Bree Collaborative Addiction and Dependence Treatment Report and Recommendations Public Comment Survey

SurveyMonkey

1. What sector do you represent? (Choose the option that is the best fit.)

	Response Percent	Response Count
Primary Care	17.0%	9
Hospital/Clinic	22.6%	12
Government/Public Purchaser	13.2%	7
Employer	3.8%	2
Health Plan	1.9%	1
Consumer/Patient	1.9%	1
Self	5.7%	3
Other (please specify)	**34.0%**	**18**
answered question		**53**
skipped question		**0**

2. Do you agree with the problem statement? (Pages 4-8)

	Response Percent	Response Count
Yes	**92.5%**	**49**
No	3.8%	2
Neutral/No Opinion	3.8%	2
answered question		**53**
skipped question		**0**

3. Do you have any changes, additions, or comments about the problem statement?

	Response Count
	31
answered question	31
skipped question	22

4. Do you have any changes, additions, or comments about Figure 9: Substance Use Disorder Framework (page 9)?

	Response Count
	53
answered question	53
skipped question	0

5. Do you agree with recommendation 1 and the specific strategies to “Reduce stigma associated with alcohol and other drug misuse screening, intervention, and treatment” (Page 11)?

		Response Percent	Response Count
Yes		81.1%	43
No		5.7%	3
Neutral/No Opinion		13.2%	7
	answered question		53
	skipped question		0

6. Do you have any changes, additions, or comments to this recommendation?

	Response Count
	27
answered question	**27**
skipped question	**26**

7. Do you agree with recommendation 2 and the specific strategies to “Increase appropriate alcohol and other drug screening in primary care and emergency room settings” (Pages 11-14)?

		Response Percent	Response Count
Yes		**81.1%**	**43**
No		9.4%	5
Neutral/No Opinion		9.4%	5
answered question			**53**
skipped question			**0**

8. Do you have any changes, additions, or comments to this recommendation?

	Response Count
	35
answered question	**35**
skipped question	**18**

9. Do you agree with recommendation 3 and the specific strategies to “Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse" (Pages 14-17)?

	Response Percent	Response Count
Yes	**84.9%**	**45**
No	9.4%	5
Neutral/No Opinion	5.7%	3
answered question		**53**
skipped question		**0**

10. Do you have any changes, additions, or comments to this recommendation?

	Response Count
	26
answered question	**26**
skipped question	**27**

11. Do you agree with recommendation 4 and the specific strategies to “Decrease barriers for facilitating referrals to appropriate treatment facilities” (Pages 18-19)?

	Response Percent	Response Count
Yes	**86.8%**	**46**
No	7.5%	4
Neutral/No Opinion	5.7%	3
answered question		**53**
skipped question		**0**

12. Do you have any changes, additions, or comments to this recommendation?

	Response Count
	31
answered question	**31**
skipped question	**22**

13. Do you agree with recommendation 5 and the specific strategies to “Address the opioid epidemic” (Pages 19-20)?

		Response Percent	Response Count
Yes		**77.4%**	**41**
No		13.2%	7
Neutral/No Opinion		9.4%	5
	answered question		**53**
	skipped question		**0**

14. Do you have any changes, additions, or comments to this recommendation?

	Response Count
	37
answered question	**37**
skipped question	**16**

15. Do you have any changes, additions, or comments to the Stakeholder-Specific Recommendations (Page 21-23)?

	Response Count
	53
answered question	53
skipped question	0

16. Do you have any changes, additions, or comments to the definitions? (Page 24)

	Response Count
	53
answered question	53
skipped question	0

17. Are there any aspects of the chemical dependency system that you feel our recommendations should address and do not?

	Response Count
	42
answered question	42
skipped question	11

18. Please provide any general comments here:

	Response Count
	33
answered question	33
skipped question	20

19. Name:

	Response Count
	43
answered question	43
skipped question	10

20. Email address:

	Response Count
	43
answered question	43
skipped question	10

21. Organization:

	Response Count
	42
answered question	42
skipped question	11

Page 2, Q1. What sector do you represent? (Choose the option that is the best fit.)		
1	psychologists	Dec 28, 2014 11:46 AM
2	Psychologist/Behavioral Health Clinic	Dec 26, 2014 4:47 PM
3	Washington State Society for Clinical Social Work	Dec 26, 2014 1:12 PM
4	Family therapist (addictions), legislative committee member of the Washington State Society of Clinical Social Work	Dec 26, 2014 12:41 PM
5	Washington Advocates for Patient Safety	Dec 26, 2014 8:59 AM
6	Maternal Fetal Medicine care provider	Dec 23, 2014 3:33 PM
7	WA Coalition	Dec 23, 2014 1:49 PM
8	Health Care Research	Dec 23, 2014 1:04 PM
9	Clinical rewsearcher in substance abuse	Dec 23, 2014 9:02 AM
10	Non profit Healthcare Advancement Organization	Dec 18, 2014 4:00 PM
11	Specialty Treatment Providers	Dec 12, 2014 5:02 PM
12	Outpatient Pain & Addiction specialist	Dec 10, 2014 9:50 PM
13	Private, non profit: harm reduction emphasis	Dec 5, 2014 10:00 AM
14	3rd party employer rep	Dec 4, 2014 2:28 PM
15	Non-Profit Association	Dec 3, 2014 10:31 AM
16	Case manager/RN in Aging and Long Term Care	Dec 3, 2014 10:29 AM
17	Chemical Dependency Treatment Facility	Dec 2, 2014 3:23 PM
18	chemical dependency program	Dec 2, 2014 12:22 PM

Page 2, Q3. Do you have any changes, additions, or comments about the problem statement?		
1	Yes. The Washington State Psychological Association (WSPA) believes that the problem statement should include: significant difficulties in accessing well trained substance use providers; the reality that about 90% of people who die by suicide have a substance use problem, mental disorder, or - in many cases - both; WSPA also would argue that this report minimizes the rate of comorbidity between substance use disorders and mental disorders; and WSPA supports the SAMSHA recommendation that screening & assessment be integrated with full access to trained health professionals.	Dec 28, 2014 11:46 AM
2	Education of primary care physicians needs to extend beyond diagnosis of addiction. Many patients regret talking about their addiction as they perceive that their medical treatment is changed for the worse: the PCP will not listen regarding medication effects, especially where pain management is concerned; some problems dismissed due to being part of the mind/attitude of addiction. These are patient perceptions, but I have heard them frequently. So, an ongoing receptivity to actually listening and responding and checking with the patient for understanding needs to be part of the education. We do not need patients who regret providing current or historical addiction data.	Dec 26, 2014 4:47 PM
3	I agree with the problem statement but not the way solutions are stated. There is no reference to the high level of co-existing disorders and the way to treat mental health problems and substance abuse problems together.	Dec 26, 2014 1:12 PM
4	No	Dec 26, 2014 12:52 PM
5	I agree with the overall view of the problem, including the necessary focus on the health risks of opiate dependence, and I agree that SBIRT is a very useful tool. Healthcare settings are an appropriate setting to screen more people for potential substance use problems.	Dec 26, 2014 12:41 PM
6	No	Dec 26, 2014 8:59 AM
7	I am concerned that the high and rapidly increasing prevalence of drug use in pregnancy and the subsequent increase in NAS was not highlighted as a key problem. Additionally, many pregnant women with drug use are not getting adequate, knowledgeable, comprehensive care for either their chemical dependency OR their obstetric needs. This is a critical area of improvement within WA.	Dec 25, 2014 10:29 AM
8	On page 7, paragraph 3, the topic abruptly changes from injection drug use to I-502 impacts. All information in this section is helpful; however, some paragraph re-ordering may be necessary for increased clarity.	Dec 24, 2014 11:04 AM
9	A specific focus about the effect of drugs/acohol in pregnancy as well as the cultural and structural barriers to care faced by women in pregnancy should be added.	Dec 23, 2014 3:33 PM
10	No	Dec 23, 2014 10:36 AM
11	Drug & Alcohol Treatment is a very important service to the chemically dependent. It is not an add on to regular medical treatment and not a prescription. Referring patients to a proper treatment facility is the beginning to a higher successful outcome. Continued dilution of treatment only leads to a	Dec 22, 2014 2:14 PM

Page 2, Q3. Do you have any changes, additions, or comments about the problem statement?		
	higher rate of failure and a waste of precious resources	
12	No	Dec 19, 2014 2:38 PM
13	no	Dec 18, 2014 4:00 PM
14	The problem statement does not have a focus when it could have one. I feel that the problem statement should identify areas where resources can be directed. Which of these areas has the biggest impact in terms of morbidity or mortality? How can we best address these areas in the treatment system in WA state? Where are the weak points in our treatment system?	Dec 12, 2014 5:02 PM
15	not at this time.	Dec 12, 2014 2:14 AM
16	Perhaps one might even acknowledge it is likely our number one Public Health problem. The lack of a Public Health perspective and expertise is problematic.	Dec 10, 2014 9:50 PM
17	No. It is impressive.	Dec 10, 2014 11:38 AM
18	Page 5 last paragraph "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" Note, about 75% of the patients whoa re screened do not have a diagnosable disorder. SBIRT is designed to catch those in the early phase. If the medical community was only looking for a SUD then they miss all those at the lower level.	Dec 9, 2014 1:49 PM
19	No	Dec 9, 2014 12:07 PM
20	no	Dec 9, 2014 8:12 AM
21	I would add that there are additional problems including an insufficient number of specialty providers for publicly funded substance use disorder treatment and an insufficient workforce to create more treatment options.	Dec 8, 2014 3:49 PM
22	I think scaring people into believing they have a true issue with substances is where all professionals go wrong. Binge drinking is harmful but that does not mean they need treatment-it could mean they need a good influence in their life and maybe brief talk therapy for why they are in that situation in the first place. Doctors screening people is a great idea because most look up to/trust doctors and will listen to what they say.	Dec 8, 2014 9:33 AM
23	I think it would be important to add that there are FEW inpatient treatment options for people who utilize Apple Health (Medicaid). Intensive outpatient is also limited. Follow up with recommendations for post treatment is also very limited and often not adhered to....	Dec 5, 2014 10:00 AM
24	none	Dec 4, 2014 11:43 AM
25	I think the problem statement should include a plan to address the underlying issues that are masked by alcohol and drug abuse.	Dec 4, 2014 7:13 AM
26	lacks specifics	Dec 3, 2014 11:40 AM
27	Regarding demographics in the problem statement, I believe it would be better to	Dec 3, 2014 10:31 AM

Page 2, Q3. Do you have any changes, additions, or comments about the problem statement?		
	delete this reference: "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." I think this statement minimizes the global nature of the problem. People reading the document are certainly able to read the document and reference these statistics to draw their own conclusions.	
28	No	Dec 3, 2014 8:40 AM
29	The MAIN reason people cannot get treatment is there are NO TREATMENT FACILITIES PERIOD. Forget all the other fluff and get to the real problem and issue	Dec 2, 2014 10:00 PM
30	Point out lack of treatment capacity and low rate of reimburement to serve CD population	Dec 2, 2014 3:23 PM
31	Training primary care staff is important but finding ways of paying them is more important. Primary care won't take on addiction unless they can get paid for the work. I am licensed in Suboxone but because I am primary care, I can not use the codes that specialists use in addiction so I do not get paid for the same work as a specialist.	Dec 1, 2014 1:40 PM

Page 2, Q4. Do you have any changes, additions, or comments about Figure 9: Substance Use Disorder Framework (page 9)?		
1	No	Dec 28, 2014 11:46 AM
2	No.	Dec 26, 2014 5:00 PM
3	1. methadone as an OST is not mentioned. It is important; treatment provides beginning of structure for individual, accountability, at a minimum crime reduction and ideally a return or access to a productive life with purpose and meaning. 2. !2-step is mentioned separately from formal treatment. 12-step is not always appropriate (meth cooks, sometimes dealers, are stigmatized), sometimes it is contraindicated (sufferers of severe PTSD -- meetings often contain trauma narratives). 12-step has a strong Christian orientation and no matter how "higher power" is explained, the orientation is unavoidable and sometimes experienced as rejecting. There is an important other consideration, in that the majority of independent non-profit treatment centers are 12-step oriented and conservative in their standards of "recovery" -- eg, opposed to Suboxone or especially methadone, some even pronounced in suspicion of psychotherapy (I suspect partly related to an assumption -- sometimes true -- of the mental health provider not understanding addiction, partly related to a not infrequent view that effective treatment can only be provided by others in recovery and actively engaged in 12-step groups (otherwise you risk the perceived status of "dry drunk"); there are probably other reasons as well. This has the unfortunate effect of making coordination of care extremely difficult or impossible. So, the framework is lacking a non-12-step informal level of care.	Dec 26, 2014 4:47 PM
4	This framework should include a mental health assessment in addition to SBIRT, conducted by mental health providers.	Dec 26, 2014 1:12 PM
5	No	Dec 26, 2014 12:52 PM
6	The framework lists inpatient and outpatient chemical dependency services as being abstinence-based; and lists harm reduction as needle exchange and overdose prevention. This ignores the role of licensed mental health therapists. Outpatient mental health psychotherapy has great value in the following ways: to assess stages of change, increase insight into the role of substance use in interpersonal and intrapersonal problems, decrease harmful substance use, and treat emotional triggers for substance use such as anxiety and depression, even if the patient is not yet ready to stop using all substances. The most frequent reason given by people not receiving treatment who reported a need for treatment was not being ready to stop. Many patients can benefit from a more flexible approach to treatment, in which abstinence may be an eventual goal, but not a requirement. This report and recommendations should carve out a more significant role for licensed mental health clinicians in its framework.	Dec 26, 2014 12:41 PM
7	I do not find this figure to be self explanatory.	Dec 26, 2014 8:59 AM
8	Inclusion of NAS under "withdrawal management" but showing withdrawal management as a flowchart step after SBIRT may inadvertently continue to confuse physiologic dependence with addiction. Although NAS is withdrawal, it is really a separate identification and treatment process compared with adult and adolescent withdrawal management. I would consider a separate figure to represent identification and management of pregnant women and their newborns.	Dec 25, 2014 10:29 AM

Page 2, Q4. Do you have any changes, additions, or comments about Figure 9: Substance Use Disorder Framework (page 9)?		
9	none	Dec 24, 2014 11:04 AM
10	A pregnant women with a low to moderate substance use disorder should be immediately referred for treatment due to risks to the fetus.	Dec 23, 2014 3:33 PM
11	Two comments.(1) Mental Health Counseling should be included in the Outpatient treatment options (per ASAM) and (2) Harm Reduction as a goal is desirable for some clients rather than a marker on the way to abstinence. While abstinence is desirable, HR may be an acceptable goal for some clients. The scope of HR work goes far beyond needle exchange and outpatient therapy has great value here.	Dec 23, 2014 1:49 PM
12	N/A	Dec 23, 2014 1:04 PM
13	NO	Dec 23, 2014 10:36 AM
14	no	Dec 23, 2014 9:02 AM
15	no	Dec 22, 2014 2:14 PM
16	No changes	Dec 19, 2014 2:38 PM
17	no	Dec 18, 2014 4:00 PM
18	12 Step facilitation is not treatment. It is a recovery support. Consider including other recovery supports in addition to 12 Step facilitation.	Dec 18, 2014 11:49 AM
19	no	Dec 13, 2014 9:30 AM
20	ABSOLUTELY! The main reason I'm writing is that methadone is a Medication Assisted Treatment. It's not even listed there! I feel this is a bias of the committee - no treatment provider from at opioid treatment program (we provide both methadone and buprenorphine) is on the committee. Buprenorphine does not work for everyone with an opioid use disorder. Methadone should have equal or greater emphasis as buprenorphine. It's still the gold standard for treatment of severe opioid use disorders. It's also less expensive with proven outcomes.	Dec 12, 2014 5:02 PM
21	not at this time	Dec 12, 2014 2:14 AM
22	History is very important. By that alone one can identify a large number of at risk patients. For example: at what age did you start smoking or using alcohol? How old were you when first exposed to opiates? Have you had any serious trauma in your life? It is obvious to me that patients on Medicaid or at higher risk for mental health problems and addictive disorders. By promoting universal routine screening it may increase false positives and perhaps even false negatives by making it all just another piece of paper that needs to be completed before being seen. I believe the screens are routinely indicated for high risk settings such as ER's, those settings with a high proportion of Medicaid, or patients with Mental Health issues, pain management centers, etc.. Also, I think the most important aspect of assuring patients get into treatment include Motivational Interviewing techniques and depending on the setting, establishing and maintaining a therapeutic relationship...Delineation of severity is a challenging clinical enterprise by the well trained experts.. Let's not assume	Dec 10, 2014 9:50 PM

