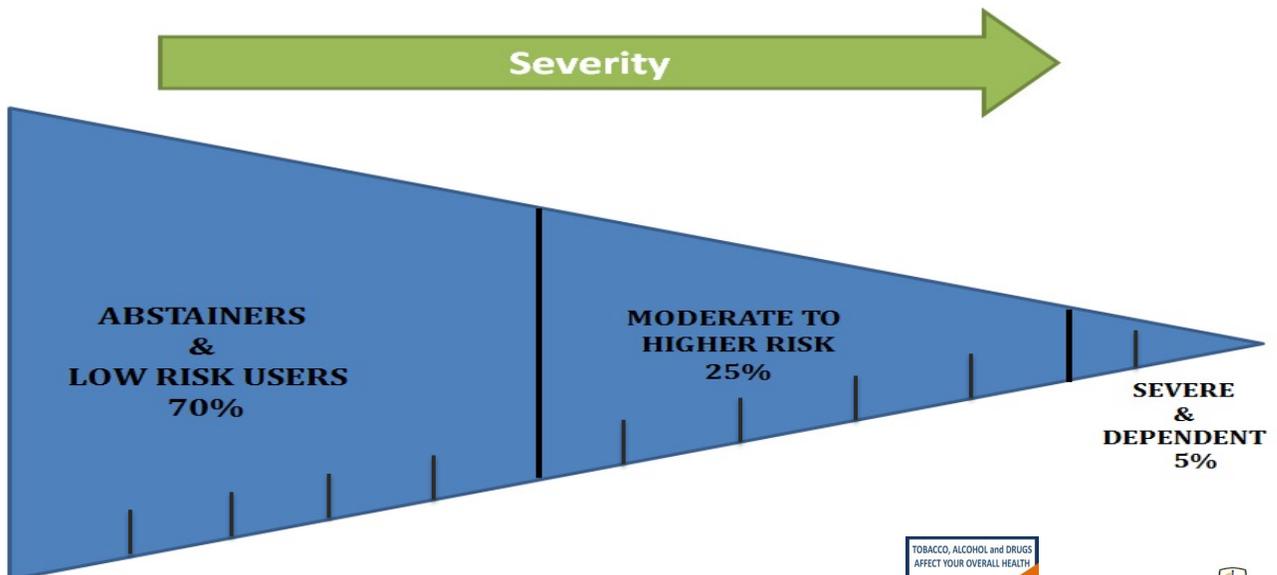




Rethinking our Approach...

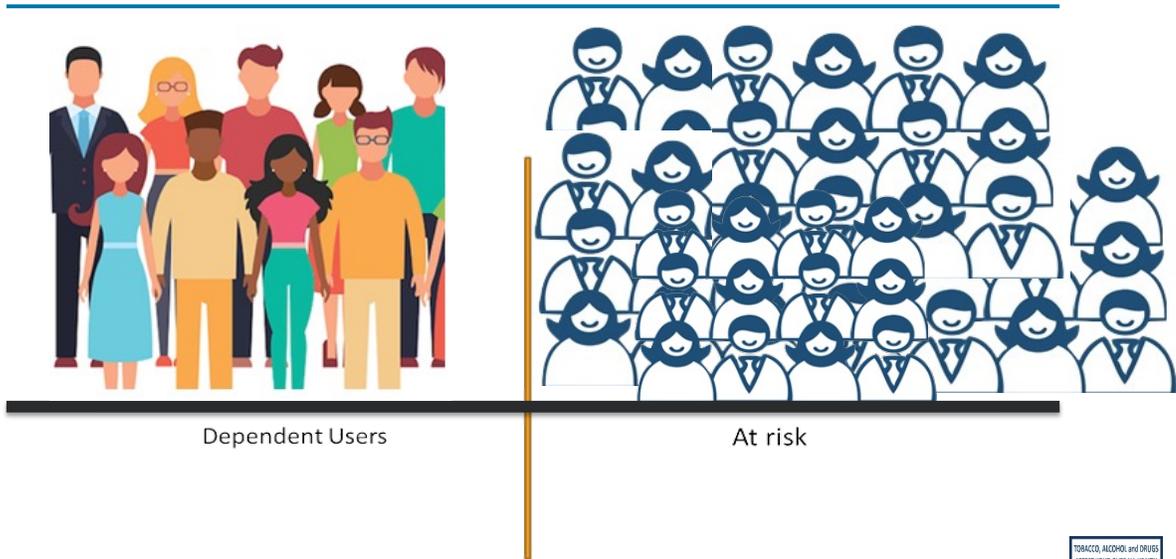


Substance Use Continuum





Rethinking Substance Use Disorder from a Public Health Perspective



There Is Help



SUD & Mental Health are CHRONIC Illnesses

(like so many others we are familiar with)

Care & Treatment can start ANYWHERE





Landscape of Addiction Treatment & Care



The Road to Recovery is not a straight line.





Words Matter



Person-centric Language | Avoid Judgmental Terminology | Be Supportive

Words to <u>avoid</u>	Words to <u>use</u>
Addict	Person with substance use disorder
Alcoholic	Person with alcohol use disorder
Drug problem, drug habit	Substance use disorder
Drug abuse	Drug misuse, harmful use
Drug abuser	Person with substance use disorder
A clean drug screen	Testing negative for substance use
A dirty drug screen	Testing positive for substance use
Former/reformed addict/alcoholic	Person in recovery, person in long-term recovery
Opioid replacement, methadone maintenance	Medication for Addiction Treatment (MAT)

Reframing,
Action, & Advocacy
is POSSIBLE



This is an epidemic is *currently* affecting all demographics

However, historically, it has affected some communities
more than others, particularly
communities of color



Motivation

To ACT.

To PARTNER.

To INNOVATE.

To CORRECT.

To provide care and social justice...

indiscriminately





Our time to right the wrongs of the past

~~despair and hopelessness~~

compassion and equity

Eliminate disparities in care and justice





Communication!
Empathetically HUMANIZING
the subject

#DESTIGMATIZE

KNOW THE FACTS AVOID THE MYTHS

Acceptance



H O P E

DISRUPTION
of the **NORM**

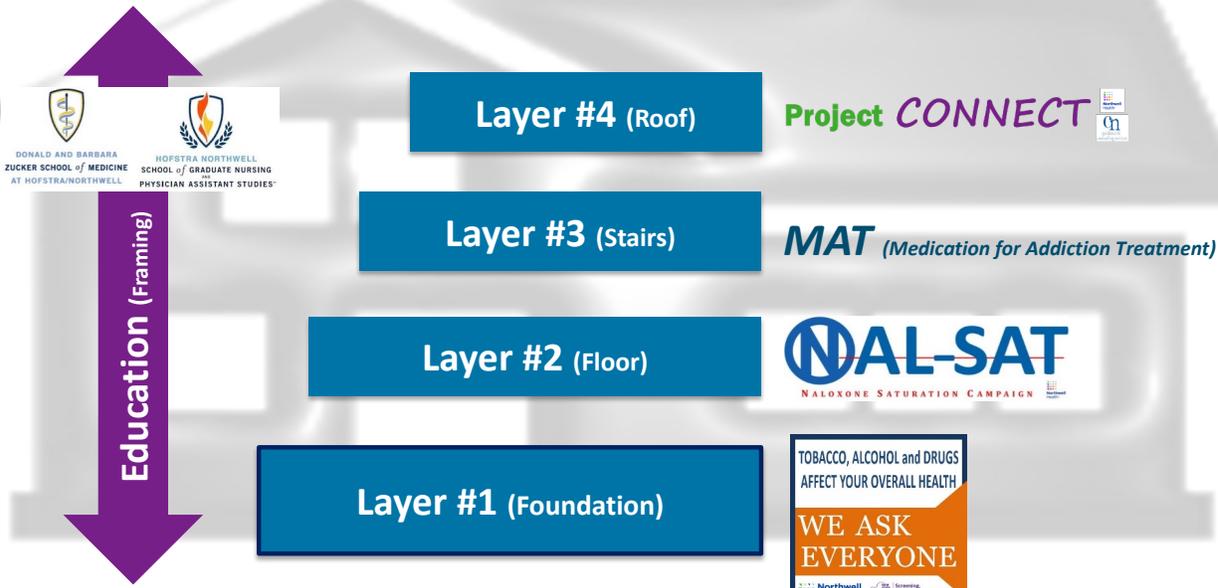




Personal Commitment to Act



Partnerships
&
Bridges

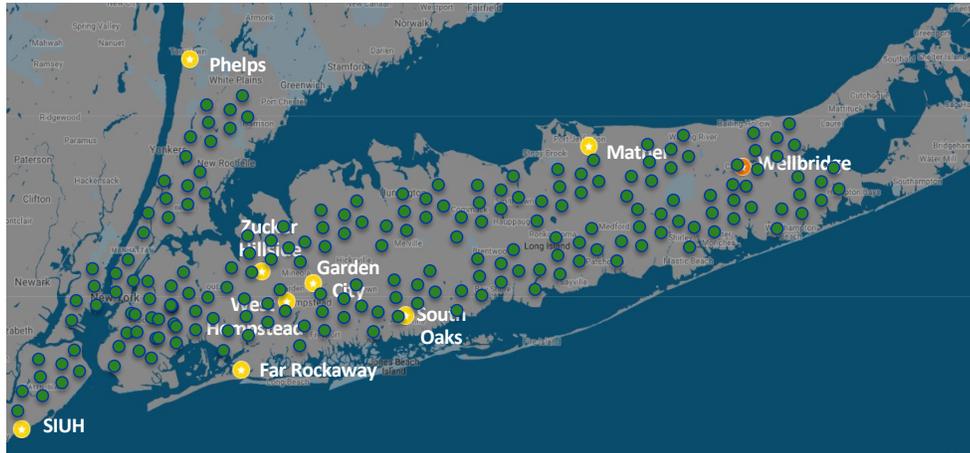




Northwell Health Resources



Northwell Treatment Facilities



Employee Substance Use Leadership Taskforce

Substance Use Policy

First created in 2006 with the last revision being made in 2016.

Diversion Training

First launched in 2019 with managers.

Substance Use Focus Groups

Conducted to collect feedback on team member perception of Northwell's position on substance use.

Organizational Philosophy

Developed to serve as a "north star" to guide all other work of our committee.

EHS Talking Points

To be used during EHS touch points with team members when appropriate.

