Central Oregon Health Council

RHIP Clinical Cardiovascular Disease Workgroup
Deschutes County Building (Lyon Room)
1300 NW Wall Street, Bend

Agenda: July 17, 2018 from 4:00-5:00pm

Goals

Clinical Goal: Improve hypertension control
Prevention Goal: Increase awareness of the risk factors for cardiovascular disease including tobacco use, uncontrolled hypertension, high cholesterol, obesity, physical inactivity, unhealthy diets, and diabetes.

Health Indicators by 2019	QIM Measure	State Measure	Healthy People 2020
1. Increase the percentage of OHP participants with high blood pressure that is controlled (<140/90mmHg) from 64% to 68% (Baseline: QIM NQF 0018 - Controlling high blood pressure, 2014).	√		√
2. Decrease the prevalence of cigarette smoking among adults from 18% to 16% (Baseline: Oregon BRFSS, 2010-13; QIM Cigarette Smoking Prevalence).	√		√
3. Decrease the prevalence of smoking among 11th and 8th graders from 12% and 6%, respectively to 9% and 3%, respectively (Baseline: Oregon Healthy Teens Survey, 2013).			√
4. Decrease the prevalence of adults who report no leisure time physical activity from 16% in Crook County, 14% in Deschutes County and 17% in Jefferson County to 14%, 12%, and 15 % respectively (Baseline: Oregon BRFSS, 2010-13).			
5. Decrease the prevalence of 11th graders and 8th graders who 0 days of physical activity from 11% and 6% to 10% and 5%, respectively (Baseline: Oregon Healthy Teens, 2013).			

1. 4:00 **Introductions—All**

2. 4:10-4:45 **Direction Assessment of Clinical CVD Workgroup—All**

3. 4:45-4:55 **Cross-Pollination/Ideas with other RHIP Workgroups—All**
   - **Reproductive Health/Maternal Child Health**
   - **Oral Health**
   - **Milestones to Health (Kindergarten Readiness)**

4. 4:55-5:00 **Action Items & Announcements—All**
   - **COHC Grant Software**
   - **Next steps**

Next Meeting: 8.21.18 from 4-5pm (Deschutes County Bldg. (Lyon Room) 1300 NW Wall St., Bend)

CardioVascular Disease: Clinical (12)	Organization
Karen Ard	Deschutes County Health Services
Mark Backus, MD, FACP	Cascade Internal Medicine Specialists
Stevi Bratschie, MPH	PacificSource
Brenna Francis	La Pine Community Health Center
Maria Hatcliffe, RN, MPH	Mosaic
David Huntley, MPH	Epidemiologist - Community Member
Alison Little, MD, MPH	PacificSource
Sara Mosher, RN, BSN, MHA	St. Charles Medical Group
Robert Ross, MD, MScED, FAAFP	St. Charles Health System/St. Charles Medical Group
Divya Sharma, MD, MS	Central Oregon IPA & Mosaic Medical
Shiela Stewart, RN, BSN	Central Oregon IPA
Kris Williams	Crook County Health Department

RHIP Clinical Cardiovascular Disease Workgroup: Direction Assessment

RHIP Workgroup Overarching Goals:

Clinical Goal: Improve hypertension control

Prevention Goal: Increase awareness of the risk factors for cardiovascular disease including tobacco use, uncontrolled hypertension, high cholesterol, obesity, physical inactivity, unhealthy diets, and diabetes.

Workgroup's Current A3 Aim: Reduce the rate of youth tobacco use in Central Oregon from 17.3% to 15% in 8th graders, and 23.2% to 20% in 11th graders.

Funds Available: $~500k

Workgroup Member Questions:

1. **In your review of the workgroup's Clinical and Prevention goals, is the workgroup's current A3 aim appropriate? Please share your opinion.**

    - Yes, appropriate but I don't see anything on the fishbone addressing tobacco marketing and sellers. There needs to be some kind of a work plan that focuses on those 2 very critical elements also.

    - Yes. Unless we reduce youth tobacco use initiation we will not address the number one cause of preventable death and chronic disease associated with hypertension.

    - It seems like everyone assumes the aim is about cessation. If so, reducing the rate of youth tobacco use feels like too large an aim to actually see outcomes for. Based on what we have discovered, there aren't very specific evidence-based interventions available, so we would be embarking on a research project to *possibly* develop useful interventions. To then expect to see the stated outcome reductions in tobacco use would be a very high expectation across Central Oregon or even just one county. And it assumes that the interventions we develop would be effective. It also assumes that decreasing current use would be sustainable and that new users wouldn't eventually push rates back up.

    - It fits with the prevention goal, but not the clinical goal. It is undoubtedly an important topic, however, how do you define improvement in an ever-moving target? (Rates are malleable, my research, although incomplete, shows no national increase in tobacco use in youth over the last decade). A very

measurable goal is to improve hypertension treatment and control in the population, which is pathetically poor nationally and probably no better here. And funding of this magnitude could improve the individual and community wide control rate, resulting in improved outcomes and the definition and widespread implementation of standardized goals…youth smoking not so much.

- I do think we need to address adolescent smoking prevention and cessation. It supports the cardiovascular affects in adulthood that teens simply don't think about. Education is key.

- I do not think the current A3 appropriately aligns with the Clinical and Prevention goals. Focusing on youth tobacco cessation is pretty far upstream, which is great, but does not provide a more immediate and direct means for improving hypertension or increasing awareness of the associated risk factors.

- No, I don't think this is appropriate, because we have no proven tools to accomplish the outcome, or even unproven tools. Our research has shown that for youth, pretty much nothing works. I would consider an intervention that involves paying teens who stop, but there is not teen specific evidence on that one, and there didn't seem to be much appetite for it at the last meeting. This A3 also seems pretty limited given that broad goals of the workgroup.

2. If we were to start a new A3, what should the focus (aim) be?

- Tobacco in and of itself is so huge that I am concerned that that alone will take significant efforts and wouldn't want that effort diluted if we add some other focus. But that said, targeting obesity may be the other thing that could complement tobacco cessation better than anything else since that is part of making healthy life-style choices.

- Still tobacco use. Again, it is the number one cause of disease and death and contributes to numerous chronic diseases. It also costs millions of dollars each year to treat!

- This is vague but could we support creative population health initiatives by clinics and/or other agencies to "improve hypertension control"? This implies that the strategies would be specifically for people who have hypertension (and pre-hypertension? The definitions are a bit tricky right now). It would be similar to the use of QIM funds of the past. It seems like now that we (clinics) have embraced this QIM of BP Control, the money is gone to support additional creative initiatives. Some examples of initiatives could be group visit

development; use of home BP monitoring; peer support development; incentivized activity programs; etc.

