Central Oregon Health Council

RHIP Substance Use & Chronic Pain Workgroup
PacificSource – Suite 210 (2nd Floor)
2965 NE Conners Ave, Bend

Agenda: August 17, 2016 from 4:00pm-5:00pm

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

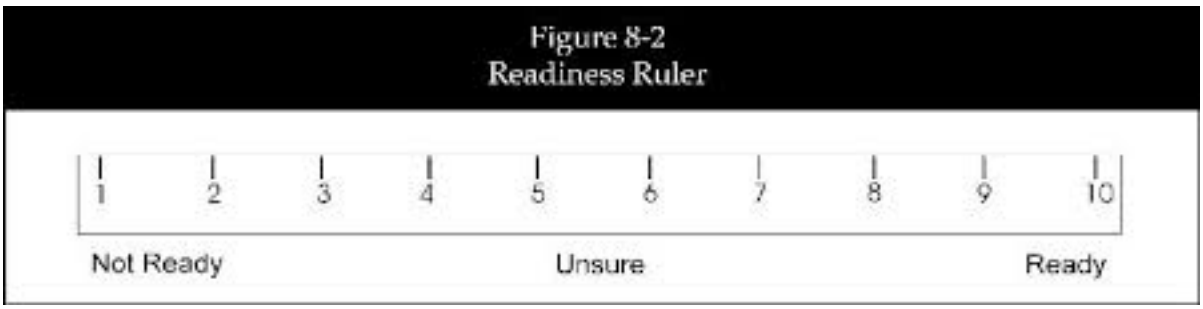
1. 4:00-4:05 **Introductions—All**

2. 4:05-4:50 **Intervention & Referrals for Zones III & IV (Alcohol & Drug)—All**

3. 4:50-4:55 **Medication Assisted Treatment (MAT) Workgroup Next Steps—Mike Franz**

4. 4:55-5:00 **Action Items—All**
   - **Next steps**

Next Meeting: **September 21 from 4-5pm**



BH Substance Use & Chronic Pain (25)	Organization
Steve Baker	Mosaic Medical
Kelby Christ	Crook County Health Department
Mike Franz	PacificSource
Erica Fuller	Rimrock Trails Adolescent Treatment Services
Larry Kogovsek	CAC Consumer Representative
Jessica LeBlanc	Mosaic Medical & Bend Treatment Center
Nicole Lemmon	Wellness & Education Board of Central Oregon (WEBCO)
Alison Litte	PacificSource
Leslie Neugebauer	PacificSource
Matt Owen	Bend Treatment Center
Laura Pennavaria	La Pine Community Healthy Center
Sally Pfeifer	Pfeifer & Associates
Christine Pierson	Mosaic Medical
Kristin Powers	St. Charles Health System
Beth Quinn	Recovery Outreach Community Center: Intentional Peer Support
Rip Sawyer	Serenity Lane
Elizabeth Schmitt	CAC Consumer Representative
Julie Spackman	Deschutes County Health Services
Barbara Stoefen	National Alliance on Mental Illness (NAMI)
Ralph Summers	PacificSource
Kim Swanson	St. Charles Medical Group
Karen Tamminga	Deschutes County Behavioral Health
Rick Treleaven	BestCare Treatment Services
Bill Ward	Serenity Lane
Scott Willard	Lutheran Community Services Northwest

How to Help Patients

Using the AUDIT to screen patients is only the first step in a process of helping reduce alcohol-related problems and risks.

Health care workers must decide what services they can provide to patients who score positive. Once a positive case has been identified, the next step is to provide an appropriate intervention that meets the needs of each patient. Typically, alcohol screening has been used primarily to find "cases" of alcohol dependence, who are then referred to specialized treatment. In recent years, however, advances in screening procedures have made it possible to screen for risk factors, such as hazardous drinking and harmful alcohol use. Using the AUDIT Total Score, there is a simple way to provide each patient with an appropriate intervention, based on the level of risk.

