Working together to improve health care quality, outcomes, and affordability in Washington State.

Addiction and Dependence Treatment Report and Recommendations

November 2014
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Executive Summary

The Robert Bree Collaborative (the Collaborative) was established in 2011 to provide a forum in which public and private health care stakeholders can work together to improve quality, health outcomes, and cost-effectiveness of care in Washington State. The number of people in Washington with addiction and substance use and abuse disorders, variation in screening protocols, and lack of access to treatment were identified by the Bree Collaborative as a priority area for improvement and the Collaborative elected to form a workgroup to address these issues. We use the term drug throughout this document to refer to marijuana, illicit drugs (e.g., hashish, cocaine, crack, heroin, hallucinogens, inhalants, etc.), and prescription psychotherapeutics used for non-medical purposes. We use alcohol and other drug misuse throughout this document, unless a study or survey used another specific term, to capture those using alcohol and drugs at low to moderate levels but who still may be at risk and may benefit from early screening and intervention.

The Addiction and Dependence Treatment workgroup met from April 2014 to November 2014 to research available evidence, meet with relevant stakeholders, and examine methods of improving the ways that those with substance abuse disorders interact with the health care system. The workgroup developed the following five focus areas to increase appropriate screening, brief intervention, brief treatment, and facilitated referral to treatment in primary care clinics and emergency room settings as to address the underutilization of drug and alcohol screening and treatment within Washington State.

- Reduce stigma associated with alcohol and other drug screening, intervention, and treatment
  - Train health care staff how to have non-judgmental, empathetic, and accepting conversations about alcohol and drug misuse
  - Train health care staff on the prevalence of alcohol and other drug misuse, the impact of alcohol and other drug misuse on other health conditions, and the importance of screening for alcohol and other drug misuse
  - Increase the number of people who see alcohol and other drug misuse screening as a usual part of care and are comfortable discussing alcohol and other drug misuse
- Increase appropriate alcohol and other drug use screening in primary care and emergency room settings
  - Increase the number of appropriately trained staff who provide screening
  - Increase annual alcohol and other drug misuse screening, starting with an initial primary care visit, using validated, scaled screening tools
  - Implement universal alcohol and other drug misuse screening in emergency rooms (ER)
- Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse
  - Increase the number of appropriately trained staff who provide brief intervention and/or brief treatment in the primary care and ER settings
  - Increase the number of patients who screen positive for alcohol and other drug misuse who receive appropriate brief intervention and/or brief treatment
  - Follow-up with patients as appropriate who have received brief intervention and/or brief treatment
  - Manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if possible
- Enhance ability to triage patients to appropriate level of care if not improving
- Increase accessibility of consulting with qualified behavioral health providers

- Decrease barriers for facilitating referrals to appropriate treatment facilities
  - Increase the number of patients who screen positive who are referred to and receive care at an appropriate chemical dependency treatment facility consistent with the American Society of Addiction Medicine criteria
  - Track patients as they receive appropriate recovery care
  - Contact patients after they receive appropriate treatment to facilitate rapid return to function
  - Increase cross-site communication and data sharing
  - Increase chemical dependency resources sufficient to facilitate successful patient recovery

- Address the opioid addiction epidemic
  - Decrease inappropriate opioid prescribing for non-cancer, non-terminal pain
  - Increase capacity for primary care providers to prescribe medication assisted treatment
  - Train appropriate primary care and emergency room staff to screen, engage, and facilitate both on-site opioid medication assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment.
  - Extend state and private capacity and support for opioid medication assisted treatment (e.g., increase Buprenorphine treatment availability)
  - Facilitate referrals and decrease barriers to opioid addiction treatment (specialized vs on-site addiction treatment)
  - Track changes to the number of admissions, cost, morbidity, and mortality in emergency room, hospital, and outpatient settings in patients using opiates to evaluate change over time
Dr. Robert Bree Collaborative Background

The Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was modeled after the Washington State Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree, a pioneer in the imaging field and a key member of the AIM project.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying up to three health care services annually that have substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice evidence-based approaches that build upon existing efforts and quality improvement activities aimed at decreasing variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See Appendix A for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

The number of people in Washington with addiction and substance use and abuse disorders, variation in screening protocols, and lack of access to treatment were identified by the Bree Collaborative as a priority area for improvement and the Collaborative elected to form a workgroup to address these issues. The workgroup met from April 2014 to November 2014 to develop the following recommendations. See Appendix B for the Addiction and Dependence Treatment workgroup charter and a list of members.
Problem Statement

Alcohol and other drug misuse leads to many debilitating health, economic, interpersonal, and social consequences with potentially long-lasting effects if left untreated. Almost 90% of individuals with identified substance dependence or abuse do not receive appropriate care or treatment partially due to alcohol and substance abuse disorders being highly stigmatized and patients not being likely to receive or seek treatment themselves. Additionally, current national and state-level data do not adequately capture the total number of individuals who engage in risky or harmful drug and alcohol use due to inconsistent or non-existent screening practices. We use alcohol and other drug misuse throughout this document, unless a study or survey used another specific term, to capture those using alcohol and drugs at low to moderate levels but who still may be at risk and may benefit from early screening and intervention.

More than half of Americans aged 12 or older reported current alcohol use in the 2013 National Survey on Drug Use and Health (NSDUH) (52.2% or 136.9 million people), approximately a quarter of those surveyed reported binge alcohol use (22.9% or 60.1 million people). Approximately 6.3% of the population reported heavy drinking (16.5 million people). Heavy alcohol use is more likely to be reported among males; those aged 21-25; those of Native Hawaiian or other Pacific Islander or White descent and those reporting two or more races; and those who are employed full time. See Figure 1 for national variation in alcohol use or abuse based on annual averages from 2010-2012 NSDUH. Approximately 10.9% reported driving under the influence of alcohol, highest among those 26-29 years of age.

Excessive use of alcohol is the fourth leading cause of preventable death in the United States, resulting in 9.8% of deaths and one in ten years of potential years lost in working-age adults.

Excessive alcohol use is strongly associated with: oral cavity, esophagus, larynx, colon, rectum, liver, and breast cancers; hypertension; liver cirrhosis; chronic pancreatitis; as well as a higher probably of injuries and violence. Drinking during pregnancy can also adversely affect the health of the developing fetus. In 2013, 60.1 million individuals aged 12 or older reported binge drinking in the past month, including 1.6 million adolescents. The economic cost of excessive drinking is estimated at $223.5 billion, or approximately $1.90 per drink, mainly due to the effects of binge drinking.