- I don't believe you change behavior with an A3, which was the business rage in 2010 or 2012-or actually that the exercise is very helpful, except in specific circumstances. Kaizen-which is the true origin of lean (Toyota) production, is a Japanese term using continuous small steps-that is why Toyota took from 1960 until about 1990 to get their defects and production better than the US automakers. They didn't start out that way .

  However, if you can bring folks to define a measurable objective, and create a plan using the A3 tool, personally I would want to start with a population measure of the control of BP in the hypertensive population, and then set a reasonable target that is achievable. If you believe that lowering the rate by Double the good, Half the bad- a peculiar and American interpretation and "lean" premise, I think that is a failing strategy.

  Using the science to inform the decision-I would benchmark BP control where it is done well (the literature could be researched for this, but I suspect some pioneer ACO's such as Advocate in Chicago or Kaiser health systems) probably have benchmarks (likely in the 80 % range I would guess). You can incorporate excellent preventive measures on the way (Like the Mediterranean diet and lifestyle change) as part of the regimen- which also treats DM and obesity-and an essential treatment/lifestyle change in control of BP.

  I believe in starting any project with Relevant, Understandable, resulting in Measurable Behavior (or outcomes) and that is Achievable (RUMBA).

- There is still work to be done around Hypertension management. Dr. Backus program is good, but we are still not seeing huge improvements in QIM rates.

- The focus should be on a more immediate intervention that improves hypertension control and increases awareness within our community of what causes hypertension. I would be passionate about focusing on health eating habits, coupling this with the Veggie Rx pilot.

- Are we supposed to have a specific prevention goal? Can you remind me of the process for how we came up with these? Is there a reason we decided to focus on kids?

3. If you believe we should stick with our current A3 aim, what would be your recommendation for our first experiment? Please keep in mind that the "I's" in the fishbone are the items the group deemed implementable.

- Unclear of this question. Are you asking which of the "I" should be tried 1st? I feel that all of the "I"s should be simultaneously worked on.

- Promoting cessation along with policy. Offering 2A's and R training for all providers with an emphasis on youth intervention for both cessation and prevention. Family education on the role adults play in preventing tobacco use among youth. Encouraging family communication around tobacco use. Promoting tobacco free policies in public places.

- "Reducing the rate of use" leaves it open in my mind to prevention or cessation. If we decide to continue our focus on the issue of youth tobacco, I think we would need to narrow our aim to raising awareness - among providers and our community about the extent of the problem; the key reasons why youth is using e-cigs; and what anyone (especially parents) can do about it. Perhaps our outcome would have to be penetration of the message or targeted before/after surveys about knowledge and learning one way to be involved (like at a health fair).
  I think providing education (2A's & R or 5A's) and opportunities for motivational interviewing training specific to this topic for providers would be beneficial (similar to the Mark Backus approach in primary care settings). We could set a goal of how many providers we reach and again, a before/after survey for impact of the training?
  Materials need to be developed to include a toolkit of posters and handouts for community events, schools and clinics. Creating and marketing a standardized messaging across our community would be beneficial. Are these things that the Deschutes and Crook staff could lead as part of their roles and we could support?

  Overall, we could build off of our already stated outcomes of:
    - Heightened awareness among providers
    - More competence to disseminate information
    - More availability of materials

- I think we still need to focus on education and tailoring our messages that help teens understand how they are being "tricked" by the tobacco industry. Also partnering with the SBHCs to work with teens who currently use tobacco is key. It sounds like we have a pilot in place for this though starting 2019.

Subject: RHIP Cardiovascular Group- Update on upcoming drug and alcohol policy related activities in Bend- La Pine School District

Date: Friday, June 22, 2018 at 11:04:31 AM Pacific Daylight Time

From: Karen Ard

To: Rebeckah Berry

Attachments: image001.png, image002.png, image003.png, image004.png, Teen Intervene Proposal_RHIP Cardiovascular Wrkgrp.docx, Teen Intervene SS (1).pdf

Rebeckah,

I wanted to share this with you and the group, as I feel this aligns with our discussion from the last RHIP Cardiovascular Workgroup meeting. Provided is an outline of the Deschutes County Substance Abuse Prevention Alternative to Suspension Policy Pilot project. The purpose of this program is meant to create possible alternatives to out-of-school suspension for nicotine, alcohol, and other drug-related policy violations and reduce the likelihood of subsequent policy violations. Teens go through two tracks based on a counselor screening: high risk or low to moderate risk. The low to moderate risk teens partake in a 4 session series with Teen Intervene curriculum (attached), including a mandatory additional tobacco cessation class based on any nicotine use, regardless of what their initial violation was. The high risk track includes working with a Certified Alcohol and Drug Counselor. Both tracks may end in referring students to treatment. The program is expected to be piloted in Spring 2019 with select high schools in Bend-La Pine School District with a full district and county-wide rollout to all high schools and middle schools in August of 2019. I thought this might be an option to see how this group could fit into supplementing or enhancing the tobacco cessation efforts, or expanding to a tri-county reach.

Thanks!

Karen Ard, MPH | Tobacco Prevention and Education Program Coordinator
DESCHUTES COUNTY HEALTH SERVICES
Tel: (541) 322-7481

Deschutes County Substance Abuse Prevention Alternative to Suspension Policy Pilot

Alternative to Suspension Recommendations

Alternatives to out-of-school suspension are considered a best-practice. Research shows that excluding young people from school for disciplinary problems is often ineffective and counterproductive.[1,2] Students perceive an out-of-school suspension as a vacation from school.[1] Further, out-of-school suspensions rarely prevent and address the underlying causes of the misbehavior.[1,3]

The following are recommendations for the Deschutes County school districts to fulfill the needs of its alcohol and other drug policy. The recommendations are meant as possible alternatives to an out-of-school suspension for an alcohol or drug-related policy violation and are intended to reduce a student's likelihood for a subsequent policy violation.