While this discussion will focus on helping those patients who score positive on the AUDIT, sound preventative practice also calls for reporting screening results to those who score negative. These patients should be reminded about the benefits of low risk drinking or abstinence and told not to drink in certain circumstances, such as those mentioned in Box 5.

Four levels of risk are shown in Box 6. Zone I refers to low risk drinking or abstinence. The second level, Zone II, consists of alcohol use in excess of low-risk guidelines[5], and is generally indicated when the AUDIT score is between 8 and 15. A brief intervention using simple advice and patient education materials is the most appropriate course of action for these patients. The third level, Zone III, is suggested by AUDIT scores in the range of 16 to 19. Harmful and hazardous drinking can be managed by a combination of simple advice, brief counseling and continued monitoring, with further diagnostic evaluation indicated if the patient fails to respond or is suspected of possible alcohol dependence. The fourth risk level is suggested by AUDIT scores in excess of 20. These patients should be referred to a specialist for diagnostic evaluation and possible treatment for alcohol dependence. If these services are not available, these patients can be managed in primary care, especially when mutual help organizations are able to provide community-based support. Using a stepped-care approach, patients can be managed first at the lowest level of intervention suggested by their AUDIT score. If they do not respond to the initial intervention, they should be referred to the next level of care.

Box 5

Advise Patients *not* to Drink

- When operating a vehicle or machinery
- When pregnant or considering pregnancy
- If a contraindicated medical condition is present
- After using certain medications, such as sedatives, analgesics, and selected antihypertensives

Box 6

Risk Level	Intervention	AUDIT score*
Zone I	Alcohol Education	0-7
Zone II	Simple Advice	8-15
Zone III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

*The AUDIT cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgment should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5 and 6) and alcohol-related problems (Questions 9 and 10). Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5 and 6, or 4 on Questions 9 or 10.

Brief interventions for hazardous and harmful drinking constitute a variety of activities characterized by their low intensity and short duration. They range from 5 minutes of simple advice about how to reduce hazardous drinking to several sessions of brief counseling to address more complicated conditions[36]. Intended to provide early intervention, before or soon after the onset of alcohol-related problems, brief interventions consist of feedback of screening data designed to increase motivation to change drinking behaviour, as well as simple advice, health education, skill building, and practical suggestions. Over the last 20 years procedures have been developed that primary care practitioners can readily learn and practice to address hazardous and harmful drinking. These procedures are summarized in Box 7.

A number of randomized controlled trials have evaluated the efficacy of this approach, showing consistently positive benefits for

Box 7

Elements of Brief Interventions

- Present screening results
- Identify risks and discuss consequences
- Provide medical advice
- Solicit patient commitment
- Identify goal—reduced drinking or abstinence
- Give advice and encouragement

patients who are not dependent on alcohol[36, 37, 38]. A companion WHO manual, *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care*, provides more information on this approach.

Referral to alcohol specialty care is common among those primary care practitioners who do not have competency in treating alcohol use disorders and where specialty care is available. Consideration must be given to the willingness of patients to accept referral and treatment. Many patients underestimate the risks associated with drinking; others may not be prepared to admit and address their dependence. A brief intervention, adapted to the purpose of initiating a referral using data from a clinical examination and blood tests, may help to address patient resistance. Follow-up with the patient and the specialty provider may also assure that the referral is accepted and treatment is received.

Diagnosis is a necessary step following high positive scoring on the AUDIT, since the instrument does not provide sufficient basis for establishing a management or treatment plan. While persons associated with the screening programme should have a basic familiarity with the criteria for alcohol dependence, a qualified professional who is trained in the diagnosis of alcohol use disorders[4] should conduct this assessment. The best method of establishing a diagnosis is through the use of a standardized, structured, psychiatric interview, such as the CIDI[39] or the SCAN[40]. The alcohol sections of these interviews require 5 to 10 minutes to complete.