We use the term drug throughout this document to refer to marijuana, illicit drugs (e.g., hashish, cocaine, crack, heroin, hallucinogens, inhalants, etc.), and prescription psychotherapeutics used for non-medical purposes. See Figure 2 for national variation in drug dependence or abuse in the past year among persons aged 12 or older.

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abuse based on annual averages from 2010-2012 NSDUH. An estimated 9.4% percent of the population aged 12 or older in 2013 used drugs (24.6 million people).¹

Deaths from heroin have doubled from 2010 to 2012. Deaths from opioid pain relievers are twice that of heroin.⁷

Deaths from opioid pain relievers have increased substantially every year, rising to 100 deaths daily in 2008.⁸ This is three times the rate 10 years prior and has led to the Centers for Disease Control and Prevention to call the situation an epidemic. Injection drug use is associated with increased risk of HIV infection and Hepatitis B and C infection. Medicaid beneficiaries with a substance use disorder have significantly higher physical health expenditures and hospital admissions when compared to beneficiaries with a behavioral health diagnosis but no substance use disorder diagnosis.⁹ Nationally, the economic cost of drug use is more than $193 billion including the impact on crime (e.g., criminal justice system, crime victims), health (e.g., hospital and emergency room costs), and productivity (e.g., labor participation, premature mortality).¹⁰

Marijuana was by far the most highly used drug, see Figure 3 for specific detail on the type of drug used.¹ Substance dependence or abuse rates are highest among: adults aged 18-25; males; American Indians or Alaska Natives, Native Hawaiians or other Pacific Islanders, or those reporting two or more races; those with lower education levels (highest among those who did not graduate high school); and those on parole or released from jail.¹ While a higher rate of those who are unemployed report substance abuse, of those working full time, almost 10.8 million have a diagnosable substance abuse disorder.¹¹

Of the estimated 23.1 million individuals aged 12 or older in 2013 needing treatment for alcohol or drug misuse, only 2.5 million received treatment at a specialty facility.¹

Despite strong recommendations to screen patients for alcohol abuse and dependence by the National Institute on Alcohol Abuse and Alcoholism and the United States Preventative Services Task Force (USPSTF), many primary care providers are not equipped with the knowledge, training, and resources to treat or refer patients with alcohol or substance abuse disorders and there has been little uptake in primary care and emergency room of screening for alcohol and other drug misuse.¹²,¹³

Surveys indicate that 94% of primary care physicians missed or misdiagnosed patients who were abusing alcohol when presented with early symptoms of alcohol abuse in adult patients.¹⁴ Approximately 55% of patients reported not believing that their physician knew how to detect addition, 54% reported that their primary care physician did nothing about their substance abuse when detected, 43% said their physician never diagnosed their existing substance abuse, and 11% believed their physician knew about their addiction but did nothing about it. In the same survey, of patients who choose to seek treatment for substance abuse, 74.1% said their primary care physician was not involved in that decision and 16.7% reported that their physician was involved only a little. Other studies have found the majority of physicians surveyed, 88%, reporting asking their patients whether they drank alcohol, but only 13% reported using a formal screening tool.¹⁵ Of those physicians, the majority reported usually or always recommending a 12-step group to patients with problem drinking.
Approximately 4.1 million persons, 1.5% of the population 12 or older, received treatment at any location related to alcohol or drugs, the majority receiving treatment through a self-help group. Detail on locations where people received treatment is shown in Figure 4. The most common reasons for not receiving treatment among those reporting a need for treatment were not having health coverage and not being able to afford the cost of treatment, 37.3%; not being ready to stop using, 24.5%; not knowing where to go for treatment, 9.0%; having health coverage that did not cover treatment, 8.2%; not having transportation or traveling to the location being inconvenient, 8.0%; the possibility of treatment having a negative effect on their job, 6.6%; being able to handle the problem without treatment, 6.6%; and not having time for treatment, 5.0.

Alcohol and other drug misuse in Washington State

Washington State has a higher than average percentage of deaths attributable to alcohol use among working age adults, 11.1% compared to 9.8% nationally. The average number of years of life lost among working age adults attributable to alcohol use is also higher than the national average, 12.7 compared to 11.5. Based on estimates using Centers for Disease Control and Prevention’s (CDC) Alcohol related Disease impact system, 2,457 alcohol related deaths occurred in Washington in 2010.

In Washington State in 2010, 16% of adults reported binge drinking, on at least one occasion in the past month, not a significant change from previous annual estimates and similar to the national rate. Reported binge drinking ranged from 21% in Ferry County to 8% in Wahkiakum County, see Figure 5. Age adjusted cirrhosis rates were 9-10 per 100,000, higher than the Healthy People goal of 8.2 per 100,000. The economic cost of alcohol and other drug abuse in Washington State is estimated at $5.21 billion in 2005, approximated to $6.21 billion in 2012 dollars. This includes costs from mortality, crime, morbidity, and health care (e.g., treatment, medical care, impact on other diseases) and is approximately $832 for every non-institutionalized Washington state resident.

Substance abuse disorders are a leading cause of unnecessary hospitalizations and in 2007 an estimated 329,000 hospitalizations in Washington State were associated with alcohol and other drug use, comprising of over half of all hospitalizations.
that year. From 2000 to 2011, rates of drug-induced deaths were higher in Washington than the national average, both have increased over time. In 2011, Washington State had 1,033 drug-induced deaths due to opioids, heroin, cocaine, tranquilizers, methamphetamine, and other drugs, a rate of 15 per 100,000, higher than the Healthy People 2020 goal for age-adjusted drug-induced deaths of 11.3 per 100,000. Age-adjusted death rates vary by county, see Figure 6 for more detail.

Deaths from opiates (heroin and prescription) have almost doubled in the past ten years, rising to 607 from 2009-2011. Heroin is the most common drug in treatment centers among 18-29 year olds and is driven by young adults and those primarily outside of the Seattle metro area.

While prevalence of HIV is low among injection drug users due to widespread syringe exchange programs, Hepatitis C prevalence is high, almost 75% in this population. It is unclear whether prevalence of marijuana misuse has increased after legalization through the passage of I-502, an initiative legalizing small amounts of marijuana for adults over 21, but Washington State Patrol reports marijuana-positive driving under the influence to have increased approximately 30% in 2013 in King County.

The Washington State Healthy Youth Survey of 2012, found current (in the last 30 days) alcohol use to be reported by: 2.5% of 6th graders, 11.9% of 8th graders, 23.3% of 10th graders, and 36.1% of 12th graders. Binge drinking was reported by 2.4%, 7.1%, 14.3%, and 21.8% of 6th, 8th, 10th, and 12th graders respectively. Marijuana use was reported by 1.2%, 9.4%, 19.3%, and 26.7% with other drugs (excluding alcohol, tobacco, or marijuana) being reported by 0.8%, 2.8%, 5.1%, and 7.3% of 6th, 8th, 10th, and 12th graders respectively. By 12th grade, lifetime alcohol use is reported by 68% and lifetime marijuana use by 45.6% of responders.