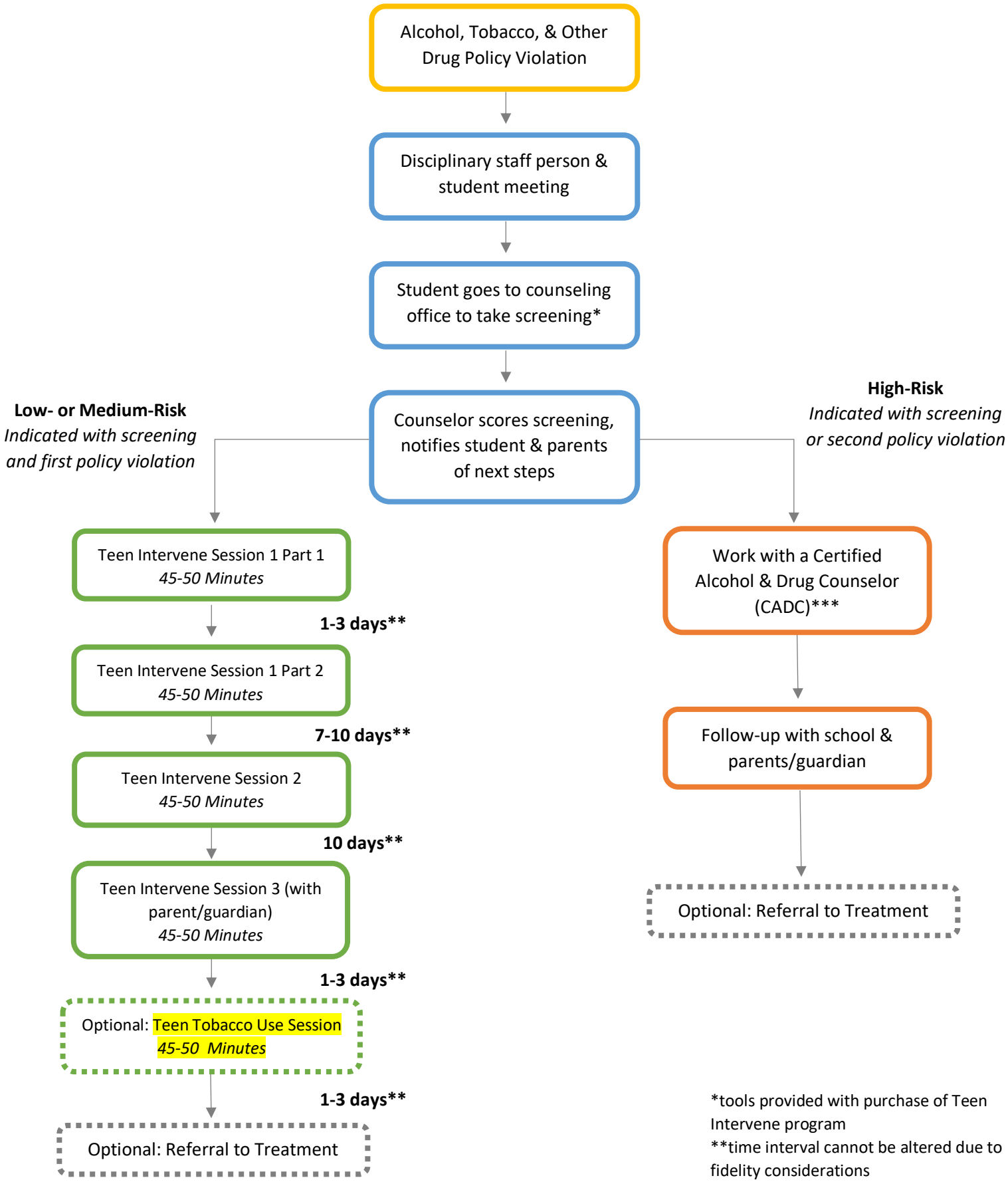
Recommended Program Selection Process

Once a student has violated a school policy regarding alcohol or drugs, assessing individual student behavior and circumstances will ensure that the student is directed to the most appropriate program option. Two triaging structures are provided: one where an in-person program option is available and the second where an online program option is available.

Screening for Substance Use Disorder

Research shows that the earlier in adolescence someone starts using alcohol or other drugs, there is higher likelihood for developing a substance use disorder[4]. Therefore, it is important to take the opportunity to screen students for substance use disorder in order to route them to necessary services. This document outlines a few recommended screening tools. Actual screening tools are provided in the Appendix of this document.

Triaging Structure



*tools provided with purchase of Teen Intervene program
**time interval cannot be altered due to fidelity considerations
***Number of sessions determined by CADC

Alternative to Suspension Program – Teen Intervene[9]

Teen Intervene is a brief, school-based intervention aimed at reducing substance use in young people between the ages of 12 to 19. The program is designed as a comprehensive screening, brief intervention, and referral to treatment (SBIRT) model of care. Teen Intervene covers all drugs, with a special focus on alcohol, marijuana, and tobacco use. The content of the program allows the facilitator to adjust discussions and goals based on students' relevant drug usage, which can include prescription drug abuse. Teen Intervene incorporates the stages of change model, motivational interviewing, and components of cognitive-behavioral therapy. The program is brief and can be administered in three or four sessions depending on time available for each session. It is recommended that Teen Intervene be administered for students who violate a Bend-La Pine School District alcohol or drug-related policy.

Teen Intervene begins with screening; if a student is considered low- to moderate-risk according to screening, it is recommended that the teen completes Teen Intervene. If a student is considered high-risk according to screening, it is recommended that student be referred to treatment with a Certified Alcohol and Drug Counselor.

Session 1 of Teen Intervene is a 60- to 75-minute session used to:

- Summarize the basic principles of the program
- Distinguish between the pros and cons of substance use
- Evaluate readiness to change
- Identify goals for reducing or eliminating substance use.

After 7 to 10 days, the student returns for Session 2. This 60-75 minute session is used to:

- Recall reasons for alcohol or other drug use discussed in Session 1
- Evaluate progress on goals established in Session 1
- Analyze and apply decision-making techniques in real-world situations with a high risk for substance use
- Distinguish supportive individuals within a social network and determine other support options
- Plan strategies for saying no and dealing with peer pressure
- Re-evaluate readiness for change
- Identify long-term goals around reducing or eliminating substance use

After 10 days, the student and their guardian(s) return for Session 3. This parent/guardian session is a standard part of the program and empirical research of the program shows increased effectiveness when the parent/guardian session is included. The program also acknowledges that there are times when it is not feasible or clinically advisable to include this session as it may present a barrier to student participation, or parents/guardians may be unwilling to participate. Session 3 is used to:

- Summarize the events that led to the student to Teen Intervene
- Summarize the Teen Intervene program
- Identify the alcohol and other drug use of the parent(s)/guardian(s)
- Analyze and create family communication methods regarding alcohol and other drug use
- Apply family rules about alcohol and other drug use and implement support strategies for helping the teen change in the positive direction

The administrator and/or guardian(s) of the student may recognize that the student may need additional support after completing the Teen Intervene program. At this point, the facilitator may refer the student to treatment. This may look like:

- Recognizing any unfavorable changes in the teen's substance use and progress toward goals
- Explain options for referral if next steps are needed
- Select the appropriate options for next steps

If through screening or through one of the sessions of Teen Intervene a student discloses tobacco use in addition to marijuana or alcohol use, there is an optional Teen Tobacco Use Session that can be administered after the first three sessions. This 60 -to 75-minute is used to:

- Analyze the pros and cons of tobacco and other nicotine product use
- Evaluate readiness for change
- Identify goals for reducing or eliminating tobacco and nicotine product use

Alternatively, Teen Intervene can be administered in four shorter sessions in the event that 60- to 75-minute sessions are unfeasible. Session 1 can be split into two parts, Session 1 Part 1 and Session 1 Part 2, followed by Session 2 and Session 3. These four sessions are 45-50 minutes; Session 1 Parts can be separated by 1 to 3 days, following 7-10 day separations between the subsequent sessions.

