

# WELCOME

## Addiction Medicine ECHO Clinic



The session will begin promptly at 12 pm.



Please mute the audio on your device.



Sessions take place Thursday on the 2<sup>nd</sup> and 4<sup>th</sup> week of the month.



Please connect your camera.

Need technical assistance? Call [907.729.2622](tel:907.729.2622) or text your phone number into the chat.



ALASKA NATIVE  
MEDICAL CENTER



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CONSORTIUM



Foundation for  
Opioid Response Efforts

# Recording

We will record the **didactic portion** of every session. After the session, the didactic portion of this clinic will be available on the ANTHC Addiction Medicine ECHO page.

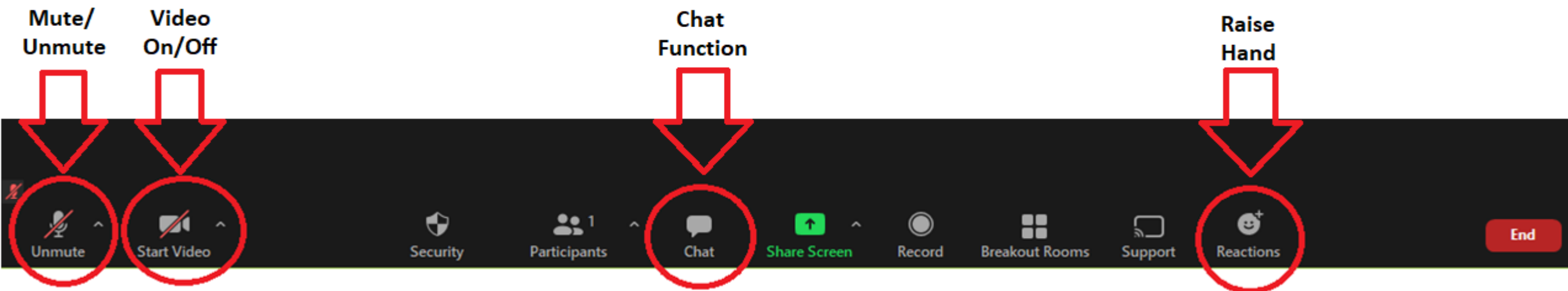
**By participating in this clinic you are consenting to be recorded.**

If you do not wish to be recorded, please email [behavioralhealth@anthc.org](mailto:behavioralhealth@anthc.org) at least one week prior to the ECHO Clinic you plan to attend.

# Some Helpful Tips

- ▶ Please mute microphone when not speaking
- ▶ Use chat function
- ▶ Position webcam effectively
- ▶ Test both audio & video

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# ANTHC Clinical ECHO Series

## Approved Provider Statements:



In support of improving patient care, Alaska Native Medical Center (ANMC) is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

## Contact Hours:

ANMC designates this activity for a maximum of 25 contact hours, including 12 total pharmacotherapeutics contact hours, commensurate with participation.

## Financial Disclosures:

None of the presenters and planners for this educational activity have any relevant relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Approved for 1 CHAP CE

## Conflict of Interest Disclosures:

None of the presenters and planners for this educational activity have any relevant relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

## Requirements for Successful Completion:

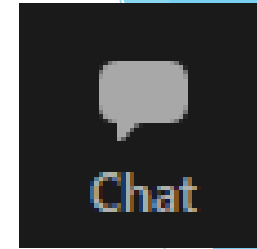
To receive CE credit be sure you are included in attendance record as directed by the facilitator/session moderator, and complete the course evaluation or post session survey via this link: <https://forms.gle/QhwCeGTf4zLNwpBX7>


For more information contact Jennifer Fielder at [jfielder@anthc.org](mailto:jfielder@anthc.org) or (907) 729-1387


# Introductions


## Addiction Medicine ECHO

- Please introduce yourself in the chat :
  - Name
  - Location
  - Profession/Credentials
  - *Note:* The chat will be saved as our attendance record for continuing education credits.



 Chat

To: Everyone 



Name, Location, Credentials: Jane Doe, MD, ANTHC|

Addiction Medicine ECHO  
Sarah Spencer DO, FASAM  
5/12/22

# Substance Use Disorder Screening Tools



# Financial Disclosures

I have no financial conflicts of interest to disclose

I am currently employed by the Ninilchik Traditional Council

I work as an addiction treatment consultant for the Opioid Response Network in Alaska and for other non-profit agencies such as ANTHC.



# OBJECTIVES

- Participants will have the ability to name two screening tools for substance use disorders.
- Participants will review the training and implementation resources for the screening tools presented.

