

Using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model to address risky substance use in New York City STD clinics: Are we in the right neighborhoods?

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BACKGROUND

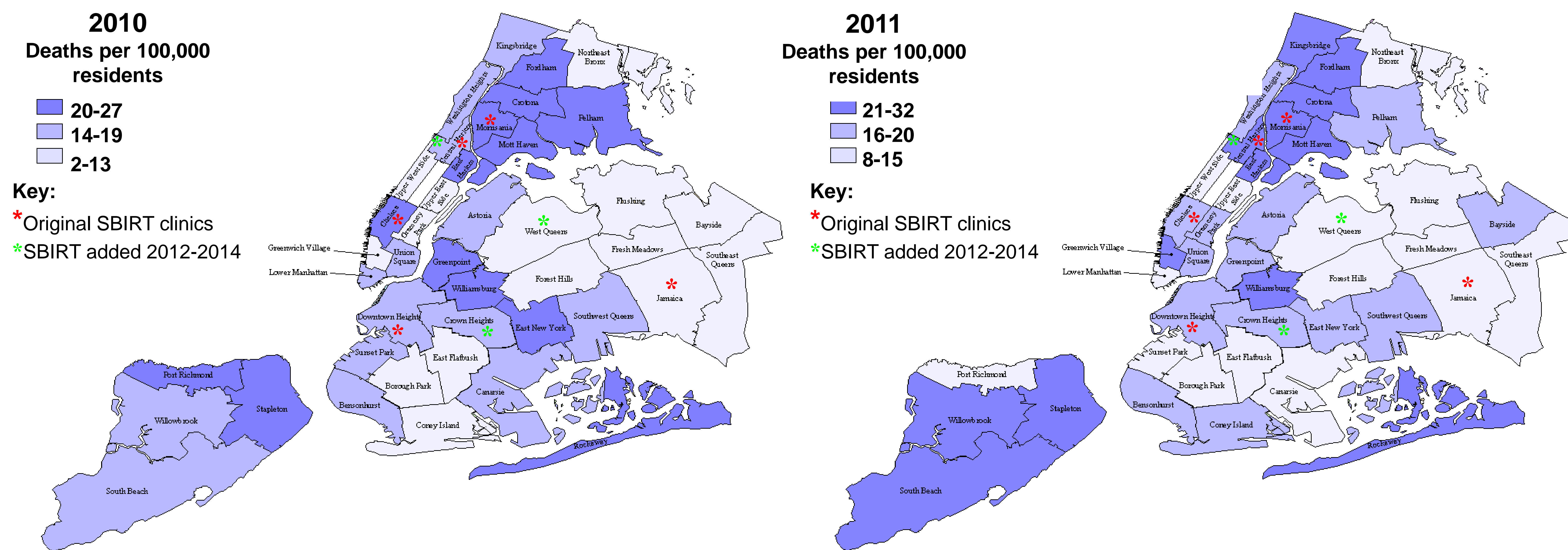
- Alcohol/other drug use (AOD) is associated with high risk sexual behavior, sexually transmitted disease (STD)/HIV transmission,^{1,2} and excess mortality.^{3,4}
- New York City Department of Health and Mental Hygiene (NYC DOHMH) STD clinics: Approximately 90,000 patient visits per year, at 8 clinics throughout NYC. 51% STD clinic patients uninsured; 42% unemployed.⁵
- SBIRT** implemented in 3 NYC DOHMH STD clinics in 2008, expanded to 5 clinics in 2010:
 - Screening:** Self-administered survey used to identify AOD use (CAGE-AID) distributed to all patients in waiting room
 - Brief Intervention (BI):** 10-15 min motivational interviewing session to positive-screened patients
 - Referral to Treatment:** Referral to substance abuse treatment provided as needed
- Goal: Early intervention for risky AOD use; improved linkages to treatment
- Low-income neighborhoods: lower rates of heavy alcohol use; greater alcohol-related mortality.⁶ 2010-2011: 55%-56% of drug overdose deaths in neighborhoods with high poverty. Overdose death rates highest in the very high poverty neighborhoods as compared to wealthiest neighborhoods (11 vs. 5/100,000 (2010); 13 vs. 9/100,000 (2011)).³