The percentage of admissions for prescription opiates and heroin in Washington State have increased from 1999 to 2013, see Figure 7. This trend for increased heroin use is also seen when looking at substance abuse treatment admissions in the age 18-29 cohort, see Figure 8 on the following page.
Initiative 502 (I-502) on the November 2012 ballot was passed by 56% of Washington State voters. I-502, “authorized the state liquor control board to regulate and tax marijuana for persons twenty-one years of age and older” and license, regulate, and tax the production and processing of marijuana. The initiative created a dedicated marijuana fund, consisting of excise taxes, license fees, penalties, and forfeitures, and specifies the disbursement of this money for a variety of health, education, and research purposes, with the remainder distributed to the state general fund. The Washington State Department of Health is the lead agency for implementing marijuana education campaigns.

- For more information, visit [www.LearnAboutMarijuanaWA.org](http://www.LearnAboutMarijuanaWA.org)

The Washington State division of behavioral health and recovery (DBHR) is required under I-502 to design and administer the Washington State Healthy Youth Survey, analyze collected data, and produce reports. Information from the survey can be used to identify trends in substance abuse over time. The goals for the survey include identifying youth attitudes and risk behaviors and their consequences, and risk and protective factors for school, community, family, and individuals. DBHR will administer the survey and, as funds allow, conduct a young adult survey utilizing social media to survey populations who are 18-25 years of age.

High variation and lack of standardized screening protocols for alcohol and other drug misuse within Washington State show opportunities for increased screening, intervention, and treatment. Without accurately identifying alcohol and other drug misuse, linking individuals to appropriate care and treatment is impossible. Primary care physicians and emergency rooms are the first line of defense for recognizing these problems and best serve their patients by using formalized screening methods.\textsuperscript{24} Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based paradigm seeking to encourage health care providers to systematically “identify, reduce, and prevent problematic use, abuse and dependence on alcohol and illicit drugs.”\textsuperscript{25} This community-based program has been endorsed nationally and has been successfully used within Washington State as well. The Substance Abuse and Mental Health Services Administration (SAMHSA) supports an SBIRT model that:\textsuperscript{26}

- Is brief
- Universally screens all patients for a specific issue (e.g., alcohol and other drug misuse)
- Occurs in a non-chemical dependency treatment setting (e.g., primary care, hospital)
- Includes a seamless transition between screening, brief intervention, brief treatment, and referral to specialty chemical dependency treatment
- Demonstrates success

Implementing evidence-based recommendations for increasing appropriate screening, brief intervention, brief treatment, and facilitated referral to treatment in primary care clinics and emergency room settings is the first step to addressing the inadequacies of alcohol and other drug misuse screening and treatment within Washington State.
Recommendations

The Addiction and Dependence Treatment workgroup developed the following framework, **Figure 9**, to illustrate the pathway through which an individual would ideally experience the health care system from initial screening and intervention through SBIRT to recovery.

**Figure 9: Substance Use Disorder Framework**

- **No Use**
- **Low to Moderate Substance Use Disorder**
- **Moderate to Severe Substance Use Disorder**
- **Ultra Severe**

- **SBIRT**

- **Withdrawal Management**
- **Asserterve Community Treatment**
  - Case Management
  - Healthcare Linkage
  - MAT
  - Benefits Management
  - Housing
  - Mobile Teams

- **Education & Reinforcement**
  - Risk Assessment
  - Brief Intervention
  - Motivational Interviewing
  - Harm Reduction

- **Recovery**
  - Inpatient
  - IOP
  - OST
  - Outpatient

- **Harm Reduction**
- **Total Abstinence**

- **Integrated Treatment within and across disciplines**
  - Medical
  - Behavioral Health
  - Social Service Supports

**Legend**
- MAT: Medication Assisted Treatment
- OST: Opioid Substitution Therapy
- IOP: Intensive Outpatient
- NAS: Neonatal Abstinence Syndrome
- MDMP: Prescription Monitoring Program
- SBIRT: Screening, Brief Intervention, Referral to Treatment

**Resource Requirements**
The workgroup also developed the following five focus areas and corresponding specific strategies to meet the goal focus areas for Washingtonians **12 years of age and older**: 

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<thead>
<tr>
<th>Focus Area</th>
<th>Specific strategies</th>
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| **1. Reduce stigma associated with alcohol and other drug screening, intervention, and treatment** | • Train health care staff how to have non-judgmental, empathetic, and accepting conversations about alcohol and other drug misuse  
• Train health care staff on the prevalence of alcohol and other drug misuse, the impact of alcohol and other drug misuse on health conditions, and the importance of screening for alcohol and other drug misuse  
• Increase the number of people who see alcohol and other drug misuse screening as a usual part of care and are comfortable discussing alcohol and other drug misuse |
| **2. Increase appropriate alcohol and other drug use screening in primary care and emergency room settings** | • Increase the number of appropriately trained staff who provide screening  
• Increase annual alcohol and other drug misuse screening, starting with an initial primary care visit, using validated, scaled screening tools  
• Implement universal alcohol and other drug misuse screening in emergency rooms (ER) |
| **3. Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse** | • Increase the number of appropriately trained staff who provide brief intervention and/or brief treatment in the primary care and ER settings  
• Increase the number of patients who screen positive for alcohol and other drug misuse who receive appropriate brief intervention and/or brief treatment  
• Follow-up with patients as appropriate who have received brief intervention and/or brief treatment  
• Enhance ability to triage patients to appropriate level of care if not improving  
• Increase accessibility of consulting with qualified behavioral health providers |
| **4. Decrease barriers for facilitating referrals to appropriate treatment facilities** | • Increase the number of patients who screen positive who are referred to and receive care at an appropriate chemical dependency treatment facility consistent with the American Society of Addiction Medicine criteria  
• Contact patients after they receive appropriate recovery care  
• Increase cross-site communication and data sharing  
• Manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if possible  
• Increase chemical dependency resources sufficient to facilitate successful patient rehabilitation |
| **5. Address the opioid addiction epidemic** | • Decrease inappropriate opioid prescribing for non-cancer, non-terminal pain  
• Increase capacity for primary care providers to prescribe medication assisted treatment  
• Train appropriate primary care and emergency room staff to screen, engage, and facilitate both on-site opioid medication assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment  
• Extend state and private capacity and support for opioid medication assisted treatment (e.g., increase Buprenorphine treatment availability)  
• Facilitate referrals and decrease barriers to opioid addiction treatment (specialized vs on-site addiction treatment)  
• Track changes to the number of admissions, cost, morbidity, and mortality in emergency room, hospital, and outpatient settings in patients using opiates to evaluate change over time |
Reduce stigma associated with alcohol and other drug misuse screening, intervention, and treatment

Stigma regarding alcohol and other drug misuse is prevalent among the general population and among health care providers. Surveys show that people with substance abuse disorders are likely to be seen as having control over their alcohol or drug use. This reduces the number of people who are screened and receive treatment. Screening for drug use among pregnant women was associated with increased fear among patients of psychological, social, and legal consequences (e.g., contacting child protective services); fears about confidentiality and judgment from the health care provider; and possible avoidance of prenatal care.