Page 2, Q4. Do you have any changes, additions, or comments about Figure 9: Substance Use Disorder Framework (page 9)?

	these issues can be measured accurately like blood pressure or blood sugars..the contextual issues are enormous when it comes to referrals. Integrated treatment is an allusion as long as the silos of care and bureacracies remain. People behave currently based on payorsand regulators. Let's not further extend the delusion that robust integration is possible based on our current system. State laws/policies/and payments/third party payments/incentives actually promote the silos in my opinion. This is first and foremost a system's problem and needs to be addressed as such...blaming or assuming providers will change within the overriding dysfunction is wishful thinking... I would keep it really simple...what are the primary risk factors for substance abuse disorders? Any pcp needs to be made aware of same. If risk factors are present screen appropriately, if screens or risk factors are significant enough refer for a formal evaluation. The prejudices and taboos about addiction are not to be denied or underestimated. To think people will start to believe the world is not flat simply because science says otherwise is not consistent with my experience. To simply think that education will change it without making significant changes to our laws, criminal justice system, and as already outlined governmental bureacracies, silos, etc.... Bottom line...we need to encourage more of a Public Health approach that will deal with the system. Juxtaposing Harm reduction and Abstinence...is misleading..As health providers we want to optimize health outcomes. Abstinence should only be part of the equation when the evidence is clear it will promote optimal outcomes in the patient being seen... The resource requirements are presented in such a way that it appears linear...this is not reality. An opiate dependent pregnant woman might be injured and her baby if withdrawal and abstinence are encouraged... Perhaps a wheel of options...with comprehensive community support in the middle..Non-professional recovery support programs better I believe than even mentioning abstinence...all good responses are harm reduction...there is no perfection and polease get across that addictive disorders are chronic relapsing diseases...get out the mind set...of simply sending the patient here or there and they come back "fixed" because they are now abstinent...That is part of the myth.."Just say No" and you are healed and the problem is over with...In wanting to help let us not perpetuate myths or simple politically expedient/acceptable models... All such forms and schemes should be done with a clear awareness of the myths, the stignmas, false beliefs, impediments, system barriers, etc.. that are out there and clear attention to avoiding them being accentuated..but yes it is a beginning...I'm very critical because this isn't academic for me...I am on the front lines and see people suffering and dying, ending up in jails, etc...because of our cultural beliefs and attitudes...To expect clinical physicians to be leaders in this arena I think is wishful...Strong Public Health leadership which focuses on system changes and gets out of the "blame" game is indicated and is my prescribed intervention. Once the "system" is more functional clinical care and expertise will fall into place.	
23	No	Dec 10, 2014 11:38 AM
24	no changes to offer	Dec 10, 2014 9:03 AM
25	This figure over emphasis diagnosable SUD and does less to address those who need brief intervention and brief therapy. Most people who score in the Risky category would not need withdrawal management and you have an arrow toward this. More should be done to demonstrate the 4 BI and the up to 12 Brief	Dec 9, 2014 1:49 PM

Page 2, Q4. Do you have any changes, additions, or comments about Figure 9: Substance Use Disorder Framework (page 9)?		
	Therapy sessions. In the boxes Treatment and Abstinence you list 12-step facilitation. This is one treatment modality not all of them and is misleading. It should say Individualized Evidenced Based Practices. The five boxes below "resource Requirments" makes it look like the bulk of the SBIRT clients are treatment patient when that is less than 5% of all those screening. If you want to promote SBIRT you should emphasis the strength of the practice which is to motivate those who are using at the risky and harmful levels to reduce their use.	
26	No	Dec 9, 2014 12:07 PM
27	No	Dec 9, 2014 8:25 AM
28	no	Dec 9, 2014 8:12 AM
29	No	Dec 8, 2014 3:49 PM
30	test	Dec 8, 2014 2:34 PM
31	I like it!	Dec 8, 2014 1:29 PM
32	no	Dec 8, 2014 12:28 PM
33	If doctors were to recommend an assessment and treatment, it would have to be someone who sees the patient regularly and has built trust with. If the patient sees a doctor once a year and they spring "treatment" on them, I know they would probably seek a new doctor. Harm reduction should really be the emphasis here...not driving drunk and not binge drinking, spacing it out with water etc.	Dec 8, 2014 9:33 AM
34	Add other options besides 12-Step (ie Rational Recovery). MANY people dislike 12 step d/t issues with religious belief or paternalistic issues, especially for women.	Dec 5, 2014 10:00 AM
35	No	Dec 4, 2014 4:29 PM
36	I can only see it working "IF" someone wants help.	Dec 4, 2014 2:28 PM
37	none	Dec 4, 2014 11:43 AM
38	no	Dec 4, 2014 7:13 AM
39	NO!	Dec 3, 2014 12:02 PM
40	no	Dec 3, 2014 11:40 AM
41	No	Dec 3, 2014 10:43 AM
42	Consider adding a box that talks about the reason for the doctor visit in the first place. (Was it due to an acute injury, general physical etc....?) Does the reason for the visit affect the path of treatment that the individual will go on?	Dec 3, 2014 10:31 AM
43	I like the framework, however these options are not available to the clients I serve (primarily Medicaid/Medicare) We have no medical detox at home and	Dec 3, 2014 10:29 AM

Page 2, Q4. Do you have any changes, additions, or comments about Figure 9: Substance Use Disorder Framework (page 9)?		
	often I find clients in withdrawal at home, PCPs don't know how to manage and the only option is to send them to ER which usually does not work well. Clients are submitted to long waits and often sent back home, the withdrawal unaddressed. Besides all the appropriate treatment strategies mentioned mindfulness meditation would also be a helpful tool.	
44	see # 10 below	Dec 3, 2014 10:26 AM
45	No	Dec 3, 2014 9:57 AM
46	No	Dec 3, 2014 8:40 AM
47	No	Dec 3, 2014 8:11 AM
48	no	Dec 2, 2014 10:00 PM
49	no changes recomended	Dec 2, 2014 3:23 PM
50	no	Dec 2, 2014 2:08 PM
51	No	Dec 2, 2014 12:22 PM
52	no	Dec 1, 2014 5:15 PM
53	No	Dec 1, 2014 1:40 PM

Page 2, Q6. Do you have any changes, additions, or comments to this recommendation?		
1	No	Dec 28, 2014 11:46 AM
2	While I generally agree with the proposal, I find the proposed “universal” screening for “all patients over age 12” is troublesome, in particular given no descriptions on how informed consent is required or being implemented in the screening process. I think informed consent is essential to guard patients’ rights and to avoid potential abuse by healthcare providers. This may be particular critical for some vulnerable populations like minors, elderly, and patients on Medicaid.	Dec 26, 2014 5:00 PM
3	Probably my comments for the "problem statement" are appropriate here.	Dec 26, 2014 4:47 PM
4	The prevalence of co-existing disorders should be added to ways to reduce stigma for both substance abuse and mental health disorders.	Dec 26, 2014 1:12 PM
5	No	Dec 26, 2014 12:52 PM
6	I feel that many people who have alcohol and drug problems actually have mental addictions and need mental help rather than medical. I do not see this mentioned. I would recommend that this be added.	Dec 26, 2014 8:59 AM
7	Acknowledge necessary cultural competency.	Dec 24, 2014 11:04 AM
8	I would modify the first statement about prescribing slightly. We seem to be in this cycle where we go back and forth with either under-treating pain or prescribing too many opiods and ending up with too many opiods on the open market. I would suggest that instead, we change that statemet to say something like "reduce the inappropriate prescription of opiods to treat chronic pain", because certainly for some acute circumstances (surgery, trauma), limited use of narcotic pain medicaiton is often medically appropriate; however chronic narcotic use has not been shown to improve long-term pain control in chronic pain patients.	Dec 23, 2014 3:33 PM
9	Reducing stigma is important, but not a direct treatment issue. Better strategies need to be developed to reduce stigma and they need to be adequately funded.	Dec 23, 2014 10:36 AM
10	Stigma is involved on the part of health care professionals, many of whom are ill-trained in substance abuse generally, and in SBIRT more specifically, not seeing this as part of their "territory" and not know how to do screening and what to do with screen-positives; stigma also affects the patient, many of whom will minimize their alcohol and drug use and many of whom, even when provided a referral for treatment, will not seek specialty care for substance use disorders.	Dec 23, 2014 9:02 AM
11	Have a robust treatment community to insure a higher rate of successful outcomes	Dec 22, 2014 2:14 PM
12	No	Dec 19, 2014 2:38 PM
13	no	Dec 18, 2014 4:00 PM
14	I have not looked at the evidence for what works to reduce stigma, but I feel that it's going to take a lot more than training health care staff although that's a great place to start. How about training judiciary, law enforcement, spiritual and other	Dec 12, 2014 5:02 PM

Page 2, Q6. Do you have any changes, additions, or comments to this recommendation?		
	communities.	
15	I would like to see more drug and ETOH treatment centers.	Dec 12, 2014 2:14 AM
16	If one can hammer it out that addictive disorders can reflect true and unequivocal brain disease. That the disease effects the brain diffusely but has known patho-physiology at least equivalent to most chronic life-threatening diseases. I think if Americans could come to accept that it is a complex chronic and relapsing disease such as diabetes but that it is often more deadly and warrants prompt and robust interventions to preserve life and limit disability...this is the most effective way to address the stigma...there are a lot of empathetic, caring physicians out there who project shame on these patients...because they simply don't accept it as a disease...Example: Patient calls and wants an appointment for their back pain...when they are told that the practice doesn't prescribe opiates for back pain the patient is concerned and asks questions but is addressed in a way far from inviting and the practice manager and the caring physician are relieved that they did not have to care for this sort of patient! The case involved a practice that prescribes buprenorphine for opiate dependent patients!...That is clearly educated etc...clearly intelligent, caring, empathetic...but they don't get it! We need specialized centers where the entire staff is trained and "gets it"...boundaries, co-dependence, and a host of issues come up with dealing with addictive disorders. These centers could be places where students and clinicians could come to see how care for these disorders can be provided in accepting, respectful, yet safe environment. Do not expect the typical outpatient family practice to be able to effectively address patients who are struggling with serious addictive disorder. Based on my experience that is naive.. Until students and young physicians have better mentoring I vote for regional centers for excellence...similar to what we do for cancer and the like. Eventually, we could be more like England or France where any GP has the privilege of addressing addiction because the social support, regulatory concerns etc...are not the same as in the USA. We voted for prohibition less than 100 years ago!...similar attitudes persist..shortly thereafter federal courts decreed that there was no place for physicians treating addictions. Where else in the world did this happen?	Dec 10, 2014 9:50 PM
17	More needs to be done to normalize SBIRT and having conversation about alcohol and other drug use. The majority of people do not have a SUD.	Dec 9, 2014 1:49 PM
18	No	Dec 9, 2014 12:07 PM
19	Doctors are well equipped to educate patients on the harm of alcohol, but not so much when it comes to crack or heroin e.g. and I just worry about drug users going to doctors as with the ACA they are slowly getting back into primary care facilities, and I worry of them being scared because they do not like to be told what to do. If a doctor tells them they need to stop, this is not news to them so the doctors should really be educated in this! They are not going to stop using just because you tell them its bad for their health, but if you bring up HepC can be transmitted if you are sharing pipes or syringes, lets test you, it comes from a caring place instead of disciplinary.	Dec 8, 2014 9:33 AM
20	Reducing stigma is critical; for me, however, having enough treatment resources is a major issue. Many of the treatment facilities, whether inpatient or IOP do not keep up on evidenced based theories and the interventions are "old standards",	Dec 5, 2014 10:00 AM

Page 2, Q6. Do you have any changes, additions, or comments to this recommendation?		
	ie 12 step only; little education regarding brain chemistry, etc.	
21	I don't believe that the average drug user "care" what someone else thinks and certainly not enough to change their behaviors. Again, I think it would only work on one group of abusers - those he want help.	Dec 4, 2014 2:28 PM
22	none	Dec 4, 2014 11:43 AM
23	no	Dec 4, 2014 7:13 AM
24	In training health professionals re: addiction I believe it is important to remember that we have a higher percentage towards addiction ourselves and many of us have been raised in households where addiction was present and these circumstances affect how we interact with our clients/patients	Dec 3, 2014 10:29 AM
25	No	Dec 3, 2014 8:40 AM
26	No approaches or plans as to how to reduce stigma, i.e. advertising, public television snipets, or public education is emphasied as ways for this attitude reduction to be accomplished	Dec 2, 2014 3:23 PM
27	This says we reduce stigma by training staff. Any evidence that this works?	Dec 1, 2014 5:15 PM

Page 2, Q8. Do you have any changes, additions, or comments to this recommendation?		
1	WSPA would recommend that screening be increased in all care settings, and that screening fully integrated with screening for other mental disorders be included as well.	Dec 28, 2014 11:46 AM
2	But see comments above.	Dec 26, 2014 5:00 PM
3	In the case study, it mentions only 21% of those referred to treatment facilities showed up. For many addicts, the first formal admission of their problem is scary. This is a place, in my opinion, for trained social workers. This is to address practical barriers to treatment, to allow the addicted person to experience feeling "normal" with his/her diagnosis and to experience that change is possible. Obviously not everyone will respond. But I think the follow-up is well worth the expense.	Dec 26, 2014 4:47 PM
4	I disagree with this recommendation if it applies only to substance abuse; mental health assessment should be included in these settings tthe same time.	Dec 26, 2014 1:12 PM
5	No	Dec 26, 2014 12:52 PM
6	I feel that there should be some qualifications to the recommendations to screen adolescents starting at age 12. 1. There is no mention that this would have to be done with the parent's permission. I would recommend that these words be added, since I believe any screening or treatment of an adolescent must (by law) only be done with the parent's permission. 2. I would also recommend that some wording be added to indicate that such screening would also only be done with the permission of the adolescent themselves, after all they too have rights.	Dec 26, 2014 8:59 AM
7	I would include a statement/paragraph highlighting screening tools validated in pregnancy. Consider mentioning CRAFFT and 4P/5P approach as well as comment on pitfalls of using urine drug testing as a screening tool (as many places do).	Dec 25, 2014 10:29 AM
8	Found typo in last paragraph on page 11 ("ADUIT" instead of "AUDIT")	Dec 24, 2014 11:04 AM
9	Payment of SBIRT assessments under Medicaid are too low. CMHA providers not afford to do these at the low payment rate.	Dec 23, 2014 10:36 AM
10	Screening for alcohol and drug use in these settings is important, but in the absence of effective brief interventions, referral and linkage to treatment, and increased treatment capacity in specialty care we will have many people identified with problems for whom there may be limited treatment options. Research by the AIMS Center in the MHIP program has shown that few individuals who are screened positive ever enter into specialty substance abuse treatment. There clearly is a need for greater focus on linkage.	Dec 23, 2014 9:02 AM
11	no	Dec 22, 2014 2:14 PM
12	No	Dec 19, 2014 2:38 PM
13	no	Dec 18, 2014 4:00 PM
14	NIH and NIDA have already developed a tool (Helping Patients Who Drink Too Much). Why are we reinventing the wheel?	Dec 12, 2014 5:02 PM