Prior Years

Q3 2020

Q4 2020

Q1 2021

Q2 2021

Anonymous Substance Use Hotline

Launched in the end of 2018 to serve as a resource for team members who may be in need of EAP services but are uncomfortable identifying themselves.

Well-Being Pledge

In early July, we launched the *Humanizing Substance Use* pledge which resulted in over 14,000 team member pledges.

Revised Substance Use Policy

Changes to the Substance Use Policy were made to simplify our process language, reflect our organizational philosophy, and incorporate focus group feedback.

Video Vignettes for Diversion Training

Training was adapted to an iLearn module and finalized with video vignettes of workplace issues.



Organizational philosophy

Northwell Health, as both a premier health care provider and an employer, is committed to action in response to the increasing rate of **substance use** and its effects on our **team members, patients, and communities**.

We will **foster an environment in which team members feel safe discussing substance issues**. **Team members are encouraged to come forward about substance use concerns to obtain and receive support and treatment**. As healthcare professionals vested in the continued health and well-being of our patients, team members and community, **it is our commitment to prevent, identify and address any known or suspected substance use issues, impairment and/or drug diversion** by any level of team member in our organization.

Because we are **“Truly Together”**, we are committed to doing all that is necessary to protect both our patients and our team members from the effects of substance use, diversion and impairment in the workplace.

[For more information, visit our Addressing Substance Use intranet page](#)



Overdose Awareness Story Shares

Thank you to Northwell for this.
My daughter overdosed a few months ago.
Thank you for being here to support me.
- RN at Cohen Children's Medical Center

I recently had a patient agree to be admitted for alcohol withdrawal. She was very young but her labs showed that her liver was already beginning to fail due to her alcohol consumption. By using open ended, nonjudgmental questions she was able to express her fears and concerns to the staff. I know the training we get at Northwell really helped with understanding this patient's needs. We truly treated her with dignity and respect and because of that she got the care she needed.

In 2013, I met the sweetest boy named Chris on a 5 day cruise leaving from New Orleans. He was from Alabama and we immediately struck up a friendship. We continued that friendship after the cruise, and I was planning on visiting at some point in 2014... but he had passed away from a drug overdose. We don't now if it was intentional or not. To this day I still think about him and wish he could have shared his struggles. A beautiful soul was lost. We need to end the stigma of substance abuse, because you don't know what people are going through or what feeling they may be trying to mask. As a society, we need to lead with kindness, not judgement.

I lost my 20-year-old cousin to an overdose. His life was so precious and just beginning. It broke my aunt's heart into a million pieces, and his



tinyurl.com/NorthwellOverdoseAwareness



15 Hospitals

100+ Volunteers

500+ Rescue Kits Dispensed



What can you do?



Spread the word!!! 'We are NOT alone...'

International Overdose Awareness Day... you are not alone
 Tuesday, Aug. 31



The CDC reports that 93,000 drug overdoses took place in 2020, with more than three-quarters attributed to opioids. Additionally, in 2019, there were more unintentional overdose deaths in the workplace than in any other year since data collection began in 2011. International Overdose Awareness Day (IOAD) is a global event held August 31 each year in remembrance of those gone too soon from overdose deaths, those impacted by overdose, and in effort to prevent future overdoses.

Let's connect, many programs and services available to our team members and the community

Become a 1st responder to prevent overdoses



Overdose Prevention Education



COVID-19 has brought increased anxiety, stress, isolation, and financial worries.

The increased use of alcohol and drugs may play a role in how we cope with these challenges.

You are not alone . . .

Northwell Health is here to partner with you.

Help is available.
Call us at **516-465-5955**.

- Free
- Confidential
- No insurance required
- Spanish available



**Monday - Friday
10am - 8pm
516-465-5955**





***EVERYONE* has power in this equation.**

Make your PLEDGE today!

**Northwell Health's
Humanizing Substance Use PLEDGE**

redcap.link/humanizing



Thank You!

For more information

SBIRTinfo@northwell.edu

skapoor@northwell.edu



[@KapoorMedED](https://twitter.com/KapoorMedED)

[@Northwell_EM](https://twitter.com/Northwell_EM)

[@NorthwellHealth](https://twitter.com/NorthwellHealth)



www.coh-fit.com



Disparities in the Screening and Treatment of Cardiovascular Diseases in Patients with Mental Health Disorders

Prof. Dr. med. Christoph U. Correll

**Professor of Psychiatry and Molecular Medicine
The Donald and Barbara Zucker School of Medicine at
Hofstra/Northwell
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**Professor of Child and Adolescent Psychiatry
Charité – Universitätsmedizin Berlin
Berlin, Germany**

Disclosures: Christoph U. Correll

I have an interest in relation with one or more organizations that could be perceived as a possible conflict of interest in the context of this presentation. The relationships are summarized below:

Interest	Name of organization
Grants	National Institute of Mental Health (NIMH), Patient Centered Outcomes Research Institute (PCORI), Takeda, Thrasher Foundation
Shares	LB Pharma (options)
Paid positions, honoraria and advisory boards	AbbVie, Acadia, Alkermes, Allergan, Angelini, Aristo, Axsome, Cardio Diagnostics, Damitsa, Gedeon Richter, Hikma, Holmusk, IntraCellular Therapies, Janssen/J&J, Karuna, LB Pharma, Lundbeck, MedAvante-ProPhase, MedInCell, Medscape, Merck, Mindpax, Mitsubishi Tanabe Pharma, Mylan, Neurocrine, Noven, Otsuka, Pfizer, Recordati, Relmada, Rovi, Seqirus, Servier, SK Life Science, Sumitomo Dainippon, Sunovion, Supernus, Takeda, Teva, and Viatrix.



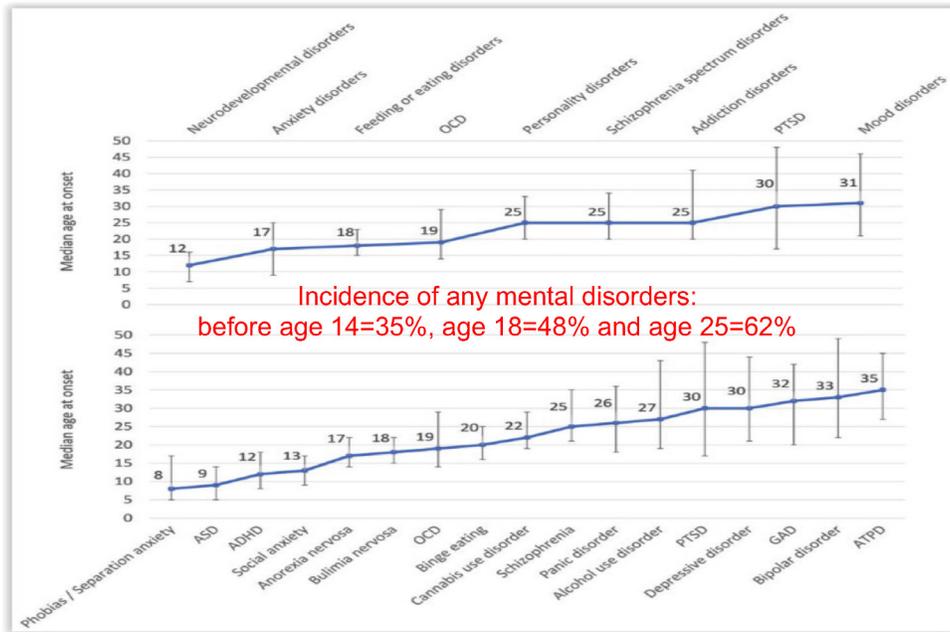
Overview

- Physical Health and Mental Health
- Disparities in Screening and Treatment
- Conclusions

Physical Health and Mental Health

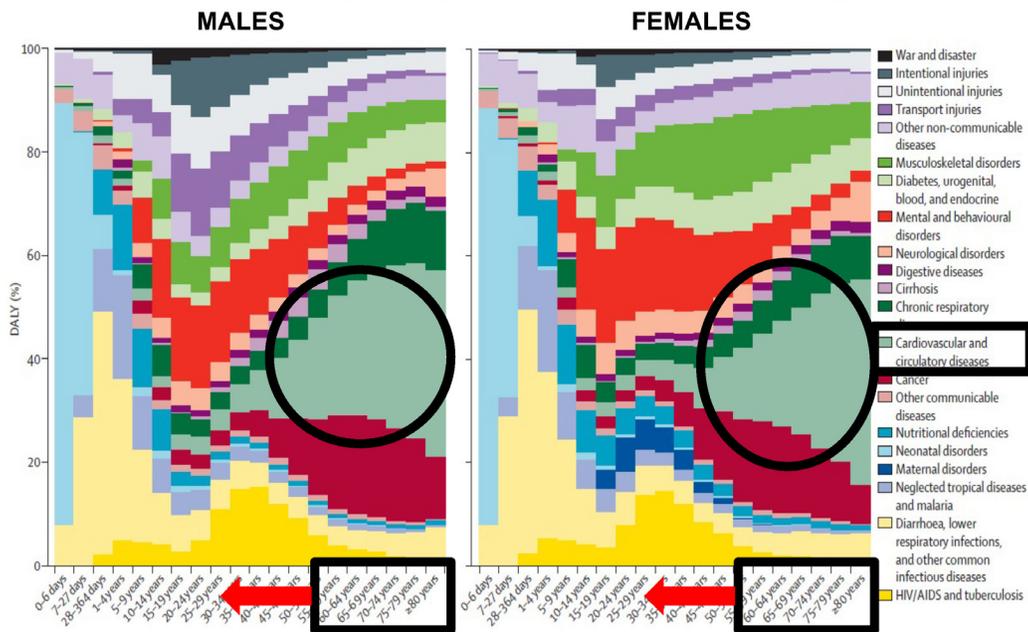


Median Age of Onset of Mental Disorders



Solmi M, et al. Mol Psychiatry. 2021 Jun 2. [Online ahead of print].