The Tenth revision of the *International Classification of Diseases* (ICD-10)[4] provides detailed guidelines for the diagnosis of acute alcohol intoxication, harmful use, alcohol dependence syndrome, withdrawal state, and related medical and neuropsychiatric conditions. The ICD-10 criteria for the alcohol dependence syndrome are described in Box 8.

Detoxification may be necessary for some patients. Special attention should be paid to patients whose AUDIT responses indicate daily consumption of large amounts of alcohol and/or positive responses to questions indicative of possible dependence (questions 4-6). Enquiry should be made as to how long a patient has gone since having an alcohol-free day and any prior experience of withdrawal symptoms. This information, a physical examination, and laboratory tests (see Clinical Screening Procedures, Appendix D) may inform a judgment of whether to recommend detoxification. Detoxification should be provided for patients likely to experience moderate to severe withdrawal not only to minimize symptoms, but also to prevent or manage seizures or delirium, and to facilitate acceptance of therapy to address dependence. While inpatient detoxification may be necessary in a small number of severe cases, ambulatory or home detoxification can be used successfully with the majority of less severe cases.

Box 8

ICD-10 Criteria for the Alcohol Dependence Syndrome

Three or more of the following manifestations should have occurred together for at least 1 month or, if persisting for periods of less than 1 month, should have occurred together repeatedly within a 12-month period:

- a strong desire or sense of compulsion to consume alcohol;
- impaired capacity to control drinking in terms of its onset, termination, or levels of use, as evidenced by: alcohol being often taken in larger amounts or over a longer period than intended; or by a persistent desire to or unsuccessful efforts to reduce or control alcohol use;
- a physiological withdrawal state when alcohol use is reduced or ceased, as evidenced by the characteristic withdrawal syndrome for alcohol, or by use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- evidence of tolerance to the effects of alcohol, such that there is a need for significantly increased amounts of alcohol to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of the same amount of alcohol;
- preoccupation with alcohol, as manifested by important alternative pleasures or interests being given up or reduced because of drinking; or a great deal of time being spent in activities necessary to obtain, take, or recover from the effects of alcohol;
- persistent alcohol use despite clear evidence of harmful consequences, as evidenced by continued use when the individual is actually aware, or may be expected to be aware, of the nature and extent of harm.

(p.57, WHO, 1993)

Medical management or treatment of alcohol dependence has been described in previous WHO publications[41]. A variety of treatments for alcohol dependence have been developed and found effective[42]. Significant advances have been made in pharmacotherapy, family and social support therapy, relapse prevention, and behaviour-oriented skills training interventions.

Because the diagnosis and treatment of alcohol dependence have developed as a specialty within the mainstream of medical care, in most countries primary care practitioners are not trained or experienced in its diagnosis or treatment. In such cases primary care screening programmes must establish protocols for referring patients suspected of being alcohol dependent who need further diagnosis and treatment.

Physician Positive Alcohol Screen Case

1. Ask 3 InSight screening questions:

   Do you smoke or use other tobacco products?

   When was the last time you had more than 4 drinks in one day?

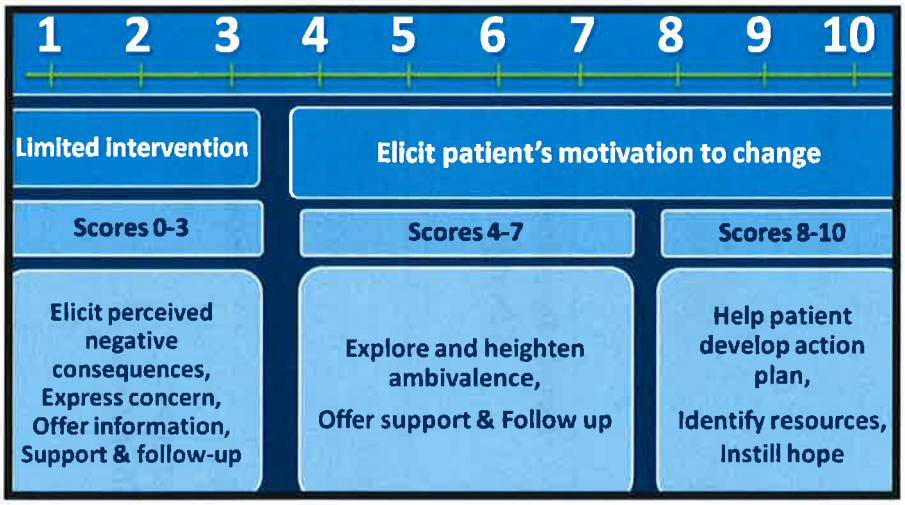
   How many times in the past year have you used an illegal drug or a prescription medication for nonmedical reasons?

