

**ADDICTIONS AND MENTAL HEALTH DIVISION (AMH)**

**SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT (SBIRT)  
WORKGROUP WEBINAR**

March 27, 2015

**Minutes - DRAFT**

**AMH Participants:** Michael Oyster, Patricia Alderson

**Other in-room participant(s):** Roxanne McAnally, Homecare Commission representative

**Webinar & Phone Participants:** Will Brake, Dominique Buhl, Valerie Davis, Sarah Dryfoos, Lynne Frost, Deena Gallaway, D.R. Garrett, Reid Hester, PhD, Stefanie Murray, Alma Nieves, Rose Rice, Ed Smith-Burns, Debbie Standridge, Molly Sullivan, Denise Taray, Ann Wagoner, Jim Winkle

**Presenters:** Michael Oyster, John McIlveen, Sarah Bartelmann

**Absent:** Sara Kleinschmidt

TOPIC	KEY DISCUSSION	ACTION/TASK/DECISION	RESPONSIBLE	DUE DATE
<b>INTRODUCTION</b> (MICHAEL OYSTER)	<ul style="list-style-type: none"> <li>• Brief review of webinar functions and features and conference line muting and unmuting.</li> <li>• Reminders:               <ol style="list-style-type: none"> <li>1. Only unmute when needing to speak.</li> <li>2. Do not place call on hold or the group cannot hear the speaker over the hold music.</li> <li>3. State your name before speaking to avoid confusion.</li> </ol> </li> </ul>		<b>Michael and audience</b>	
<b>UPDATES:</b> <b>METRICS-CCO (PRIMARY CARE)</b> <b>METRICS-ED (HOSPITALS)</b> <b>SARAH B./SARA K.</b>	<ul style="list-style-type: none"> <li>❖ No updates; the measure specifications for <b>2015</b> are out and available, and don't fore see any changes.</li> <li>❖ Working on creating the <i>2014 Baseline</i> that will include <b>SBIRT for Adolescents</b> and should have it out for CCOs and additional contacts in late April or May with the calendar year 2014 data.</li> </ul>			

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	<ul style="list-style-type: none"> <li>❖ More data to come on these.</li> </ul>			
<p><b>PRESENTATION: OPIATE TREATMENT, DETECTION OF USE, &amp; MEDICATION MIS-USE &amp; COLLABORATION WITH SBIRT (JOHN MCILVEEN)</b></p>	<ul style="list-style-type: none"> <li>❖ John is responsible for all methadone (opioid) treatment programs in the state, such as compliance, and policy around this issue.</li> <li>❖ Oregon has ranked high (#1) in the nation for prescription drug misuse/abuse</li> <li>❖ Job is to make sure clients have access to treatment when needed (as a “dependency” shows up)</li> <li>❖ PDMP: the value of collaboration between physiological and behavioral health</li> <li>❖ <i>Medication Assisted Treatment</i>: most evidence-based practice used in Oregon to treat this issue</li> <li>❖ Medications that assist in the treatment of Opioid dependency: buprenorphine, Naltrexone, (can also be used to treat alcohol disorders) methadone</li> <li>❖ Opioids are a unique class of drugs: opioids will induce tolerance, creating a physical dependence so user will need more and more to get the “buzz”</li> <li>❖ Outcomes for <i>non-medication assisted</i> treatment intervention: results/outcomes are not as good as desired</li> <li>❖ Working to get more <i>penetration</i> in residential and outpatient treatment settings for medication assisted treatment</li> <li>❖ Historically, the Oregon Health Plan hasn’t paid for these medications as treatment, is getting better at paying for these medications as opioid dependency treatment, but varies between CCOs and other healthcare providers. There are evidence based outcomes that show <i>medication assisted treatment</i> works, so it is becoming more favored as a paid treatment by the O.H.P.</li> </ul>			

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	<p><b>Question:</b> What can PCP's prescribe?</p> <p><b>Response:</b> PCPs can prescribe methadone for pain but not for opioid treatment. Methadone can only be dispensed to treat opioid treatment from specialized treatment centers and one of the most highly regulated forms of treatment by the State, DEA, SAMHSA, etc. A lot of methadone overdose cases are from prescriptions by a medical providers who are prescribing methadone for pain.</p> <p><b>Question:</b> How does Naltrexone work for alcohol dependency?</p> <p><b>Response:</b> Injections significantly lessens the compliance factor instead of needing to take a pill daily. Nevertheless, Naltrexone is usually taken orally, and lessens cravings and affects the mesolimbic system in the pre-frontal cortex. There is evidence there could be some impact on <i>process</i> addictions (such as gambling, eating, sex). Both oral Naltrexone and the monthly Vivitrol injection is billable to the Oregon Health Plan.</p> <ul style="list-style-type: none"> <li>❖ These addictions are managed as chronic conditions and to improve quality of life.</li> <li>❖ Naltrexone can be prescribed by PCPs for alcohol and opiate problems</li> <li>❖ These patients are not the most compliant when it comes to treatment and medication can help their compliance a great deal</li> <li>❖ Chronic use of opiates can make a person more pain sensitive (hypersensitive)</li> <li>❖ Patients should have a good choice between treatment options</li> </ul> <p><b>Question:</b> What does prescription misuse have to do with SBIRT?</p>	<p><b>Michael will send out an article about alcohol and Naltrexone. Heads up: it is a little harsh on the 12 step program and it's importance</b></p>		