2010: Disability Adjusted Life Years (DALYs)

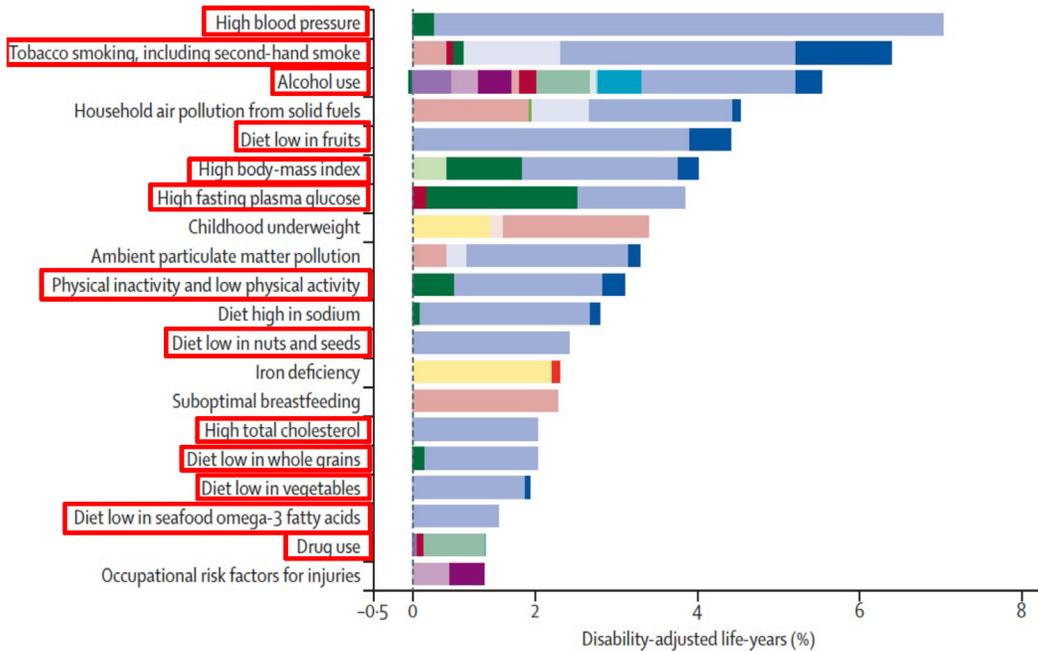


DALYs= Years of Life Lost + Years Lived with Disability

Murray C et al. Lancet 2012; 380: 2197-223.

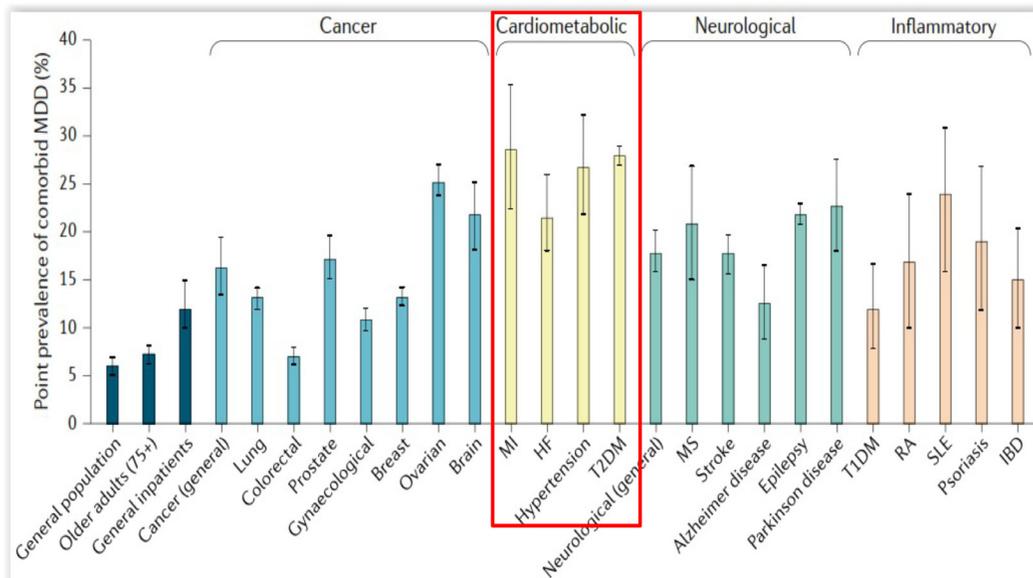


Burden of Disease Attributable to 20 Leading Risk Factors



Lim SS et al. Lancet 2012;380: 2224-60.

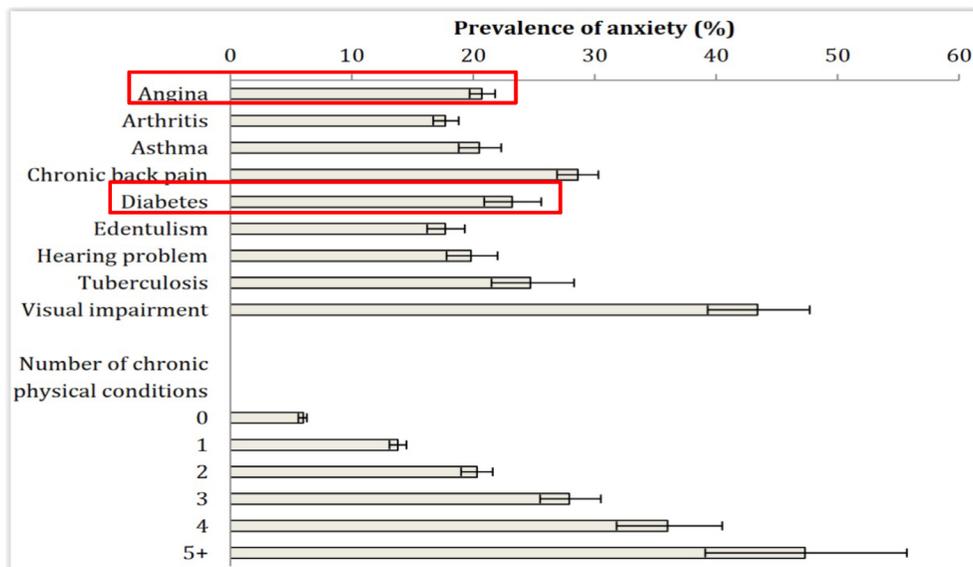
Prevalence estimates of comorbid major depressive disorder in patients with chronic medical diseases



Gold SM et al. Nat Rev Dis Primers. 2020 Aug 20;6(1):69.



Relationship between chronic physical conditions, multimorbidity and anxiety in the general population: A global perspective across 42 countries



Vancampfort D et al. Gen Hosp Psychiatry. 2017 Mar-Apr;45:1-6.

Adult ADHD and Comorbid Somatic Disease: A Systematic Literature Review

Diagnosis	ICD-10 code	Number of individual studies	Association and quality of evidence ^a
In general		4	
Resistance to thyroid hormone	E07.8	1	Association (3)
Hypothyroidism	E00-E03	1	Association (3)
Diabetes	E10-E14	3	No/negative association (3)
Nutritional diseases			
Obesity	E66	22	Association (1)
Metabolic disorders	E70-E90		
In general		1	Association (3)
Albinism	E70.3	1	Association (3)
Maple syrup urine disease	E71.0	1	Association (3)
Diseases of the nervous system			
Restless legs	G25	6	Association (3)
Dementia with Lewy bodies	G31.83	1	Association (3)
Epilepsy	G40	3	Association (3)
Migraine	G43	2	Association (2)
Sleep disorders	G47	25	Association (1)
Myotonic dystrophy	G71.1	2	Association (3)
Chronic fatigue syndrome	G93.3	2	Association (3)
Diseases of the circulatory system	Chapter IX	4	No association (2)
Allergic diseases			
In general		2	Association (3)
Allergic rhinitis	J30	1	Association (3)
Respiratory disorders	Chapter X		
In general		2	Association (3)
Asthma	J46	7	Association (1)

Strength of the association between ADHD and the somatic disease: (1) well established, (2) tentative evidence, (3) evidence is too weak to make conclusions.

Instanes JT, et al. J Atten Disord. 2018 Feb;22(3):203-228.



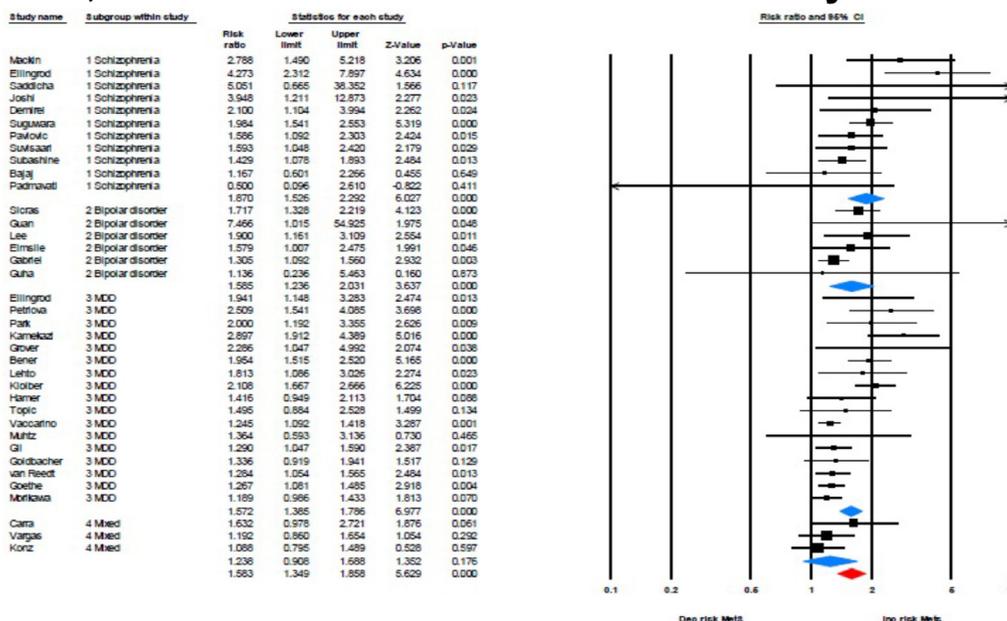
Estimated Prevalence and Relative Risk of Modifiable Cardiovascular Disease Risk Factors is 1-5 times Greater in Patients with Schizophrenia and Bipolar Disorder Compared to the General Population

Modifiable Risk Factors	Estimated Prevalence & Relative Risk (RR)	
	Schizophrenia	Bipolar Disorder
Obesity	45–55%, RR: 1.5-2	21–49%, RR: 1-2
Smoking	50–80%, RR: 2-3	54–68%, RR: 2-3
Diabetes	10%–15%, RR: 2	8–17%, RR: 1.5-2
Hypertension	19–58%, RR: 2-3	35-61%, RR: 2-3
Dyslipidemia	25-69%, RR: ≤5	23-38%, RR: ≤3
Metabolic Syndrome	37-63%, RR: 2-3	30-49% RR: 1.5-2

RR=relative risk

Correll CU. CNS Spectr. Vol 12. No 10 (Suppl 17), 2007:12-20,35.