Teen Intervene has been endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry of Evidence Based Programs.[10] Research evaluating the effectiveness of Teen Intervene has also been supported by the National Institute of Health.[10] Multiple studies show significant reductions in dependence symptoms as well as negative consequences of alcohol and other drug involvement at 6-month follow-up.[10] Since its development in early 2000, Teen Intervene has been implemented with more than 75,000 students in more than 1,000 sites in all 50 states as well as several other countries including Canada, Ireland, Japan, and the United Kingdom, to name a few.[10]

A robust facilitator's guide and program materials can be purchased for $395.95. The package includes a facilitator guide, screening tools, digital files for exercise packets, parent guides, consent forms, drug fact sheets, and posttests. Further inquiry regarding training and its associated costs would need to be explored with the developers of the program.

Outcome Measures for Protocol Pilot

The following outcomes will be used to measure the success of the Teen Intervene pilots:

1. Number of Policy violations
2. Types of policy violations
    a. Alcohol
    b. Cannabis
    c. Nicotine
    d. Prescription drugs not prescribed to a student
    e. Illicit drugs
    f. Multiple drugs

3. Number of students served
4. Number of sessions provided
5. Number of students with repeated violations
6. Basic student demographics
    a. Grade
    b. Gender
    c. Ethnicity
    d. Age
7. Number of unexcused absences (school level)
8. Student satisfaction of Teen Intervene program
9. Parent satisfaction of Teen Intervene program
10. Student attitudes towards substance use
11. Student intentions around substance use
12. Student behaviors around substance use
13. Student perceptions around substance use
14. Student consequences related to substance use?

Projected Timeline for Protocol Pilot

August 2018: Protocol Pitch & opt in for Bend-La Pine High Schools

September 2018 – January 2019: Planning for protocol implementation

January 2019 – June 2019: Protocol Pilot implementation

June 2019 – August 2019: Evaluating and planning for district & county-wide roll out – ALL high schools and middle schools in Deschutes County. Could be expanded to Jefferson and Crook Counties if interested and able be part of planning, implementing, and evaluating.

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[1]Dufresne, A., Hillman, A., Carson, C., & Kramer, T. (2010). Teaching discipline: A toolkit for educators on positive alternatives to out-of-school suspensions. *Connecticut Voices For Children*.

[2]Tolerance Task Force. (2008). Are zero tolerance policies effective in schools?. *American Psychologist, 63*(9), 852-862.

[3]Iverson, S., Joseph, E., Oppenheimer, C. (2015). Keeping kids in class: School discipline in Connecticut, 2008-2013. *Connecticut Voices for Children*.

[4]Hingson RW, Heeren T, Winter MR. Age at drinking onset and alcohol dependence: Age at onset, duration, and Severity. *Arch Pediatr Adolesc Med.* 2006;160(7):739-746. doi:10.1001/archpedi.160.7.739

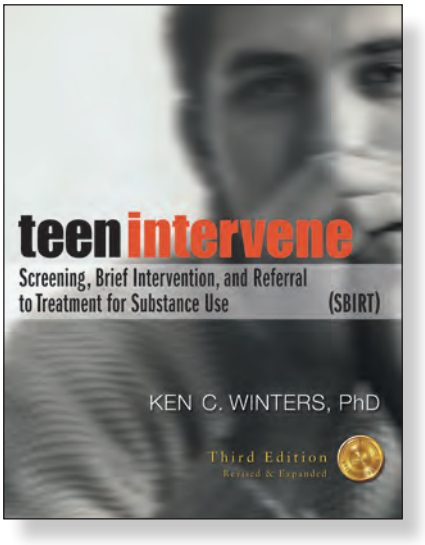
[5]*Teen Intervene*. (2018). *Hazelden.org*. Retrieved from http://www.hazelden.org/web/go/teenintervene

[6]Intervention Summary - Teen Intervene. (2018). National Registry of Evidence Based Programs. Retrieved from https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=287

TEEN INTERVENE

Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Substance Use

Third Edition



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January 2016

What Is *Teen Intervene*?

Teen Intervene is a tested, time-efficient, evidence-based program for teenagers (twelve to nineteen years old) suspected of experiencing a mild or moderate substance use disorder, covering all drugs but with a special focus on alcohol, marijuana, and tobacco use. The program is designed to include teens' parents or guardians. The *Teen Intervene* program incorporates the stages of change model, motivational interviewing, and cognitive-behavioral therapy, and has been expanded to offer a full Screening, Brief Intervention, and Referral to Treatment (SBIRT) model.

The core *Teen Intervene* program can be administered in an initial screening, two one-hour sessions with the adolescent, and an additional optional session for the parent(s)/guardian(s) and the teenager together. While the parent/guardian session is a standard part of this evidence-based program, and empirical research shows increased program efficacy when the parent/guardian session is included, there are times when it is not feasible or clinically advisable to include this session. The parent/guardian session may present a barrier to adolescent participation or parents/guardians may be unwilling to participate. Seventy-five minutes would be a more desirable length for each of the two teen sessions, which are individual sessions with the adolescent. Session 3, the parent/guardian session, is an individual counseling session with the parent(s) or guardian(s) of the teenager. This last session should include a brief wrap-up conversation with both the parent(s)/guardian(s) and the adolescent together. A seven- to ten-day interval is recommended between sessions 1 and 2, and a ten-day interval is recommended between sessions 2 and 3.

As an evidence-based program, the structure of *Teen Intervene* should be followed as closely as possible. However, the length of the sessions may be an issue for some (e.g., school environments with set class periods; clinical settings where insurance reimbursement includes requisite session length quotas), so the program can be broken down into an alternative four-meeting format. This format has three forty-five- to fifty-minute individual meetings with the youth, followed by a fourth parent/guardian meeting. The four-meeting version is as follows: Teen Session 1 is broken down into two meetings (Teen Session 1—Part 1 and Teen Session 1—Part 2), which can be administered separately; Teen Session 2 is retained as a single meeting; and Parent/Guardian Session 3 is also retained as a single meeting. Additionally, some facilitators may choose to implement teen or parent/guardian booster sessions after the core three- or four-session program is complete.