A systematic review of interventions to reduce stigma around substance misuse found interventions to be generally targeted toward people with substance use disorders; the general public; or groups such as medical students, police officers, or substance use counselors. More than half of the studies found significant reductions in stigma. A structured drug and alcohol education and clinical experience program reduced stigma among medical students. Stigma appears to be most effectively reduced through positive depictions of people with substance use disorders and educational and skills training among professionals. Screenings for alcohol and other drug misuse themselves may help to reduce the stigma attached to seeking help.

The Bree Collaborative recommends training health care staff how to have “empathetic, accepting, and non-judgmental” conversations about drug misuse and clear policies and communication about testing practices and confidentiality of testing. The Collaborative also recommends training health care staff on the prevalence of alcohol and other drug misuse, the impact of alcohol and other drug misuse on health conditions, and the importance of screening for alcohol and other drug misuse. The Collaborative seeks to increase the number of people who see alcohol and other drug misuse screening as a usual part of care and are comfortable discussing alcohol and other drug misuse.

Increase appropriate alcohol and other drug screening in primary care and emergency room settings

There are several widely used and validated screening tools for alcohol and other drug misuse. The Bree Collaborative recommends using a scaled and validated question or series of questions for both alcohol and other drug misuse for all patients over age 12 and also to be aware of the cross-cultural challenges and appropriateness specific to any tool. Co-morbidity of alcohol and other drug misuse can be common and can greatly impact health and social function. Screening alone has also been shown to reduce alcohol misuse, potentially due to increased self-awareness and self-monitoring.

The Alcohol Use Disorders Identification Test (AUDIT) is designed for low to moderate alcohol users, has ten questions, a sensitivity of 0.92 and a specificity of 0.94 for harmful use when a cutoff of eight or more is used and has been validated across many diverse populations. The AUDIT-C is a modified version of the 10 question AUDIT instrument containing only the first three questions and can also help identify persons who are hazardous drinkers or have active alcohol use disorders, including alcohol abuse or dependence. The full AUDIT, AUDIT-C, and a single-item AUDIT screener (sometimes called AUDIT-3 as it is the third question in the full ADUIT) have been validated in primary care settings among both men and women as well as having been extensively used by the Veterans Administration. It is important to keep in mind that while faster, some studies have shown single-item screeners to be slightly less accurate in predicting alcohol use disorders.
The AUDIT can be given as an interview by clinical staff or as a self-report questionnaire. The self-report questionnaire takes less time, is easy to administer, and may lead to more accurate answers due to the lack of potential stigma on the part of the clinical staff person, but may be unsuitable for patients with low health literacy or poor reading skills. Issues with interview-based screening stem from a lack of workforce development, having to do with biased and error-prone questioning on the part of the interviewer. This potentially results in high rates of false-negatives and indicates that use of a validated screening tool needs to be accompanied by staff training and education. Lessons learned from the Veterans Administration implementation of interview-based screening for alcohol use disorders include: educating staff about screening as prevention, addressing the assumption that a positive screen means the patient is a problem-drinker or an alcoholic, addressing the fact that alcohol misuse in a continuum rather than a dichotomous condition, and the problematic impact of administrative protocols that target high rates of screening not necessarily incentivizing high-quality screening. A scaled questionnaire allows individual progress to be tracked over time and possible prediction of a patient’s alcohol or drug misuse-related health conditions such as increased hospitalizations or increased likelihood of health conditions (e.g., gastrointestinal illness).

A survey of trauma surgeons found that a majority believed a trauma center to be an appropriate setting to address alcohol misuse and frequently checked blood alcohol consumption. Use of a validated screening test occurred in about a quarter of cases. About half of the physicians surveyed understood brief interventions but fewer than half of patients received any type of intervention or treatment at the center.

Education about the importance of screening and a corresponding brief intervention, if needed, could increase the number of people who are screened, receive appropriate intervention or treatment, and reduce injury related to alcohol and other drug misuse.

The Drug Abuse Screening Test (DAST) has 28 questions with a shorter 10 item version known as the DAST-10. The DAST has been successfully used in both primary care and emergency room settings. A one-item screener, How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons with answers of None or once or more is used as a pre-screen by the Washington SBIRT program, profiled on the following page.

The Bree Collaborative recommends that adolescents be screened for alcohol and other drug use annually starting at age 12. The American Academy of Pediatrics recommends an SBIRT protocol adapted from Children’s Hospital in Boston starting with a series of pre-screen questions asking “In the past 12 months, did you 1) Drink any alcohol (more than a few sips) 2) Smoke any marijuana or hashish, 3) Use anything else to get high (“Anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or huff.) If the patient answers yes to any, it is recommended that the provider administer the CRAFFT, a mnemonic acronym of the six questions (Car, Relax, Alone, Forget, Friends, Trouble). The CRAFFT is designed for alcohol and other drug use screening in adolescents and teenagers aged 12-21. This validated instrument recommends a score of 2 or higher as a positive screen, screens for both alcohol and other drug use, and has sensitivities ranging from 0.61-1 and specificities ranging from 0.33-0.97. If patients answer no to the pre-screen questions, providers should provide “brief positive feedback” and ask the Car question of the CRAFFT, “Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?”

Other validated screeners include the CAGE, also a mnemonic acronym of key words within the four questions (Cut down, Annoyed, Guilty, and Eye-open) to which patients answer yes or no. The CAGE has been adopted to assess drug use, called the CAGE-AID. Two positive responses are considered a positive test and indicate that further assessment is warranted. A systematic review found an average sensitivity of 0.71 and specificity of 0.97. However, the CAGE has been shown to be less accurate in screening low to moderate levels of alcohol misuse and may not be developmentally appropriate for adolescents.
Case Study: Washington Screening, Brief Intervention, and Referral to Treatment Primary Care Integration

The Washington Screening, Brief Intervention, and Referral to Treatment Primary Care Integration (WA-SBIRT) started as a five-year grant from SAMHSA from 2003 to 2008 to implement Screening, Brief Intervention, and Referral to Treatment in nine emergency departments across the state. After a successful five years, Washington State applied and received a grant to expand services for another five years from 2011 to 2016 in clinics across the state.

