Pre-Summit Workshop

Addressing Gaps in the Addiction Specialty Workforce

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Disclosures

- Elizabeth Salisbury-Afshar, MD, MPH, FAAFP, FASAM, FACPM; Hillary Kunins, MD, MPH, MS; and Kelly Clark, MD, MBA, DFAPA, DFASAM, have disclosed no relevant, real, or apparent personal or professional financial relationships with proprietary entities that produce healthcare goods and services.
Disclosures

- All planners/managers hereby state that they or their spouse/life partner do not have any financial relationships or relationships to products or devices with any commercial interest related to the content of this activity of any amount during the past 12 months.

- The following planners/managers have the following to disclose:
  - Kelly J. Clark, MD, MBA, FASAM, DFAPA – Consulting fees: Braeburn, Indivior
Learning Objectives

- Explain the gap between the current needs of addiction treatment and the current state of addiction treatment resources.
- Identify the challenges to increasing access to appropriate treatment.
- Describe strategies to maximize available resources.
Increasing the Addiction Treatment Workforce: How Communities Can Leverage Providers and Science to Treat an Epidemic

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April 2, 2018
Session Outline

- The Scope of the issue:
  - National overview of physician specialist workforce

Public health responds:

- Chicago approach
- New York City approach
National Overview

- Addiction physician workforce 2017:
  - 3000 addiction medicine specialists (old ABAM certification)
  - 1000 addiction psychiatrist specialists (active ABPM certification)

New American Board of Medical Specialties gave first test last year!

Addiction Medicine is a sub-specialty within Preventive Medicine

More on this later…..
Why focus on specialist physicians?

- Hold the expertise in the field
- Inform research needs
- Set best practices and evidence based care which can then be taught throughout the caregiver system
  - Non-specialist physicians
  - Advance practice clinicians
  - Nurses, psychotherapists, counsellors
  - Peer coaches
  - Patients, families, other stakeholder groups
Specific issues related to OUD:

- The most effective treatment for OUD is ongoing medication management (Agonist or antagonist).
- Prescribers are key to treatment for OUD.
- “Medication Assisted Treatment”, or “MAT”, is considered by ASAM as a transitional term.
- The language of the new SAMHSA TIP63 is clear:
SAMHSA TIP 63: “MAT” no more

- “Medication is an effective treatment for OUD. People with OUD should be referred for an assessment for the pharmacotherapy unless they decline”

- “Counseling shouldn’t be arbitrarily required as a condition for receiving OUD medication.....especially when the benefits of receiving medication outweigh the risks of not receiving counseling.

- It is “inappropriate to refuse evidence-based treatment with medications for a patient with OUD, when that may be the most clinically appropriate course of treatment”.

- And medications can be used effectively and appropriately throughout the continuum of care
“Discussing medications that can treat OUD with patients who have this disorder is the clinical standard of care and should cover at least:

- The proven effectiveness of methadone, naltrexone, and buprenorphine compared with placebo and with outpatient counseling without medication
- Risks and benefits of pharmacotherapy with all three types of medication, treatment without medication, and no treatment.
- Safety and effectiveness of the medications when used appropriately
- Pharmacologic properties, routes of administration, and where and how to access treatment with each medication”
In this presentation:

- You will hear a lot about expanding access to pharmacotherapy, because that is the core treatment of OUD

- “MAT” will be used in this presentation to mean “Medication for Addiction Treatment” – there is no “assistance” implied
OUD Epidemic: All Hands On Deck!