# Alcohol and Drug Screening

- Used for illnesses with high prevalence.
- Used for early detection for better outcomes.
- Screening tests should have high sensitivity.
- The USPSTF 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.
- Positive screening does *not* result in substance use disorder (SUD) diagnosis, but indicates importance of further evaluation.
- Universal, quick, non-judgmental tools/methods
- Detect risky or problematic use

## SCREEN

- Use validated screening tools
- Alcohol, tobacco, and substance misuse (including opioids)
- If individual screens positive for risk of harm from substance use, then assess

## ASSESS

- Determination of OUD and/or AUD diagnosis and severity, including intoxication or withdrawal
- Include patient medical, social, psychiatric, SUD and family histories
- Laboratory and drug testing
- Query the PDMP

## TREATMENT OR REFERRAL

- Determine treatment plan
- Offer or refer for psychosocial treatment based on individual need
- Refer to SUD treatment if applicable

# SBIRT

## Screening

- Quickly assess the severity of substance use and identify the appropriate level of treatment.

## Brief Intervention

- Increase insight and awareness of substance use; motivation toward behavioral change.

## Referral to Treatment

- Provide those identified as needing more extensive treatment with access to specialty care.

# SBIRT

Screening, Brief Intervention  
and Referral to Treatment

## Screening



High Risk Use

Severe Use

Brief  
Intervention

Referral to  
Treatment

# SBIRT Step by Step

4 Phases of SBIRT

## Phase 1 ESTABLISH RAPPORT

**ASSURE CONFIDENTIALITY AND  
ADMINISTER ASSESSMENTS**

## Phase 2 ELICIT THOUGHTS - PROVIDE FEEDBACK

**EXPLORE PROS AND CONS OF CHANGING,  
PROVIDE EDUCATION**

## Phase 3 ENHANCE MOTIVATION

**ASSESS READINESS TO CHANGE AND  
ENHANCE MOTIVATION**

## Phase 4 NEGOTIATE A PLAN

**SUMMARIZE SESSION, INVITE THEM BACK**

## Behavior of Patient



Risky or Substance Use Disorder



Risky or Alcohol Use Disorder



## Screening

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

How many times  
in the past year have you had **X** or  
more drinks in a day?

For **men**,  $x = 5$  For **women**,  $x = 4$



If patient answers positive on single  
screen proceed to DAST-10  
Questionnaire with Clinician BHSS



Response of  $\geq 1$  is considered positive  
if positive proceed to AUDIT  
Questionnaire with Clinician BHSS



## Annual questionnaire

Once a year, all our patients are asked to complete this form because drug and alcohol use can affect your health as well as medications you may take.

Please help us provide you with the best medical care by answering the questions below.

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

### Alcohol:

One drink =



12 oz.  
beer



5 oz.  
wine



1.5 oz.  
liquor  
(one shot)

|   | None                  | 1 or more             |
|---|-----------------------|-----------------------|
| <b>MEN:</b> How many times in the past year have you had 5 or more drinks in a day?   | <input type="radio"/> | <input type="radio"/> |
| <b>WOMEN:</b> How many times in the past year have you had 4 or more drinks in a day? | <input type="radio"/> | <input type="radio"/> |

**Drugs:** Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

|   | None                  | 1 or more             |
|---|-----------------------|-----------------------|
| How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? | <input type="radio"/> | <input type="radio"/> |

## Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:



12 oz.  
beer



5 oz.  
wine



1.5 oz.  
liquor  
(one shot)

|  |       |                   |                     |                    |                        |
|--|-------|-------------------|---------------------|--------------------|------------------------|
| 1. How often do you have a drink containing alcohol?   | Never | Monthly or less   | 2 - 4 times a month | 2 - 3 times a week | 4 or more times a week |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking?  | 0 - 2 | 3 or 4            | 5 or 6              | 7 - 9              | 10 or more             |
| 3. How often do you have five or more drinks on one occasion?  | Never | Less than monthly | Monthly             | Weekly             | Daily or almost daily  |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started?                       | Never | Less than monthly | Monthly             | Weekly             | Daily or almost daily  |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking?                       | Never | Less than monthly | Monthly             | Weekly             | Daily or almost daily  |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly             | Weekly             | Daily or almost daily  |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking?   | Never | Less than monthly | Monthly             | Weekly             | Daily or almost daily  |

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. Have you used drugs other than those required for medical reasons?