2. If + on alcohol question, administer AUDIT:

3. Give feedback about AUDIT score:

Score	Category of Use
0-7	Healthy
8-15	At-risk
16-19	Abuse/Harmful
20+	Dependence

4. Assess patient's readiness to change:

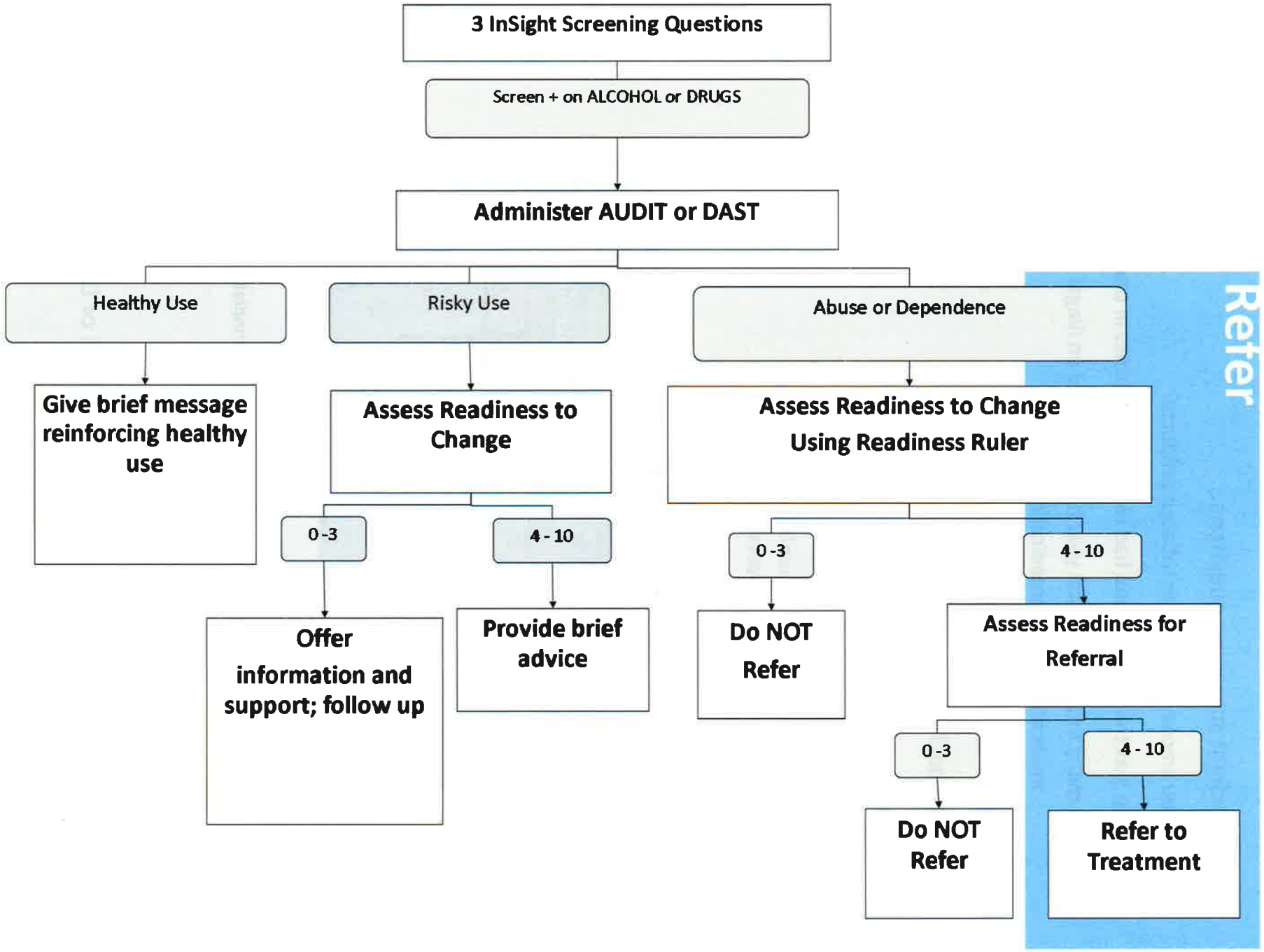


Readiness	Stage of Change
0-3	Precontemplation; early contemplation
4-7	Contemplation
8-10	Preparation; action

5. Provide appropriate BI based on pt's readiness:

6. If pt is appropriate for referral and meets ABUSE or DEPENDENCE, assess readiness for referral

7. If pt is ready for referral, make referral


3 InSight Screening Questions
Screen + on ALCOHOL or DRUGS
Administer AUDIT or DAST
Healthy Use
Risky Use