What Is New in the Third Edition of *Teen Intervene*?

Although *Teen Intervene* has been a highly effective brief intervention program for teens, this third edition of the program has been greatly enhanced to meet the requirements of a full Screening, Brief Intervention, and Referral to Treatment (SBIRT) program, as well as being updated for compliance with the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (*DSM-5*). This includes the addition of guidance on implementing a screening tool to determine if the brief intervention sessions are warranted, and also information on how to refer teens to treatment if the brief intervention sessions indicate that a teen may benefit from treatment due to the severity of his or her use. CPT coding information is included for reimbursement purposes. Program language has also been updated to apply to all drugs.

Some environments call for shorter meetings than the sessions recommend, so the program now includes a 4-meeting format. Using this version will ensure that meetings do not run longer than 50 minutes while still covering all of the content. Additionally, drug-specific information has been updated, as has the information on efficacy research.

For adolescents who are current and frequent tobacco users (at least on a weekly basis), the third edition of *Teen Intervene* also includes an additional individual session (Teen Tobacco Use Session) that focuses on this topic. The screening tool will identify those teens who have issues with tobacco. It is recommended that this tobacco session be implemented after the sessions focused on alcohol and other drugs. It may be overwhelming for teens to try to address both issues at the same time. If a teen is only using tobacco, you can use the tobacco session as a stand-alone intervention.

The complete *Teen Intervene* collection now includes *Youth and Drugs of Abuse,* a two-disc set which consists of a DVD featuring firsthand video accounts discussing drugs of abuse across the continuum of care: prevention, intervention, treatment, and recovery; as well as a CD-ROM containing a facilitator guide and fact sheets for teens and parent(s)/guardian(s).

How Does *Teen Intervene* Use the SBIRT Model?

In recent years, there has been attention focused toward expanding and improving clinically related services in order to address individuals involved with alcohol and other drugs. Clinically, Screening, Brief Intervention, and Referral to Treatment (commonly referred to by the acronym SBIRT), is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with a mild or moderate form of a substance use disorder, as well as for those who are at risk of developing these disorders (Babor et al. 2007). **Screening** quickly assesses for the presence of risky substance use. For those with a mild to moderate substance use problem, a brief intervention is recommended. Further assessment and possibly treatment are needed for those who show a more severe substance use problem. **Brief intervention** focuses on increasing insight and awareness regarding problems associated with substance use and motivation and guidance toward behavioral change. **Referral to treatment** provides those identified as needing more extensive treatment after the brief therapy sessions with access to specialty care.

The research on the efficacy of SBIRT for youth has not yet gone past the SBI portion of the model (screening and brief intervention). As detailed later, studies have found that brief interventions (BIs) are associated with positive outcomes when applied to adolescents, and this includes research on the efficacy of *Teen Intervene*. Of note is that BIs have significantly outperformed control or comparison conditions, which include education- and assessment-only groups. As many experts have observed, the referral to treatment (RT) element of SBIRT is very understudied and, thus, guidance for applying RT can only be based at this time on clinical judgment.

The third edition of *Teen Intervene* provides guidance for the facilitator on employing a full SBIRT service model.

Who Can Implement *Teen Intervene*?

Teen Intervene is designed for trained professionals, including teachers, school counselors, social workers, psychologists, youth treatment service providers, and other youth-serving professionals who are experienced in working with teenagers with substance use disorders. Facilitators of the *Teen Intervene* program should have formal training in basic counseling skills, as well as a basic understanding of the etiology, course, and treatment of adolescent substance use disorders. Also, it is desirable, but not required, that facilitators have a certified degree in addiction counseling or a license in a related field of behavioral science.

What Constitutes the *Teen Intervene* Program?

Teen Intervene is divided into three main sections: the facilitator guide, the exercise packets, and other supplementary materials. The facilitator guide is divided into the following parts:

- Introduction (background information on the program's development, program scope and sequence, session descriptions and preparation, and guidance on program administration)
- Screening
- Teen Session 1
- Teen Session 2
- Parent/Guardian Session 3
- Referral to Treatment
- Teen Tobacco Use Session
- Appendices (Frequently Asked Questions, Resources and References)

You will find the exercise packets, and other ancillary materials needed for the adolescent and parent/guardian sessions, in the program's digital files. Print these reproducible materials for use with program participants. All the materials to be used with parents/guardians are also available in Spanish. These Spanish documents are also found in the program's digital files.

What Are the Goals and Objectives of *Teen Intervene*?

Abstinence is usually the long-term goal of substance use disorder treatment. However, to start in motion the process of abstinence, it stands to reason that harm reduction is a logical early-stage goal of *Teen Intervene*. Any behavior change that reduces harm is a positive result. By taking on a more flexible approach toward goal attainment, defiant adolescents may be more receptive to the change process.

The *Teen Intervene* program also emphasizes that behavior change goals need to be individualized. This feature recognizes the variety and range of adolescent substance use involvement. Each young person has his or her own reasons for substance use, and individual teens may differ greatly in terms of willingness to change and their treatment goals. By using individualized goals and personalized feedback, brief interventions can be more directly focused for each adolescent's specific needs.

The *Teen Intervene* program integrates a variety of techniques to establish behavior change goals with the adolescent. One strategy is to engage the adolescent in discussion

of the pros and cons of substance use. This method helps the individual recognize that while use may have short-term personal benefits for the individual, it can also affect school performance and increase health risks.

The facilitator using *Teen Intervene* is instructed to be nonjudgmental, nonlabeling, and nonconfrontational. To put this another way, the facilitator's job is to act as a teacher or coach in order to help the adolescent progress through the stages of change. The intent is to move the teen from low problem recognition and little willingness to change, to the "action" stage, in which specific steps of positive behavior change are identified and implemented by the youth.

To summarize, *Teen Intervene* is designed to help the teen:

- decide for himself or herself the pros and cons of use
- identify the reasons why he or she uses
- learn new skills that promote healthier behaviors
- take responsibility for self-change

Which Teens Can Benefit from *Teen Intervene*?

The *Teen Intervene* program has been developed for application with teenagers who display the early stages of substance use problems. It is intended for teenagers who are displaying or exhibiting mild or moderate problems associated with alcohol or other drug use. Such early-stage users often meet *DSM-5* (American Psychiatric Association 2013) formal criteria for a substance use disorder at a mild or moderate level. That is, these youth show harmful or hazardous consequences from their substance use and may begin to show some signs of dependence (e.g., preoccupied with use). For example, the youth may be experiencing problems at school resulting from substance use or may be getting into arguments with his or her parents and friends as a result of substance use. Also, this third edition of *Teen Intervene* is applicable for teenagers who are regular users of a tobacco product (at least a weekly smoker or chewer).