Medicaid patients visiting one of the nine emergency departments were approached by a chemical dependency professional and after agreeing to participate in the program, 48% classified as screening only, 49% were screened and received a brief intervention, and 3% were screened, received a brief intervention, and went on to receive brief therapy or chemical dependency treatment. However, of those referred to brief therapy or chemical dependency treatment, only 21% went to the facility to which they were referred.

For more key findings from the initial grant period, read: www.wasbirt.com/sites/default/files/Final%20tracking%20report%20WASBIRT1.pdf

Next steps depend on the patient’s risk levels determined by a score on the AUDIT or DAST-10:

1. **Low Risk**: AUDIT score of 0-6 for women and 0-7 for men, DAST-10 score of 0
   a. No intervention.

2. **Risky**: AUDIT score of 7-15 for women and 8-15 for men, DAST-10 score of 1-2
   a. Brief intervention.

3. **Harmful**: AUDIT score of 16-19 for both women and men, DAST-10 score of 3-5
   a. Brief intervention and referral to brief treatment.

4. **Dependent**: AUDIT score of over 20 for both women and men, DAST-10 score of 6 or more
   o Brief intervention and referral to chemical dependency treatment.

Screening and brief intervention took approximately 15 minutes per patient. Chemical dependency professionals also used their clinical judgment to assess level of risk independent of the AUDIT or DAST score. In order to receive reimbursement for SBIRT under Medicaid, the Health Care Authority requires those billing to have at least four hours of training. More information is available, here: www.wasbirt.com/content/training. Advanced registered nurse practitioners, mental health counselors, marriage and family therapists, independent and advanced social workers, physicians, psychologists, dentists, and dental hygienists can bill for SBIRT services and chemical dependency professionals, licensed practical nurses, physician assistants, and registered nurses can provide the services but cannot themselves bill.

In phase two, services are provided to adults receiving primary care in selected community health clinics in King, Whitman, Cowlitz, and Clallam Counties. An anticipated 96,000 adults will be screened and served over the life of the grant, which is anticipated to reduce substance abuse and related injuries as well as health care use and costs for chronic conditions such as depression and anxiety.

For more information about WA-SBIRT, visit www.wasbirt.com.
The Bree Collaborative recommends annual drug and alcohol misuse screening, starting with an initial primary care visit, using one or a combination of the validated, scaled, and cultural appropriate screening tools as appropriate for patients aged 12 and above. The Collaborative also recommends implementing standardized drug and alcohol screening for all emergency room visits among those 12 and older. The Collaborative proposes supporting this recommendation through increasing the number of appropriately trained health care staff who provide appropriate screening and increasing health care providers’ awareness of and comfort with alcohol and other drug misuse screening.

**Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse**

Evidence suggests that those with moderate to risky alcohol use benefit from access to brief intervention and/or brief treatment, showing an opportunity to intervene before patients’ lives are overly impacted. A systematic review of primary care interventions to reduce alcohol misuse across multiple payers found screening and behavioral counseling interventions to be cost effective and perhaps cost saving to delivery systems. Evaluation of the WA-SBIRT program found significant cost savings in Medicaid per member per month cost and decreased utilization of inpatient services through SBIRT implementation in emergency departments compared to patients not receiving SBIRT.

The United States Preventative Services Task Force recommends that “clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse” giving the recommendation a B rating meaning that, “there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.”

SAMHSA defines brief interventions as consisting of 5 minutes of brief advice to 15 to 30 minutes of brief counseling intended “to treat problematic or risky substance use” and using “brief versions of cognitive behavioral therapy and/or motivational interviewing.” Many guidelines exist outlining brief interventions. The WA-SBIRT program limits reimbursement for brief interventions to four per client, per provider annually.

**WA-SBIRT suggests the following for brief interventions**

- **Raising the subject**: establish rapport with the patient, ask permission to discuss alcohol or other drug misuse which may be a sensitive issue, explain who you are and set an agenda
- **Provide feedback**: review alcohol or drug use patterns, share the score from the screener, talk about the effect of alcohol and other drug use on health
- **Enhance motivation**: assess readiness to change, explore the patient’s ability to change
- **Negotiate a plan**: summarize the conversation, recommend changes, ask the patient what they will do, agree on a strategy


For adolescents, brief interventions can include positive feedback for a negative screen and for a positive screen can range from brief advice to a brief negotiated motivational interview to encourage behavior change and, if relevant, acceptance of a referral for treatment. The contract for life, available here: [http://www.sadd.org/contract.htm](http://www.sadd.org/contract.htm), can facilitate discussion. The American Academy of Pediatrics recommends different pathways depending on whether an adolescent patient scores 0 to 1 or more than 2 on the CRAFFT.
If the patient scores 0 or 1 they should receive clear advice to stop alcohol and/or drug use, education on health effects of continued use, and recognition of individual strengths. If adolescent patients score 2 or greater on the CRAFFT, it is recommended that providers:

- Conduct a brief assessment (e.g., “Tell me about your alcohol use. Has this caused problems?”) to assess acute danger or addiction.
  - If there are no signs of acute danger or addiction, conduct a brief negotiated interview.
  - If signs of addiction are present, refer patient to treatment (e.g., summarize, refer, invite parental involvement).
  - If there are signs of acute danger, conduct an immediate intervention (e.g., contract for safety, consider breaking confidentiality to involve parents).

A study of Washington State Medicaid expenditures found significant cost savings associated with provision of substance abuse treatment. Additionally, a brief motivational intervention for patients through inner-city hospital outpatient clinics found a significant effect on cocaine and heroin abstinence six months post-intervention. However, the USPSTF concluded that although treatments reduce drug use in the short term, evidence was insufficient to find an association between treatment and longer-term positive effects on morbidity or mortality. This conclusion is partially due to the majority of patients who were in treatment for drug use having already developed drug-use associated problems. Additionally, two recent randomized clinical trials have shown no effect of brief treatment in primary care on drug use. One study compared a 10-15 minute negotiated interview conducted by a health educator, a 20-30 minute adaption of motivational interviewing with a 20-30 minute booster conducted by a masters level counselor, and no intervention while the other study compared a brief intervention with motivational interviewing and an attempted 10-minute telephone booster two weeks later with usual care.