☐No

☐Yes

2. Do you use more than one drug at a time?

☐No

☐Yes

3. Are you always able to stop using drugs when you want to?

☐No

☐Yes

4. Have you had "blackouts" or "flashbacks" as a result of drug use?

☐No

☐Yes

5. Do you ever feel bad or guilty about your drug use?

☐No

☐Yes

6. Does your spouse (or parents) ever complain about your involvement with drugs?

☐No

☐Yes

7. Have you neglected your family because of your use of drugs?

☐No

☐Yes

8. Have you engaged in illegal activities in order to obtain drugs?

☐No

☐Yes

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

☐No

☐Yes

10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?

☐No

☐Yes

## Drug Abuse Screening Test (DAST-10)

### Interpretation of Score:

| Score | Degree of Problems Related to Drug Abuse | Suggested Action                  |
|-------|--|-----------------------------------|
| 0     | No problems reported                     | None at this time                 |
| 1-2   | Low level                                | Monitor, reassess at a later date |
| 3-5   | Moderate level                           | Further investigation             |
| 6-8   | Substantial level                        | Intensive assessment              |
| 9-10  | Severe level                             | Intensive assessment              |

[https://cde.drugabuse.gov/sites/nida\\_cde/files/DrugAbuseScreeningTest\\_2014Mar24.pdf](https://cde.drugabuse.gov/sites/nida_cde/files/DrugAbuseScreeningTest_2014Mar24.pdf)

# **NIDA Drug Screening Tool**

NIDA-Modified ASSIST (NM ASSIST)

Clinician's Screening Tool for Drug Use in General Medical Settings\*

**In the past year, how often have you used the following?**

**Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day)**

**Never**

Once or Twice

Monthly

Weekly

Daily or Almost Daily

**Tobacco Products**

**Never**

Once or Twice

Monthly

Weekly

Daily or Almost Daily

**Prescription Drugs for Non-Medical Reasons**

**Never**

Once or Twice

Monthly

Weekly

Daily or Almost Daily

<https://archives.drugabuse.gov/nmassist/>

## Substance Involvement Score – Risk Level

### Low

- Brief intervention (*M-ASSIST Score 0-3*)
- Provide feedback on the screening results
- Reinforce moderation and/or abstinence
- Offer continuing support

### Moderate

- Brief treatment onsite or via referral (*M-ASSIST Score 4-26*)
- Provide feedback on the screening results
- Advise, assess, and assist
- Consider referral based on clinical judgement
- Offer continuing support

### High

- Referral to specialty treatment (*M-ASSIST Score > 27*)
- Provide feedback on the screening results
- Advise, assess, and assist
- Arrange referral
- Offer continuing support

## LOW-RISK DRINKING LIMITS

Source: National Institutes of Health

MEN 18-65



No more than:  
**4 drinks per day**  
AND no more than:  
**14 drinks per week**

WOMEN 18-65\*



No more than:  
**3 drinks per day**  
AND no more than:  
**7 drinks per week**

AGE 66+



No more than:  
**3 drinks per day**  
AND no more than:  
**7 drinks per week**

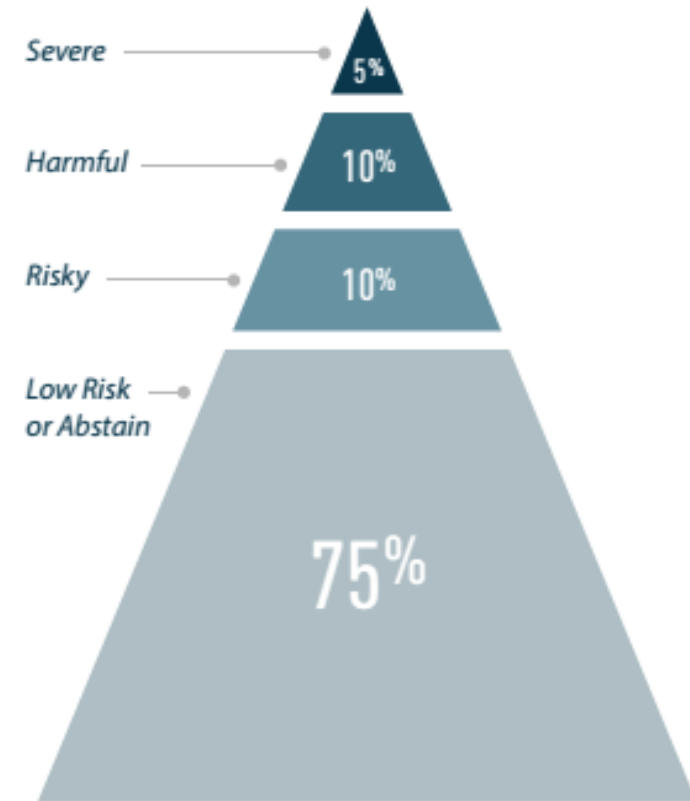
\*Women who are pregnant or breastfeeding should not drink.