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	<p><b>Response:</b> Because Oregon has such a high rate of opiate misuse, SBIRT is a good way to give structure to a nonjudgmental, <i>non-confrontive</i> way of discussing the issue with patients instead of dismissing them from the clinic due to noncompliance.</p> <p>(J.M.) Physical dependence and addiction are at opposite ends of the spectrum, although there is some overlap. Need to recognize the vulnerability of the patient's condition (the physical dependence) so the Dr. can intervene and engage the patient, instead of running the patient off to another practitioner.</p> <p>John and Michael have been working with Public Health on PDMP (prescription drug monitoring program) database as a means of identifying potential concerns when patients are being prescribed the same or similar medication from different physicians or are taking medications that may interact with other medications. Access to this database is strictly regulated, and seems to be a good tool to address the prescription misuse/abuse problem in Oregon.</p> <p><b>Question:</b> What percentage of physicians use this database?  <b>Response:</b> 70-80%  John will forward the 2013 annual report for Michael to send out to everyone.</p> <p><b>Question:</b> What medications are in this database?  <b>Response:</b> Sedatives, tranquilizers, opiates, other controlled substances. It is a great informational tool for integration between physical and behavioral health for physicians.</p>	<p><b>John will forward the 2013 annual report for Michael to send out to everyone</b></p> <p><b>Michael will send out a list of resources after the webinar</b></p>		

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	<p><b>Question:</b> What about <i>policing</i> of physicians' prescription patterns?</p> <p><b>Response:</b> It's designed to be a tool to educate and inform physicians of their own prescribing patterns and to alert physicians of potential medication misuse. The PDMP is not used to police physicians or to prosecute patients.</p>			
ANNOUNCEMENTS & UPDATES (M.O.)	<p>Michael shared graphics from an article called, <a href="#">The Epidemic Hiding in Your Living Room</a> about prescription drug misuse and its correlation with street drugs such as heroin.</p>			
DISCUSSION: SCREENING FOR OPIATE MISUSE, ABUSE, AND DEPENDENCY, FACILITATING THE BRIEF INTERVENTION, MAKING REFERRAL TO TREATMENT WORK (M.O. & J.M.)	<p><b>Question:</b> What about <i>adolescent</i> opiate abuse and treatment?</p> <p><b>Response:</b> a large number (70-80%) of adolescents get their medications from parents/relatives/friends to start the misuse/abuse. Treatment options: certain people are suitable for certain types of treatment, such as detox, medication assisted treatment, abstinence.</p> <p><b>Question:</b> What about chronic pain- how is this handled when there is a dependency?</p> <p><b>Response:</b> Opioids is a class of drugs that is very good for <i>chronic</i> pain. There is a strong relation between physical dependence and addiction, and a difficult population to manage, but if needed, the patient should have access to the medication. There are other ways to manage pain such as basic meditation and yoga, progressive relaxation and exercise which are all self-empowering and gives patients control over their own pain.</p>			

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	<p><b>Naloxone (Nar-can):</b> How do patients get a hold of this and what is the regulation?  <b>Response:</b> An opiate overdose reversal drug. Covered under the OHP, available via prescription, but not available everywhere, working to change this on a policy level. Administered intramuscularly, and via intra-nasal spray. Many lives have been saved by this drug. AMH goal is to increase penetration around the state, use highly concentrated in Lane &amp; Multnomah counties. The prescription for this medication can be gotten not only for oneself but to have on hand for others as well. You need to take a class to get the prescription card then take to a Pharmacy to get filled. Overdose deaths decreased significantly last year in the Portland area.</p> <p><b>Question:</b> Does a person with this dependence get their own prescription?  <b>Response:</b> Patients are encouraged to enlist help of families, friends to help with administration due to person not being able to give it to themselves when in an overdose state. Chance of overdose greater with the increase in dosage.</p> <p><b>Question:</b> Can the <i>Opiate Screening Tool</i> function as an SBIRT screen?  <b>Response:</b> Not for a general SBIRT screen, but Michael encourages providers to use it for clinics that see a high number of opiate dependent patients.</p>	<p><b>Michael will send out John's contact info for those who want to follow up with him/feel free to contact John with any questions you may have.</b></p>		
FUTURE TOPICS FOR WORKGROUP?	•	Email Michael with your agenda/topic ideas	all	
NEXT MEETING	<input type="checkbox"/> Meetings are the <b>last Friday</b> of the month starting Jan. 2015 <input type="checkbox"/> Next meeting: <b>May 29, 9:00-10:30 a.m.</b> (April 24 <sup>th</sup> meeting is cancelled)			