- Nurse Practitioners and Physicians Assistants can prescribe buprenorphine and naltrexone under federal law
- Any physician, regardless of their additional specialty training, can also prescribe and treat addiction – just like depression
- With three physicians at this podium, we will Fight Stigma with Science!
Chicago
Chicago Context: Opioid Crisis

- Population: 2.7 million people
- 77 Community areas
  - 73 community areas had at least 1 opioid-related overdose
- 741 opioid-related overdose deaths in 2016

Source: Epidemiology Report: Increase in overdose deaths involving opioids, Chicago 2015-2016
Chicago Context: OUD Treatment Access

- Historically addiction treatment had been a “carve out”
  - IL is a Medicaid expansion state
  - Some state dollars have been transitioned from state carve-out into Medicaid
- Legislative change in 2016:
  - Required that all 3 forms of pharmacotherapy for OUD be covered by Medicaid without prior authorization
  - Eliminated Medicaid lifetime limits for buprenorphine
  - IL Medicaid methadone coverage started in mid-2017
  - Required naloxone coverage through Medicaid

*Source: Diminishing Capacity: The Heroin Crisis and Illinois treatment in National Perspective
Role of Chicago Department of Public Health in promoting workforce and access to care

- IL Division of Alcoholism and Substance Abuse (DASA)
  - Allocate federal and state dollars for treatment across the state
  - IL DASA license substance use disorder treatment facilities
  - IL DASA monitors all “Drug Overdose Prevention Programs” and allocates federal prevention dollars (including naloxone funding)

- Chicago Department of Public Health
  - Invests additional dollars for prevention and treatment
  - Funds 2 syringe exchange programs
  - Funds overdose prevention and naloxone distribution
  - Increasingly playing a role provider education
Chicago Context: Heroin Task Force Recommendations

- Community Education
- Provider Education
- Data
- Increased Access to Treatment (MAT)
- Overdose Prevention and Naloxone Distribution
- Drug Trafficking

Safer opioid prescribing
Chicago Context: Opioid Prescribing

US Opioid Prescription by MME Per Capita 2015 By County

Source: MMWR July 7, 2017; Vol 66, No 26
Chicago Context: Majority of Opioid-Related Deaths involve Heroin and Fentanyl

Data Source: Cook County Medical Examiner’s Office, US Census Bureau
Note: Numbers include all opioid-related overdose deaths that occurred in Chicago, regardless of decedent’s address of residence.

¹ The Cook County Medical Examiner’s office began routinely testing for fentanyl involvement in June 2015. For this reason, the number of fentanyl-involved overdose deaths in 2015 may be higher than reported.

² Opioid pain reliever: buprenorphine, codeine, hydrocodone, hydromorphone, meperidine, morphine, oxycodone, oxymorphone, or tramadol.

Source: Epidemiology Report: Increase in overdose deaths involving opioids, Chicago 2015-2016
Chicago Opioid Overdose: some communities impacted more than others

Source: Epidemiology Report: Increase in overdose deaths involving opioids, Chicago 2015-2016
OUD Treatment Capacity in Chicago

- 32 Opioid Treatment Programs (methadone providers) in Chicago
- Few licensed treatment programs provide MAT with buprenorphine or naltrexone
  - No reimbursement structure to support prescriber time within treatment programs
- Limited access to buprenorphine in office-based settings (especially for people with Medicaid)
- 10,246 licensed physicians in Chicago
  - 329 providers (including NP and PA) with a buprenorphine waiver*
  - 168 (1/2) of waivered providers wrote at least one Rx in past year*

*Sources: IL Dept of Financial and Professional Regulation, SAMHSA, and ILPMP, as of October 2017
Chicago Context: Heroin Task Force Recommendations

- Community Education
- Provider Education
- Data
- Increased Access to Treatment (MAT)
- Overdose Prevention and Naloxone Distribution
- Drug Trafficking

Safer opioid prescribing
OUD treatment
Goal: Expand access to high quality MAT services with specific focus on communities with highest rates of overdose
Challenges

- Difficult to increase methadone capacity - NIMBY
- Reimbursement structure
- Workforce
  - Many existing licensed addiction treatment programs “don’t believe” in using medication for OUD
  - CADC training programs - very little training on MAT
  - Schools of social work offer substance use classes as electives (not required)
  - Very limited addiction training for medical students or residents
    - Primary care residencies have not been training residents in addiction treatment
  - Only 2 addiction medicine fellowships in Chicago are through psychiatry (VA funded) and do not always fill
    - Major psychiatry shortage in Chicago - particularly in underserved areas
    - Very few addiction medicine certified physicians working outside of VA or private practice
Local Strengths