### WHAT COUNTS AS ONE DRINK?

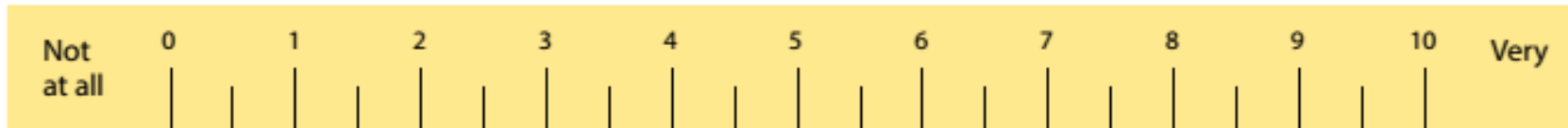


**One drink is:**  
12-ounce can of beer  
5-ounce glass of wine  
A shot of hard liquor (1½ ounces)

### RISK ZONE PYRAMID



Adapted from World Health Organization



Mid-America (HHS Region 7)

ATTC

Addiction Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration

UMKC | SBIRT

## Thinking About Change

What change(s) are you considering?

How important is it that you make this change?

How confident are you that you are able to make this change?

### How ready are you to make this change?

## Readiness Ruler





Engage

Motivate

Plan

- Inquire about current patterns of substance use
- Determine patient **perception** of substance use
- Identify personal **values and goals**
- Discuss **impact** of substance use on goals
- Develop **discrepancy** between substance use and achieving goals
- Elicit the **need** and perceived **ability** to change

Engage

Motivate

Plan

- Provide clear, specific, **personalized feedback**
- Include risks and consequences of use
- Express concern and recommend explicit changes
- Support patient **self-determination** and **autonomy**
- Tailor to patient's level of health literacy
- Emphasize **confidence** in ability to change
- Assure continued **support** throughout process
- Emphasize **strengths & past successes**
- **Validate** frustrations, but remain optimistic
- **Reflect & Summarize**
- **Prepare** patient for next steps

Engage

Motivate

Plan

- **Make goals** aligned with readiness to change
- Goals should be **attainable**, **measurable**, and **timely**
- Help **anticipate** potential challenges
- Change strategies as needed
- Avoid argumentation & defensiveness
- Recommend ideal, but **accept less if patient resists**
- **Follow-up** within 1 month
- **Reinforce, reassess**, and **update** plan
- **Acknowledge** efforts & experiences
- Offer continued support, despite progress
- Give self-help and guidance for social support

## Referral to Treatment: Brief Intervention for a Patient in the Severe Zone

|                     |  |
|---------------------|--|
| Risk Zone           | IV-Severe  |
| AUDIT Score         | 14+  |
| DAST Score          | 6+   |
| Description of Zone | "Could benefit from more assessment and assistance." |

For a patient in the Severe zone, the aim of the brief intervention is to enhance the patient's motivation to accept a referral to treatment *for an initial appointment/assessment*.

### Step 1 – Raise the Subject

If a patient scores in Zone 4, he/she is likely to have some "initial" awareness of consequences related to substance use as evidenced by the items marked on the AUDIT/DAST.

- Explain your role; ask permission to discuss alcohol/drug use screening forms
- Ask about alcohol/drug use patterns: "What does your alcohol/drug use look like in a typical week?"
- Ask about the patient's concerns about substance use: "I'm interested in finding out what concerns you have about your alcohol/drug use?"
- Listen carefully and provide reflections of change talk.

## Step 2 – Provide Feedback

- Provide feedback on the AUDIT and/or DAST: “Your score on the screening form puts you in the Severe Zone. Individuals who score in that Zone are usually experiencing significant consequences related to their alcohol/drug use. They often benefit from more assessment and assistance (than I can offer).” Review low-risk drinking limits.
- Elicit the patient’s reaction – “What do you think about that?”
- Explore connection to health/social/work issues (patient education materials): “What connection might there be...?”