METHODS

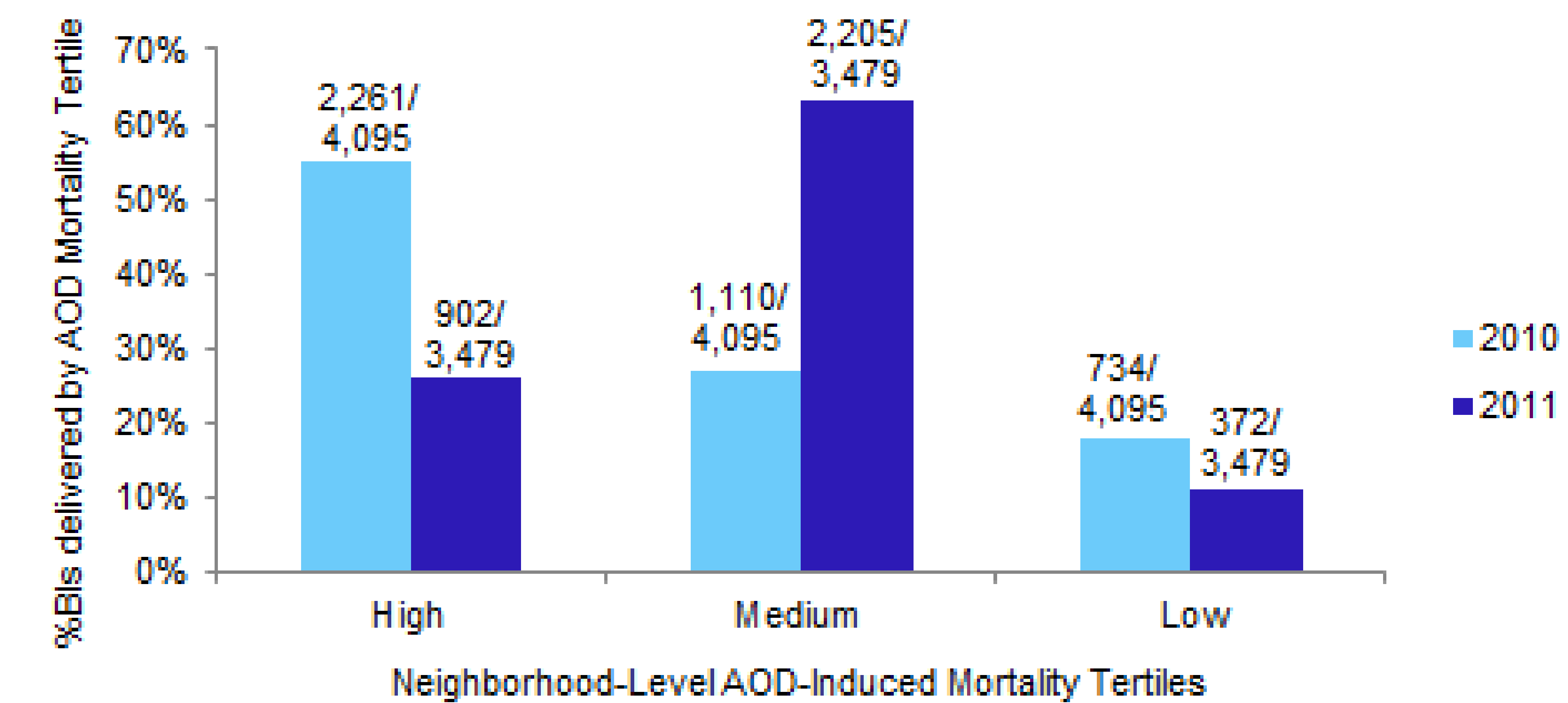
- Objective: Determine if SBIRT served highest-need populations based on AOD-induced mortality. Calculated total number of BIs conducted from January 2010-December 2011 and examined NYC Vital Statistics data for 2010-2011 alcohol- and drug-induced mortality rates.
- Utilized CDC definition of alcohol- and drug-induced mortality: ICD-10 codes indicating acute intoxication, withdrawal, poisoning (overdose) or physical diseases as a direct result of use (i.e. alcoholic liver disease; drug-induced anemia, etc.).⁷
- Alcohol and drug induced mortality data combined to produce AOD-induced mortality rates across the 42 NYC neighborhoods, which were then grouped by neighborhood-level tertiles of high, medium, and low AOD-induced mortality rates.
- Neighborhood-level AOD-induced mortality rates correlated with total number of BIs conducted by NYC STD clinic locations within neighborhood-level AOD-induced mortality tertiles.

RESULTS

AOD-Induced Death Rates per 100,000 residents by NYC Neighborhood and NYC STD Clinics with SBIRT



Percent of SBIRT Brief Interventions by AOD-Induced Mortality Neighborhood-Level Tertiles, 2010-2011



CONCLUSIONS

- 2010 and 2011: 4 of 5 NYC STD clinics with SBIRT located in high or middle AOD-induced mortality neighborhoods.
- AOD-induced mortality rates varied across neighborhoods from year to year.
- From 2010-2011, Chelsea shifted from the high to middle mortality group. Chelsea is highest volume STD clinic; therefore, fewer SBIRT BIs done in high AOD-induced mortality neighborhoods in 2011.
- NYC DOHMH STD clinic locations will not change; as of March 2014, SBIRT expanded to all 8 STD clinics.

NEXT STEPS

- DOHMH could attempt to partner with community organizations and primary care clinics in additional neighborhoods with high AOD-induced mortality to expand SBIRT beyond NYC DOHMH STD clinics.
- DOHMH will consider alternate funding opportunities to sustain services beyond current grant period.
- Important to consider other indicators for AOD-related health disparities since AOD-induced mortality varies over time.

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