- More residents with health coverage post-ACA
  - IL State legislation required all Medicaid plans to cover buprenorphine and naltrexone products- no more lifetime limits
  - Methadone now a Medicaid covered service
- IL received $16.3M State Targeted Response (STR)
- 9 Federally Qualified Health Centers (FQHC) in Chicago received HRSA awards for MAT expansion
- Chicago has 7 medical schools and many training hospitals
- Chicago Department of Public Health funds 13 treatment programs (training opportunities)
Workforce Goals:

- Increase MAT knowledge and expertise among students in CADC training
- Increase addiction training among psychology and social work students
- Increase knowledge and expertise among currently practicing addiction treatment providers about MAT
  - Mandatory trainings on MAT for programs that CDPH funds
  - Continuing education events at low/no cost
  - New grant dollars for OUD are going only to programs that provide or accept patients on MAT
Workforce Goals:

- **Increase addiction training in medical schools, residency programs**
  - Participation in Coalition on Physician Education (COPE) in Substance Use Disorders
  - Provide lectures for residency programs/support interested residents and faculty when possible

- **Increase addiction fellowship programs in Chicago and don’t limit them to psychiatry**
  - Hosted a meeting with all major academic centers and The Addiction Medicine Foundation to discuss fellowship opportunities

- **Increase knowledge and expertise among currently practicing prescribers (physicians, NPs, PAs)**
  - Continuing educational events at low/no cost
  - Fee buprenorphine waiver trainings
  - Medication Assisted Treatment Learning Collaborative
Training and Technical Assistance around MAT

- Learning Collaborative for federally qualified health centers (FQHCs) expanding access to MAT
  - Met with all health centers who had received HRSA awards to understand their plans and any needs
  - Most voiced interest in having a forum to come together for information sharing (7/9 participated, and 4 additional health centers/systems that did not receive HRSA award)
  - 2 tracks: Decision Maker Track (high level programming) and Provider Track (clinical training and discussions)
  - Meet quarterly
  - Provide a forum for sharing workflows, documents, etc
Training and Technical Assistance around MAT

- City-wide Trainings:
  - Provide free buprenorphine waiver trainings for their providers
  - Offer technical assistance
  - Offer low/no cost CME events
  - Offer shadowing experiences across centers
Lessons from Chicago

- Expanding access to MAT is more than just having prescribers get a waiver to prescribe buprenorphine— it takes a system!
  - Insurance/Medicaid coverage considerations
  - Reimbursement structures should support integrated care
  - Need for culture change— high levels of misinformation and stigma around MAT
  - Addiction training opportunities:
    - Training programs (medical schools, nursing schools, schools of social work, psychology programs, CADC programs, residency programs)
    - Existing workforce (training around MAT— technical assistance and ongoing support are crucial)
NYC context

- Population: 8.5 million people
- 5 boroughs (also state counties)
  - Manhattan
  - Bronx
  - Brooklyn
  - Queens
  - Staten Island
- Centralized city municipal government
New York City context: Overdose epidemic

- More New Yorkers die from overdose than from suicides, homicides and motor vehicle crashes combined
- Drug overdose is a leading cause of premature death among NYC residents and top cause of death for NYC residents age 25 to 34

NYC context: Overdose deaths have increased for six consecutive years

Number of unintentional drug poisoning deaths (overdoses), New York City, 2010 – 2016**

Source: New York City Office of the Chief Medical Examiner & New York City Department of Health and Mental Hygiene 2000-2016*

*Data for 2015 and 2016 are provisional and subject to change (Published June 13, 2017)
NYC context: Nearly all drug overdoses involve opioids

- 72% involve heroin or fentanyl
- 4/5 involve any opioid
- Nearly 3/4 involve heroin or fentanyl

Source: New York City Office of the Chief Medical Examiner & New York City Department of Health and Mental Hygiene 2000-2016*
*Data for 2015 and 2016 are provisional and subject to change (Published June 13, 2017)
NYC context: High opioid-involved overdose rates concentrated in the Bronx and Staten Island