Page 2, Q8. Do you have any changes, additions, or comments to this recommendation?		
15	I would like to have a law implamented that women cannot get their methadone unless they are up to date on depravera shots. We are not taking away their rights to have children, just not now when they are not making appropirate decisions.	Dec 12, 2014 2:14 AM
16	My concern is that the screening is done but the clinicians ans staff do not know how to respond both when positive or negative..they can come across as shaming even as they are expressing deep concern for the patient's benefit. I've seen it and continue to have patients recount horror stories. I suspect we would start to hear things like.."this a questionnaire we are required to provide all patients but don't worry we don't really think you might have a problem like that" The medical director of DSHS I have quoted as saying about patients addicted to opiates something like..Well, if they are not fixed after six months..what's the use? All that being said..routine screening is indicated in high risk settings...	Dec 10, 2014 9:50 PM
17	Pregnancy-specific references are missing.	Dec 10, 2014 11:38 AM
18	I would discourage the use of the CAGE because its aimed at dependent not risky and harmful use and not useful for this application.	Dec 9, 2014 1:49 PM
19	No	Dec 9, 2014 12:07 PM
20	Please add OB providers as a screening point.	Dec 9, 2014 8:12 AM
21	There is a shortage of licensed chemical dependency professionals in the State.	Dec 8, 2014 1:29 PM
22	It depends on the age. The younger the user is the more likely they will at least hear the doctor out, but the older ones will not have the patience. They have heard it a million times before and they will score very high on all the questions asked, but there will be little change. It is unfortunate but has been the main reality I have seen. They have other issues that doctors need to focus on because that is their job-such as injection wounds. Detox and treatment facilities will not accept them with wounds, so that really needs to be taken care of first and foremost.	Dec 8, 2014 9:33 AM
23	Again, this is all well and good to identify; I believe we have a resource crisis, however, when it comes to the next step after the ER.	Dec 5, 2014 10:00 AM
24	Only if the drug or alcohol abuse is impeding the patients recovery. Otherwise - refer to answer #6	Dec 4, 2014 2:28 PM
25	I would suggest that not only screening but actual clinical evaluation be available within the primary care setting. That would require that CDP's be located within primary care settings to provide assessment and care coordination with primary medical.	Dec 4, 2014 11:43 AM
26	no	Dec 4, 2014 7:13 AM
27	compelling medical professionals to look at this is hard -- what is the mechanism that would get PCPs, ER providers to act on what they see?	Dec 3, 2014 11:40 AM
28	I think it would be nice to emphasize the need for health care coordination in assessing the risk for individuals. What if the patient has some clear issues	Dec 3, 2014 10:31 AM

Page 2, Q8. Do you have any changes, additions, or comments to this recommendation?		
	around alcohol and other drugs, but is not able to articulate it to the care provider? I appreciate that the goal is to take away the stigma, but what if the patient still is not able to ask for the help?	
29	This is vitally important - and to have trained professionals in addiction and recovery being in these positions are also vital.	Dec 3, 2014 10:29 AM
30	It is a good idea. However 15 minutes added to a office visit or PE is excessive. We need something faster.	Dec 3, 2014 10:26 AM
31	No	Dec 3, 2014 8:40 AM
32	We are already doing drug and alcohol screening in the ED	Dec 2, 2014 10:00 PM
33	This is a beginning point. What will be done for all the doctor offices where the majority of people are seen.	Dec 2, 2014 3:23 PM
34	this will be abused	Dec 2, 2014 2:08 PM
35	Again this is about training providers on why they should screen, which can be helpful, but I think the more active issue may be what people do with the results.	Dec 1, 2014 5:15 PM

Page 2, Q10. Do you have any changes, additions, or comments to this recommendation?		
1	Yes, The Washington State Psychological Association (WSPA) notes that many patients with undiagnosed substance use disorders self refer to mental health providers. In the Recommendation at the top of page 14, WSPA recommends that substance misuse screening also occur with the diagnostic intake session at outpatient mental health sessions. We also urge documentation of screening in all electronic health records. We recommend that (figure 10, page16) referral to specialty treatment might occur at any point subsequent to "screening." Finally, WSPA acknowledges that this report highlights the current difficulty in accessing well trained - but not just masters level - addiction counselors in this section. However, we repeat, this problem should be front and center in the report's Problem Statement. There is little need to address the myriad issues of treating substance use disorders if our state residents cannot get the help they need.	Dec 28, 2014 11:46 AM
2	If someone tests positive, I suggest automatically screening them for a history of physical abuse/neglect and sexual abuse. Kaiser has done several studies on this topic. Those individuals are high utilizers of services (with real diseases) and present needs that are most often not addressed because they are not screened for. The overwhelming number of addicted women are sufferers of PTSD. I have seen countless relapses on particular anniversary dates or other PTSD-relevant criteria. In addition to counseling, drugs like Campral are really helpful to reduce cravings when PTSD symptoms escalate and the patient is struggling with new skills to handle symptoms. Acknowledgement and acceptance of these mental illness-related dilemmas is important. It might be helpful to have two other follow-up investigations: sleep and pain. Sleep medications or the consequences of chronic fatigue are often culprits in addiction. If possible, a primary source of sleep difficulty needs to be identified. At the same time that sleep studies are done, group CBT for insomnia should be an automatic recommendation. This is true even for sleep apnea, as we all are subject to beliefs about sleep and these beliefs tend to support our experience. I do not know of a single group CBT for insomnia in Central WA, let alone one that would permit the low-income patient. Patient education integrated in the Primary Care environment could address this. Pain is tricky. An addicted person may have significant real pain. The pain needs still need to be addressed and it needs to be understood that pain is subjective. Medications can be managed and dispensed in small quantities by pharmacies. Non-pharmaceutical pain management education courses need to be available. Again, these need to be at no-cost for low-income patients and accessible in the familiar surroundings of the primary care clinic. Patient education programs in general need to be available. This needs to be a number of sessions over a course of 6 to 8 or maybe even 12 weeks. Mindfulness-based CBT for Depression is just about exactly what is done for addiction treatment. Again, it needs to be clear you cannot assume the quality or type of treatment a person will receive at a particular facility. Some treatment can (unintentionally) be harmful to the patient.	Dec 26, 2014 4:47 PM
3	I agree with this recommendation as long as abstinence is not the only follow up treatment and mental health treatment is also an option.	Dec 26, 2014 1:12 PM
4	No	Dec 26, 2014 12:52 PM
5	The report states, "The amount of trained masters-level addiction counselors is not currently adequate to meet the growing population need," but does not go on to call for any strategies to increase the number of Masters-level therapists with specialty training in addiction. This is especially important because of the	Dec 26, 2014 12:41 PM

Page 2, Q10. Do you have any changes, additions, or comments to this recommendation?		
	magnitude of people with co-occurring mental health disorders. It is well documented that at least half of those with a substance use disorder also have a mental health disorder. Licensed mental health therapists have the scope of practice necessary to treat patients with co-occurring disorders. To call on "competency-based counselors" to address this is inadequate.	
6	Once again, I feel that in many cases patients should be referred to a psychologist to deal with alcohol and drugs problems.	Dec 26, 2014 8:59 AM
7	none	Dec 24, 2014 11:04 AM
8	This specifically addresses utilizing appropriately trained Mental Health Professionals.	Dec 23, 2014 1:49 PM
9	No	Dec 23, 2014 10:36 AM
10	While in general I agree, recent research has raised serious questions about the efficacy of SBIRT targeting drug use in both primary care and emergency departments. The U.,S. Preventive Task Force not recommend SBIRT for drug use in either adults or adolescents. Again, there is need for greater focus on linkage to specialty care given limitations of brief treatment	Dec 23, 2014 9:02 AM
11	The concern about brief is that a serious addiction can be overlooked and no intervention takes place.	Dec 22, 2014 2:14 PM
12	No changes	Dec 19, 2014 2:38 PM
13	no	Dec 18, 2014 4:00 PM
14	I'm a little nervous that SBIRT may not actually make that much difference in primary care vs. hospital and emergency department settings.	Dec 12, 2014 5:02 PM
15	not at this time.	Dec 12, 2014 2:14 AM
16	The devil is in the details..but being open and talking about it openly definitely is a move in the right direction. How about requiring smoking status and interventions for tobacco dependence...Is that part of it?...will that be required? If not why not? Tobacco addiction is different? Even though it kills more people? Our prejudices and biases along with system incentives need to be carefully tailored...Again I vote for a thoughtful Public Health perspective that clearly focused on general public well being and looked at systems rather than blaming patients, clinicians, parents, schools, police, etc...	Dec 10, 2014 9:50 PM
17	This section should be highlighted for its importance and effectiveness. But also because its a level of care not provided and not reimbursed (BI is for 4 sessions). The traditional SUD programs are not trained to provided Brief treatment and philosophically and policy wise do not included that in their level of care. DBHR has not reimbursed for this level of care. Thi is more akin to the EAP role and should be developed and reimbursed. I like the graph on page 16 showing primary care addressing this level. Not sure in the Specialty World are ready to do this.	Dec 9, 2014 1:49 PM
18	No	Dec 9, 2014 12:07 PM

Page 2, Q10. Do you have any changes, additions, or comments to this recommendation?		
19	In a hospital setting I am not sure how good screenings will be from a treatment standpoint....medically it makes perfect sense, but what I like most about recommendation three is the followup. That will show the patient that their best interest is really being taken into account instead of just part of the hustle and bustle of an ER. I once again worry that addicts are slowly regaining the trust to go see doctors, and the last thing they need is to be bombarded with (negative) questions of their drug use.	Dec 8, 2014 9:33 AM
20	only in principal. As a WA resident, non drinker, non drug user I do not want the cost of my medical care driven up to facilitate programs that... see #6	Dec 4, 2014 2:28 PM
21	Yes. The real work is done in after care. You need to focus efforts on bridging patients to the community resources and increase support programs to help them maintain sobriety and deal with common stressors that may be triggers.	Dec 4, 2014 7:13 AM
22	We need treatment centers in the community that can respond in a timely manner, it is best to talk with the client during the crisis if at all possible. We also need professionals who can do home visits for people who are homebound.	Dec 3, 2014 10:29 AM
23	It depends on what is "brief treatment" for drug misuse. Treatment for Opioid abuse (not just threw withdrawal can and frequently is lengthy due to the nature of the changes that occur in the brain with opioid abuse.	Dec 3, 2014 10:26 AM
24	No	Dec 3, 2014 8:40 AM
25	Increase not only the primary care and emergency room but all health care facilities	Dec 2, 2014 3:23 PM
26	These people who are providing brief intervention should be skilled in chemical dependency and know local resources available for services if needed. Seamless referral process should be in place.	Dec 2, 2014 12:22 PM

Page 2, Q12. Do you have any changes, additions, or comments to this recommendation?		
1	The fact that "79% of patients referred to an external treatment agency as part of phase 1 of the WA-SBIRT program did not engage in treatment" should have been at the start of the Problem Statement. The Washington State Psychological Association (WSPA) agrees with the statement that all referrals should comply with ASAM placement criteria. To this end, WSPA recommends as we did in the answer to this questionnaire's question #10 above. Referral to specialty providers, including those competent to diagnose co-occuring mental disorders should be available earlier in your treatment recommendations.	Dec 28, 2014 11:46 AM
2	There is an important role for social workers here -- actually taking a client through from primary care to treatment center/mental health/psychiatric care is so important. Admission of addiction and then self-motivating to follow-through with recommendations is a huge order. Contacting the patient following the diagnosing event, even offering transportation to the Center or other setting (this is relationship-based rather than need-based -- letting the patient know someone cares), de-mystifying the unknown -- until the patient is established in the new routine of treatment. This role is critical to engagement.	Dec 26, 2014 4:47 PM
3	I agree with this recommendation as long as there is an outpatient mental health treatment option.	Dec 26, 2014 1:12 PM
4	No	Dec 26, 2014 12:52 PM
5	While I support the expanded use of SBIRT in healthcare settings as an important strategy to reduce stigma and increase the number of people with substance use disorders receiving care, I disagree with the singular focus on referrals to chemical dependency agencies. The expanded use of SBIRT is a step forward in the medical setting, what is missing is a collaboration with the mental health system of MH agency and private practice therapists. The Report acknowledges that 79% of patients referred to an external treatment agency as part of phase 1 of the WA- SBIRT program did not engage in treatment; and acknowledges that the prime reason patients do not engage in treatment is that they are not ready to quit. Yet, no mention is made of the role of licensed mental health therapists who are willing and able to treat patients with substance use disorders, even before they are ready to commit to abstinence. Again, the report is also missing the role of licensed mental health therapists in treating the large number of people with co-occurring mental health and substance use disorders. Both the National Survey on Drug Use and Health and the National Epidemiologic Survey on Alcohol and Related Conditions have demonstrated that people with substance use disorders more often receive care in mental health settings than chemical dependency settings, yet this Report's recommendations make almost no mention of this care in the treatment of addictions.	Dec 26, 2014 12:41 PM
6	Add refer alcohol and drug patients to psychologists.	Dec 26, 2014 8:59 AM
7	Additional comments around cultural competency would also be helpful in this section.	Dec 24, 2014 11:04 AM
8	Washington state has a serious lack of facilities to provide appropriate treatment.	Dec 23, 2014 3:33 PM
9	Appropriate treatment must include skilled, dually licensed mental health professionals to provide co-existing disorder treatment which CDP's are not	Dec 23, 2014 1:49 PM

Page 2, Q12. Do you have any changes, additions, or comments to this recommendation?		
	licensed to provide.	
10	NO	Dec 23, 2014 10:36 AM
11	This is critical given he evidence that has been generated within Washington State, where a very small percentage of individuals screened positive i n primary care for substance use disorders ever make it into specialty care, even though they have been provided with a referral.	Dec 23, 2014 9:02 AM
12	no	Dec 22, 2014 2:14 PM
13	no	Dec 18, 2014 4:00 PM
14	I was relieved to see the references and support for use of the ASAM criteria. Something left out is that many treatment facilities are abstinence-only. That limits options for medication assisted treatment in residential settings. I think it would be helpful if this report made it clear that medication assisted treatment is the standard of care for some disorders, such as alcohol and opioid use disorders.	Dec 12, 2014 5:02 PM
15	not at this time.	Dec 12, 2014 2:14 AM
16	I would focus on widespread system changes and the involvement of Public Health to assure this happens..	Dec 10, 2014 9:50 PM
17	Addictions in pregnancy often need services specific to pregnant women. I do not see any mention of this population.	Dec 10, 2014 11:38 AM
18	reduce barriers for older adults and medically fragile individuals to obtain an appropriate referral and access to the services	Dec 10, 2014 9:03 AM
19	But I would caution referring client who need brief treatment to programs that are accustomed to providing Full Treatment. This would be the wrong medicine and could cause more harm than help.	Dec 9, 2014 1:49 PM
20	No	Dec 9, 2014 12:07 PM
21	Increase capacity for Mothers and babies so that they are not separated during treatment.	Dec 9, 2014 8:12 AM
22	Many of the new insurance plans through the ACA have very high deductibles making treatment an unobtainable option for many who can not afford the deductible.	Dec 8, 2014 1:29 PM
23	There are so few treatment facilities for pregnant and newly delivered mothers, it is pitiable - we need more facilities to care for/treat pregnant women who use alcohol/drugs	Dec 8, 2014 12:28 PM
24	I feel that with the doctor, their position should only be for referrals, anything else is too much. Hospitals are a great place for intervention and outreach, but if someone knows that if they go to the hospital they will be inundated with these questions, they may not go. We want to keep them out of the ER and we want them to go see their primary doctor as much as needed, and we need to work on keeping it that way. Once again they can not go into detox/treatment with	Dec 8, 2014 9:33 AM