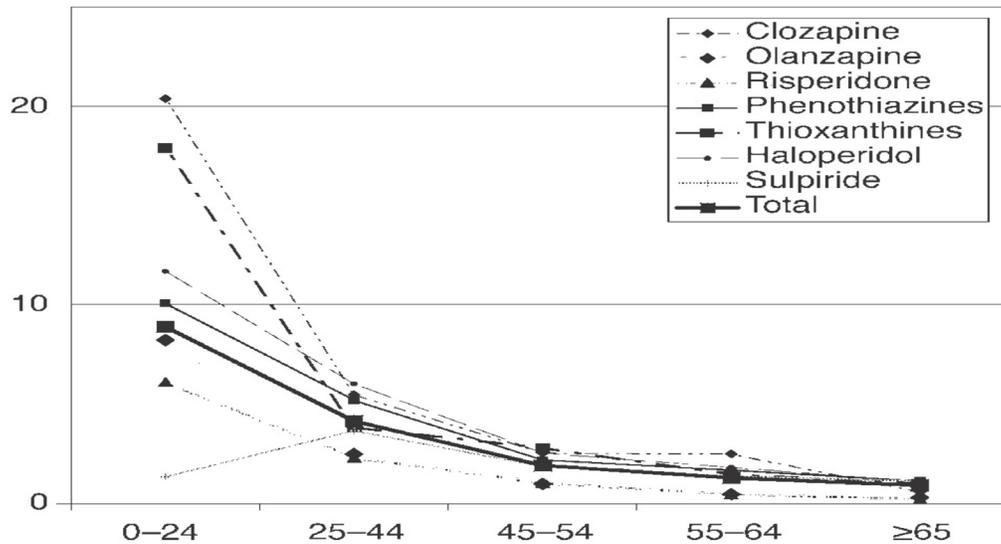
Overlapping Risk Ratios of MetSy in Patients with SCZ, BD and MDD versus Matched Healthy Controls



37/98 studies with comparative data Vancampfort D et al. World Psychiatry 2015;14(3):339-347.



ORs for Diabetes Among Antipsychotic Users vs. Non-Users: Greatest Antipsychotic-Related Risk Among Younger Age Groups



Hammerman A et al. Ann Pharmacother 2008 42(9):1316-1322.

Effect of Antipsychotics, Antidepressants and Mood Stabilizers on Physical Health

Physical disease/condition	Antipsychotics	Antidepressants	Mood stabilizers
<i>Nutritional and metabolic diseases</i>			
Obesity	0/+ (haloperidol, lurasidone, ziprasidone, aripiprazole) to +++ (clozapine, olanzapine, low potency FGAs)	- (bupropion) to + (mirtazapine, paroxetine, TCAs)	0 (lamotrigine) to ++ (valproate, lithium)
Dyslipidemia	+ to ++	0 to + (if weight gain)	- (valproate: cholesterol) to +
<i>Endocrine system diseases</i>			
Diabetes	0/+ (haloperidol, lurasidone, ziprasidone, aripiprazole) to +++ (clozapine and olanzapine > low and mid potency FGAs)	0 to +	0 to ++ (valproate)
Thyroid disorders	0	0	0 to ++ (lithium)
Hyponatremia/SIADH	+	+ to ++ (SSRIs)	0 to +
<i>Cardiovascular diseases</i>			
Hypertension	0 to ++	0 to + (venlafaxine)	0
Coronary heart disease and stroke	+ to ++	0 to +	0 to +
Myocarditis	0 to + (clozapine)	0	0
QTc prolongation/sudden cardiac death	0 to + (thioridazine > sertindole > ziprasidone)	0 to + ?	0

- = reduction; 0 = likely/generally no effect; + = some effect; ++ = moderate effect; +++ = marked effect; ? = questionable

Correll CU et al. World Psychiatry. 2015 Jun;14(2):119-36.



Disparities in Screening and Treatment

Consensus Statement on Antipsychotic Drugs, Obesity and Diabetes: Monitoring Protocol for Patients on Second-Generation Antipsychotics*

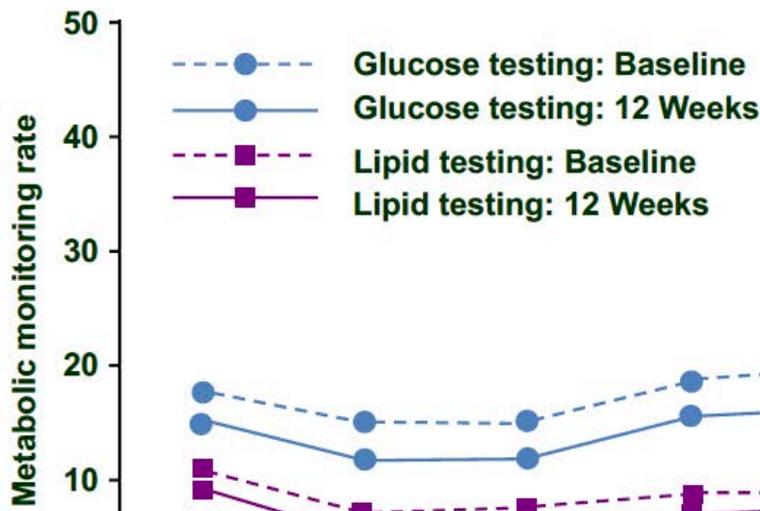
	Short-Term				Long-Term		
	Baseline	4 wk	8 wk	12 wk	Quarterly	Annually [*]	Every 5 y
Personal/Family History	X					X	
Weight (BMI)	X	X	X	X	X		
Waist Circumference	X					X	
Blood Pressure	X			X		X	
Fasting Plasma Glucose [^]	X			X		X	
Fasting Lipid Profile	X			X		X ←.....[X]	

*More frequent assessments may be warranted based on clinical status; [^] consider also

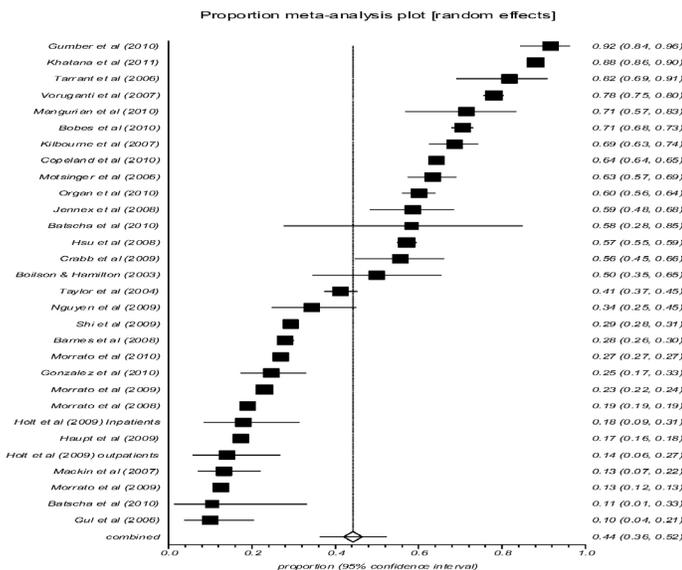
Adapted from: American Diabetes Association et al., Diabetes Care.2004;27:596



Changes in Monitoring Practices After FDA Warning and ADA/APA Consensus Guidelines



Routine Baseline Glucose Monitoring Across 39 Studies Conducted 2000-2001 (n=218,940)



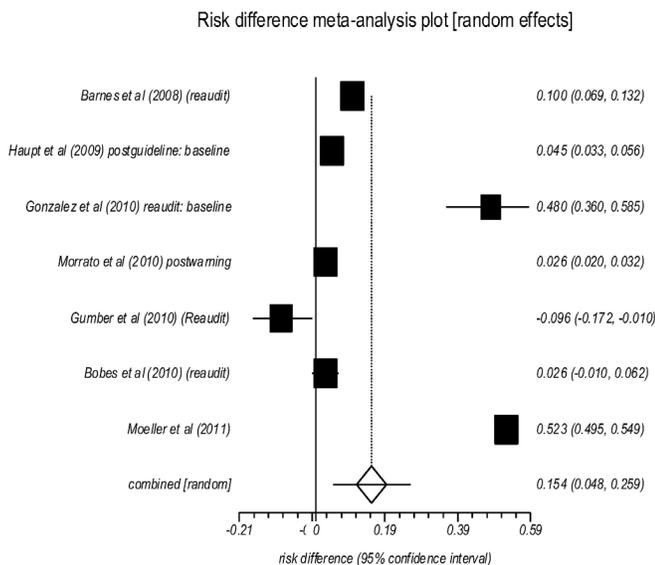
5 countries. 25 studies in Sz-disorder patients. Routine *baseline* screening was generally low and above 50% only for blood pressure (69.8%; CI:50.9-85.8%) and triglycerides (59.9%; CI:36.6-81.1%). Cholesterol was measured in 41.5% (CI:18.0-67.3%), glucose in 44.3% (CI:36.3-52.4%) and weight in 47.9 (CI:32.4-63.67%). All lipids and HBA1c were monitored in <25%.

2006
doi:10.1177/0963823006288888

16(3):345-53



Change in Glucose Monitoring Pre- to Post-Guideline in 9 Studies (n=71,594)



Monitoring improved for weight (75.9%; CI:37.3-98.7%); blood pressure (75.2% CI=45.6%-95.5%), glucose (56.1%; CI:43.4-68.3%) and lipids (28.9%; CI:20.3-38.4%). Direct head-to-head pre-post-guideline comparison showed a modest but significant (15.4%) increase in glucose testing (P=0.0045).

Mitchell A et al. Psychol Med. 2012 Jan;42(1):125-47.