Unintentional opioid-involved drug poisoning deaths by neighborhood (UHF 42) of residence, NYC, 2016

Source: New York City Office of the Chief Medical Examiner & New York City Department of Health and Mental Hygiene 2000-2016*
*Data for 2015 and 2016 are provisional and subject to change (Published June 13, 2017)
NYC context: 2016 overdose mortality

Highest rate among Staten Island residents
Largest number among Bronx residents

Rate of drug overdose death, by borough of residence, 2016

Number of drug overdose deaths, by borough of residence, 2016

Source: New York City Office of the Chief Medical Examiner & New York City Department of Health and Mental Hygiene, 2016*
*Data for 2016 are provisional and subject to change. (Published June 13, 2017)
NYC context: Treatment + workforce landscape

- NYS licensed substance use services:
  - Withdrawal management/crisis: 30
  - Inpatient: 11
  - Methadone/Opioid Treatment Program: 70
  - Outpatient: 168
  - Residential: 53

- Licensed physicians: 32,859 (as of 1/1/2018)
- Prescribers of buprenorphine: 1,800 (2016)

Sources: Office of the Professions: http://www.op.nysed.gov/prof/med/medcounts.htm
New York State (NYS) Prescription Monitoring Program (PMP)
Role of NYC in promoting workforce and access to care

- New York state
  - Oversight, licensing, and funding for substance use disorder treatment
  - Supportive of medications for addiction treatment
  - Medicaid redesign
    - E.g. In community services → peers delivering care in communities
New York City context

- New York City Health Department contracts with and funds treatment, prevention, and harm reduction services:
  - 56 substance use disorder treatment programs
    - 22 opioid treatment programs
    - 34 outpatient programs
  - 7 prevention programs
  - 14 syringe exchange programs
    - Syringe exchange
    - HIV and HCV testing, care and coordination
    - Overdose prevention
  - 52 opioid overdose prevention programs – distribution of naloxone
- NYC signature initiatives: ThriveNYC and HealingNYC
New York City context

- Access to and uptake of pharmacotherapy
  - Methadone
    - 30,000 patients in care
    - No waiting list and flexible patient cap
  - Buprenorphine
    - 1,800 physicians prescribed in 2016
    - 13,000 patients received at least one prescription
      - ~6,000 received > 6 months of treatment
  - Goal: an additional 20,000 New Yorkers receiving pharmacotherapy for opioid use disorders by 2022

Sources: New York State (NYS) Prescription Monitoring Program (PMP)
NYS Office of Alcoholism and Substance Abuse Services (OASAS) Client Data System
HealingNYC: Decreasing opioid overdose deaths by 35% over 5 years

- $38M investment announced by the Mayor in March 2017
- 12 overall strategies
- Collaborative effort among multiple NYC agencies
## NYC’s response: HealingNYC

### Goal 1: Prevent opioid overdose deaths
- **Strategy 1**: Distribute 100,000 naloxone kits citywide

### Goal 2: Prevent opioid misuse and addiction
- **Strategy 2**: Invest in early interventions for youth to prevent opioid misuse and addiction
- **Strategy 3**: Educate New Yorkers about effective treatment for opioid misuse and addiction
- **Strategy 4**: Connect up to five of the communities at highest risk with targeted prevention messages and care
- **Strategy 5**: Educate clinicians to reduce overprescribing
- **Strategy 6**: Expand crisis intervention services for nonfatal overdose

### Goal 3: Connect New Yorkers to effective treatment
- **Strategy 7**: Increase access to medication-assisted treatment for addiction for 20,000 additional New Yorkers by 2022
- **Strategy 8**: Make NYC Health + Hospitals a system of excellence, delivering increased and effective opioid services
- **Strategy 9**: Target treatment and expand resources to people in the criminal justice system