Page 2, Q12. Do you have any changes, additions, or comments to this recommendation?		
	wounds, which almost all users have, so this should be the primary focus in treatment of their drug use at a hospital.	
25	The barriers are many! Not enough detoxification services available prior to treatment. Also, detoxification services are barely (at best) adequate. Most patients enter inpatient treatment still in a post acute withdrawal phase and are not ready for the hard work of focusing on recovery.	Dec 5, 2014 10:00 AM
26	Adamantly opposed to Federal intervention and again not willing to pay for others that won't help themselves.	Dec 4, 2014 2:28 PM
27	This is why its important to embed the CDP in primary care to facilitate referrals to appropriate care that isn't able to be provided in the primary care setting but requires an assessment to access.	Dec 4, 2014 11:43 AM
28	no	Dec 4, 2014 7:13 AM
29	No	Dec 3, 2014 8:40 AM
30	There aren't any treatment facilities. If there were, I would agree with this	Dec 2, 2014 10:00 PM
31	Identification of barriers especially the lack of knowledge of what is avalable to the community is very little known in the medical community	Dec 2, 2014 3:23 PM

Page 2, Q14. Do you have any changes, additions, or comments to this recommendation?		
1	no	Dec 28, 2014 11:46 AM
2	The concept and the general approach are good. But, I am concerned about the proposal to increase Buprebrohine treatment availability. Recent reports have shown some new concerns about Suboxone, which has not been proved to be the silver bullet for opioid addiction treatment. I would recommend more studies done with Washington population and more educations on both prescribing physicians and patients, before recommending to increase Buprebrohine treatment availability.	Dec 26, 2014 5:00 PM
3	Pain is complicated, as I noted above, and we are sorely lacking in access to formal non-pharmaceutical pain treatment groups. Acknowledging a patient's perception of pain does not obligate a physician to prescribe opiates but greatly facilitates the relationship going somewhere productive for actual pain management. These are the patients I find who most regret disclosing addiction to their physicians. Physicans could also require these patients to behavioral health care -- both pain-management groups and individual counseling at the physician's discretion (or at least a formal psychiatric evaluation). Pain management for these patients has to be collaborative. Also, mood disorders need to be screened for and treated. Mood disorders frequently co-occur with pain.	Dec 26, 2014 4:47 PM
4	There is no outpatient mental health treatment option available.	Dec 26, 2014 1:12 PM
5	No	Dec 26, 2014 12:52 PM
6	No	Dec 26, 2014 8:59 AM
7	Consider again specific statements regarding opioid dependence in pregnancy. There is a different degree of urgency and more specific recommendations that should briefly be called out in order to clarify appropriate care and the need for more widespread education as well as continued funding for OB/addiction specialty services. I might also consider including a statement about increased provider education for ordering/interpreting urine drug screens as this is an area of widespread misunderstanding and thus misapplication in clinical care.	Dec 25, 2014 10:29 AM
8	none	Dec 24, 2014 11:04 AM
9	I would suggest the amendment from earlier regarding care of chronic pain vs acute or traumatic pain.. I would modify the first statement about prescribing slightly. We seem to be in this cycle where we go back and forth with either under-treating pain or prescribing too many opiods and ending up with too many opiods on the open market. I would suggest that instead, we change that statemet to say something like "reduce the inappropriate prescription of opiods to treat chronic pain", because certainly for some acute circumstances (surgery, trauma), limited use of narcotic pain medicaiton is often medically appropriate; however chronic narcotic use has not been shown to improve long-term pain control in chronic pain patients.	Dec 23, 2014 3:33 PM
10	ASAM criteria specifically include outpatient counseling as a modality & outpatient in mentioned in this recommendation.	Dec 23, 2014 1:49 PM
11	I don't know a lot about this.	Dec 23, 2014 10:36 AM

Page 2, Q14. Do you have any changes, additions, or comments to this recommendation?		
12	Yes -- more individuals in Washington die from drug-related "poisoning" (e.g., overdose) than from car accidentals, with the greatest percentage of these deaths involving opiuates.	Dec 23, 2014 9:02 AM
13	no	Dec 22, 2014 2:14 PM
14	no	Dec 18, 2014 4:00 PM
15	Yes. Please specify the need to expand capacity in the specialized services (OST). Everyone talks about the need to expand OST capacity but the mechanisms by which to do this are not clear (meaning $).	Dec 13, 2014 9:30 AM
16	You mention OBOT buprenorphine, but you leave out OTP (Opioid Treatment Program) methadone treatment. This is a glaring omission that has the flavor of either bias or a blind-spot. Please insert language that includes OTPs and methadone with equal emphasis as buprenorphine. You also left out naltrexone which is a promising treatment that does not yet have a lot of evidence. It is also worth mentioning this. Another recommendation would be for residency training programs to increase their emphasis on training residents in primary care to identify and treat substance use disorders.	Dec 12, 2014 5:02 PM
17	Not at this time.	Dec 12, 2014 2:14 AM
18	No one talked about the "cultural belief" that licit opiates cause a disease different than illicit opiates...why do colleagues continue to believe that almost anyone who is foolish enough to try heroin deserves jail time,,while only 20% or so develop addiction. Meanwhile, when it comes to the oxycodone they prescribe they will confirm only maybe 3-5% get addicted... This sort of cultural bias/prejudice is rampant..and not based on any solid scientific evidence...and I have done a thorough review of the literature on this subject.. Physicians continue to believe simply because the patient needs the opiates for pain management that means they can't be addicted...This is foolish..but reinforced by fears of DEA and state regulators if they properly prescribe an opiate for pain in a patient who is opiate addicted.	Dec 10, 2014 9:50 PM
19	Yes, we need form SBIRT in the school and college systems with an emphasis on the BI and BT. This population can be easily dissuaded from following recommendation if "treatment" is the only choice.	Dec 9, 2014 1:49 PM
20	No	Dec 9, 2014 12:07 PM
21	Identify and work with OB providers to decrease the use of opioid prescriptions during pregnancy.	Dec 9, 2014 8:12 AM
22	I'm not convinced that providing medication assisted treatment in primary care settings would lead to good outcomes. There's more to treating opiate addiction than medication. There are key cognitive, social, and behavioral changes that must simultaneously be supported. Not going to happen in a primary care setting.	Dec 8, 2014 3:49 PM
23	We need more suboxone prescribers. The DEA needs to let physician assistants and RN's prescribe. They also need to increase the yearly number of patients a Doc can prescribe to at any one time. At this time it is 100 and 30 the first year.	Dec 8, 2014 1:29 PM

Page 2, Q14. Do you have any changes, additions, or comments to this recommendation?		
24	I agree in that people should be held accountable. It was bad doctors that created this problem in the first place and so it should be them picking up the pieces and fixing the problem. In saying that, nurses need extra training in the fact that most people are not just seeking pills but that their tolerance is so high, they are in literal pain and giving them more will not likely hurt them. A nurse's and doctor's job is to make patients better, and the more pain you allow them to be in the less likely they will come back to receive medical treatment. That to me is unethical and I hear it every day-drug users are not given enough pain support in the hospital and it angers them greatly	Dec 8, 2014 9:33 AM
25	Yes, however, opiate medications don't have to just apply to cancer pain....Many individuals have severe chronic pain that is not related to cancer. Using cancer only as your basis perpetuates the stigma, in my humble opinion.	Dec 5, 2014 10:00 AM
26	Not willing to pay for someone else's life-choices.	Dec 4, 2014 2:28 PM
27	Yes, however I feel like the use of suboxone/buprenorphine without the daily dose model of Methadone is really not a great plan. Opioid addicts need a lot of structure and accountability. The current Methadone dosing and bundled service model is not effective either as it take the most acute individuals and applies the least amount of counseling. While they dose daily they receive only minimal counseling. Need to have IOP available in addition to daily dosing.	Dec 4, 2014 11:43 AM
28	The issues is not the opioid itself but the individual. Addictive personalities or behaviors need to be identified before prescribing/using opioid. Done through patient history and family collaboration.	Dec 4, 2014 7:13 AM
29	What are ways that providers will be able to collaborate with one another in real time regarding follow up care or referral to a dependency clinic? Are there strategies to ensure that patients once referred and identified as at-risk don't fall through the cracks?	Dec 3, 2014 10:31 AM
30	I go to many MD appts with my clients. PCPs are trying to address chronic pain but are fearful at this point of getting in trouble. When referred to pain clinic our client's wait 2- 4 months and even with those recommendations are not always followed by PCPs. I think they need training on chronic pain vs. addiction. Chronic pain clients often feel that they are viewed as addicts even when following the doctors instructions.	Dec 3, 2014 10:29 AM
31	no	Dec 3, 2014 10:26 AM
32	There is very little detail in this section. How would you recommend increasing capacity to provide medication assisted treatment? You list as a bullet point goal but have no discussion of this which is the most essential part of provided appropriate treatment.	Dec 3, 2014 9:57 AM
33	No	Dec 3, 2014 8:40 AM
34	Currently ED's notify a PCP every time their pt is seen in the Ed. Care plans and care coordination MUST BEGIN WITH THE "Care home"---the PCP Office. Furthermore a hospital has no obligation to continue caring for a patient once they are discharged	Dec 2, 2014 10:00 PM

Page 2, Q14. Do you have any changes, additions, or comments to this recommendation?		
35	Address the rising opioid epidemic is necessary but should be incorporated in existing treatment services. Fads, Waves, and popularities of different drugs comes and goes. Overall adaptability of treatment principals are the same for all chemical addictions. Pharmacology and physical effects and reactions differ with each drug.	Dec 2, 2014 3:23 PM
36	Long over due. Opioid addicts are by far the most difficult population to treatment. It is difficult to work collaboratively with medical staff when an opioid addict presents for services. It is easy for the patient and physician to justify ongoing opioid use leading to significant distress.	Dec 2, 2014 12:22 PM
37	It is not a how, it is a statement of an ideal	Dec 1, 2014 5:15 PM

Page 2, Q15. Do you have any changes, additions, or comments to the Stakeholder-Specific Recommendations (Page 21-23)?		
1	The Washington State Psychological Association (WSPA) supports the recommendations in the Primary Care section of stakeholder specific recommendations. We urge the Bree Collaborative to amend bullet points 11 & 12 in this section to to read "...establish & maintain working relationships with chemical dependency treatment facilities AND OUTPATIENT TREATMENT PROVIDERS." This change suggests the appropriate referral to entities other than inpatient facilities only. WSPA supports the specific recommendations for hospitals, but again offers the recommendation above for bullet points 6 & 7 in this section.	Dec 28, 2014 11:46 AM
2	I would like to recommend the screening be extended to all healthcare providers because their jobs put patients' safety on the line.	Dec 26, 2014 5:00 PM
3	The integration of chemical dependency treatment and mental health is an important mandate that isn't necessarily addressed here. Again, non-clinically educated treatment providers have a place but are sometimes inadvertently guilty of doing harm to patients. I have seen mental health issues exacerbated by "treatment." I have also seen where ignorance on the part of the licensed mental health provider has had negative consequences for the patient. These are really really important issues.	Dec 26, 2014 4:47 PM
4	Mental health clinicians are not included as stakeholders.	Dec 26, 2014 1:12 PM
5	No	Dec 26, 2014 12:52 PM
6	The Report and Recommendations has missed an opportunity to identify strategies to bridge the chemical dependency and mental health systems. The mental health system is not even listed as a stakeholder. The report has erased the role of licensed mental health therapists from the treatment system, even though a licensed mental health therapist office is the most likely place people with substance use disorders receive treatment. The report should 1) identify the role of MH therapists in its framework 2) call for more integration of MH and CD treatment 3) call for more training opportunities for MH therapists wanting to specialize in addictions 4) support the current work being done at DOH to create an expedited path to CDP credentials for licensed MH therapists interested in working in the CD system.	Dec 26, 2014 12:41 PM
7	Add comments from above about screening adolescents, get parents permission and that of the adolescent.	Dec 26, 2014 8:59 AM
8	Specifically include buprenorphine training as a recommendation for primary care; perhaps with a statement about receiving stabilized patients back from specialized treatment and managing them within the primary care environment. This would increase access, knowledge, and comfort in primary care and distribute the burden of management across sites. For hospitals, I would recommend adding a statement to have staff/providers knowledgeable about managing physiologic dependence during hospital admissions as well as appropriate pain management and withdrawal management and transition to treatment facilities. For health plans, continue to encourage removal of time limitations for MAT (such as buprenorphine) as the evidence does not support such restrictions.	Dec 25, 2014 10:29 AM

Page 2, Q15. Do you have any changes, additions, or comments to the Stakeholder-Specific Recommendations (Page 21-23)?		
9	The layout of this section is clear and accessible.	Dec 24, 2014 11:04 AM
10	People who provide care to pregnant women should be included	Dec 23, 2014 3:33 PM
11	At all levels, more and clearer integration of the role of Mental Health Clinicians in SUDs assessment and treatment.	Dec 23, 2014 1:49 PM
12	N/A	Dec 23, 2014 1:04 PM
13	The strategies proposed need to be adequately funded to succeed.	Dec 23, 2014 10:36 AM
14	no	Dec 23, 2014 9:02 AM
15	no	Dec 22, 2014 2:14 PM
16	Requires adjustments to some EMR systems	Dec 19, 2014 2:38 PM
17	no	Dec 18, 2014 4:00 PM
18	For Primary Care Providers include screen for comorbid conditions such as depression, anxiety disorders/trauma issues, treatment in concert with SUD treatment or referral to behavioral health specialits. For Health Plans -- add the word Adequate to reimbursement for SBIRT, current medicaid rates do not include payment for the screening and do not represent the cost or the value of the screening.	Dec 18, 2014 11:49 AM
19	no	Dec 13, 2014 9:30 AM
20	See recommendation in 14 for training. Set standards of care for substance use disorders and measure how treatment providers in different settings do on them. I see no mention for Health Information Exchanges and for programs such as the PDMP or EDIE.	Dec 12, 2014 5:02 PM
21	Not at this time.	Dec 12, 2014 2:14 AM
22	Of course, my perspective is not academic but from the front lines...been there. Education is less important than having proper monitoring...Health care providers are trained and incentivized to be in control, have the right answers, fix the problem...illusions of control are rampant and counter the realities of the value of motivational interviewing and accepting a lack of control of when and where..in order to promote healthier behavior and choices.. Many are still very judgemental about abstinence..Indeed, most clinical trials are based entirely on the outcome of abstinence...While abstinence is often a good predictor of health outcomes in the majority of addictive disorders, in some it isn't, and overall the shift toward optimal health outcomes...progress not perfection, is something the average surgeon/physician is loathe to hear...and in the proper context understandably so. Education is less likely to create the dramatic changes without cultural/system changes and the opportunities to have appropriate mentoring about how most effectively to help someone who has or who one is concerned has a CD problem. CDP's I would suggest be under the direction a licensed physician. CDP's base their expertise on their personal experience...and do not have the training and often the aptitude to understand population based studies, risks vs. benefits, contextual and confounding	Dec 10, 2014 9:50 PM

Page 2, Q15. Do you have any changes, additions, or comments to the Stakeholder-Specific Recommendations (Page 21-23)?