## Step 3 – Enhance Motivation

- Provide a summary and express concern: “As we just talked about, your alcohol/drug use puts you in the Severe zone. I am concerned about how your alcohol/drug use may be impacting your health, and it sounds like you have some concerns too. I would like to [have you talk to our behavioral health specialist or refer you to a treatment program], to assess together what might be most helpful for you.”
- Explore the patient’s reaction to the information; listen closely and reflect.
- If the patient doesn’t express “significant” concerns or seem interested in a referral, explore pros/cons: “What do you like about your alcohol/drug use? What don’t you like?” then explore readiness “On a scale of 0-10, how ready are you to make a change in your alcohol/drug use?” If readiness is greater than a 2: “Why that number and not a \_\_\_\_\_ (lower one)?”
- If the patient is somewhat open to referral, use the readiness ruler: “On a scale of 0-10 how ready are you to consider seeing someone to talk more about your alcohol/drug use?” If readiness is greater than 2: “Why that number and not a \_\_\_\_\_ (lower one)?”
- Ask pros/cons of seeing someone for an assessment for treatment (ask about cons first, then pros).

## Step 4 – Negotiate Plan

If not motivated for referral or to change substance use, stop, thank patient, offer patient education materials, negotiate follow-up visit.

If not motivated for referral but motivated to change substance use:

- Summarize the conversation (zone, pros/cons, readiness); ask question: “What steps would you be willing to take?”
- Explore patient’s goal for change (offer options if needed); write down steps to achieve goal; assess confidence
- Negotiate follow-up visit; thank patient

If interested in accepting the referral:

- Explore the patient’s understanding of what “treatment” is, provide feedback to explain types of treatment and support, and most importantly that treatment takes many forms. Elicit reactions: “Sounds like you are open to considering getting some help. I’m wondering what you know about the different types of treatment options?”
- Use a warm handoff and plan how to get help or support: “Would it be okay if we called right now to make you an appointment?” or “Can I call in my colleague to talk to you for a few minutes?”
- If needed, assess for withdrawal risks and management

# MOUD Patient Intake Screening

# Phone Intake Questions

## Buprenorphine/Naloxone Maintenance Treatment Intake Questionnaire for Patient Treatment-Planning Questions

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions which will help us design your plan of treatment:

What is the best time of day and day of week for you for clinic visits?

Are there any months of the year when you may have difficulty making it in for appointments?

Is there any problem that makes it hard for you to give routine urine specimens?

Do you have any disabilities that make it hard for you to read labels or count pills?

What are your reasons for being interested in Buprenorphine/Naloxone treatment?

What "triggers" do you know which have put you in danger or relapse in the past or which might in the future?

<https://3oqkon2g8eif8wrj03zeho41-wpengine.netdna-ssl.com/wp-content/uploads/2015/03/Sample-intake-questionnaire.pdf>

What coping methods have you developed to deal with these triggers to relapse?

What plans do you have for the coming year?

Work? \_\_\_\_\_

Home? \_\_\_\_\_

Other? \_\_\_\_\_

What kinds of help would you like from your counselor?

What are your strengths and skills to handle take-home Buprenorphine/Naloxone (Suboxone)?

What worries do you have about extended take homes?

Is anyone in your home actively addicted to drugs or alcohol?

What are the major sources of stress in your life?

What family or significant others will be supportive to you during your treatment?

Would you be willing to sign a release so that the person(s) identified above can be spoken to regarding your treatment?

# Phone Intake Forms

| PRIOR SUBSTANCE USE DISORDER TREATMENT HISTORY   |  |
|--|--|
| <b>Methadone:</b>  |  |
| Have you ever been on Methadone Maintenance?   |  |
| <input type="checkbox"/> 1 = Yes<br><input type="checkbox"/> 2 = No  |  |
| When and where were you on Methadone Maintenance? _____  |  |
| What was your dose? _____  |  |
| Why did you stop Methadone treatment?<br>_____   |  |
| Are you currently on Methadone Maintenance?  |  |
| <input type="checkbox"/> 1 = Yes<br><input type="checkbox"/> 2 = No  |  |
| What is your dose? _____   |  |
| Where are you receiving services for your Methadone treatment? _____   |  |
| What is the name of your counselor at your Methadone clinic? _____   |  |
| Buprenorphine/naloxone: Have you ever been prescribed buprenorphine/naloxone (Suboxone, Zubsolv, etc.) before? |  |
| <input type="checkbox"/> 1 = Yes<br><input type="checkbox"/> 2 = No  |  |
| If yes, when were you on buprenorphine/naloxone? _____   |  |
| What was your dose? _____  |  |
| Why did you stop taking buprenorphine/naloxone? _____  |  |