Changes in Monitoring Practices in Antipsychotic Treated Patients After FDA Warning and ADA/APA Consensus Guidelines

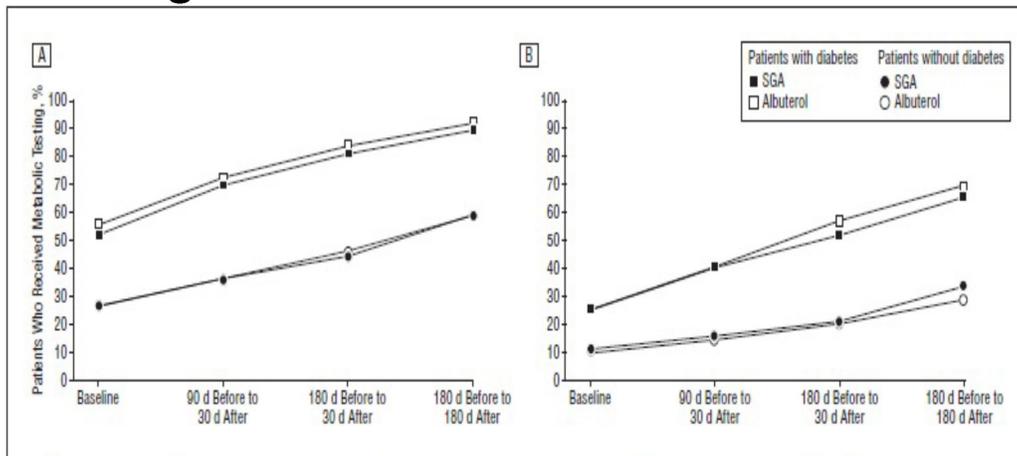
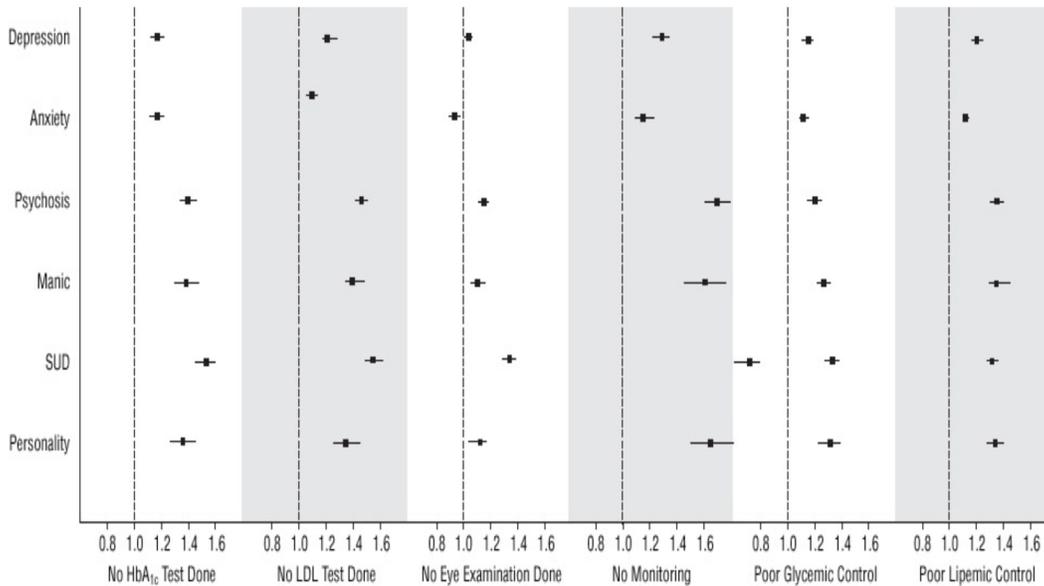


Figure 1. Serum glucose (A) and lipid (B) testing rates by diabetes status. Data are from California, Missouri, and Oregon state Medicaid programs, September 2004 through December 2005. Propensity-matched groups of albuterol and second-generation antipsychotic (SGA) persistent users are shown (n=33213).

Morrato EH et al. Arch Gen Psychiatry. 2010 Jan;67(1):17-24.



Odds Ratios of Substandard Medical Care in Mentally Ill Outpatients with Diabetes



Data from 313,586 Veteran outpatients with diabetes, 25% of which had mental disorders
Frayne et al. J Arch Int Medicine 2005;165:2631-8

Disparities in Screening and Treatment of Cardiovascular Diseases in Patients With Mental Disorders Across the World: Systematic Review and Meta-Analysis of 47 Observational Studies

Marco Solmi, M.D., Ph.D., Jess Fiedorowicz, M.D., Ph.D., Laura Poddighe, M.Psy., Marco Delogu, M.Psy., Alessandro Nicola, M.D., Anne Høy, M.D., Ph.D., Ina H. Heiberg, M.Sc., Ph.D., Brendon Stubbs, M.Sc., Ph.D., Lee Smith, M.Sc., Ph.D., Henrik Larsson, Ph.D., Rubina Attar, M.D., René E. Nielsen, M.D., Ph.D., Samuele Cortese, M.D., Ph.D., Jae Il Shin, M.D., Ph.D., Paolo Fusar-Poli, M.D., Joseph Firth, Ph.D., Lakshmi N. Yatham, M.B.B.S., F.R.C.P.C., Andre Carvalho, M.D., Ph.D., David J. Castle, M.D., F.R.C.Psych., Mary V. Seeman, M.D., Christoph U. Correll, M.D.

Cardiovascular Disease and Mental Disorder	Publications and Samples (k/k)	Odds Ratio	95% CI	p	I ²	Egger's Test p	Fail-Safe N	Effect Size After Trim and Fill ^a	95% CI
Any cardiovascular disease									
Any	23/38	0.757	0.719, 0.797	<0.001	92.900	0.43	5,391	0.813	0.769, 0.859
Mood disorders	8/9	0.877	0.792, 0.973	0.013	84.358	0.80	241		
Schizophrenia spectrum disorders	15/16	0.611	0.554, 0.673	<0.001	91.055	0.005	2,709	0.728	0.660, 0.803
Mixed ^b	10/13	0.812	0.733, 0.899	<0.001	92.982	0.695	603		
Acute myocardial infarction, ischemic heart disease									
Any	16/29	0.718	0.670, 0.770	<0.001	94.461	0.048	3,302	0.800	0.745, 0.860
Mood disorders	6/7	0.830	0.732, 0.941	<0.001	82.248	0.697	240		
Schizophrenia spectrum disorders	12/13	0.552	0.490, 0.622	<0.001	88.030	0.06	1,861	0.673	0.597, 0.757
Mixed ^b	6/9	0.856	0.748, 0.980	<0.001	93.625	0.993	277		
Cerebrovascular disease, stroke, transient ischemic attack									
Any	3/4	0.683	0.533, 0.87	0.003	0	0.078	5	Unchanged	
Mood disorders	1								
Schizophrenia spectrum disorders	2/2	0.591	0.388, 0.899	<0.001	0	NP ^c			
Mixed ^b	1								
Mixed cardiovascular disease									
Any	7/10	0.786	0.712, 0.868	<0.001	88.739	0.397	326		
Mood disorders	3/3	1.011	0.935, 1.094	0.784	0	0.610	NP ^c		
Schizophrenia spectrum disorders	4/4	0.775	0.719, 0.835	<0.001	46.769	0.017	149	0.797	0.733, 0.867
Mixed ^b	3/3	0.730	0.552, 0.966	<0.001	95.934	0.514	48		

^a In cases of publication bias.
^b Mixed disorders include anxiety disorders, posttraumatic stress disorder, substance-related disorders, and other disorders.
^c NP=not pertinent.

47 studies (N=24,400,452 patients, of whom 1,283,602 had mental disorders) from North America (k=26), Europe (k=16), Asia (k=4), and Australia (k=1) were meta-analyzed.
 Solmi M et al. Am J Psychiatry. 2021 Sep 1;178(9):793-803.



Disparities in Screening and Treatment of Cardiovascular Diseases in Patients With Mental Disorders Across the World: Systematic Review and Meta-Analysis of 47 Observational Studies

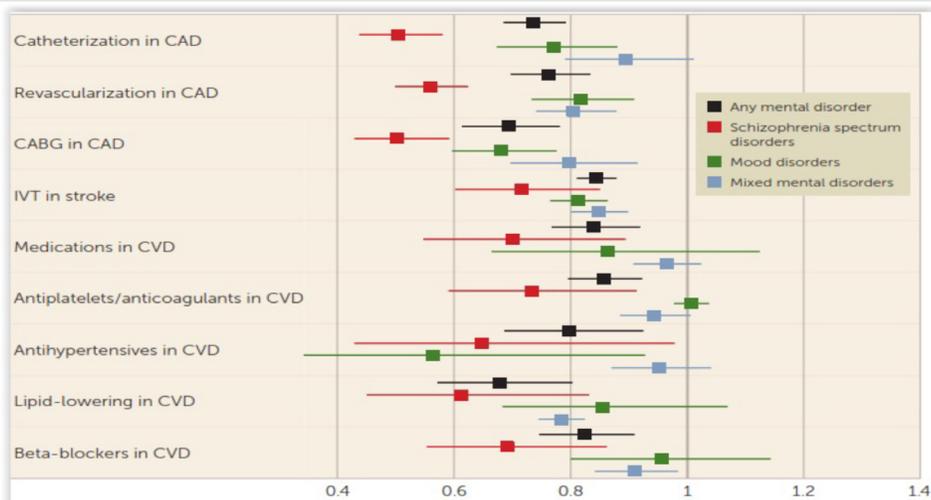
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Cardiovascular Disease and Mental Disorder	Publications and Samples (k/k)	Odds Ratio	95% CI	p	I ²	Egger's Test p	Fail-Safe N	Effect Size After Trim and Fill ^a	95% CI
Any cardiovascular disease									
Any	45/86	0.765	0.730, 0.801	<0.001	94.613	0.276	6,062		
Mood disorders	17/21	0.816	0.755, 0.882	<0.001	94.829	0.858	1,361		
Schizophrenia spectrum disorders	27/28	0.597	0.538, 0.662	<0.001	93.97	0.046	6,723	0.609	0.549, 0.674
Mixed ^b	25/37	0.843	0.792, 0.898	<0.001	91.792	0.310	2,483		
Acute myocardial infarction, ischemic heart disease									
Any	33/61	0.728	0.681, 0.778	<0.001	95.661	0.115	8,254		
Mood disorders	12/14	0.830	0.755, 0.912	<0.001	91.470	0.251	255		
Schizophrenia spectrum disorders	20/21	0.556	0.489, 0.633	<0.001	93.470	0.140	4,444		
Mixed ^b	18/26	0.816	0.754, 0.884	<0.001	92.637	0.511	1,726		
Cerebrovascular disease, stroke, transient ischemic attack									
Any	7/17	0.811	0.779, 0.844	<0.001	74.451	0.511	985		
Mood disorders	3/5	0.813	0.766, 0.863	<0.001	71.612	0.239	349		
Schizophrenia spectrum disorders	4/4	0.719	0.619, 0.835	<0.001	56.059	0.266	132		
Mixed ^b	4/8	0.849	0.807, 0.894	<0.001	31.973	0.901	54		
Mixed cardiovascular disease									
Any	9/12	0.837	0.723, 0.969	0.017	84.441	0.113	46		
Mood disorders	2/2	0.667	0.447	0.995	0.047	NP ^c			
Schizophrenia spectrum disorders	4/4	0.683	0.492, 0.947	0.022	81.197	0.101	22		
Mixed ^b	6/6	0.940	0.805, 1.097	0.433	78.478	0.452	NP ^c		

47 studies (N=24,400,452 patients, of whom 1,283,602 had mental disorders) from North America (k=26), Europe (k=16), Asia (k=4), and Australia (k=1) were meta-analyzed. Solmi M et al. Am J Psychiatry. 2021 Sep 1;178(9):793-803.