	variables..etc..etc.. Also, they are notorious for neglecting the importance of medical care. I have never had a CDP in a licensed facility refer a patient to me and I have been a specialist in Adddiction Medicine for well over 10 years, board certified etc... Have I referred patients to CD agencies..of course...I recognize the essential value of behavioral care... I think CDP's should she patients only under a physician's supervision. This would require the training of more physicians in addiction medicine..yes...and I vote for that.. Like Physical Therapists and other licensed therapists their skills are to be respected but are not to be used to the exclusion of proven effective interventions. Does any state licensed outpatient CD service routinely recommend naltrexone or other FDA approved medications, despite their clear and unequivocal effectiveness as adjuncts to behavioral interventions...I vote for physician leadership in this field...Most serious addicts have serious co-morbid psychiatric and medical condtions...These patients are arguable some of the most complex and challenging patients..do we want CDPs who have relatively little formal education or aptitude, despite significant and valuable experience, directing the traffic. To me it would be like physical therapists being given greater authority and autonomy than physicians when dealing with musculo-skeletal complaints... This is the reality in our state with regard to CDPs...I want to see our best and brightest at the forefront of leadership and direction. The ASAM placement criteria are relatively arbitrary and were designed for relatively untrained clinicians to help them make complex decisions about treatment...They also served the purpose of justifying care to third parties. It would be like giving a 3rd year medical student an instruction manual on what patients need to be hospitalized..there's some truth in it but really what we want to see is the astute clinician who recognizes complex issues and can process multiple variables determine the best option for the patient.. I think we need to resist simple formulas regarding what a paitent needs or doesn't need..particularly as options are rapidly expanding.. If we develop these tools that are primarily designed for third parties...is this the best way to promote better outcomes or is it not more of...well that's what is paid for so that is what we should do...	
23	Again, obstetric providers are not specifically mentioned. They have transitioned away from a primary physician role over the last decades, but have a population that may not have another provider. Plus, they special needs of pregnant patient, her fetus, and the future newborn are complex and have special requirements.	Dec 10, 2014 11:38 AM
24	add issues related to screening and assessing older adults, substance use is often over looked with this population attributing the symptoms to medication reaction, dementia, or old age.	Dec 10, 2014 9:03 AM
25	Under Primary Care, bullet 10. I would take out the word "addiction" because a majority of youth do not see a specialist. They need to see a BI and BT specialist who understands MI, CBT and skill building. Add: Promote policy to train and reimburse practitioners for BT. Under Health Plans the first bullet, Brief Treatment should be added. Employers, Brief Treatment should be added. Second bullet, add Brief in front of intervention	Dec 9, 2014 1:49 PM
26	No	Dec 9, 2014 12:07 PM
27	No	Dec 9, 2014 8:25 AM

Page 2, Q15. Do you have any changes, additions, or comments to the Stakeholder-Specific Recommendations (Page 21-23)?		
28	Include OB providers as Primary Care Stakeholders.	Dec 9, 2014 8:12 AM
29	I'm not convinced that our system of care needs to foreclose on the ASAM patient placement criteria. There are other level of care utilization systems for behavioral health that can guide placement in an appropriate level of care.	Dec 8, 2014 3:49 PM
30	test	Dec 8, 2014 2:34 PM
31	CD Agencies do not get paid to perform outreach to patients not yet referred to them. Unless the mechanisms for payment change it makes it difficult for treatment agencies to do these kinds of activities.	Dec 8, 2014 1:29 PM
32	see below	Dec 8, 2014 12:28 PM
33	(Under Primary Care) I really like the fact that you would like the basic questioning/screening of drug use to begin when they are teenagers and make this the norm. It will feel less like interrogation if it is a common occurrence. I also like that these questions will be tracked over time	Dec 8, 2014 9:33 AM
34	Co-occurring disorders also have to be addressed; I see no where in this document where it's been addressed. Treatment facilities may say they address co-occurring but they rarely do. Staff need to be trained. Also, I really doubt that a facility is going to communicate with primary care. Primary care RARELY refers to treatment. The communication needs to be with the person who does the assessment; treatment facilities (medicaid) are very poor at post communication or treatment planning prior to release from treatment. It all sounds good on paper but this is unrealistic (the communication with primary care).	Dec 5, 2014 10:00 AM
35	No	Dec 4, 2014 4:29 PM
36	Leave the treatment of drug and alcohol abuse out of the main stream treatment facilities, but make it available to those that want it.	Dec 4, 2014 2:28 PM
37	none	Dec 4, 2014 11:43 AM
38	Address Interpersonal concerns: The disease speaks through these individuals. In being empathetic, remember they are being led by their addiction.	Dec 4, 2014 7:13 AM
39	No!	Dec 3, 2014 12:02 PM
40	no	Dec 3, 2014 11:40 AM
41	No	Dec 3, 2014 10:43 AM
42	No	Dec 3, 2014 10:31 AM
43	No	Dec 3, 2014 10:29 AM
44	no	Dec 3, 2014 10:26 AM
45	no	Dec 3, 2014 9:57 AM

Page 2, Q15. Do you have any changes, additions, or comments to the Stakeholder-Specific Recommendations (Page 21-23)?		
46	No	Dec 3, 2014 8:40 AM
47	No	Dec 3, 2014 8:11 AM
48	no	Dec 2, 2014 10:00 PM
49	Emphasize the need for sufficient funding to deliver services by establishing fully equitable rates to deliver the necessary quality and quanity of needed services	Dec 2, 2014 3:23 PM
50	no	Dec 2, 2014 2:08 PM
51	It is vital to continue keeping all stakeholders involved in the decision making process.	Dec 2, 2014 12:22 PM
52	the long list of things for primary care to do (lots of trainings, new procedures, new reporting, new tracking) aren't going to go far without talking about support and funding.	Dec 1, 2014 5:15 PM
53	No	Dec 1, 2014 1:40 PM

Page 2, Q16. Do you have any changes, additions, or comments to the definitions? (Page 24)		
1	no	Dec 28, 2014 11:46 AM
2	No.	Dec 26, 2014 5:00 PM
3	Illicit drugs need to specifically include synthetics and over-the-counter drugs of abuse, such as ingredients in cough and cold syrups, pills and so on.	Dec 26, 2014 4:47 PM
4	No, not as stated. I believe the definitions should be expanded to include some reference to assessment and treatment of co-existing mental health disorders.	Dec 26, 2014 1:12 PM
5	No	Dec 26, 2014 12:52 PM
6	no	Dec 26, 2014 12:41 PM
7	No	Dec 26, 2014 8:59 AM
8	no	Dec 25, 2014 10:29 AM
9	Add: chemical dependency, substance use disorder	Dec 24, 2014 11:04 AM
10	I would specifically include pregnant women as an at risk population	Dec 23, 2014 3:33 PM
11	No.	Dec 23, 2014 1:49 PM
12	N/A	Dec 23, 2014 1:04 PM
13	NO	Dec 23, 2014 10:36 AM
14	no	Dec 23, 2014 9:02 AM
15	no	Dec 22, 2014 2:14 PM
16	No	Dec 19, 2014 2:38 PM
17	no	Dec 18, 2014 4:00 PM
18	Add medication assisted treatment, stigma, recovery, SBIRT, brief intervention	Dec 18, 2014 11:49 AM
19	no	Dec 13, 2014 9:30 AM
20	You left out designer drugs such SPICE and agents that may be legal or not specifically illegal.	Dec 12, 2014 5:02 PM
21	Not at this time.	Dec 12, 2014 2:14 AM
22	I'm not going to quibble much but I hate the definition of drugs.not including medical use..clearly substances are abused even in the context of them being prescribed for a medical condition. On what rational basis can one include Marihuana in the list when our own State law recognizes it has medical uses. In my opinion benzodiazepine abuse is rampant. Often opiate overdoses are associated with sedative abuse whether prescribed or not.. Indeed, alprazolam, clonazepam, and the rest are widely abused and create significant dependencies, disabilities, and mortality. I think one might just have a rubrique called abused substances...and let go of trying to define drugs..to what end?	Dec 10, 2014 9:50 PM

Page 2, Q16. Do you have any changes, additions, or comments to the definitions? (Page 24)		
	Ends up just reflecting cultural biases predjudices...Indeed, note that tobacco was not even mentioned and it is statistically the #1..killer...yet Marijuana was listed as number one...Hmm..significant bias/prejudices are present in the group, as of course I would expect. I appreciate the request of outside perspectives. Our perspectives are all limited.	
23	No	Dec 10, 2014 11:38 AM
24	no changes to offer	Dec 10, 2014 9:03 AM
25	no	Dec 9, 2014 1:49 PM
26	No	Dec 9, 2014 12:07 PM
27	No	Dec 9, 2014 8:25 AM
28	NO	Dec 9, 2014 8:12 AM
29	No	Dec 8, 2014 3:49 PM
30	test	Dec 8, 2014 2:34 PM
31	No.	Dec 8, 2014 1:29 PM
32	none	Dec 8, 2014 12:28 PM
33	I totally agree with the word 'abuse' as not all drug users are addicted, but per the DSM-V they have taken that word out when describing drug and alcohol problems.	Dec 8, 2014 9:33 AM
34	Additional information about changes in brain chemistry? Damage? Viewing addiction as a progressive disease process that left untreated leads to death?	Dec 5, 2014 10:00 AM
35	No	Dec 4, 2014 4:29 PM
36	No	Dec 4, 2014 2:28 PM
37	none	Dec 4, 2014 11:43 AM
38	no	Dec 4, 2014 7:13 AM
39	No!	Dec 3, 2014 12:02 PM
40	no	Dec 3, 2014 11:40 AM
41	No	Dec 3, 2014 10:43 AM
42	No	Dec 3, 2014 10:31 AM
43	No	Dec 3, 2014 10:29 AM
44	no	Dec 3, 2014 10:26 AM
45	no	Dec 3, 2014 9:57 AM

Page 2, Q16. Do you have any changes, additions, or comments to the definitions? (Page 24)		
46	No	Dec 3, 2014 8:40 AM
47	No	Dec 3, 2014 8:11 AM
48	no	Dec 2, 2014 10:00 PM
49	Somewhere the use of DSM 5 Substance Use disorders need to be matched with these definitions to assist in the transitions required by the CD field by September 30, 2015	Dec 2, 2014 3:23 PM
50	no	Dec 2, 2014 2:08 PM
51	No	Dec 2, 2014 12:22 PM
52	no	Dec 1, 2014 5:15 PM
53	No	Dec 1, 2014 1:40 PM

Page 2, Q17. Are there any aspects of the chemical dependency system that you feel our recommendations should address and do not?		
1	The Washington State Psychological Association (WSPA) would argue that this report does not fully address the degree and significance of co-occuring mental and substance use disorders. If indeed the aim of this report is to "improve and standardize the screening and referral process for drug & alcohol addiction and dependence in Washington State," then fully integrated mental health and substance use screening must occur at all entry points to care. WSPA believes that integrated screening and significantly improved access to care can result in a reduction in the state's suicide level, and increased community wide health. Please note that the vast majority of residents who complete a suicide attempt have a co-occuring mental and substance use disorder AND never see a primary care provider. WSPA urges the Bree Collaborative to make the best use of all entry points to care.	Dec 28, 2014 11:46 AM
2	No.	Dec 26, 2014 5:00 PM
3	The integration of mental health and chemical dependency, beyond treatment providers in different venues with differing protocols occasionally talking with one another -- even that is sometimes hard to accomplish.	Dec 26, 2014 4:47 PM
4	There is an artificial bifurcation of substance abuse and mental health disorders. These frequently co-existing problems should be considered jointly.	Dec 26, 2014 1:12 PM
5	No	Dec 26, 2014 12:52 PM
6	Chemical Dependency agencies play an integral role in the treatment of substance use disorders. However, more can be done to make the system better equipped to treat all people who are in need of care. CD agencies can employ more masters-level licensed therapists to more holistically treat people with co-occurring disorders, become more comprehensive in the integration of families into the primary-patient's care, and offer more individualized care that allows for patients who realize a need for care but are not yet ready for abstinence to get support.	Dec 26, 2014 12:41 PM
7	One area that appears to be totally overlooked in this Bree recommendation, is that all medical professional especially doctors should be screened for annually for alcohol and drug use during work hours. Although it is not a problem for anyone to consume alcohol or use drugs on their own time, it would be a safety issue to the patients for a medical professional to be under the influence of alcohol or drugs while treating patients. I view this to be no different than the screening or airline pilots. No one wants airline pilots to using alcohol or drugs while flying an airplane, nor would be want doctors doing the same while treating patients.	Dec 26, 2014 8:59 AM
8	Pregnancy-specific care - this MUST be highlighted as it is common, widespread, and a critical time to intervene when there is high motivation and access to resources.	Dec 25, 2014 10:29 AM
9	none	Dec 24, 2014 11:04 AM
10	Pregnancy	Dec 23, 2014 3:33 PM
11	Absolutely.The National Comorbidity Study found that roughly half of	Dec 23, 2014 1:49 PM

Page 2, Q17. Are there any aspects of the chemical dependency system that you feel our recommendations should address and do not?		
	respondents who met criteria for a substance use disorder at some time in their lives also met criteria for one or more lifetime mental disorders. There is a role for both Mental Health Clinicians and CDPs to play in the growing need for treatment of SUDs, and these two systems need to become more integrated. This report does not adequately address that issue.	
12	Public Chemical Dependency Agencies are going out of business due to inadequate funding. CD Funding needs to increase as CD services become an entitlement under Medicaid Managed Care/BHOs.	Dec 23, 2014 10:36 AM
13	Outpatient is overused as a means to cut costs. Addiction is a difficult problem requiring strong treatment and continued support.	Dec 22, 2014 2:14 PM
14	no	Dec 18, 2014 4:00 PM
15	Perhaps Chemical Dependency Treatment facilities should be cal behavioral health treatment organizations including CD Tx facilities and mental health clinics	Dec 18, 2014 11:49 AM
16	I would add help educate medical providers and hospital staff on OST services specifically to reduce the stigma associated with this treatment modality.	Dec 13, 2014 9:30 AM
17	Yes, I feel that a very important part of the system that deals with a large number of the sickest and most costly patients was left out or underemphasized. That is methadone treatment for severe opioid use disorders. I don't think of methadone as "opioid substitution" - it's a medication assisted treatment.	Dec 12, 2014 5:02 PM
18	Just proof that the mothers are on birth control.	Dec 12, 2014 2:14 AM
19	Clearly address the lack of a formal Public Health response to the "epidemic"...I have written on the subject and as FACPM I'm convinced that turning this epidemic over to the people best trained to address epidemics, not only from a clinical standpoint, but to bring all players to the table, induce system changes...they are the ones...the institution to best address this problem is in place. Funding and "tradition" along with the stigma of addictions being the domain of the criminal justice system and not the realm of medicine remain strong in our culture. This collaborative has been charged with making the best recommendations...go for it!...we need those who are prepared to say the world is indeed round..even when the majority prefer the flat old world they grew up..	Dec 10, 2014 9:50 PM
20	Pregnancy, fetus, newborn.	Dec 10, 2014 11:38 AM
21	Increase the availability to provide services directed toward older adults.	Dec 10, 2014 9:03 AM
22	The title of the report is good but it doesn't capture the essence of the report. Isn't this about System Redesign and Integration. Helping the medical community with early intervention and helping the treatment community serve clients at a lower level of need. The goals are to close the gap in care, eliminate stigma, increase access to appropriate care and strengthen the outcomes for people with SUD.	Dec 9, 2014 1:49 PM
23	1. Financial constraints/reimbursement rates and low salaries for CDPs. Very	Dec 9, 2014 12:07 PM