These recommendations seek to increase the number of patients screened for drug use prior to patients encountering the treatment system for other reasons and prior to developing drug-use associated problems. Additionally, a growing body of evidence is showing positive effects from brief intervention for drug use in primary care and emergency rooms. The National Institute on Drug Abuse and many other organizations recommend brief intervention for non-medical prescription drug use.

The National Institute on Drug Use suggests five A’s for brief intervention:

1. Ask permission to discuss the screening results and review the results with the patient
2. Advise – provide medical advice about drug use
3. Assess the patient’s readiness to quit
4. Assist the patient in making a change
5. Arrange – specialty assessment, drug treatment, follow-up visit as appropriate

However, the limitations of brief intervention on drug use and potentially severe alcohol use must be acknowledged. The University of Washington Advanced Integrated Mental Health Solutions (AIMS) Center recommends extending the role of primary care from only providing screening and brief intervention to also providing brief treatment, as seen in Figure 10 on the following page.
While a brief intervention can be 1-5 sessions lasting 5-10 minutes, a brief treatment can consist of about 5-12 sessions that can last up to an hour. The goal of brief treatment is to address alcohol and/or drug misuse and “also to address long-standing problems with harmful drinking and drug misuse and help patients with higher levels of disorder obtain more long term care” and it is often performed by “allied health professionals such as nurses, social workers, or health educators, with results and actions noted in the patient chart for physician notification and oversight.” SAMHSA estimates that approximately 3% of patients screen into brief treatment. Rather than being an extension of brief intervention, brief treatment “should be characterized as a self-contained modality” with specific goal-setting and change strategies.

The AIMS Center model has been used in Washington State’s Mental Health Integration Program whose purpose extends beyond that of substance abuse screening and treatment into “integrat[ing] high quality mental health screening and treatment into primary care settings serving safety net populations.” The program was funded by the Washington State Legislature, Community Health Plan of Washington (CHPW), and Public Health Seattle and King County and involved over 200 community health centers across the state. Key additions of this program to usual care were a Care Management Tracking System allowing centers to share data across sites and a collaborative team approach in which the primary care provider and care manager were able to consult with a psychiatrist regarding the caseload. This allowed heightened focus on more challenging patients, ability to increase level of care if needed with a facilitated referral, multiple brief consultations, and better opportunity to make treatment recommendations if patients did not improve. Care managers used the registry to track patient progress, regularly review and assess the appropriate level of intervention, and connect to community resources as necessary.

**Key Recommendations for Integrating Brief Treatment:**
- Develop mechanisms (e.g., electronic health record system) to support patient screening, tracking, ability to triage to appropriate level of care if not improving, and capacity to facilitate referrals
- Increase provider and staff knowledge and comfort with SBIRT
- Train and supervise appropriate staff to enhance skills
- Access to psychiatric consult to help support this process
The amount of trained masters-level addiction counselors is not currently adequate to meet the growing population need. To address this, the Bree Collaborative wishes to acknowledge the importance of competency-based counselors who may not have masters-level counseling training but exhibit the skills necessary to engage with patients and who have received adequate training. Competencies can be gained through experience and focused training. While this role has been challenged by a greater emphasis on education as qualification, experience and focused training may also contribute to greater empathy and the necessary connection to patients needed for a brief intervention, brief treatment, or referral to treatment at a chemical dependency facility. Additionally, the Bernstein et al. study found a positive effect of behavioral intervention on drug use abstinence at six months after intervention led by trained peer educators who themselves had been in recovery for three years. Dr. Dorynne Czechowicz of the National Institute on Drug Abuse added that the findings, “...suggest that peer educators can play an important role in busy clinical environments and enhance outreach to abusers of cocaine, opiates, and perhaps other drugs.”

SAMHSA recommends four transdisciplinary foundations for addiction professionals:

- Understanding addiction,
- Knowledge of types of treatment,
- Application to practice, and
- Professional readiness.

The Washington State Department of Health licenses chemical dependency professionals based on meeting specific requirements including having postsecondary education.

The Bree Collaborative seeks to increase the availability of brief intervention and brief treatment within primary care and emergency room settings and the number of people receiving these services appropriately. The Collaborative recommends increasing the number of appropriately trained staff who can provide brief intervention and/or brief treatment in the primary care and ER settings through increased staff and provider education and training about brief intervention and brief treatment. The Collaborative also recommends following up with patients as appropriate who have received brief intervention or brief treatment; enhancing the ability of primary care and emergency room staff to triage patients to more appropriate level of care if follow-up shows a lack of improvement; and managing adolescents with addictions collaboratively with child and adolescent addiction specialists, if possible. The Collaborative also recommends consulting with qualified behavioral health providers as necessary to supplement staff ability to intervene with patients.
Decrease barriers for facilitating referrals to appropriate treatment facilities

The Bree Collaborative’s goal is to increase the number of patients needing treatment who receive the entire recommended course of treatment and to facilitate information sharing between the referring provider, the chemical dependency treatment facility, and the patient. Being referred to a chemical dependency facility outside of the primary care setting or the emergency room without a supportive facilitating referral can lead to patients disengaging from care. Financial, managed care, administrative, informational, confidentiality, and access (e.g., travel or distance) are all significant barriers to successful care transitions. Approximately 79% of patients referred to an external treatment agency as part of phase I of the WA-SBIRT program did not engage in treatment.\textsuperscript{50}

One of the primary barriers to facilitated referrals across sites are funding streams. Adequate resources to ensure coverage of people receiving care from different sites must support the public chemical dependency system’s move into a managed care environment.

Substance abuse education, treatment, and prevention confidentiality are codified in Federal law through 42 CFR part 2.\textsuperscript{69} Protected information can be shared through informed written consent.

One of the most important aspects of facilitating a referral to an appropriate chemical dependency treatment facility for primary care and hospitals is verbal confirmation with the facility and with the patient. Refer to Figure 9 for more information on available treatment pathways and Figure 11, on the next page, for the American Society of Addiction Medicine’s (ASAM)’s continuum of care. SAMHSA emphasizes that one of the roles of primary care is to assist patients in accessing specialized treatment and “helping to navigate any barriers such as treatment cost or lack of transportation that could hinder treatment in a specialty setting.”\textsuperscript{70}

Referrals to chemical dependency treatment facilities should be consistent with protocols as for any other specialty referral.