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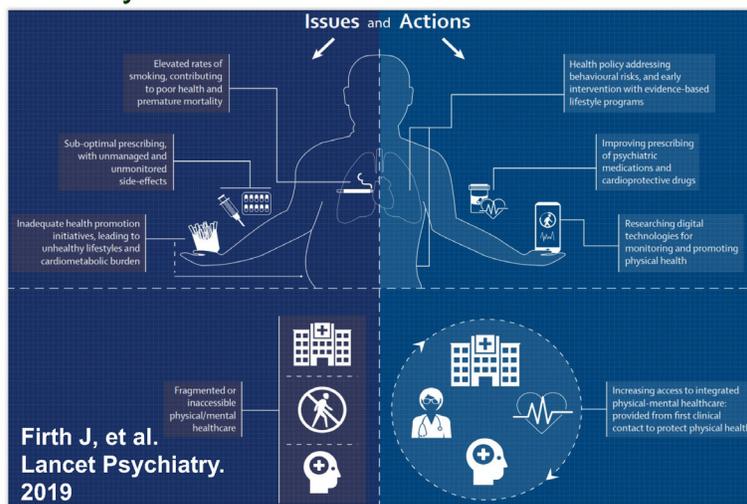


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Conclusions

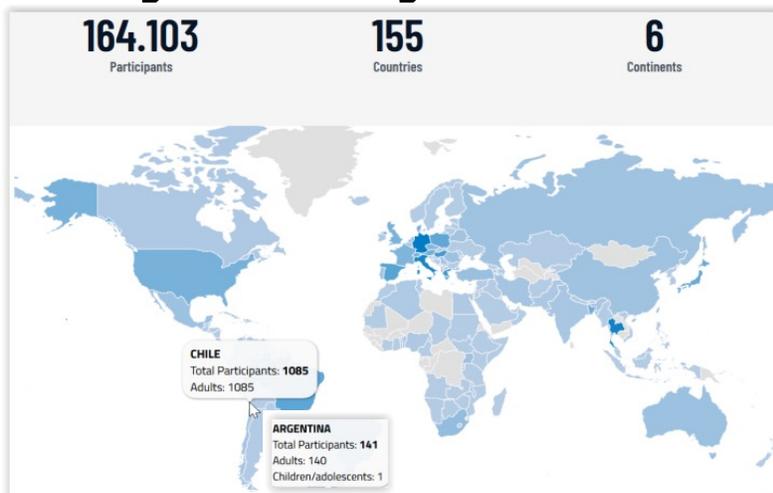
- Physical and mental illness are interrelated
- Pathways include genetic, lifestyle and medication factors
- Both physical and mental illness require strong attention
- Disparities in the monitoring for and care of somatic conditions in the mentally must be remediated



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Thank you for your attention!





CULTURALLY RESPONSIVE INTERVENTIONS FOR POSTTRAUMATIC STRESS DISORDER

NICOLE H. WEISS, PH.D.
ASSISTANT PROFESSOR | DEPARTMENT OF PSYCHOLOGY
DIRECTOR | STRESS LAB
UNIVERSITY OF RHODE ISLAND



TRAUMA AND PTSD

89.7%

... of people will experience a **traumatic event** in their lifetime¹

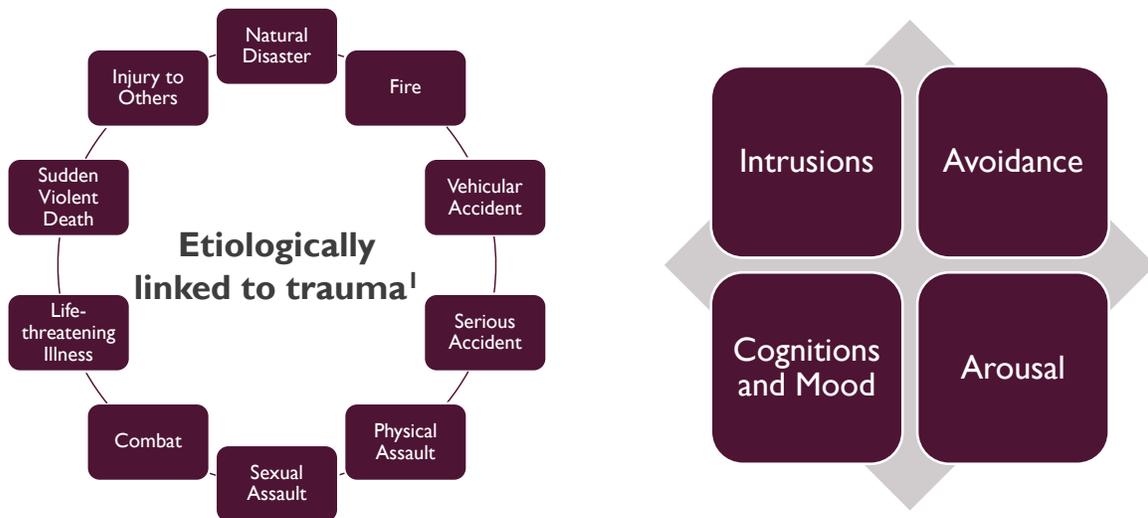
8.3%

... of people who experience a traumatic event will develop **PTSD**¹

¹Kilpatrick et al., 2013



DSM-5 PTSD



¹APA, 2013

BURDEN OF PTSD

- ↑ Healthcare costs¹
- ↑ Psychosocial impairment²
- ↑ Comorbid health concerns^{3,4}
- ↑ Risky behaviors^{5,6}

¹Chan et al., 2009; ²Breslau et al., 2004; ³Stein & Kennedy, 2001; ⁴Dutton et al., 2006; ⁵Weiss et al., 2017; ⁶Simpson et al., in press



CO-OCCURRING PTSD AND SUD

- Individuals identified by SUD¹⁻⁶
 - Lifetime PTSD: 26% to 52% Compared to 8.3% for no-SUD⁸
 - Current PTSD: 15% to 42% Compared to 3.8% for no-SUD⁸
- Individuals identified by PTSD^{3,7}
 - Current SUD: 36% and 52% Compared to 2.3% for no-PTSD⁹

¹Dragan & Lis-Turlejska, 2007; ²Driessen et al., 2008; ³Mills et al., 2006; ⁴Reynolds et al., 2011; ⁵Reynolds et al., 2005; ⁶Schäfer et al., 2010; ⁷Pietrzak et al., 2011; ⁸Kilpatrick et al., 2013; ⁹McCabe et al., 2017

PTSD-SUD EXPLANATIONS

1. Negative reinforcement:^{1,2} SUD emerges following the development of PTSD and functions to “self-medicate” trauma-related emotional distress
2. High-risk:^{3,4} SUD precedes the development of PTSD and is associated with high-risk behaviors that subsequently increase the likelihood of traumatic exposure
 - Places individuals in risky situations⁵
 - Impairs detection of danger cues in the environment⁶
3. Mutual maintenance: Reflexive link between PTSD and SUD, such that PTSD leads to SUD and in turn, SUD maintains or exacerbates PTSD^{4,7}
4. Non-temporal (e.g., shared vulnerability hypothesis⁸): Implicates the role of common genetic and environmental risk factors for PTSD and SUD⁹

¹Baker et al., 2004; ²Mills et al., 2005b; ³Begle et al., 2011; ⁴McFarlane et al., 2009; ⁵Windle, 1994; ⁶Davis et al., 2009; ⁷Kaysen et al., 2011; ⁸María-Ríos & Morrow, 2020; ⁹Sartor et al., 2011



SELF-MEDICATION

- Emotional pain: Leading reason for substance use¹
 - 95% use substances to alleviate negative affective states²
 - Earlier negative affect → later substance use^{3,4}
- More prevalent in PTSD
 - Use substances in contexts that signal negative reinforcement (e.g., to reduce distress)⁵

¹Merlo et al, 2013; ²Garland et al., 2015; ³Preston et al., 2018a; ⁴Preston et al., 2018b; ⁵Stewart et al., 2000

CO-OCCURRING PTSD AND SUD

- More severe SUD profile
 - Stronger drug cravings^{1,2}
 - More withdrawal symptoms³
 - More frequent and risky use^{4,5}

¹Coffey et al., 2002; ²Saladin et al., 2003; ³Boden et al., 2013; ⁴Back et al., 2006; ⁵Jacobsen et al., 2001



CO-OCCURRING PTSD AND SUD

- More complex clinical picture
 - Greater impairment in functioning⁴
 - Higher rates of disability⁵
 - Greater comorbid mental (e.g., depression), physical (e.g., chronic pain), and behavioral (e.g., suicide) health problems^{3,5}

¹Mills et al, 2005a; ²Mills et al., 2005b; ³Driessen et al., 2008; ⁴Riggs et al., 2003; ⁵Mills et al., 2006

CO-OCCURRING PTSD AND SUD

- Difficult-to-treat and marked by a more costly/chronic clinical course when compared to either disorder alone¹⁻³
 - Less improvement during treatment
 - Higher treatment drop-out
 - Earlier relapse following treatment