Page 2, Q17. Are there any aspects of the chemical dependency system that you feel our recommendations should address and do not?		
	few of the recommendations can be implemented if there are no dedicated financial resources. 2. Maintaining CD counseling as a discrete professional competency whether or not counselors have master's-level training (this was touched upon but deserves more attention).	
24	Care of the pregnant woman with drug or alcohol dependency.	Dec 9, 2014 8:12 AM
25	Lack of treatment providers. If physicians suddenly started referring all the patient they might, there would not be capacity to serve them. Vendor reimbursement rates - insufficient to fund outpatient services - especially in rural areas. Licensing and training barriers to development of an adequate workforce.	Dec 8, 2014 3:49 PM
26	The huge problem of insurance companies that have large deductibles for CD treatment and those that find a way to say they have a CD benefit but do not. There are some employers, Boeing for one, that use third party administrators who won't pay for a licensed chemical dependency professional to provide treatment services. Essentially a benefit without a benefit.	Dec 8, 2014 1:29 PM
27	the care of pregnant women who are users - the paucity of treatment facilities and the difficulty getting pregnant women in to treatment	Dec 8, 2014 12:28 PM
28	The fact that they do not accept clients with wounds, and the fact that it usually takes multiple attempts to reach sobriety. Doctors should know this fact and be gentle when talking about the subject of treatment and fact that it does take multiple tries.	Dec 8, 2014 9:33 AM
29	It appears (I may be wrong) that no one on your panel really represented the harm reduction community or providers from facilities mostly reimbursed by medicaid. Also, I really understand the emphasis upon youth, but the chronically addicted, mentally ill individual is left out and the resources are antiquated and abysmal. The high utilizes group are costing tax payers a huge amount of money. Also, there is no discussion about an involuntary treatment for addictions system; it doesn't exist (don't say Pioneer Center North, b/c it really is voluntary).	Dec 5, 2014 10:00 AM
30	No	Dec 4, 2014 2:28 PM
31	none	Dec 4, 2014 11:43 AM
32	no	Dec 4, 2014 7:13 AM
33	See my comments in the questions listed above.	Dec 3, 2014 10:31 AM
34	Have you also addressed using school nurses and counselors in the school system also as early intervention.	Dec 3, 2014 10:29 AM
35	See comment on # 10.	Dec 3, 2014 10:26 AM
36	How do you recommend capacity for MAT?	Dec 3, 2014 9:57 AM
37	No	Dec 3, 2014 8:40 AM
38	If the state is going to mandate things (for example decrease inappropriate use	Dec 2, 2014 10:00 PM

Page 2, Q17. Are there any aspects of the chemical dependency system that you feel our recommendations should address and do not?		
	of the Emergency Department then they need programs that pt can go to for treatment so they don't come to the ED for treatment. We are required to find inpt psych bed within 12 hours yet there are NONE and if we cannot find a bed in 12 hours (totally UNREALISTIC given the logistics) we MUST discharge them. If you think things are bad now they are only going to get worse. DMHP often refuses to put psych holds on pt because then they would be required to provide services and the State does not want to pay for these services. So everything, including your report, looks fantastic on paper but your recommendations mean nothing if we do not have inpt psych beds and tx facilities. I also think the public has a mistrust about how successful these programs have been in helping people so you will need to prove yourself as well. After all what is the recidivism rate? How many are dying from overdoses?	
39	The overlacking absence for a completely locked down treatment facility in the State of Washington is not addressed. Some facility should have this ability with complete treatment services for clients with the chronic advances of chemical diseases.	Dec 2, 2014 3:23 PM
40	no	Dec 2, 2014 2:08 PM
41	Have programs be more accountable to adhere to the ASAM PPC. There are many programs who continue to offer services as they were designed in 1980's; one size fits all with "cookie-cutter" lengths of stay and intensity.	Dec 2, 2014 12:22 PM
42	We are implementing WASBIRT at our primary care facility but we are having difficulty with provider "buy in" because it is extra work that they don't get paid for.	Dec 1, 2014 1:40 PM

Page 2, Q18. Please provide any general comments here:		
1	The Washington State Psychological Association (WSPA) would like to include here our appreciation of the special focus in this report of screening for and increased access to all types of care for children and adolescents with substance use disorders. We also fully support access to integration of substance use treatment with appropriate and effective mental health services for all of our state's residents, but with a special focus on children and adolescents. Thank you very much	Dec 28, 2014 11:46 AM
2	See above comments.	Dec 26, 2014 5:00 PM
3	A recent NIDA study showed brain changes in adolescent-onset marijuana users that are not present in adult-onset users. This kind of urgency and positive life alternatives need to reach into the schools. Hep C is a big issue. I know of no treatment support group -- simply for those with the diagnosis, not necessarily receiving treatment -- in Central WA. When I ask patients for their genotype or whether or not they know how concerning their viral load is, I have not yet had a patient who knew what I was talking about. Most did not understand the danger of drinking and Hep C. I suspect this is not being addressed in primary care settings. I have seen first hand the benefits of group support, it is amazing to see the dynamic of peer support on this issue. Hep C is a sleeper problem and education is sorely lacking.	Dec 26, 2014 4:47 PM
4	Thank you for the opportunity to submit comments on this important topic and for the work that has gone into the Bree report.	Dec 26, 2014 1:12 PM
5	The Washington Association of Naturopathic Physicians supports the proposed Bree guidelines and supports the inclusion of naturopathic physician primary care providers (NDs) as much as possible in implementing the new system.	Dec 26, 2014 12:52 PM
6	Thank you to the Collaborative members and the important work that they are each doing to improve care for people with substance use disorders. I am very glad to see the expansion of SBIRT and improvements in addressing the opiate-death epidemic.	Dec 26, 2014 12:41 PM
7	One area that appears to be totally overlooked in this Bree recommendation, is that all medical professional especially doctors should be screened for annually for alcohol and drug use during work hours. Although it is not a problem for anyone to consume alcohol or use drugs on their own time, it would be a safety issue to the patients for a medical professional to be under the influence of alcohol or drugs while treating patients. I view this to be no different than the screening or airline pilots. No one wants airline pilots to using alcohol or drugs while flying an airplane, nor would be want doctors doing the same while treating patients.	Dec 26, 2014 8:59 AM
8	Great work, very helpful and easy to read!	Dec 25, 2014 10:29 AM
9	Needs editing -- found multiple typos.	Dec 24, 2014 11:04 AM
10	Great document, but really left out pregnant women, who require treatment more urgently than others but who, due to stigma and other barriers are less able to access care.	Dec 23, 2014 3:33 PM
11	There is validity in the concerns regarding whether sufficient Mental Health	Dec 23, 2014 1:49 PM

Page 2, Q18. Please provide any general comments here:		
	Clinicians are dually licensed to provide treatment for SUD. The fact is that much more integration between Licensed Mental Health clincians, medical providers and addiction treatment agencies is needed and necessary	
12	To Whom It May Concern: I am writing on behalf of the Institute for Clinical and Economic Review (ICER), a non-profit health care research organization located in Boston, MA. We were very interested to read your recent report and felt that it provided a thorough view of the issues surrounding addiction and dependence in the US, but wanted to make you aware of an additional resource that may add further insights to your report. In June of 2014, one of our core programs, the New England Comparative Public Advisory Council (CEPAC), held a meeting to evaluate the comparative clinical effectiveness and value of management strategies for opioid dependence based on an evidence review completed by ICER. The final report, titled “Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options,” provides a comprehensive review of available evidence, economic models, and recommendations to guide policy and practice surrounding treatment of opioid dependence. Inclusion of our findings in your report would provide support to your recommendations, particularly those related specifically to strategies to address the opioid epidemic. To provide a bit of background about our program, CEPAC is a regional body whose goal is to provide objective, independent guidance on the application of medical evidence to clinical practice and payer policy decisions across New England. Backed by a consortium of New England state health policy leaders, CEPAC holds public meetings to consider evidence reviews on a range of topics, including clinical interventions and models for care delivery, and provide judgments regarding how the evidence can best be used across New England to improve the quality and value of health care services. In our report on opioid dependence, ICER reviewed the evidence on comparative clinical effectiveness and value of various strategies to manage the condition, including medication assisted maintenance therapy using either methadone or buprenorphine, as well as short-term withdrawal therapy with or without medication assistance. During the public meeting, CEPAC voted that evidence supports long-term medication-assisted treatment (MAT) with either buprenorphine and methadone as the most clinically effective option for a majority of patients and as the most cost-effective strategy. Our economic models estimate that for every additional dollar spent on maintenance treatment in New England, $1.80 in savings would be seen in the health care system. Based on CEPAC’s discussion during the meeting with a policy Roundtable of experts in the subject of opioid dependence that included clinicians, researchers, payers, policymakers, and a patient representative, key recommendations to guide policy and practice were formed. These recommendations include: •Coordinated efforts are needed to improve access to opioid dependence treatment for the large number of individuals who lack adequate access to high quality care options. Mechanisms that should be considered to accomplish this goal include: •Relaxing limits on the number of patients clinicians can treat • Supporting development of skills and expertise of DATA 2000 waivered physicians to increase capacity and willingness to treat patients •Screening for dependency in primary care settings • Clinicians should individualize treatment, including decisions about medication choice, counseling, and supportive social services, according to an initial assessment of a patient’s baseline severity and unique health care needs. •For most patients, MAT will be more effective than attempts at short-term managed withdrawal. However, short-term managed withdrawal may be a reasonable consideration for	Dec 23, 2014 1:04 PM

Page 2, Q18. Please provide any general comments here:		
	a subset of patients with relatively short-term histories of addiction and less intravenous opioid use. •Develop systems to triage patients entering treatment to the level of care more appropriate for their individual needs in order to support patient-centered treatment and allow for more capacity in the system. •Coordinated care networks allow patients to receive intensive short-term care until stabilized, and then be referred to lower levels of ongoing care. •Mandatory requirements for certain kinds of counseling can have unintended consequences and should be reconsidered to ensure that they are not negatively affecting patient outcomes. • Decisions for counseling should be individualized to each patient. • Mandatory counseling can bottleneck treatment access, since there are not enough counselors to serve every patient with addiction. • Provide treatment for opioid dependence through comprehensive, team-based care with collaboration across health care providers. • Multi-disciplinary care teams can help to address all aspects of dependence. Care teams may include addiction-certified physicians, psychologists, counselors, social workers, and other complementary practitioners that coordinate care and integrate with other medical and psychiatric services, as necessary. • Integration can be complicated by barriers to sharing information across providers to monitor patients as they transition through different treatment systems. For the full list of recommendations and an in-depth explanation of our findings, please review the final report at http://cepac.icer-review.org/wp-content/uploads/2014/04/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf. We hope you find our report to be of value to your initiative as you finalize your report, and please feel free to contact us with any questions about the report or our organization. Erin Lawler Program Coordinator Institute for Clinical and Economic Review Elawler@icer-review.org	
13	The report seems solid and well thought out. There really is not enough focus on the funding crisis in public CD services.	Dec 23, 2014 10:36 AM
14	Insist upon a robust alcohol and Drug treatment community to insure higher percentage of successful outcomes.	Dec 22, 2014 2:14 PM
15	The severe lackof treatment for Substance Abuse in Whatcom County in our greatest barrier to providing quality care while lowering healthcare costs. Plus it's morally wrong to not provide treatment for these folks.	Dec 18, 2014 4:00 PM
16	A line around the importance of improving training on SUD in professional programs would be very helpful - medical students, nursing programs, social work programs, etc. These students of course end up on the front line of the system sooner or later.	Dec 13, 2014 9:30 AM
17	None at this time.	Dec 12, 2014 2:14 AM
18	Thank you for the opportunity to express my opinions...I am thankful for the efforts made by this collaborative. I took the time to respond and be critical because I believe and am hopeful about the value of your endeavors. Of course my aptitude is not to be politically correct. Nonetheless I am confident that my perspectives have value, not only as a seasoned clinician working on the front lines of pain management and addiction medicine, but also one who believes in the value of a robust Public Health response to this concern. So let me finish with a consturctive suggestion: .fund the Jefferson and Clallum County Health Departments to effectively address the opiate epidemic on the north olympic	Dec 10, 2014 9:50 PM

Page 2, Q18. Please provide any general comments here:		
	peninsula. Tom Locke, is a seasoned and capable Health Officer...given him the means as well as the responsibility to effectively address the problem with the help of the CDC, the U of W School of Public Health, and all the expertise and experience of our Public Health institutions as well as the help of all the distinguished addiction medicine specialists who reside in our state. He'll surely assure that the studies to assure that there is more than adequate evidence to reject the null hypothesis are done. Can we afford to continue to go as we have..build more jails and prisons and watch are young people die in the prime of their lives... We must effectively approach this from a system's standpoint...Once again to think clinicians on the front lines with just a little or even a lot more education and encouragement can dramatically change things I believe is naive. I'm about as educated and trained as one can be...and I can say with some confidence, despite my very best efforts, I have been unable to make a significant dent even in our small community. I'm confident it wasn't simply about a lack of money or lack of information or clinical expertise. I admit to a lack of political savvy and a former naivete about the depth and nature of our prejudices in this domain, and the relative ignorance and regulatory zeal that has been used in attempts to quench collective fears. J. K. Rotchford, M.D.	
19	Excellent and much needed work. I offer admiration and appreciation to the work group.	Dec 10, 2014 11:38 AM
20	include older adults in the discussion, other special populations were not mentioned including support for individuals with developmental disabilities and traumatic brain injury who may also be using/miss-using drugs/alcohol	Dec 10, 2014 9:03 AM
21	Thank you for allowing me to comment.	Dec 9, 2014 1:49 PM
22	In our nation's attempt to drive down Rx opiate overdoses, we have driven up heroin use and overdoses. I believe this was an entirely predictable consequence. Perhaps the following points should be considered: 1) Perhaps addicts are "safer" when they have legal access to pharmaceutical rather than street drugs. 1) There needs to be a common-sense approach that recognizes the legitimate prescription of opiates for chronic pain conditions. The current approach seems to create stigma rather than remove it. Patients with a legitimate need for Rx pain medication--especially those on Medicaid--are now "monitored" which can translate to being viewed as criminals. This will do nothing to encourage those who may need help to get it, while creating fear and apprehension in patients. In some cases these individuals will turn to questionable online sources or the illegal drug market.	Dec 9, 2014 12:07 PM
23	I think all hospitals should be equipped with harm reduction resources and talk to patients about this. They will not stop using just because you tell them they need to and it is hurting their health, but what is also hurting their health are things like not using clean needles, and not using a new needle every time. This leads to abscesses, edema, HepC, and on and on, but if they are linked up with their local needle exchange, they can help with the topics doctors can not. They are very useful tools to the health care community and all need to work together for the optimal care of the client.	Dec 8, 2014 9:33 AM
24	Prevention is critical and it's good that it's being addressed and youth really need the emphasis. Again, however, the chronic nature of the disease process isn't really emphasized and how to assist those individuals who are at the further end	Dec 5, 2014 10:00 AM

Page 2, Q18. Please provide any general comments here:		
	of the spectrum. Thanks for all your hard work and for allowing the opportunity to provide feedback.	
25	People should be held accountable for their own actions and the rest of us should not be responsible for paying for their poor choices.	Dec 4, 2014 2:28 PM
26	none	Dec 4, 2014 11:43 AM
27	none	Dec 4, 2014 7:13 AM
28	Good work on a really difficult problem.	Dec 3, 2014 10:31 AM
29	Addiction and early intervention services are desperately needed in our community that are easily accessible for all who need them. I hope that this can happen, everyone deserves a chance to experience recovery.	Dec 3, 2014 10:29 AM
30	It is very difficult to have ANYsympathy for those who abuse drugs, give birth to THREE babies (separate pregnancies) born with deformities because of meth use during pregnancy, to have all three of those children taken away by the state and to then get pregnant a FOURTH TIME--all on the taxpayers dime. This was a real case I dealt with. And if you try to provide help they refuse to answer their phone, or they live on the street and you cannot find them. It is not a question of people having a prejudice but DISGUST for what we are seeing in healthcare. These patients suck the resources and the life out of our system and deny other pt who want help, the help they need. When asked if they want help, they flat out tell us they do not want help-they just want detox so they can lower to dose of the drug they are taking so it is a more affordable habit. Let's get real here.	Dec 2, 2014 10:00 PM
31	There needs to be an emphasis for fully co-occurring services needed by the greater majority of addicted clients including all the necessary support services of housing, transportation, vision care, food and other needed support services so that clients can successfully be rehabilitated	Dec 2, 2014 3:23 PM
32	Changes have to made in the legal system. One person gets a felony arrest and their job is gone....this is wrong. Addiction is a horrible thing, but losing your job will not allow treatment to proceed if the person cant entered rehab because they have to keep a roof over their families head thus keeping the person for becoming clean.	Dec 2, 2014 2:08 PM
33	None	Dec 2, 2014 12:22 PM