### Goal 4: Reduce the supply of dangerous opioids
- **Strategy 10**: Use data to target outreach and take action
- **Strategy 11**: Expand the NYPD’s enforcement against dealers of opioids that cause overdose deaths
- **Strategy 12**: Expand the NYPD’s capacity to disrupt the trafficking of opioids into New York City
NYC’s approach: A multi-pronged public health approach to opioid misuse and overdose

| 1. Know what is happening | • Surveillance: morbidity and mortality  
• Rapid assessment and response |
|---------------------------|----------------------------------------------------------------------------------|
| 2. Prevent/reduce risky use | • Access and availability of prescription opioids  
• Increase perception of risk for licit and illicit opioids |
| 3. Expand access and continuum of care | • Expand access to effective treatment, particularly methadone and buprenorphine  
• Establish post non-fatal overdose supports |
| 4. Prevent complications of opioid misuse | • Expand naloxone distribution  
• Expand syringe services |
| 5. Increase recovery supports | • Promote peer workforce  
• Decrease stigma around treatment |
| 6. Sectors and settings | • Multi-sector |
NYC’s approach: A multi-pronged public health approach to opioid misuse and overdose

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|                           | • Decrease stigma around treatment |
| 6. Sectors and settings | • Multi-sector |
NYC’s approach: opioid analgesic action kit

- clinical tools
- provider resources
- patient education materials
NYC public health detailing on judicious opioid prescribing

- Data driven approach to “sell” good health and promote public health interventions
- One-to-one educational visits with health care providers and staff
- Three campaigns conducted (>3,000 prescribers reached):
  - Staten Island (2013)
  - The Bronx (2015)
  - Brooklyn (2017)
- Results:
  - Public health detailing works
  - Knowledge change about key recommendations
  - Decreases in high-dose prescribing (Staten Island)
NYC approach: Increasing access to medications for addiction treatment

1. Fund 14 safety net health centers to implement buprenorphine treatment

2. Fund 4 adolescent and emerging adult programs in NYC (with NYS support)

3. Fund selected syringe exchange programs to start buprenorphine treatment

4. Train 1,500 MDs, NPs and PAs to prescribe buprenorphine (>500 trained)
   4.a. Offer implementation assistance following training

5. Raise public awareness about methadone/buprenorphine treatment
NYC workforce development: increasing access to medications for addiction treatment

1. Direct funding of clinical programs:
   • Nurse care manager
   • Adolescent programs
   • Syringe exchange

2. Training and technical assistance
   • Waiver training for 1500 new prescribers
   • Technical assistance to implement
   • Mentorship

3. Work across settings
   • Substance use disorder treatment
   • Primary care
   • Harm reduction
   • Emergency care
Buprenorphine nurse care manager model in NYC

- Nurse care manager (NCM) coordinates care of buprenorphine patients in FQHCs and other safety-net settings
- Based on successful model from Massachusetts
- NYC health department funding 14 organizations to incorporate NCM
  - 4 new prescribers per organization
NYC health department strategies supporting buprenorphine expansion

- **Primary care learning community**
  - Held quarterly and led by PC-based buprenorphine expert
  - Topics included home induction, interpreting urine toxicologies, polysubstance use, pain
  - Attended by HRSA grantees, buprenorphine nurse care manager grantees, and participants in our monthly buprenorphine trainings

- **Buprenorphine advisory board**
  - Convened small group of NYC buprenorphine experts and leaders in the field to advise on expanding access to buprenorphine in NYC

- **Buprenorphine nurse care manager booster trainings**
  - Quarterly trainings for RNs, LCSWs, and other non-prescribers that support and coordinate buprenorphine patient care
  - Topics included naloxone, motivational interviewing, stigma, correctional health and MAT
Challenges in buprenorphine access expansion

- Hiring prescribers
- Hiring ASAM accredited physicians
- Converting waived clinicians → prescribing clinicians
- Attracting patients
Workforce development: Mental health service corps

- Places >400 mental health clinicians in high need communities throughout NYC over 3 years
- In primary care and specialty care settings
- Includes funding for addiction medicine fellows
Workforce development: Mental health service corps addiction medicine fellows