All referrals should comply with ASAM’s placement criteria. ASAM recommends “six dimensions of multidimensional assessment:\textsuperscript{71}

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications (e.g., health history, current conditions)
- Emotional, behavioral, or cognitive conditions and complications
- Readiness to change
- Relapse, continued use, or continued problem potential (e.g., history with treatment and relapse)
- Recovery and living environment”

For adolescents, a supported referral to an appropriate substance abuse specialist or chemical dependency treatment center is especially important. It can be appropriate to conduct motivational interviewing with the patient and family to encourage acceptance of the referral.\textsuperscript{45} Primary care and emergency room settings are recommended to manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if available.

- WA-SBIRT suggests how to make good referrals through familiarization with treatment options and having a good relationship with local treatment centers. More information, here: www.wasbirt.com/content/referrals-treatment
- SAMHSA provides a behavioral health services treatment locator, here: http://findtreatment.samhsa.gov/

Assessment and referral should be realistic and holistic. ASAM recommends that referrals follow a continuum of care as shown in Figure 11, on the next page.
There are many guides available on facilitating referrals including: The Bree Collaborative seeks to increase the number of patients screening positive who are referred to and receive care at an appropriate chemical dependency treatment facility consistent with the American Society of Addiction Medicine criteria. The Collaborative recommends accurate and timely communication from the referring primary care or emergency room setting to the chemical dependency treatment facility and also from the facility to primary care or the emergency room. Primary care and emergency rooms are recommended to track patients as they receive recovery care and contact patients after treatment has been concluded when the chemical dependency facility has communicated this. Increased cross-site communication and data sharing consistent with CFR 42 should help increase the probability that patients contact and complete recovery care at the chemical dependency treatment facility. To support this, the Bree Collaborative recommends that chemical dependency treatment facilities reach out to patients who have been referred to but have not reached out the facility and increasing chemical dependency resources sufficient to facilitate successful patient recovery.

Address the opioid epidemic

The Bree Collaborative recognizes that drug misuse trends change over time and recommends that the chemical dependency system remain aware of and able to respond to these trends. Opioids are discussed here due to their current trend toward increased misuse and the example that this epidemic makes of the deficits of the capacity of the chemical dependency system to facilitate rehabilitation.

Currently, deaths from opioid overdose have propelled the annual increase in overall deaths from unintentional drug overdose; now the second-leading cause of accidental death nationally. As discussed earlier, deaths from opiates (heroin and prescription) have almost doubled in the past ten years, rising to 607 from 2009-2011 in Washington State. Heroin is the most common drug in treatment centers among 18-29 year olds and is driven by young adults and primarily outside of the Seattle metro area.
The Bree Collaborative recommends that primary care and emergency room staff be aware of current drug misuse trends in their community and effective treatment modalities. Primary care clinics and emergency rooms have the potential to be very effective in helping to stop high rates of opioid misuse in our community.

To address the high and increasing rates of opioid misuse in Washington State, the Bree Collaborative recommends:

- Decreasing inappropriate opioid prescribing for non-cancer, non-terminal pain
- Increasing capacity for primary care providers to prescribe medication assisted treatment
- Training appropriate primary care and emergency room staff to screen, engage, and facilitate both on-site opioid medication assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment.
- Extending state and private capacity and support for opioid medication assisted treatment (e.g., increase Buprenorphine treatment availability)
- Facilitating referrals and decreasing barriers to opioid addiction treatment (specialized vs on-site addiction treatment)
- Tracking changes to the number of admissions, cost, morbidity, and mortality in emergency room, hospital, and outpatient settings in patients using opiates to evaluate change over time
Stakeholder-Specific Recommendations

Although these recommendations are directed at specific stakeholders, we encourage all those involved with chemical dependency screening and treatment to be aware of recommendations for other stakeholders. We encourage the chemical dependency system as a whole to work more collaboratively and adopt better, more consistent communication and information sharing practices in order to help patients navigate the chemical dependency system and fully recover.

Primary Care

- Educate staff on the prevalence of alcohol and other drug misuse, current trends in alcohol and other drug misuse, the impact of alcohol and other drug misuse on health conditions, and the importance of screening for alcohol and other drug misuse
- Train health care providers how to have non-judgmental, empathetic, and accepting conversations about and screen for alcohol and other drug misuse
- Screen all patients over age 12 at the first visit and annually using a validated and scaled screening tool or pre-screen followed by a validated full screen, if appropriate
- Train primary care providers and other appropriate staff to provide brief intervention and if possible brief treatment
- Track patient results from alcohol and other drug misuse screens over time
- Follow-up with patients who have received brief intervention or brief treatment as appropriate
- Enhance ability to triage patients to appropriate level of care if not improving
- Increase provider and site accesses to qualified behavioral health providers
- Increase site knowledge of available chemical dependency treatment facilities
- Manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if available
- Establish and maintain working relationships with chemical dependency treatment faculties to facilitate referrals and ensure appropriate communication
- Facilitate patient referral to a chemical dependency treatment facility
- Contact patients after they have been referred to chemical dependency treatment to address any barriers to accessing treatment
- Communicate verbally with the chemical dependency treatment facility to follow-up on any referrals and assess whether treatment was initiated and/or completed
- Address the opioid epidemic through:
  - Staff education about opioid use disorders
  - Education about medication assisted treatment and appropriate counseling
- Plan for inclusion of the patient’s perspective as additional work is done to increase the capability of the chemical dependency system
Hospitals

- Educate staff on the prevalence of alcohol and other drug misuse, current trends in alcohol and other drug misuse, the impact of alcohol and other drug misuse on health conditions, and the importance of screening for alcohol and other drug misuse
- Train health care providers and other appropriate staff to provide un-biased alcohol and other drug misuse screening for all patients who come to the emergency room
- Increase the number of staff trained to provide brief intervention and, if possible, brief treatment
- Manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if available
- Follow-up with patients as appropriate who have received brief intervention or brief treatment
- Enhance staff ability to triage patients to appropriate chemical dependency treatment facilities if needed
- Establish and maintain working relationships with chemical dependency treatment faculties to facilitate referrals and ensure appropriate communication.
- Communicate verbally with the chemical dependency treatment facility to follow-up on any referrals and assess whether treatment was initiated and/or completed

Chemical Dependency Treatment Facilities

- Establish and maintain working relationships with primary care providers and hospitals to facilitate referrals and ensure appropriate communication.
- Communicate with referring primary care providers and hospital staff when a patient is initially referred and again when the patient is discharged from treatment
- Reach out to patients who have been referred to chemical dependency treatment but have not reached out to your facility
- Preserve the role of competency-based counselors who may not have masters-level counseling training but exhibit the skills necessary to engage with patients and are state certified as Chemical Dependency Professionals

Health Plans

- Reimburse for screening, brief intervention, and referral to treatment (SBIRT) services
- Track health care cost and utilization trends over time including hospital admissions as well as morbidity and mortality in patients with substance abuse disorders
- Comply with the American Society of Addiction Medicine patient placement criteria
**Employers/Purchasers**

- Work with the health plan or third party administrator to make benefit design changes to:
  - Reimburse for SBIRT services in primary care and emergency room settings
  - Comply with the American Society of Addiction Medicine patient placement criteria
  - Provide mental health parity
  - Adopt performance-based contracting for identification, treatment, and follow-up of people with substance abuse disorders
- Work to reduce stigma associated with receiving alcohol and other drug misuse screening, intervention, and treatment
- Provide educational material to employees about alcohol and other drug misuse screening, intervention, and treatment
- Ensure that adequate staff exist to monitor compliance with recommendations
**Definitions**

**Abuse**: Recurring pattern of alcohol or other drug use impairing ability to function in at least one important area of life (e.g., family relationships, employment, social events, psychological health, physical health, legal matters) or any use by youth.