Abuse or Dependence
Refer
Give brief message reinforcing healthy use
Assess Readiness to Change
Assess Readiness to Change Using Readiness Ruler
0 -3
4 - 10
0 -3
4 - 10
Offer information and support; follow up
Provide brief advice
Do NOT Refer
Assess Readiness for Referral
0 -3
4 - 10
Do NOT Refer
Refer to Treatment

Physician Positive Drug Screen Case

1. Ask 3 InSight screening questions

   Do you smoke or use other tobacco products?

   When was the last time you had more than 4 drinks in one day?

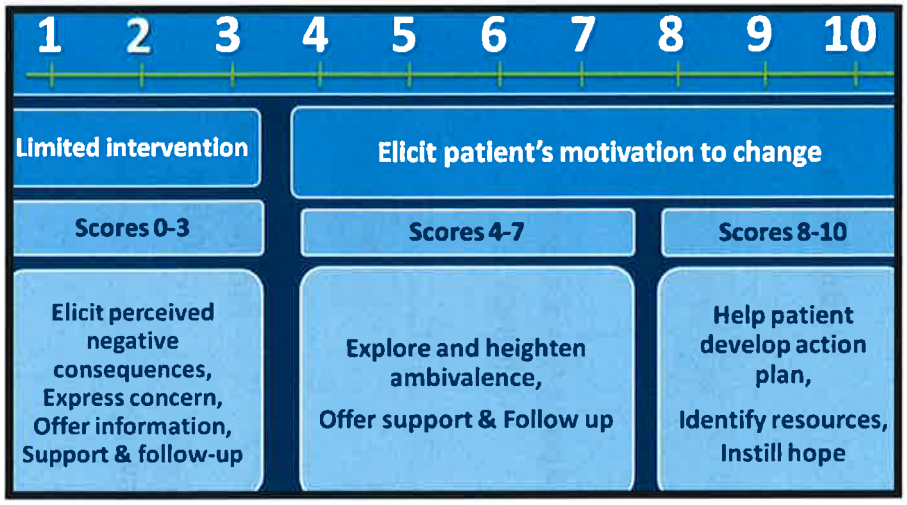
   How many times in the past year have you used an illegal drug or a prescription medication for nonmedical reasons?