¹McCauley et al., 2012; ²Mills et al., 2006; ³Schäfer & Najavits, 2007



PTSD-SUD TREATMENT

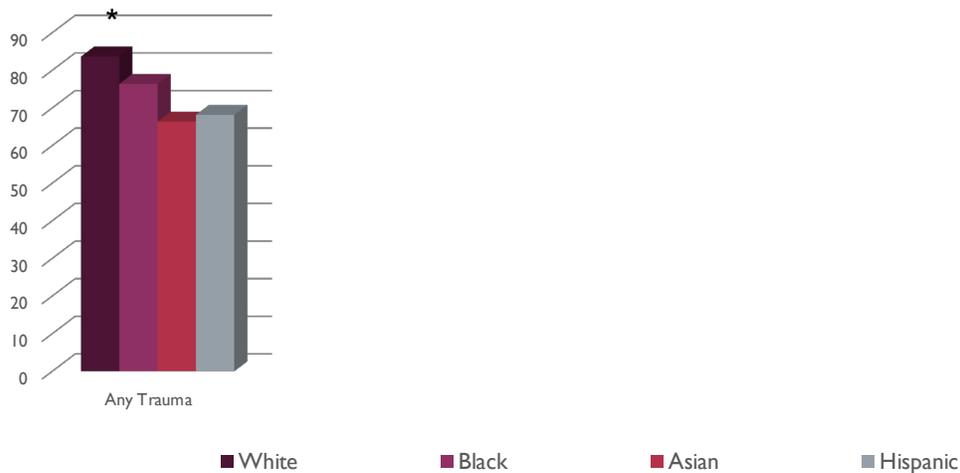
- Best treatment outcomes: Trauma-focused psychological interventions alongside or combined with SUD treatments¹⁻³
 - Parallel treatment: Trauma-focused therapy alongside, but separate from, an evidence-based SUD treatment; this approach is considered most effective¹
 - Integrated treatment: Involves both trauma-focused and substance-use-focused therapies being delivered simultaneously, or combined into a single treatment; this approach has received comparatively less evidence-based support¹

¹Roberts et al., 2015; ²Fareed et al., 2013; ³Ecker & Hunt, 2018

CULTURAL CONSIDERATIONS

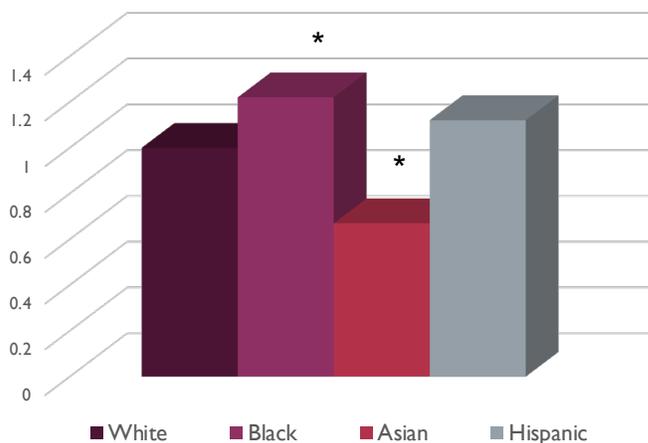


RACIAL/ETHNIC DIFFERENCES IN TRAUMA¹



¹Roberts et al., 2011

PROBABILITY¹ AND PERSISTENCE OF PTSD

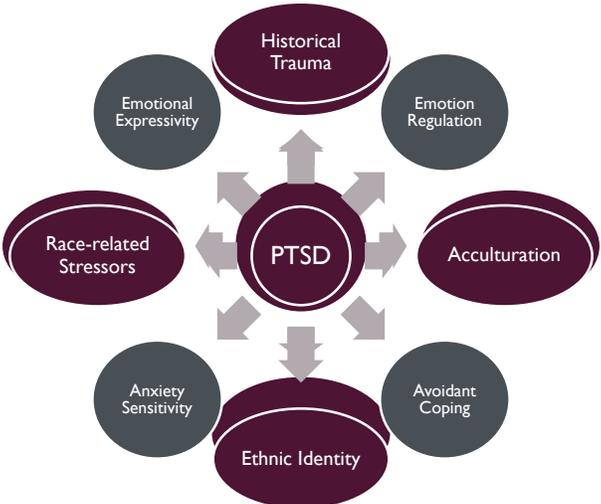


Persistent: two-year recovery is .10 for Black individuals versus .18 for white individuals²

¹Roberts et al., 2011; ²Benitez et al., 2014



UNIQUE FACTORS AND RELATIONS



DEVELOPMENT OF A CULTURALLY GROUNDED, TRAUMA-INFORMED ALCOHOL INTERVENTION WITH A RESERVE-DWELLING FIRST NATION GROUP

FUNDER: NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (R34AA028587)

PRINCIPAL INVESTIGATORS: WEISS & SPILLANE





ALCOHOL IN INDIGENOUS POPULATIONS

- Alcohol is a primary determinant of health disparities facing Indigenous populations¹
 - Exhibit the highest rates of binge and heavy drinking^{2,3}
 - Lifetime (43.4%) and 12-month (19.2%) rates of alcohol use disorder are substantially higher than those among other racial and ethnic groups⁴
- Disparities in alcohol treatment outcomes are prominent in Indigenous populations
 - Less likely to complete alcohol treatment⁵
 - Quicker to relapse^{6,7}
 - Display more severe patterns of alcohol use following treatment^{6,7}

¹Spillane & Smith, 2007; ²Dawson et al., 2015; ³SAMSHA, 2015; ⁴Vaeth et al., 2017; ⁵Evans et al., 2006; ⁶Query, 1985; ⁷Westermeyer & Peake, 1983

HISTORICAL TRAUMA

- Indigenous populations have faced histories of genocide, colonization, forced assimilation, and exclusion, causing historical losses of people, land, family, and culture
 - Disruption and devastation of economic systems, sustenance practices, spiritual customs, kinship networks, and family ties¹⁻³
- Historical trauma describes emotional and psychological wounding over the lifespan and across generations associated with these historical losses²
 - Distinguishing characteristics: widespread, perpetration by outsiders with purposeful and often destructive intent, and resultant collective distress in contemporary communities⁴

¹Brave Heart & DeBruyn, 1998; ²Brave Heart et al., 1998; ³Brave Heart et al., 2011; ⁴Evans-Campbell, 2008



HISTORICAL TRAUMA RESPONSE

- Physical, psychological, and social problems related to historical trauma^{1,2}
 - Individual (e.g., mental health)
 - Familial (e.g., parental stress)
 - Community (e.g., breakdown of traditional culture)
- Transmitted intergenerationally: descendants identify emotionally with ancestral suffering³

¹Walters et al., 2011; ²Evans-Campbell, 2008; ³Sotero, 2006

HISTORICAL TRAUMA → ALCOHOL USE

- Alcohol was not part of Indigenous culture prior to colonial contact¹
- The banning of traditional ways of healing left Indigenous populations without mechanisms for coping with emotional distress²
 - Coupled with emotional after-effects of mass cumulative trauma, left vulnerable
- Individuals: alcohol to self-medicate trauma memories and related emotional pain¹
- Family: changes in culturally normative parenting (e.g., affection, discipline³); linked to Indigenous populations' use of alcohol^{1,4}
- Community: breakdown of culture; weak cultural identity, lack of adherence to traditional values, and poor spiritual foundations relate to alcohol use^{1,4}

¹Brave Heart, 2003; ²Brave Heart, 2008; ³Brave Heart, 1999; ⁴Hawkins et al., 2004



ADDRESSING HISTORICAL TRAUMA

- Little research examining the utility of addressing historical trauma; none for alcohol
 - Reliance on adaptations for non-Indigenous populations (e.g., Seeking Safety)^{1,2}
 - Approaches to guide adaptations are based on Western/individualistic paradigms^{3,4}
 - Rely on decontextualized cultural add-ons (e.g., tribal language replaces English)⁶
 - Not adapted by Indigenous populations⁵
- Diminish the power and valuing of Indigenous knowledge and reflect a lack of appreciation and respect for efforts that communities may have developed using Indigenous ways of knowing to deal with historical trauma and alcohol use

¹Marsh et al., 2016a; ²Marsh et al., 2016b; ³Kagawa-Singer et al., 2015; ⁴Walsh, 2014; ⁵Walsh, 2014; ⁶Walters et al., in press

CULTURALLY GROUNDED INTERVENTION

- Indigenous communities¹ and researchers² advocate culturally grounded interventions
 - Rooted in Indigenous knowledge, protocols, and practices from the “ground up”
 - Draw cultural strengths: Indigenous history, language, values, and healing traditions
 - Reclaim cultural beliefs, practices, and aspirations that promote health/well-being
 - Restore daily living in accordance with ancient and enduring cultural values

¹Bassett et al., 2012; ²Okamoto et al., 2012



CULTURALLY GROUNDED INTERVENTION

- Availability of culturally aligned services key to recovery for Indigenous populations¹
 - Skepticism and resistance to treatments developed by non-Indigenous researchers for non-Indigenous populations being used in Indigenous communities²
 - Aspects of treatments developed by non-Indigenous researchers for non-Indigenous are at odds with Indigenous culture^{3,4}
 - Indigenous populations' indicate greater comfort with treatments that integrate Indigenous customs, traditions, and spirituality,^{3,4} and frequently seek traditional healing modalities for addressing alcohol use⁵

¹Rowan et al., 2014; ²Calabrese, 2008; ³Venner et al., 2016; ⁴Novins et al., 2016; ⁵Beals et al., 2005

AIMS

- **SA1:** Community-Based Participatory Research methods to deepen partnerships with First Nation community through capacity-building and knowledge sharing.
- **SA2:** Qualitative data to develop culturally grounded, trauma-informed intervention to reduce alcohol use and problems that is focused on historical trauma.
- **SA3:** Pilot RCT to examine feasibility, acceptability, and efficacy of the intervention.