Teenagers who are *not* good candidates for *Teen Intervene* include those who

- have a *DSM-5* severe level substance use disorder (e.g., they show loss of control of their substance use or have developed significant tolerance of substance use)
- are daily substance users
- suffer from an untreated psychiatric disorder, such as a major affective disorder or psychosis

Why Was *Teen Intervene* Developed?

The impetus for developing this model is based on five premises.

- First, the gap between treatment need and treatment availability appears to be significantly increasing for adolescents, particularly for those with mild or moderate substance use disorders. Low-end severe cases are estimated to represent about 30 percent of adolescents who present for a substance use disorder evaluation in Minnesota (Winters 2000).
- Second, this gap in service access is most likely the result of a tightening of treatment eligibility criteria by cost-conscious third-party payers.
- Third, with some exceptions, brief and relatively inexpensive interventions (for example, three to four sessions) have been shown to be effective as stand-alone therapies for *adults* with an alcohol problem (see reviews by Bien, Miller, and Tonigan 1993; Hettema, Steele, and Miller 2005; Lundahl, Kunz, Brownell, Tollefson, and Burke 2010; U.S. Department of Health and Human Services 2000), although the picture is mixed when treating illicit drug using adults (see Saitz et al. 2014). Also, other brief intervention work with youth has been shown to be promising (Breslin et al. 2002; Erickson, Gerstle, and Feldstein 2005; McCambridge and Strang 2004; Monti, Colby, and O'Leary 2001; Tanner-Smith and Lipsey 2015; Wachtel and Staniford 2010; Walker, Roffman, Stephens, Berghuis, and Kim 2006; Walker, Stephens, Roffman, Demarce, Lozano, Towe, and Berg 2011).
- Fourth, lower-cost treatment options for adolescents with less severe substance use disorders are potentially attractive to cost-conscious managed-care systems.
- Fifth, brief interventions make developmental sense given that (a) many youth with substance use disorders have not been struggling with their use long enough to think that a disease-oriented approach makes sense, and (b) developmentally, young people are likely to be receptive to self-guided behavior change strategies, a cornerstone of brief interventions (Miller and Sanchez 1993; Winters, Tanner-Smith, Bresani, and Myers 2014).

What Research-Based Theories Were Used to Develop *Teen Intervene*?

The core components of *Teen Intervene* are based on the following research theories, techniques, and therapies:

- stages of change model
- cognitive-behavioral therapy
- motivational interviewing

These components, also used in adult therapy, have been adjusted for adolescents. These adjustments include simplification of concepts, heavy emphasis on teen engagement, and consideration of behavioral change goals likely to be relevant to an adolescent. The following is a summary of these components.

Stages of Change Model

The stages of change model, as described by Prochaska, DiClemente, and Norcross (1992), provides a framework to understand the motivational state of a person with respect to changing health behaviors. The primary five stages of change can be readily adapted to apply to a young person examining his or her substance use behaviors.

Many adolescents in therapy are likely in the pre-contemplation or contemplation stage. The facilitator should recognize that this status need not be a barrier to change. Rather, the facilitator should focus on ways to help the young person progress to the next stage. One should not assume that a teenager in the pre-contemplation or contemplation stage is at a therapeutic dead end. Thus, the facilitator should consider the teen's ambivalence about change as normal and not necessarily permanent.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) is a therapeutic technique used to change one's perceptions, thoughts, and feelings about his or her behavior and to increase a person's awareness about how social experiences affect the way we act. CBT is based on the principles of the social learning theory. CBT focuses on the importance of overcoming skill deficits and increasing the adolescent's existing coping skills by providing a means of obtaining social support.

The "ABC" principles of CBT are included in *Teen Intervene* in order to facilitate the change process. The ABC model refers to an *antecedent* that is responded to by various *behaviors* or *beliefs* and that is followed by *consequences*.

For example, a teen may receive a low score on a test (antecedent). This student may believe that he or she cannot be successful in school (belief) and then act out

(behavior) in frustration by using substances on campus. As a result, the student may incur punishment by school officials (consequences). By applying specific therapeutic steps, such as assessing high-risk situations and identifying errors in thinking that may contribute to poor decisions, the facilitator helps the young person choose attitudes and behaviors that are alternatives to substance use.

Motivational Interviewing

Motivational interviewing, or motivational enhancement, is a therapy technique designed to enhance the adolescent's motivation to change some specified behavior. The *Teen Intervene* program has incorporated many features of motivational interviewing.

Miller and Rollnick (2007) have identified key elements that are important to the successful application of motivational interviewing. An intervention that contains even some of these elements has been proven effective in instigating change and reducing substance use (Bien, Miller, and Tonigan 1993). These elements are:

- personalizing feedback about the adolescent's problems and willingness to change
- emphasizing the point that change is the adolescent's responsibility
- providing specific and action-oriented recommendations on how to change, including a list of alternative behaviors
- conducting oneself as an empathetic facilitator
- encouraging self-efficacy or optimism in the adolescent

Teen Intervene is considered an evidence-based intervention, based on standards from the National Registry of Evidence-based Programs and Practices (NREPP) (see www.nrepp.samhsa.gov). *Teen Intervene* is summarized by NREPP on their website.

The small but growing empirical evidence for the effectiveness of the three-session program offered by *Teen Intervene* is encouraging. Two separate studies indicate that this intervention is associated with significant improvement on the basis of pre-post comparisons and when compared to an assessment-only control group (Winters and Leitten 2007; Winters et al. 2012; Winters et al. 2014). However, the magnitude of effects were greater at 6-months outcome compared to 12-months outcome (Winters et al. 2014). Also both studies provide support that clinical improvement can be achieved if only the two youth sessions are administered. Finally, preliminary indications are that a consistent active ingredient of *Teen Intervene* is that the program is associated with utilization of additional counseling services for the adolescent after completion of the program.