- Funding for addiction medicine fellow
  - 2 fellows 2016-17; 3 2017-18; expand to 6 fellows 2018-19
  - Standard fellowship training for 1 year; optional 2nd year
  - Public health components added:
    • 1-month long rotation at NYC Health Department
    • Longitudinal rotation on practice improvement
    • Develop/present at least one talk on an addiction-related topic for MHSC clinical staff audience
**Substance use workforce development: Training & practice implementation institute (TPII)**

<table>
<thead>
<tr>
<th><strong>What</strong></th>
<th>Training and implementation support on selected evidence-based practice (EBP), offered free of charge to enrolled substance use disorder treatment (SUD) programs</th>
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| **Who** | Counselors and supervisors receive initial EBP training  
Supervisors receive advanced training and coaching to assess counselor skills and provide effective EBP-specific supervision |
| **How** | Foster development of learning communities; enrolled SUD programs become cohorts that train together  
Audio-recording counseling sessions rated by clinical supervisors  
Develop program-specific sustainability plans for long-term EBP integration into SUD program |
| **When** (duration) | Initial training and at least nine months of ongoing integration support and technical assistance |
Health profession curriculum and pipeline development

- **Target areas:**
  - Medical, nursing and pharmacy schools; internal medicine and primary care residencies

- **Goals:**
  - Enhance classroom + clinical exposure for substance use and addiction education and training
    - Form medical education working group with curricular leads and champions from each institution
    - Integrate buprenorphine training into residency curricula
  - Support harm reduction student groups
  - Build networking opportunities for students to connect with mentors and local experts in the field
New York City resources to enhance addiction workforce

- Publish guidance for clinicians:
  - Addressing alcohol and drug use – An integral part of primary care
  - Brief intervention for excessive drinking
  - Buprenorphine guidance
- Online screening and brief intervention training module
- Mentorship and technical assistance
  - Buprenorphine waiver trainings for physicians, nurse practitioners and physician assistants
  - Technical assistance to practices (and to residencies)
  - Mentor pairing
NYC challenges: Requires multi-sector approach and continuum of care

- Recovery Support
  - Specialty Care
  - Educational System
  - Social Services
- Harm Reduction
  - Prevention
  - Treatment
- Prevention
  - Emergency Care
  - Criminal Justice System
  - Primary Care
Collaboration across sectors (examples)

- **RxSTAT**
  - Multisectoral collaboration between public health and public safety
  - Monthly meetings with single shared goal to reduce overdose deaths

- **Diversion programs with district attorneys**
  - Diversion of desk-appearance-ticket eligible detainees
  - Offer of peer-led linkage to care
Lessons from New York City

- Workforce development is required among ALL health professions.
- Continuum of care is not possible without a multi-sector approach.
- Addiction is a chronic disease → workforce training is difficult to modify in a system that does not support chronic care models.
- Need to focus on health equity and adequate access to quality healthcare for ALL.
Discussion (small groups)

- What workforce shortages are you facing in your jurisdiction?
Discussion (small groups)

- Identify local strengths and challenges in your:
  - Workforce capacity
  - Policy
  - Funding resources
  - Network ties
Action Steps – Make a Plan (small groups)

- Efforts beyond physicians are essential
- Engage multiple sectors, including:
  - educators
  - academic institutions
  - researchers
  - policymakers
  - coalitions
  - law enforcement
  - emergency medical services
  - the criminal justice system
  - health care professionals
  - health care systems
Quiz 1: True or False?

Medication for Addiction Treatment is an evidence based practice to treat addiction which can only be provided by specialist physicians.
Quiz 2: True or False?

All addiction counselors have been trained on what evidence based treatments for opioid addiction are.
Quiz 3: True or False?

Addiction medicine is not an official subspecialty recognized by The American Board of Preventive Medicine (ABPM).
Addiction Medicine

Overview

Addiction Medicine is concerned with the prevention, evaluation, diagnosis, treatment, and recovery of persons with the disease of addiction, of those with substance-related health conditions, and of people who show unhealthy use of substances including nicotine, alcohol, prescription medications and other licit and illicit drugs. Physicians in this subspecialty also help family members whose health and functioning are affected by a loved one’s substance use or addiction.
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THANK YOU

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