Page 3, Q19. Name:		
1	Lucy Homans, Ed.D Licensed Psychologist Director of Professional Affairs	Dec 28, 2014 11:48 AM
2	Yanling Yu, PhD	Dec 26, 2014 5:00 PM
3	Maureen Gatt, PhD	Dec 26, 2014 4:48 PM
4	Laura Groshong, LICSW	Dec 26, 2014 1:13 PM
5	Robert May, ND	Dec 26, 2014 12:52 PM
6	Lara Okoloko, LICSW	Dec 26, 2014 12:50 PM
7	Rex Johnson	Dec 26, 2014 9:00 AM
8	Abi Plawman, MD	Dec 25, 2014 10:30 AM
9	Anna McConnell	Dec 24, 2014 11:04 AM
10	Katy Drennan	Dec 23, 2014 3:33 PM
11	Abby Smith, MA, LMHC, CDP	Dec 23, 2014 1:50 PM
12	Erin Lawler	Dec 23, 2014 1:04 PM
13	Greg Long	Dec 23, 2014 10:37 AM
14	Dennis Donovan, Ph.D.	Dec 23, 2014 9:03 AM
15	Deborah Wright	Dec 22, 2014 2:14 PM
16	Kevin Abel	Dec 19, 2014 2:38 PM
17	Lynnette Treen	Dec 18, 2014 4:00 PM
18	Geoff Miller	Dec 18, 2014 11:49 AM
19	Molly Carney	Dec 13, 2014 9:31 AM
20	David Beck, MD	Dec 12, 2014 5:03 PM
21	Colleen Widden, RN	Dec 12, 2014 2:15 AM
22	J. K. Rotchford, M.D.	Dec 10, 2014 9:52 PM
23	Marcia Gould Rohlik	Dec 10, 2014 11:39 AM
24	Ruth Leonard	Dec 10, 2014 9:03 AM
25	David Jefferson	Dec 9, 2014 1:50 PM
26	Alice Buckles	Dec 9, 2014 8:25 AM
27	Debbie Raniero MBA, RNC Regional Director, Franciscan Family Birth Centers, Lactation and Childbirth Education.	Dec 9, 2014 8:13 AM

Page 3, Q19. Name:		
28	Mike McIntosh	Dec 8, 2014 3:49 PM
29	Donna Wells	Dec 8, 2014 1:29 PM
30	Madeline Meisburger	Dec 8, 2014 9:35 AM
31	Rachel Diaz, LICSW; CDP	Dec 5, 2014 10:01 AM
32	Ramona Graham	Dec 4, 2014 4:29 PM
33	Janine L Coaxum	Dec 4, 2014 7:13 AM
34	Steven C. Pepping	Dec 3, 2014 12:03 PM
35	David Newman	Dec 3, 2014 11:40 AM
36	Karen Langer	Dec 3, 2014 10:44 AM
37	Patrick Koenig	Dec 3, 2014 10:33 AM
38	Denise Porter	Dec 3, 2014 10:29 AM
39	Abby Schmitz	Dec 3, 2014 8:40 AM
40	Hae Man Song	Dec 3, 2014 8:12 AM
41	Lorenzo L. Driggs	Dec 2, 2014 3:25 PM
42	Melody Lorenzo	Dec 2, 2014 12:22 PM
43	Kathleen M. Farrell DO	Dec 1, 2014 1:41 PM

Page 3, Q20. Email address:		
1	lucy.homans@gmail.com	Dec 28, 2014 11:48 AM
2	yy8@uw.edu	Dec 26, 2014 5:00 PM
3	maureentgatt@gmail.com	Dec 26, 2014 4:48 PM
4	lwgroshong@comcast.net	Dec 26, 2014 1:13 PM
5	executive@wanp.org	Dec 26, 2014 12:52 PM
6	lara.okoloko@caresnw.com	Dec 26, 2014 12:50 PM
7	wapatientrights@gmail.com	Dec 26, 2014 9:00 AM
8	abigail.plawman@multicare.org	Dec 25, 2014 10:30 AM
9	annamc@smh.org	Dec 24, 2014 11:04 AM
10	kathryn.drennan@multicare.org	Dec 23, 2014 3:33 PM
11	aclcounseling@gmail.com	Dec 23, 2014 1:50 PM
12	Elawler@icer-review.org	Dec 23, 2014 1:04 PM
13	greg_long@nsmha.org	Dec 23, 2014 10:37 AM
14	ddonovan@uw.edu	Dec 23, 2014 9:03 AM
15	debwright@wamedes.com	Dec 22, 2014 2:14 PM
16	kabel@lcch.net	Dec 19, 2014 2:38 PM
17	letreen@hinet.org	Dec 18, 2014 4:00 PM
18	geoff.miller@kingcounty.gov	Dec 18, 2014 11:49 AM
19	mcarney@evergreentx.org	Dec 13, 2014 9:31 AM
20	davidlbeckmd@gmail.com	Dec 12, 2014 5:03 PM
21	cebwidden@hotmal.com	Dec 12, 2014 2:15 AM
22	JKRotchford@gmail.com	Dec 10, 2014 9:52 PM
23	mrohlik@masongeneral.com	Dec 10, 2014 11:39 AM
24	leonamr@dshs.wa.gov	Dec 10, 2014 9:03 AM
25	davidj@co.skagit.wa.us	Dec 9, 2014 1:50 PM
26	abuckles@nhccspokane.org	Dec 9, 2014 8:25 AM
27	debbieraniero@fhshealth.org	Dec 9, 2014 8:13 AM

Page 3, Q20. Email address:		
28	mmcintosh@co.grays-harbor.wa.us	Dec 8, 2014 3:49 PM
29	donnaw@ccsww.org	Dec 8, 2014 1:29 PM
30	madey@nasen.org	Dec 8, 2014 9:35 AM
31	oracheldiaz@gmail.com racheld@etsreach.org	Dec 5, 2014 10:01 AM
32	rgraham@chs-nw.org	Dec 4, 2014 4:29 PM
33	jlcoaxum@gmail.com	Dec 4, 2014 7:13 AM
34	peacefulsolutions@earthlink.net	Dec 3, 2014 12:03 PM
35	dnewman@cpcwa.org	Dec 3, 2014 11:40 AM
36	klanger@cityu.edu	Dec 3, 2014 10:44 AM
37	patrick.koenig@wsiassn.org	Dec 3, 2014 10:33 AM
38	dporte1@co.pierce.wa.us	Dec 3, 2014 10:29 AM
39	Abigail.Schmitz1@millercoors.com	Dec 3, 2014 8:40 AM
40	hsong@co.pierce.wa.us	Dec 3, 2014 8:12 AM
41	ldriggs@newta.org	Dec 2, 2014 3:25 PM
42	awakenings04@live.com	Dec 2, 2014 12:22 PM
43	kfarrell25@midwestern.edu	Dec 1, 2014 1:41 PM

Page 3, Q21. Organization:		
1	Washington State Psychological Association	Dec 28, 2014 11:48 AM
2	Washington Advocates for Patient Safety	Dec 26, 2014 5:00 PM
3	Catholic Family and Child Service, Wenatchee	Dec 26, 2014 4:48 PM
4	Washington State Society for Clinical Social Work Washington State Coalition of Mental Health Professionals and Consumers	Dec 26, 2014 1:13 PM
5	Washington Association of Naturopathic Physicians	Dec 26, 2014 12:52 PM
6	Center for Advanced Recovery Solutions (private practice) & member of the legislative committee of the Washington State Society for Clinical Social Work (WSSCSW)	Dec 26, 2014 12:50 PM
7	Washington Advocates for Patient Safety	Dec 26, 2014 9:00 AM
8	MultiCare East Pierce Family Medicine	Dec 25, 2014 10:30 AM
9	Sound Mental Health	Dec 24, 2014 11:04 AM
10	Multicare Regional Maternal-Fetal Medicine	Dec 23, 2014 3:33 PM
11	Washington State Coalition of Mental Health Professionals and Consumers	Dec 23, 2014 1:50 PM
12	Institute for Clinical and Economic Review	Dec 23, 2014 1:04 PM
13	North Sound Mental Health Administration (RSN)	Dec 23, 2014 10:37 AM
14	Director, Alcohol & Drug Abuse Institute Professor, Psychiatry & Behavioral Sciences University of Washington School of Medicine	Dec 23, 2014 9:03 AM
15	self	Dec 22, 2014 2:14 PM
16	Lake Chelan Community Hospital	Dec 19, 2014 2:38 PM
17	WAHA	Dec 18, 2014 4:00 PM
18	King County MHCADSD	Dec 18, 2014 11:49 AM
19	Evergreen Treatment Services	Dec 13, 2014 9:31 AM
20	Washington Society of Addiction Medicine	Dec 12, 2014 5:03 PM
21	Swidish Hospital. First Hill Campus.	Dec 12, 2014 2:15 AM
22	OPAS P.C. Past President of Washington Chapter of Addiction Medicine	Dec 10, 2014 9:52 PM
23	Mason General Hospital & Family of Clinics	Dec 10, 2014 11:39 AM
24	Division of Behavioral Health and Recovery	Dec 10, 2014 9:03 AM
25	Answering as Advocate for services.	Dec 9, 2014 1:50 PM

Page 3, Q21. Organization:		
26	New Horizon Care Centers	Dec 9, 2014 8:25 AM
27	Franciscan Health System	Dec 9, 2014 8:13 AM
28	Grays Harbor County Regional Support Network	Dec 8, 2014 3:49 PM
29	Catholic Community Services Recovery Centers	Dec 8, 2014 1:29 PM
30	Reach Project Evergreen Treatment Services Seattle, WA	Dec 5, 2014 10:01 AM
31	Center for Human Services	Dec 4, 2014 4:29 PM
32	Dept of Commerce	Dec 4, 2014 7:13 AM
33	Puyallup Tribal DV Treatment Program.	Dec 3, 2014 12:03 PM
34	Community Psychiatric Clinic	Dec 3, 2014 11:40 AM
35	City University Counseling Center/City University of Seattle	Dec 3, 2014 10:44 AM
36	Washington Self-Insurers Association	Dec 3, 2014 10:33 AM
37	Pierce County Aging and Disability Resources	Dec 3, 2014 10:29 AM
38	MillerCoors	Dec 3, 2014 8:40 AM
39	Pierce County Community Connections	Dec 3, 2014 8:12 AM
40	North East Washington Treatment Alternatives	Dec 2, 2014 3:25 PM
41	Awakenings, Inc.	Dec 2, 2014 12:22 PM
42	Jamestown Family Health	Dec 1, 2014 1:41 PM

December 26, 2014

Dear Bree Collaborative,

Thank you for the opportunity to comment on the draft document, Addiction and Dependence Treatment Report and Recommendations.

I understand from our discussion that it is not the intent of this document to recommend specific treatments. However, as Washington State agencies move forward in addressing addiction and prescription opiate abuse, it is useful to keep in mind the significant impact that policies for access to acupuncture services can have for these patients, not only in treatment of addiction, but as an option in pain management. Acupuncture is a promising option for treatment of pain, and drug courts continue to use acupuncture for treatment of addiction to prevent recidivism.

Pain

East Asian medicine practitioners offer treatments for pain which could be an option before addiction to prescription drugs begins. Acupuncture's effectiveness for treatment of pain is supported by a recent article in Archives of Internal Medicine. In Acupuncture for Chronic Pain, Vickers et al drilled down to individual patient data from 29 randomized clinical trials comparing acupuncture group to control group. They found that, "...acupuncture was superior to both sham and no-acupuncture control for each pain condition (P<.001 for all comparisons)…Patients receiving acupuncture had less pain, with scores that were 0.23 (95% CI, 0.13-0.33), 0.16 (95% CI, 0.07-0.25), and 0.15 (95% CI, 0.07-0.24) DSs lower than sham controls for back and neck pain, osteoarthritis, and chronic headache, respectively…" (Vickers et al, 2012). The specific relationship between acupuncture and prescription opiate addiction prevention needs to be explored further.

Drug Treatment

Acupuncture has also been used as part of drug treatment programs across the US. The Multnomah County, Oregon, Drug Diversion Program is one of the oldest successful drug courts in the country. The program requires that defendants receive acupuncture three times a week in the initial phase of the complete treatment program, which includes group counseling, community service, and drug testing. The program significantly reduces subsequent arrests and convictions for drug and non-drug offenses for those who participated in the program (National Institute of Justice).

Patients and their providers face difficult decisions in treating addiction and pain. Acupuncture is a useful alternative. If more information about acupuncture and East Asian Medicine is required, please do not hesitate to get in touch with me. (Note that I work with the Research Group of the Washington East Asian Medicine Association (WEAMA), but, due to holiday schedules, I am letting my colleagues rest and rejuvenate, and am submitting this brief comment to you privately to meet the deadline.)

Best regards,

Mercy Yule, EAMP

206.498.5306

mercyyule@earthlink.net

References

National Institute of Justice (n.d.). Program Profile: Multnomah County (Ore.) Sanction Treatment Opportunity Progress (STOP) Drug Diversion Program. Retrieved from https://www.crimesolutions.gov/ProgramDetails.aspx?ID=128

Vickers, A., Cronin, A., Maschino, A., Lewith, G., MacPherson, H., Foster, N., Sherman, K., Witt, C., Linde, K. (2012). Acupuncture for chronic pain: Individual patient data meta-analysis. Archives of Internal Medicine. 172(19): 1444-1453.

December 18, 2014

Ginny Weir, MPH
Program Director, Bree Collaborative
Foundation for Health Care Quality
705 Second Avenue, **Suite 410** | Seattle, WA 98104
GWeir@qualityhealth.org | **(206) 204-7377**
www.breecollaborative.org

Dear Ms. Weir,

As the manufacturer of extended-release naltrexone (VIVITROL®), Alkermes would like to provide the Bree Collaborative with our critique and comments on the draft document entitled, *"Addiction and Dependence Treatment Report and Recommendations."*

Alkermes is committed to helping patients suffering from mental illnesses, in particular opioid and alcohol dependence. Alkermes commends the Bree Collaborative and the Addiction and Dependence Treatment workgroup on their efforts to provide the State of Washington scientific evidence and recommendations for improving treatment, access, and care for patients with substance use disorder.

As you may know VIVITROL is indicated for the prevention of relapse to opioid dependence, following opioid detoxification. Treatment with VIVITROL should be part of a comprehensive management program that includes psychosocial support.[1] VIVITROL is also indicated for the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment with VIVITROL.

Following a close review of the draft document and the data included within it, we agree in the approach to improving screening, reducing stigma, increasing the capacity to provide brief intervention and brief treatment, and decreasing barriers for facilitating referrals to appropriate treatment facilities. However, within the section titled "*Address the opioid epidemic,"* the workgroup appears to only recommend the use of agonist-based maintenance medication assisted treatment (MAT) and further recommends increasing the availabilities for treatment with these forms of MAT (e.g., buprenorphine). The current recommendations omitted any mention of abstinence-based antagonist MAT treatment options (e.g., naltrexone, and extended-release naltrexone). Naltrexone is a non-narcotic opioid antagonist available in the form of a short-acting daily oral medication and an extended release once-monthly injectable medication. Extended release naltrexone is specifically indicated for the prevention of relapse to opioid dependence, following opioid detoxification, in conjunction with a comprehensive management program that includes psychosocial support. Given the heterogeneity of this patient population, and the inherent complexities of opioid use disorder, awareness and access to all MAT options seems vital within this context. Thus, Alkermes would like to encourage the workgroup to incorporate recommendations that consider antagonist-based MAT for the treatment of opioid dependence in subsequent drafts of this collaborative initiative so providers and patients may have full access to all MAT options.

We appreciate the Addiction and Dependence Treatment workgroup's attention to this matter, and we look forward to further opportunities for dialogue and information exchange.

Sincerely,

Jeffrey J. Stoddard, MD
Vice President, Medical Professional Services
Alkermes, Inc.