Session	Goals
Screening	• assess for risky substance use • identify youth presenting a mild or moderate substance use disorder and recommend the *Teen Intervene* brief intervention • identify youth presenting a severe substance use disorder and recommend further assessment and referral to treatment
Teen Session 1	• summarize the basic principles of the *Teen Intervene* program • distinguish between the pros and cons of substance use • evaluate readiness for change • identify goals for reducing or eliminating substance use
Teen Session 2	• recall reasons for alcohol and other drug use discussed in session 1 • evaluate progress on goals established in session 1 • analyze and apply decision-making techniques in real-world situations with high risk for substance use • distinguish supportive individuals within a social network and determine other support options • plan strategies for saying no and dealing with peer pressure • re-evaluate readiness for change • identify long-term goals around reducing or eliminating substance use

Session	Goals
Parent/Guardian Session 3	• summarize the events that led the teen to the brief intervention • summarize the *Teen Intervene* program • identify the alcohol and other drug use of the parent(s)/guardian(s) • analyze and create family communication methods regarding alcohol and other drug use • apply family rules about alcohol and other drug use and implement support strategies for helping the teen change in a positive direction
Referral to Treatment	• recognize any unfavorable changes in the teen's substance use and progress toward goals • explain options for referral if next steps are needed • select the appropriate options for next steps
Teen Tobacco Use Session	• analyze the pros and cons of tobacco and other nicotine product use • evaluate readiness for change • identify goals for reducing or eliminating tobacco and other nicotine product use

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Subject: RE: Last Thing for Today :)
Date: Monday, July 2, 2018 at 12:53:02 PM Pacific Daylight Time
From: Kris Williams
To: Rebeckah Berry, Karen Ard
Attachments: image003.png

Of course!

The tri-county TPEP coordinators approved the media buy plan and the actual ads that will be placed on June 22. At that time it was determined that the original proposal from last year included some evaluation that did not truly capture the retailer-focused campaign which we had chosen to move the region toward tobacco retail licensure. I then asked Pacific Source permission to keep the original evaluation questions in the mix for our local data, but to use the questions specific to the outcomes we wanted measured for the effectiveness of the campaign that were specific to the retail environment. They agreed that was the best approach, so OHA is in the process of working with the contractor to make the buys. The actual campaign will start in August, with the bulk of the ads running Sept./Oct. OHA will then do a late Fall, one-month post campaign survey to determine success with the results to us and Pacific Source by 12/31/18.

Kris Williams
Crook County Tobacco Prevention and Education Program
541-416-1827
www.smokefreeoregon.com
Oregon Indoor Clean Air Act
http://healthoregon.org/morefreshair

From: Rebeckah Berry [mailto:rebeckah.berry@cohealthcouncil.org]
Sent: Monday, July 02, 2018 12:03 PM
To: Kris Williams; Karen Ard
Subject: Last Thing for Today :)

Hi Kris,

Sorry to keep bugging you. I am wondering if you have any updates you can share regarding the tobacco messaging campaign that was QIM funded? I would love to learn what the timeline is and how it's going.

Thank you!

Rebeckah C. Berry, M.S., C.H.E.S.
Operations & Projects Manager
Central Oregon Health Council
rebeckah.berry@cohealthcouncil.org
General Office Line: 541-306-3523

Million Hearts®

Hypertension Control

ACTION STEPS for Clinicians

A MILLION HEARTS® ACTION GUIDE

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To reduce the burden of heart attack and stroke in the United States, the Department of Health and Human Services launched Million Hearts®. The goal of this initiative is to prevent one million heart attacks and strokes by 2017 by implementing proven and effective interventions in clinical settings and communities. Million Hearts® brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke.

High blood pressure is one of the leading causes of heart disease and stroke.[1] One in every three U.S. adults (67 million) has high blood pressure, and only about half of these individuals have their condition under control.[2] Of the 36 million Americans who have uncontrolled hypertension, most have a usual source of care (89.4%), received medical care in the previous year (87.7%), and have health insurance (85.2%).[3]

The purpose of this document is to deliver tested strategies for busy clinicians to aid in efforts related to hypertension control. These strategies were gathered from the published scientific literature (evidence-based) or found to be effective in clinical settings (practice-based). The strategies are organized into three categories of actions to improve delivery system design (Table 1), improve medication adherence (Table 2), and optimize patient reminders and supports (Table 3). This document contains additional resources and references where more information can be found for each action step.

Strategies for Hypertension Control

Table 1. Actions to Improve Delivery System Design
Implement a standardized hypertension treatment protocol.[4] ▸ Support titration of hypertension medications by clinical team members via a physician-approved protocol.[5,6]
Designate hypertension champions within your practice or organization.[7]
Proactively track and contact patients whose blood pressure is uncontrolled using an electronic health record (EHR)-generated list, patient registry, or other data source.[7–9]
Create a blood pressure measurement station where all patients can rest quietly for 5 minutes before measurement and that is designed to support proper measurement techniques (e.g., feet on floor, proper arm position, multiple cuff sizes conveniently located).[9]
Have care team members review a patient's record before the office visit to identify ways to improve blood pressure control.[7]
Proactively provide ongoing support for patients with hypertension through office visits or other means of contact until blood pressure is controlled.[10]
Implement systems to alert physicians about patterns of high blood pressure readings taken by support staff.[11,12] ▸ Place a sign or magnet on the outside of the examination room. ▸ Build clinical decision supports into the EHR.
Provide feedback to individual clinicians and clinic sites on their hypertension control rates. Provide incentives for high performance, and recognize high performers.[4]
Provide blood pressure checks without a copayment or appointment. Train clerical personnel in proper blood pressure measurement technique so they are capable of obtaining drop-in blood pressure readings.[4,13]
Encourage clinicians to take continuing education on hypertension management and care of resistant hypertension.[4,14]

Table 2. Actions to Improve Medication Adherence

Encourage patients to use medication reminders.[15–18] ▸ Promote pill boxes, alarms, vibrating watches, and smartphone applications.
Provide all prescription instructions clearly in writing and verbally.[19] ▸ Limit instruction to 3–4 major points. ▸ Use plain, culturally sensitive language. ▸ Use written information or pamphlets and verbal education at all encounters.
Ensure patients understand their risks if they do not take medications as directed. Ask patients about these risks, and have patients restate the positive benefits of taking their medications.[19]
Discuss with patients potential side effects of any medications when initially prescribed and at every office visit thereafter.[20]
Provide rewards for medication adherence.[21] ▸ Praise adherence. ▸ Arrange incentives, such as coupons, certificates, and reduced frequency of office visits.
Prescribe medications included in the patient's insurance coverage formulary, when possible.[22]
Prescribe once-daily regimens or fixed-dose combination pills.[23–26]
Assign one staff person the responsibility of managing medication refill requests.[27] ▸ Create a refill protocol.
Implement frequent follow-ups (e.g., e-mail, phone calls, text messages) to ensure patients adhere to their medication regimen.[15,28–30] ▸ Set up an automated telephone system for patient monitoring and counseling.