DISCUSSION

1. Significant role of PTSD in SUD among trauma-exposed individuals
2. PTSD may drive substance use; critical target for clinical assessment/intervention
3. Majority of patients with PTSD-SUD only receive SUD treatment^{1,2}
 - Counter to most patients' preferences³⁻⁵
 - Worse retention, adherence, and outcomes post-treatment⁶
 - Best: Trauma-focused interventions alongside/combined with SUD treatments⁶⁻⁸
4. Cultural considerations to inform culturally responsive PTSD-SUD interventions

¹Navajits et al., 2004; ²Young et al., 2005; ³Back et al., 2005; ⁴Brown et al., 1998a; ⁵Brown et al., 1998b; ⁶Roberts et al., 2015; ⁷Fareed et al., 2013; ⁸Ecker & Hunt, 2018

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The Clubhouse Model: Role of Psychosocial Rehabilitation in Addressing Social Determinants of Health

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Chief Research & Knowledge Officer

November 19, 2021

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Serious Mental Illness (SMI) in America: Social Impacts & Health Inequity

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SMI creates ripples of impact on individuals, families, and society



Individuals with Serious Mental Illness (SMI)

- **Premature death:**
 - 10-25 years shorter lifespan
 - 2-4X more likely to die from unnatural causes (e.g., suicide, homicide)
 - Higher rates of chronic physical disease (e.g., diabetes) and infectious disease (e.g., HIV)
 - 20% more likely to experience substance abuse disorder
- **Criminal justice:** Admitted to jail 2M times per year in the U.S.; 383k inmates with mental illness in jails and prisons
- **Housing:** Represent 25% of homeless population in U.S.; 165K homeless people with SMI
- **Employment:**
 - Unemployment rates of up to 45%
 - Earn about \$16K less per year
- **Education:** High school students with symptoms of depression 2X more likely to drop out compared to peers



Families

- 8.4M+ Americans provide care to an adult with a mental or emotional health issue
- 32 hours per week of unpaid labor provided by caregivers for of adults with mental or emotional health issues
- Lost productivity and earnings
- Long-term physical and mental health impacts



Community

- **Public health costs: \$200B** in healthcare costs
 - 1 out of 8 adult ER visits in US involve mental illness and substance abuse disorders (12M visits/year)
- **Economic losses: \$193B** in lost earnings
- **Criminal justice costs:** Jails spend 2-3X more on adults with mental illness
 - In 2013, largest mental health providers in US were 3 largest prison systems
- **Increased welfare and social service costs**

\$1 Trillion

in annual lost productivity costs to global economy due to depression and anxiety

Source: WHO Mental Health Info Sheet; NAMI Mental Health Stats; Center for High Impact Philanthropy: Health in Mind; SteppingUp Initiative

Mental Health: An issue rooted in inequality

- Access to MH treatment is significantly lower for Black Americans
- Most people living in 'mental health deserts' are people of color
- African Americans living below the poverty line are 2x more likely to report psychological distress
- ½ of Black adults who need mental health care for serious conditions receive it
- 86% of psychologists are white - Black and brown Americans receive care from providers that do not have shared racial, ethnic or cultural experiences

Source: Vasan, A., & LeMelle, S. (2021, February 17). Biden wants to fix racial inequality. Mental health access is an important place to start. NBCNews.com. <https://www.nbcnews.com/think/opinion/biden-wants-fix-racial-inequality-mental-health-access-important-place-ncna1257376>.



This is a social justice issue - as current systems punish and criminalize mental illness

➔ People with mental illness are overrepresented in other vulnerable populations

2.5x
people
experiencing
homelessness

3.5x
incarcerated
people

5x
unemployed
people with
SMI

➔ People of color bear a disproportionately high burden from mental illness

15 ^{out} **16**
people with mental
illness killed by NYPD
since 2015 were
people of color

1 ⁱⁿ **2**
Black people who
need mental health
receive it

Source: Center for High Impact Philanthropy, "Health in Mind" (2020); American Psychiatric Association, Health Affairs; "Why the \$6B N.Y.P.D. is now a target of 'Defund the Police'" *NYTimes*, 4 August 2020

Fountain House

Providing a community of care and on-ramps to health systems



Fountain House is a national mental health nonprofit fighting to improve health, increase opportunity, and end social and economic isolation for people living with serious mental illness



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Our History

- Public-private partnership, founded in 1948 in NYC by people living with **serious mental illness**
- *Members* at the center of their own recovery **by choice**
- Community is our therapy; housed in a physical **clubhouse environment** where skilled *social practitioners* accompany **members in their recovery**
- Provides employment and educational programs, in addition to housing, healthcare and creative programming
- Breaks debilitating social isolation, which results in poor health and life expectancy 25 years less than general public
- **Replicated at >200 sites in 40 states, additional 100 in 30 countries**



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Our Membership

Fountain House uses the term “member” to reflect the voluntary, community-based nature of Fountain House. Using this term makes it clear that members are integral and active participants of the program

- >60% of members are people of color
- 40% previously homeless
- 24% prior justice involvement



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The Missing Link: Social Infrastructure



At Fountain House, community provides an anchor that is not only therapeutic in itself, it empowers people to be more durably engaged with housing, healthcare, and the other social determinants of health that are needed to thrive and recover

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Fountain House Community System of Care

Setting

- Intentional therapeutic community
- Socialization leads to self-directed recovery

Method

- **Social Practice:** staff therapeutically engage members and work in partnership to operate the Clubhouse
- Work mediates relationships providing the foundation for individual purpose and development of engagement and community
- Individually and peer driven recovery
- Social Inclusion and transitional environments

Intersection with Healthcare

- Shared decision making and navigation to other Healthcare services
- Greater adherence and utilization of outpatient services
- Single point of access for social needs leads to trust brokerage in seeking additional care or support.

Partners in Care



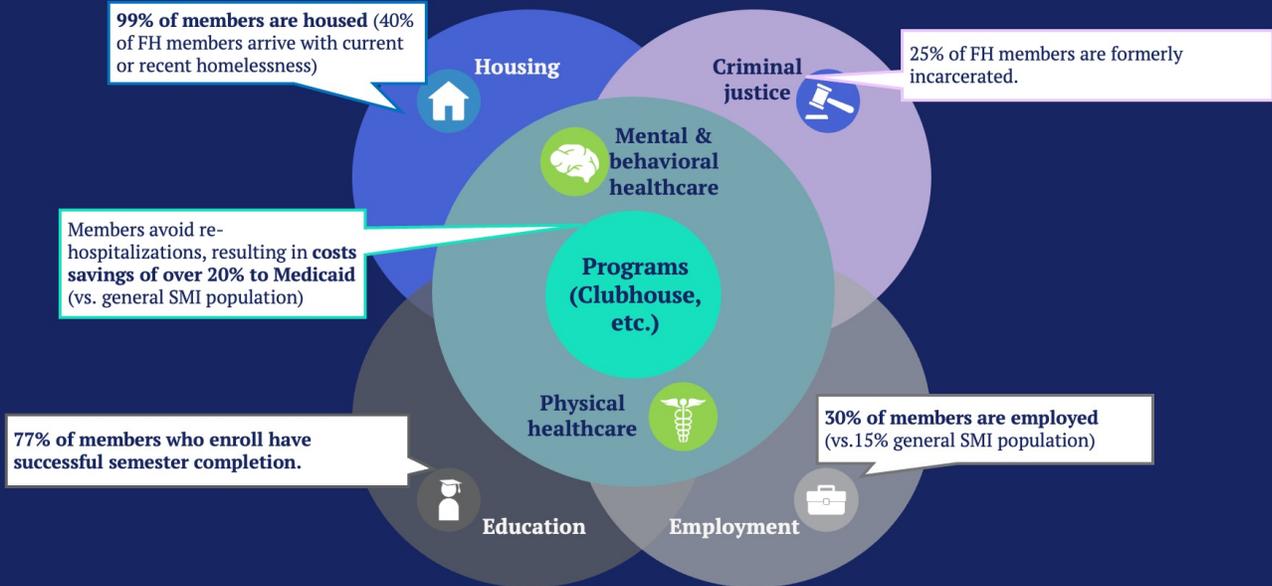
+





What has made Fountain House successful?

It's grounded in lived experience & is intersectional



Research & Supporting Evidence

Social Support

- Participating in the Clubhouse model promotes a sense of unity and belonging. Unique to the Clubhouse may be the aspect of support gained through the sense of shared achievement when working on tasks throughout the Work-Ordered Day.^{18,19,20}
- Families of Clubhouse members also benefit from the model; they reported improved family interactions since involvement with the Clubhouse.²¹

Improved Quality of Life

- Randomized controlled trials have shown improved quality of life in Clubhouse members, compared to general community services and other models.^{22,23,24,25,26}

Reduced Hospitalizations

- Randomized controlled trials have shown reduced hospitalizations in Clubhouse members, compared to general community services and other models.^{20, 23, 27}
- Clubhouse costs are substantially lower than partial hospitalization and Clubhouse membership reduces overall cost of healthcare ²⁸

Employment

- In RCTs, Clubhouse members worked longer and had better pay compared to other models.^{23, 24, 26, 29, 30}
- Length of Clubhouse participation was directly correlated to increases in competitive employment duration and greater employment status.^{18, 19, 27}



Outreach to the Most Vulnerable

In 2020, Fountain House launched numerous on-ramp programs to connect high-risk populations with intensive supports within our community.

- OnRamps: A Program for Justice-Involved Individuals with Mental Health Concerns.
 - Partnerships with Fortune Society, Center for Court Innovation
- Community First: connecting people who are housing insecure and living with severe mental health issues and/or substance use addictions gathering in and immediately around the Times Square area with supportive services.
 - In partnership with Times Square Alliance, Breaking Ground and Mid-Manhattan Community Court
- Fort Greene Park Conservancy: Fountain House social well-being teams will proactively develop relationships with, respond to, and engage park users who need mental health support and services.



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We Need to Measure What Matters

CLINICAL QUALITY

- Process measures
- Intermediate outcome measures
- Outcome measures
- MH, SUD, metabolic, other physical health

SOCIAL NEEDS

- Housing
- Employment
- College reentry, GED, other ed.
- Food security
- Income security
- Recidivism

COST-EFFECTIVENESS

- ER visits
- Hospitalizations
- Mental health costs
- Total costs of care

FUNCTION & QUALITY OF LIFE

- Patient-reported health-related quality of life
- PHQ-9
- SF-36

SOCIAL CONNECTION & MEMBER EXPERIENCE

- Loneliness/social isolation (also as a risk factor)
- CAHPS (per health plan needs)

ACTIVATION/AGENCY

- Metacognition scale
- Patient activation/ACE
- Engagement/empowerment
- Stickiness/consistency of participation

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About Healthfirst

Healthfirst is New York's largest not-for-profit health insurer, earning the trust of nearly 1.7 million members by offering access to affordable healthcare. Sponsored by New York City's leading hospitals, Healthfirst's unique advantage is rooted in its mission to put members first by working closely with its broad network of providers on shared goals. Healthfirst takes pride in being pioneers of the value-based care model, recognized as a national best practice. For nearly 30 years, Healthfirst has built its reputation in the community for top-quality products and services New Yorkers can depend on. It has grown significantly to serve the needs of members, offering market-leading products to fit every life stage, including Medicaid plans, Medicare Advantage plans, long-term care plans, qualified health plans, and individual and small group plans. Healthfirst serves members in New York City and on Long Island, as well as in Westchester, Sullivan, and Orange counties. For more information on Healthfirst, visit healthfirst.org.



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Outcomes in 2021 and Beyond