|   |
|---|
| Have you ever overdosed?  |
| <input type="checkbox"/> 1 = Yes<br><input type="checkbox"/> 2 = No   |
| Number of lifetime overdoses: _____   |
| Have you ever been hospitalized due to an overdose?   |
| <input type="checkbox"/> 1 = Yes<br><input type="checkbox"/> 2 = No   |
| Was naloxone administered?  |
| <input type="checkbox"/> 1 = Yes<br><input type="checkbox"/> 2 = No   |
| How many times have you overdosed in the past year? _____   |
| Was your most recent overdose an attempt to kill yourself?  |
| <input type="checkbox"/> 1 = Yes<br><input type="checkbox"/> 2 = No   |
| Do you have any history of any other addictive behaviors such as?   |
| <input type="checkbox"/> 1 = Gambling<br><input type="checkbox"/> 2 = Sex<br><input type="checkbox"/> 3 = Shopping<br><input type="checkbox"/> 4 = Eating disorder (overeating, bulimia, anorexia)<br><input type="checkbox"/> 5 = Other _____<br><input type="checkbox"/> 6 = No |

| SUBSTANCE USE HISTORY   |                   |  |   |   |              |
|---|-------------------|--|---|---|--------------|
|   | Age of initiation | Date of most recent use  | Frequency   | Route of administration   | Amounts used |
| What is your substance of choice?   | 0 If never used   | 1 = 12 or more months ago (specify date)<br>2 = 3-11 months ago<br>3 = 1-2 months ago<br>4 = 1-3 weeks ago<br>5 = used this week | 1 = less than 1 per month<br>2 = 1-3 times per month<br>3 = 1-2 times per week<br>4 = 3-6 times per week<br>5 = daily   | 1 = oral<br>2 = smoking<br>3 = intranasal<br>4 = intravenous injection<br>5 = skin popping<br>6 = other |              |
| Opioid:<br><input type="checkbox"/> Heroin<br><input type="checkbox"/> Fentanyl<br><input type="checkbox"/> Oxycodone product<br><input type="checkbox"/> Buprenorphine<br><input type="checkbox"/> Methadone<br><input type="checkbox"/> Other opioid _____  |                   |  |   |   |              |
| Benzodiazepines   |                   |  |   |   |              |
| Alcohol   |                   |  |   |   |              |
| Cocaine   |                   |  |   |   |              |
| Amphetamines, including methamphetamine   |                   |  |   |   |              |
| Tobacco/nicotine  |                   |  |   |   |              |
| Other   |                   |  |   |   |              |
| What substances are you currently using at this time? Include age of first use, last use, route, frequency, and quantity.   |                   |  |   |   |              |
| <input type="checkbox"/> 1 = Heroin<br><input type="checkbox"/> 2 = Fentanyl<br><input type="checkbox"/> 3 = Buprenorphine/naloxone<br><input type="checkbox"/> 4 = Methadone<br><input type="checkbox"/> 5 = Oxycodone product<br><input type="checkbox"/> 6 = Other opioid: _____<br><input type="checkbox"/> 7 = Cocaine |                   |  | <input type="checkbox"/> 8 = Benzodiazepines<br><input type="checkbox"/> 9 = Tobacco/nicotine<br><input type="checkbox"/> 10 = Alcohol<br><input type="checkbox"/> 11 = Amphetamines<br><input type="checkbox"/> 12 = Other: _____<br><input type="checkbox"/> 13 = Nothing |   |              |

**After support staff collects initial patient information to assess level of risk, urgency and appropriateness for treatment, the data gathered is reviewed with the medical provider to plan for appointment for medical assessment**

# Resources

SBIRT Screening Tools

<https://www.sbirt.care/tools.aspx>

Buprenorphine Intake forms, COWS form

<https://www.bmcobat.org/resources/?category=4>

# Case Presentation

Project ECHO's goal is to protect patient privacy

- ▶ To help Project ECHO accomplish that goal, please only display or say information that doesn't identify a patient or that cannot be linked to a patient.
- ▶ **References:** For a complete list of protected information under HIPAA, please visit [www.hipaa.com](http://www.hipaa.com)

Thank you for joining us today.  
We appreciate your participation and hope  
to see you at the **NEXT ECHO Session:**  
**May 26, 2022 from 12pm -1 PM**

You will be receiving a follow up survey that we hope you will complete to help us improve. If you are requesting continuing education credits, you will be required to complete the survey to receive your CMEs.