Table 3. Actions to Optimize Patient Reminders and Supports

Provide patients who have hypertension with a written self-management plan at the end of each office visit.[12,31] ▸ Encourage or provide patient support groups. ▸ Use all staff interactions with patients as opportunities to assist in self-management goal-setting and practices. ▸ Print visit summaries and follow-up guidance for patients.
Generate lists of patients with hypertension who have missed recent appointments. Send phone, mail, e-mail, or text reminders.[13]
Contact patients to confirm upcoming appointments, and instruct them to bring medications, a medication list, and home blood pressure readings with them to the visit.[7]
Send a postcard to or call patients who have not had their blood pressure checked recently. Invite them to drop in to have their blood pressure checked by a medical assistant, nurse, or other trained personnel without an appointment and at no charge.[12]
Send patients text messages about taking medications, home blood pressure monitoring, or scheduled office visits.[30]
Encourage patients to use smartphone or Web-based applications to track and share home blood pressure measurements.[32,33]
Encourage home blood pressure monitoring plus clinical support using automated devices with a properly sized arm cuff.[7,34,35] ▸ Advise patients on choosing the best device and cuff size. ▸ Check patients' home monitoring devices for accuracy. ▸ Train patients on proper use of home blood pressure monitors.
Implement clinical support systems that incorporate regular transmission of patients' home blood pressure readings and customized clinician feedback into patient care.[35] ▸ Train staff to administer specific clinical support interventions (e.g., telemonitoring, patient portals, counseling, Web sites). ▸ Incorporate regular transmission of patient home blood pressure readings through patient portals, telemonitoring, log books, etc., to clinicians and EHR systems. ▸ Provide regular customized support and advice (e.g., medication titration, lifestyle modifications) based on patient blood pressure readings.

Resources

Resources for Delivery System Design

American Academy of Family Physicians. Using a Simple Patient Registry to Improve Your Chronic Disease Care.

American Medical Group Foundation. Provider Toolkit to Improve Hypertension Control.

Centers for Disease Control and Prevention. Protocol for Controlling Hypertension in Adults.

Washington State Department of Health. Improving the Screening, Prevention, and Management of Hypertension—An Implementation Tool for Clinical Practice Teams.

Resources for Medication Adherence

American Academy of Family Physicians. Improving Patient Care: Rethinking Refills.

American College of Preventive Medicine. Medication Adherence Time Tool: Improving Health Outcomes.

Centers for Disease Control and Prevention. Medication Adherence Educational Module.

Script Your Future. Adherence Tools.

Surescripts. Clinician's Guide to e-Prescribing: 2011 Update.

Resources for Patient Reminders and Supports

Agency for Healthcare Research and Quality. Electronic Preventive Services Selector (ePSS).

American Heart Association. Heart360. An Online Tool for Patients to Track and Manage Their Heart Health and Share Information with Healthcare Providers.

Institute for Healthcare Improvement. Partnering in Self-Management Support: A Toolkit for Clinicians.

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Million Hearts® is a U.S. Department of Health and Human Services initiative that is co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services, with the goal of preventing one million heart attacks and strokes by 2017.

millionhearts.hhs.gov

December 2013

COHC Spring 2018 RHIP Updates

Behavioral Health Identification & Awareness

AIM: Identify and engage 100% of individuals in Central Oregon that have a behavioral health need and ensure an effective and timely response.

Recent Activities

- Voted to request PacificSource house a regional behavioral health support person.

Behavioral Health Substance Use & Chronic Pain

AIM: All Central Oregonians with a SUD that enter the hospital system including the ED will receive engagement, treatment, or harm reduction services.

Recent Activities

- Collected LOIs from organizations to employ two individuals embedded in St. Charles Bend who will support and make referrals for SUD patients.

Cardiovascular Disease & Diabetes Prevention

AIM: Cost will never be a barrier to participate in a variety of physical activities for students.

Recent Activities

- Released RFP and awarded funds for region-wide project to increase Active Modes of Transportation for youth
- Drafting RFP for region-wide project for provider-based referrals to physical activity for youth

- Began A3 to increase healthy diets in Central Oregon

Cardiovascular Disease Clinical

AIM: Reduce the rate of youth tobacco use in Central Oregon from 17.3% to 15% in 8th graders, and 23.2% to 20% in 11th graders.

Recent Activities

- Discovered few resources exist for helping teens quit tobacco. Held focus groups and determined those resources were not well-received.
- Pursuing more information regarding the work of school-based health centers in reference to tobacco.

Diabetes Clinical

AIM: 95% of Central Oregonians with Type 2 Diabetes will have an HbA1c of < 9%

Recent Activities

- All A1c algorithms completed
- Preparing comprehensive diabetes materials roll-out events in three locations (Bend, Madras, Prineville) in September for all healthcare providers.
- QIM grant clinics are being trained and processes are being put in place for Point of Care A1c testing.
- **Funded Initiative:** High Desert Food & Farm Alliance Veggie Rx Pilot

Oral Health

AIM: Improve Oral Health and keep children cavity free.

Recent Activities

- Cross proposal with Diabetes Workgroup
- Launch New A3 – Oral Health for the older adult
- Launch New A3 – Integration with Primary Care initiative

Reproductive Maternal Child Health

AIM: Prevent Unintended Pregnancies

Recent Activities

- Released RFP for Unintended Pregnancies media campaign
- Partnered with Power to Decide to bring a One Key Question training to Central Oregon
- Partnering with Milestones workgroup on Early Learning pathways

SDOH: Housing

AIM 1: Central Oregon communities have sufficient, actionable data to guide direction, establish priorities, support regional solutions and bring a call to action to mobilize citizens to create a healthier Central Oregon.

AIM 2: The approximately 200 chronically homeless and/or high utilizers in Central Oregon will be stabilized and supported to achieve well-being.

Recent Activities

- Began work on homelessness prevention A3.
- **Funded Initiatives:** Sisters Habitat for Humanity, Sisters Cold Weather Shelter, Redemption House, Jericho Road, Thrive

SDOH: Milestones to Health & Education

AIM 1: Central Oregon children become more resilient

AIM 2: Every Central Oregonian thriving in the face of diversity

AIM 3: Children in Central Oregon have lifelong health and learning challenges due to lack of early identification and access to services

AIM 4: Every child in kindergarten has the early literacy skills to be ready to learn

Recent Activities

- Nurturing 3 subgroups; Literacy, Social and Emotional, Access to Integrated Services (TRACEs part of Social and Emotional subgroup)
- Literacy team partnering with Equity Team around reading program proposal
- TRACEs awarded $2m by COHC Board of Directors
- Partnering with Reproductive Maternal Child Health on Early Learning Pathways