2. If + on drug question, administer DAST:

3. Give feedback about DAST score:

Score	Category of Use
0	Healthy
1-2	At-risk
3-5	Abuse/Harmful
6+	Dependence

4. Assess patient's readiness to change:



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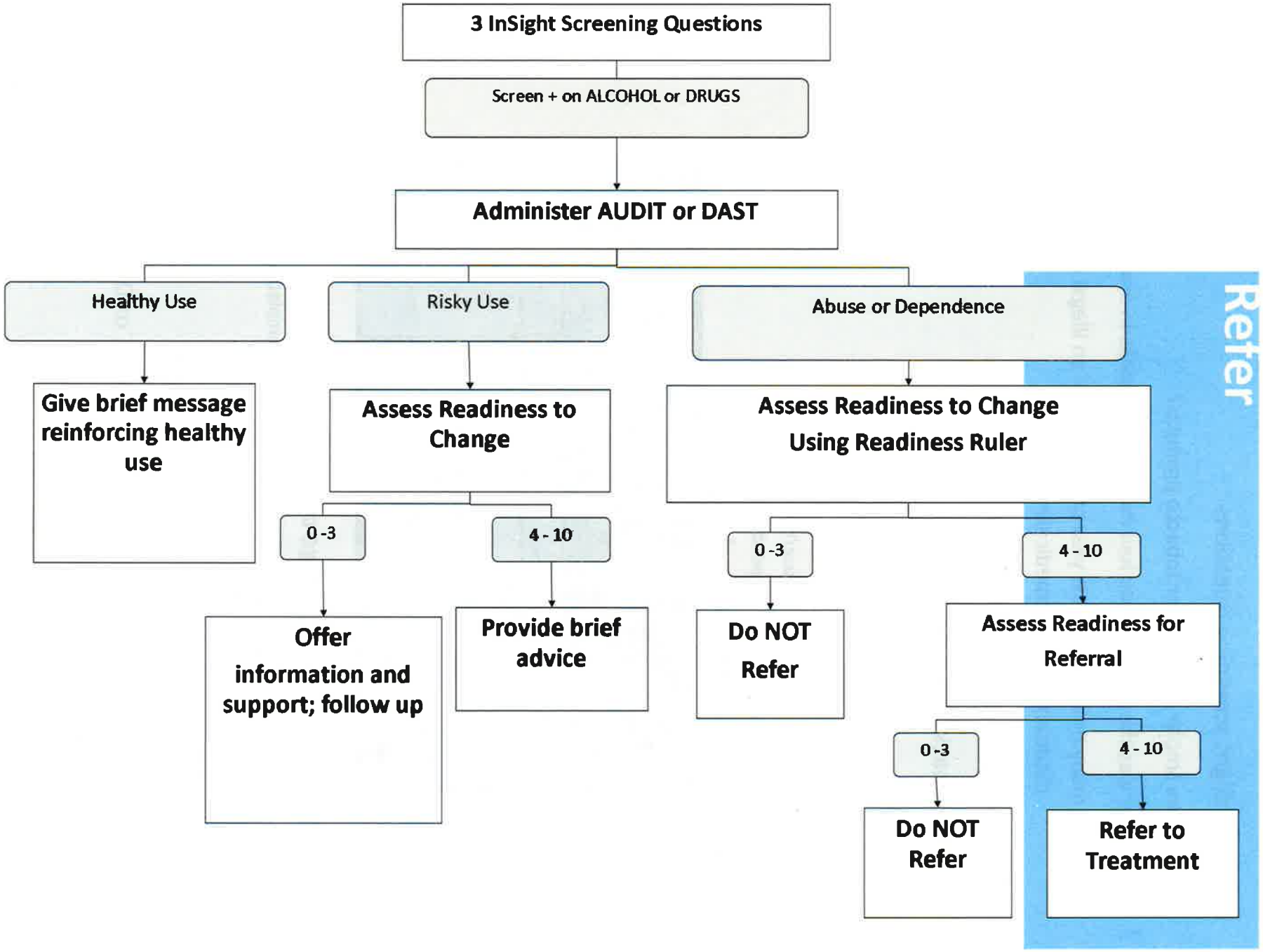
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RHIP Workgroup Updates: July