**Binge Drinking**: Consistent with the National Advisory Council of the National Institute on Alcohol Abuse and Alcoholism and the Centers for Disease Control and Prevention, consuming four or more drinks for women within two hours and five or more drinks for men within two hours.

**Heavy Drinking**: Consistent with the National Advisory Council of the National Institute on Alcohol Abuse and Alcoholism and the Centers for Disease Control and Prevention, consuming eight or more drinks per week for women and 15 or more drinks per week for men.

**Drugs**: Marijuana, illicit drugs (e.g., hashish, cocaine, crack, heroin, hallucinogens, inhalants, etc.), and prescription psychotherapeutics used for non-medical purposes

**SBIRT**: Screening, Brief Intervention, and Referral to Treatment Primary Care Integration project is a universal, evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and other drugs.

**Standard Drink**: One 12-ounce bottle of beer, one 5-ounce glass of wine, or 1.5 ounces of distilled spirits.

**Use**: Any use of alcohol or other drugs.
References


Bradley KA. Presentation to the Addiction and Dependence Treatment Workgroup. June 20th, 2014. Seattle, WA.


Ratzliff A, Duncan M. Improving Substance Use Treatment in Primary Care. August 15th, 2014. Seattle, WA.


# Appendix A: Bree Collaborative Members

<table>
<thead>
<tr>
<th>Member</th>
<th>Title</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Susie Dade MS</td>
<td>Deputy Director</td>
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<tr>
<td>John Espinola MD, MPH</td>
<td>Vice President, Quality and Medical Management and Provider Engagement</td>
<td>Premera Blue Cross</td>
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<tr>
<td>Gary Franklin MD, MPH</td>
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<td>Washington State Department of Labor and Industries</td>
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<tr>
<td>Stuart Freed MD</td>
<td>Medical Director</td>
<td>Wenatchee Valley Medical Center</td>
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<tr>
<td>Tom Fritz</td>
<td>Chief Executive Officer</td>
<td>Inland Northwest Health Services, Spokane</td>
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<tr>
<td>Joe Gifford MD</td>
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<td>Providence Health and Services</td>
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<td>Richard Goss MD</td>
<td>Medical Director</td>
<td>Harborview Medical Center – University of Washington</td>
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<tr>
<td>Steve Hill (Chair)</td>
<td>Retired</td>
<td>Previously Director, Department of Retirement Systems, and Chair, Puget Sound Health Alliance</td>
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<tr>
<td>Christopher Kodama MD</td>
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<td>Kimberly Moore MD</td>
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<td>John Robinson MD, SM</td>
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<td>Terry Rogers MD (Vice Chair)</td>
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<td>Jeanne Rupert DO, PhD</td>
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<td>Shawn West MD</td>
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Problem Statement
The total financial cost of drug use disorders to the United States is estimated to be $180 billion. The economic costs of alcohol abuse were $184.6 billion in 1998. Washington State has high variation in screening for drug and alcohol abuse leaving many patients undiagnosed with no access to treatment.

Aim
To improve and standardize the screening and referral process for drug and alcohol addiction and dependence in Washington State.

Purpose
The purpose of the Addiction/Dependence Treatment (ADT) workgroup is to propose recommendations to the full Bree Collaborative on evidence-based standards to improve screening for drug and alcohol addiction and dependence.

1. Focus initially on optimal drug and alcohol screening protocol. Research evidence-based guidelines for drug and alcohol screening. Recommend standard tools regarding drug and alcohol screening discussions between patients and physicians using clear, stigma-free language.

2. Encourage widespread adoption of standardized drug and alcohol screening. Identify opportunities for the Bree Collaborative to endorse and otherwise support broad adoption of drug and alcohol screening to be adopted by employers, health plans, and the broader medical community.

3. Increase measurement and reporting of drug and alcohol screening. Promote the collection of measures for drug and alcohol screening.

Duties & Functions
The ADT workgroup shall:
- Coordinate with members of WSHA, WSMA, other stakeholder organizations and subject matter experts to maximize impact.
- Present findings and recommendations in a report.
- Provide updates at Bree Collaborative meetings.
- Research evidence-based guidelines, emerging best practices, and current initiatives to improve drug and alcohol screening.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Post draft report on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
Structure

The ADT workgroup will consist of individuals appointed by the chair of the Bree Collaborative, and confirmed by
the Bree Collaborative steering committee.

The chair of the ADT workgroup will be appointed by the chair of the Bree Collaborative. The Bree Collaborative
program director will staff and provide management and support services for the ADT workgroup.

Less than the full ADT workgroup may convene to: gather and discuss information; conduct research; analyze
relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be
a simple majority and shall be required to accept and approve recommendations to the Bree Collaborative.

Meetings

The ADT workgroup will hold meetings as needed.

The ADT workgroup chair will conduct meetings. Committee staff will arrange for the recording of each meeting
and distribute meeting agendas and other materials prior to each meeting.

ADT Workgroup Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Tom Fritz <em>(Chair)</em></td>
<td>Chief Executive Officer, Bree Member</td>
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<td>Charissa Fotinos, MD, MS</td>
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<td>Linda Grant, MS, CDP</td>
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<td>Tim Holmes, MHA</td>
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<td>Ray Chih-Jui Hsiao, MD</td>
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<tr>
<td>Jim Walsh, MD</td>
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<td>Swedish</td>
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Workgroup Staff

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<tr>
<th>Name</th>
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<tr>
<td>Steve Hill</td>
<td>Chair</td>
<td>Bree Collaborative</td>
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<tr>
<td>Ginny Weir</td>
<td>Program Director</td>
<td>Bree Collaborative, Foundation for Health Care Quality</td>
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