Behavioral Health: Identification & Awareness (Support: Rebeckah Berry & Steve Strang)

- This group meets the fourth Tuesday of every month from 9-10am and currently has 23 members.
- In July the group reviewed the draft work plan and provided feedback as a team. Currently, a second draft of the plan is being circulated for edits and additions. The work plan will be presented at Operations Council on August 19th. In the coming months, this workgroup will discuss how to implement a four-tiered plan for responding to a variety of positive behavioral health screenings. The group will also try to clearly identify the problem(s) that exist in order to create a clear pathway for referral to specialty care for individuals with Medicaid, Medicare, or private pay insurances.

Behavioral Health: Substance Use and Chronic Pain (Support: Rebeckah Berry & Rick Treleaven)

- This group meets the third Wednesday of every month from 4-5pm and currently has 21 members.
- In July the group reviewed a second draft of their work plan. Edits have been made and a final draft of the plan is being circulated for approval from all members of the group. The work plan will be reviewed by Operations Council on August 5th. In the coming months, this group will be defining clear and standardized pathways for patients that display one of four levels of SUD risk within primary care settings. These pathways will be personalized for our region to support providers in offering the best care for their patients.

Cardiovascular Disease—Clinical (Support: Rebeckah Berry)

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 9 members.
- In July this group developed the first draft of their work plan. This draft is being circulated among the members and finalized to be reviewed by Operations Council on August 19th. In the coming months, this group will further develop patient education documents around proper blood pressure procedures and things that raise blood pressure. These documents will be shared broadly with clinics. The group will also discuss e-referrals for the tobacco Quit Line, and potential clinic champion trainings around evidence-based guidelines for blood pressure measurement and treatment.

Diabetes—Clinical (Support: Rebeckah Berry)

- This group meets the second Thursday of every month from 9-10am and currently has 12 members.
- In July this group reviewed their draft work plan and provided input. Edits were made and the final draft is currently being circulated. The work plan will be reviewed by Operations Council on August 5th. In the coming months this group will develop standardized care pathways for four HbA1c categories that are personalized for our region. These pathways will be shared broadly to support care of our population with pre- and type II diabetes.

Cardiovascular Disease & Diabetes—Prevention (Support: MaCayla Arsenault & Channa Lindsay)

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 26 members.
- The workgroup met in July to continue to develop their work plan. Additionally, workgroup decided to develop a subcommittee composed of workgroup members and content experts to collaborate and develop feasible strategies to promote bicycling/active transportation and encourage healthy community design. The work plan will be reviewed by Operations Council on August 5th.

RHIP Workgroup Updates: July

Oral Health (Support: Donna Mills & Suzanne Browning)

- This group meets the third Tuesday of every month from 11-12pm and currently has 19 members.
- The Oral Health workgroup did not meet in July while the leads and a small sub-group worked on their respective work plans. This work plan will be reviewed by Operations Council on August 5th.

Reproductive Health/Maternal Child Health (Support: Donna Mills & Muriel DeLaVergne-Brown)

- This group meets the second Tuesday of every month from 4-5pm and currently has 22 members.
- The workgroup did not meet in July while the leads and a small sub-group worked on their respective work plans. This work plan will be reviewed by Operations Council on August 5th.

Social Determinants of Health

- This group meets the third Friday of every month from 10-11am and currently has 27 members in kindergarten readiness and 26 members in housing.

Education & Health (Support: Donna Mills & Desiree Margo)

- Kindergarten Readiness heard two RHIP presentations and agreed to move into a smaller sub group to complete the work plan due to Operations Council by August 19th.

Housing (Support: Bruce Abernathy & MaCayla Arsenault)

- The workgroup met in July to finalize their workgroup one-page overview and description and continue to develop their work plan. They continue to discuss goals, strategies, responsible parties, target metrics, and timelines. Additionally, the workgroup has decided to develop a housing data inventory in order to get the lay of the land and to use for future projects. Their work plan will be reviewed by Operations Council on August 19th.