Hi Ginny,

I submitted my comments about the Bree's draft proposal on addiction and dependence treatment via the Survey Monkey, but because I was in a hurry to enter the survey by 5 pm, I did not get all my comments typed in. Here I would like to elaborate a bit on my comments about the Bree's recommendation to increase Buprenorphine treatment availability under strategic plan #5.

Perhaps the ADT working group is aware of some recent articles concerning the increased concern on using Suboxone to treat opioid addition. Here is one of the articles:

http://www.csmonitor.com/USA/Society/2014/0530/Drugs-for-treating-heroin-users-a-new-abuse-problem-in-the-making

According to the article, a 2011 Harvard-led study found that 91 percent of Suboxone users had returned to opioid use within eight weeks of weaning off it. But more disturbing is the new addiction problem that has been created by using Suboxone to treat opioid dependence, as described in this report.

Given the emerging concern regarding Suboxone addition, I would recommend that the state not rush to expand the Buprenorphine treatment availability without evaluating adequate solutions to address this potentially new problem. Otherwise, the increased state-wide prescription of Suboxone will only help to create a new kind of opioid addiction in this state.

Maybe I have missed, but reading through the draft proposal I did not see that this potentially serious issue was addressed. That is why in the survey I suggested that the state evaluate the effectiveness of Buprenorphine (Suboxone) treatment on different population groups before making a state-wide recommendation.

As patients and consumers, we appreciate the time and energy that the ADT working group has spent to put this proposal together. Please help me forward my additional comments to the working group members.

Thanks, and Happy New Year!

Yanling

To Whom It May Concern:

I am writing on behalf of the Institute for Clinical and Economic Review (ICER), a non-profit health care research organization located in Boston, MA. We were very interested to read your recent report and felt that it provided a thorough view of the issues surrounding addiction and dependence in the US, but wanted to make you aware of an additional resource that may add further insights to your report. In June of 2014, one of our core programs, the New England Comparative Public Advisory Council (CEPAC), held a meeting to evaluate the comparative clinical effectiveness and value of management strategies for opioid dependence based on an evidence review completed by ICER. The final report, titled "Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options," provides a comprehensive review of available evidence, economic models, and recommendations to guide policy and practice surrounding treatment of opioid dependence. Inclusion of our findings in your report would provide support to your recommendations, particularly those related specifically to strategies to address the opioid epidemic.

To provide a bit of background about our program, CEPAC is a regional body whose goal is to provide objective, independent guidance on the application of medical evidence to clinical practice and payer policy decisions across New England. Backed by a consortium of New England state health policy leaders, CEPAC holds public meetings to consider evidence reviews on a range of topics, including clinical interventions and models for care delivery, and provide judgments regarding how the evidence can best be used across New England to improve the quality and value of health care services.

In our report on opioid dependence, ICER reviewed the evidence on comparative clinical effectiveness and value of various strategies to manage the condition, including medication assisted maintenance therapy using either methadone or buprenorphine, as well as short-term withdrawal therapy with or without medication assistance. During the public meeting, CEPAC voted that evidence supports long-term medication-assisted treatment (MAT) with either buprenorphine or methadone as the most clinically effective option for a majority of patients and as the most cost-effective strategy. Our economic models estimate that for every additional dollar spent on maintenance treatment in New England, $1.80 in savings would be seen in the health care system.

Based on CEPAC's discussion during the meeting with a policy Roundtable of experts in the subject of opioid dependence that included clinicians, researchers, payers, policymakers, and a patient representative, key recommendations to guide policy and practice were formed. These recommendations include:

- Coordinated efforts are needed to improve access to opioid dependence treatment for the large number of individuals who lack adequate access to high quality care options. Mechanisms that should be considered to accomplish this goal include:
    - Relaxing limits on the number of patients clinicians can treat
    - Supporting development of skills and expertise of DATA 2000 waivered physicians to increase capacity and willingness to treat patients
    - Screening for dependency in primary care settings
- Clinicians should individualize treatment, including decisions about medication choice, counseling, and supportive social services, according to an initial assessment of a patient's baseline severity and unique health care needs.
    - For most patients, MAT will be more effective than attempts at short-term managed withdrawal. However, short-term managed withdrawal may be a reasonable

consideration for a subset of patients with relatively short-term histories of addiction and less intravenous opioid use.

- Develop systems to triage patients entering treatment to the level of care more appropriate for their individual needs in order to support patient-centered treatment and allow for more capacity in the system.
    - Coordinated care networks allow patients to receive intensive short-term care until stabilized, and then be referred to lower levels of ongoing care.
- Mandatory requirements for certain kinds of counseling can have unintended consequences and should be reconsidered to ensure that they are not negatively affecting patient outcomes.
    - Decisions for counseling should be individualized to each patient.
    - Mandatory counseling can bottleneck treatment access, since there are not enough counselors to serve every patient with addiction.
- Provide treatment for opioid dependence through comprehensive, team-based care with collaboration across health care providers.
    - Multi-disciplinary care teams can help to address all aspects of dependence. Care teams may include addiction-certified physicians, psychologists, counselors, social workers, and other complementary practitioners that coordinate care and integrate with other medical and psychiatric services, as necessary.
    - Integration can be complicated by barriers to sharing information across providers to monitor patients as they transition through different treatment systems.

For the full list of recommendations and an in-depth explanation of our findings, please review the final report at http://cepac.icer-review.org/wp-content/uploads/2014/04/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf.

We hope you find our report to be of value to your initiative as you finalize your report, and please feel free to contact us with any questions about the report or our organization.

Hello Ginny,

I already gave my feedback on the report. However, there was something I did not put in my feedback that has been on my mind. It was of concern to me that the collaborative so whole-heartedly accepted the value of SBIRT as a given, yet recent evidence is casting some doubt on that. I've attached some recent and relevant articles.

Screening and Brief Intervention for Drug Use in Primary Care: The ASPIRE Randomized Clinical Trial

- Brief Intervention for Patients With Problematic Drug Use Presenting in Emergency Departments: A Randomized Clinical Trial
- Screening and Brief Intervention and Referral to Treatment for Drug Use in Primary Care: Back to the Drawing Board
- Bias Favoring Report of Positive Alcohol Brief Intervention Trials: Time to Get the Whole Truth
- Brief Intervention for Problem Drug Use in Safety-Net Primary Care Settings: A Randomized Clinical Trial

Thank-you,

Dr. Beck

David L Beck, MD

President, Washington Society of Addiction Medicine

Ginny:

I have enclosed comments we have about the draft. Please let me know if you have questions.

Polly Taylor would like to add the following information :

Consider including " support the Health Care Authority's Washington Link4Health effort to implement a platform for exchange of medical information to enhance communication and coordination among physical and behavioral health care."

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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Appendices:

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 primary care, including obstetric providers ~~health care staff~~on how to have non-judgmental, empathetic, cultural competent 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, including pregnancy 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, prenatal and ~~care and~~ emergency room settings
  - Increase the number of appropriately trained staff who utilize ~~provide~~an evidence based screening tool
  - 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 primary , prenatal and 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~~, prenatal 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

Commented [ess1]: Need to address the disparities among population groups – both race ethnicity as well as "sub" groups such as the pregnant and parenting population.

Commented [ess2]: Lack of access to treatment:

1.Reimbursement rates
2.Two systems – one for people with private insurance and HIGH co-pays and the other for publically funded treatment without adequate capacity to meet the population needs

specialists, if possible

- Manage pregnant women collaboratively between addiction, obstetric and pediatric providers.

- 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 for publically- and privately--insured individuals. [note: this also includes access to safe and sober housing and other social programs]
  - Address the workforce shortage for certified chemically dependency professionals which includes training, continuing education, and wages.
  - Address the issues for availability of access to the continuum of treatment including medically supervised detoxification in the context of treatment. [note: clients may detoxify in one facility and then transfer to chemically dependency treatment].
  - Integrate medical care into chemically dependency treatment facilities to insure that client's medical needs as well as mental health/behavioral needs are addressed in a coordinated fashion. [note: this also applies to clients with developmental disabilities – need to insure that there are provisions for appropriate care for this population]
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- 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
  - Insure access to appropriate harm reduction strategies such as opiate substitution and needle exchange programs which include access to treatment.

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.

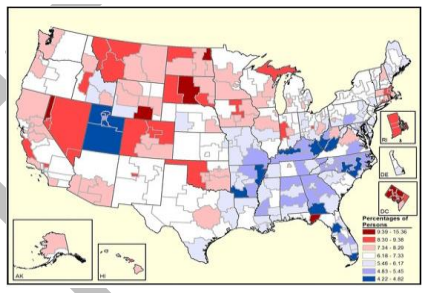
For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

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.[1] 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.

Figure 1: Alcohol Dependence or Abuse in the Past Year among Persons Aged 12 or Older[2]

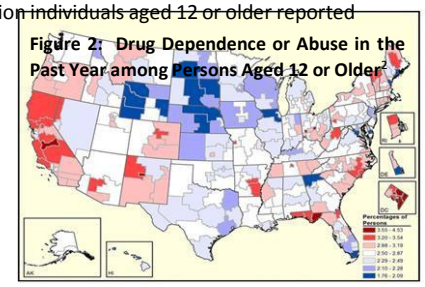


More than half of Americans aged 12 or older reported current alcohol use in the 2013 National Survey on Drug Use and Health (NSDUH) (52.2% or 136.9 million people), approximately a quarter of those surveyed reported binge alcohol use (22.9% or 60.1 million people). Approximately 6.3% of the population reported heavy drinking (16.5 million people).[1] 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.[2] Approximately 10.9% reported driving under the influence of alcohol, highest among those 26-29 years of age.[1]

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.[3]

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.[4,5] Drinking during pregnancy can also adversely affect the health of the developing fetus.3Alcohol can cause major organ birth defects, growth disorders and brain damage leading to lifelong disabilities. There is no known safe level of alcohol during pregnancy, therefore, all pregnant women should be advised not to drink alcohol. In 2013, 60.1 million individuals aged 12 or older reported binge drinking in the past month, including 1.6 million adolescents.[1] 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.[6]

Figure 2: Drug Dependence or Abuse in the Past Year among Persons Aged 12 or Older[2]



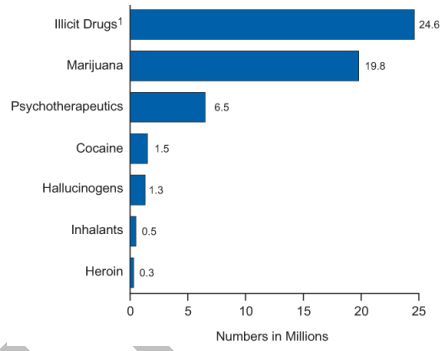
We use the term *drug* throughout this document to refer to marijuana, illicit drugs (e.g., hashish, cocaine, crack, heroin, hallucinogens, inhalants, etc.), and prescription psychotherapeutics used for non-medical purposes. See **Figure 2** for national variation in drug dependence or

Commented [ess3]: This section needs to incorporate additional narrative and data on:
1. use trends in WA state using DSHS and Medicaid data.
2. Racial and ethnic disproportionality use rates
3. #2 and arrest and incarceration data (social consequences)
4. Data on pregnant and parenting women – prevalence as well as the treatment penetration rate in WA

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]

Figure 3: Drug use in the past month, aged 12 or older, 2013[1]



Deaths from opioid pain relievers have increased substantially every year, rising to 100 deaths daily in 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]

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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]

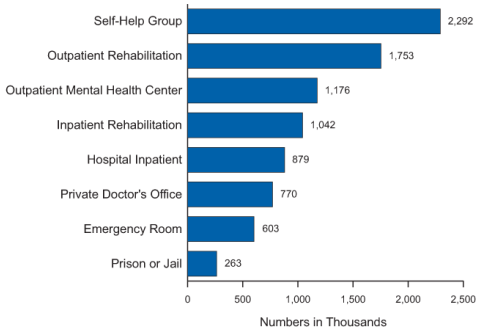
Surveys indicate that 94% of primary care physicians missed or misdiagnosed patients who were abusing alcohol when presented with early symptoms of alcohol abuse in adult patients.[14] Approximately 55% of patients reported not believing that their physician knew how to detect addiction, 54% reported 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 used a formal screening tool.[15] Of those physicians, the majority reported usually or always recommending a 12-

Commented [TP(5]: addiction

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.[1] 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%.[1]

Figure 4: Location detail where patients received substance abuse treatment, aged 12 or older, 2013[1]



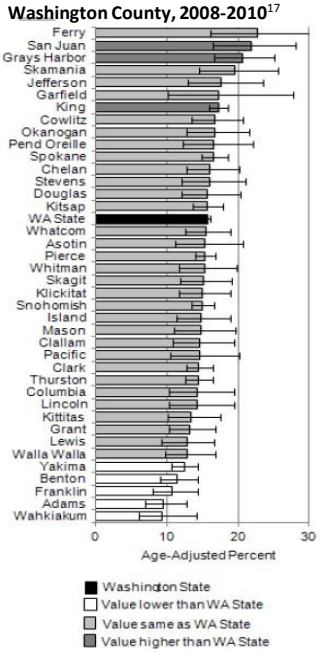
Alcohol and other drug misuse in Washington State

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.[3] 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.[16]

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.[17] 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.[18] 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

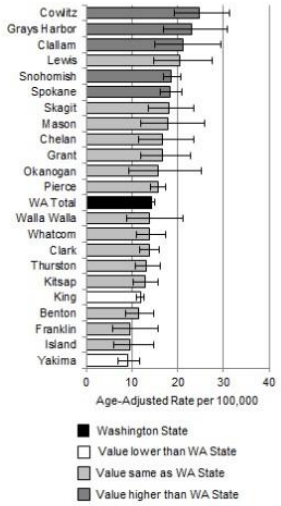
Figure 5: Binge Drinking by Washington County, 2008-2010[17]



Commented [ess6]: there is data from the healthy youth reports about children with disabilities and substance use, increased risk, etc. this should be included in this report.

Also need correlation with unintended pregnancy, teen pregnancy, and increase in STDs associated with substance use/abuse/addiction, etc.

Figure 6: Drug-induced death rates by Washington County, 2009-2011[20]



that year.[19] From 2000 to 2011, rates of drug-induced deaths were higher in Washington than the national average, both have increased over time.[20] 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.[20] 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.[21]

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.[21] 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.[22]

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.[23] 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**.[20] 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.[21]

Figure 7: Admissions for substance abuse by percentage, 1999-2013 [20]

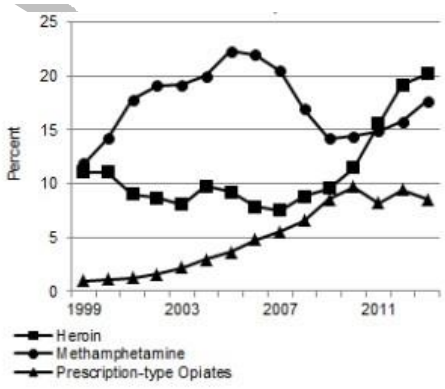
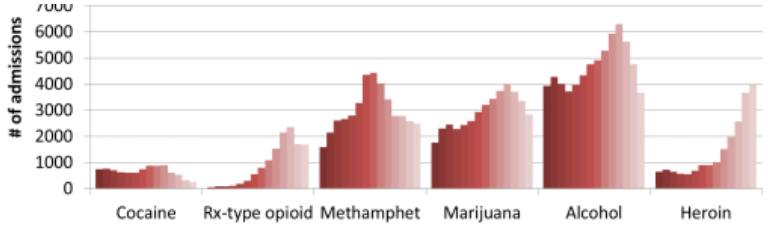


Figure 8: Substance abuse treatment admissions, age 18-29, 1999-2012[21]



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

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.

Screening

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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.[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."[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:[26]

Commented [ess8]: Add how the ACA, US task force, etc. requests this as a benefit in all insurance plans….including Medicaid…

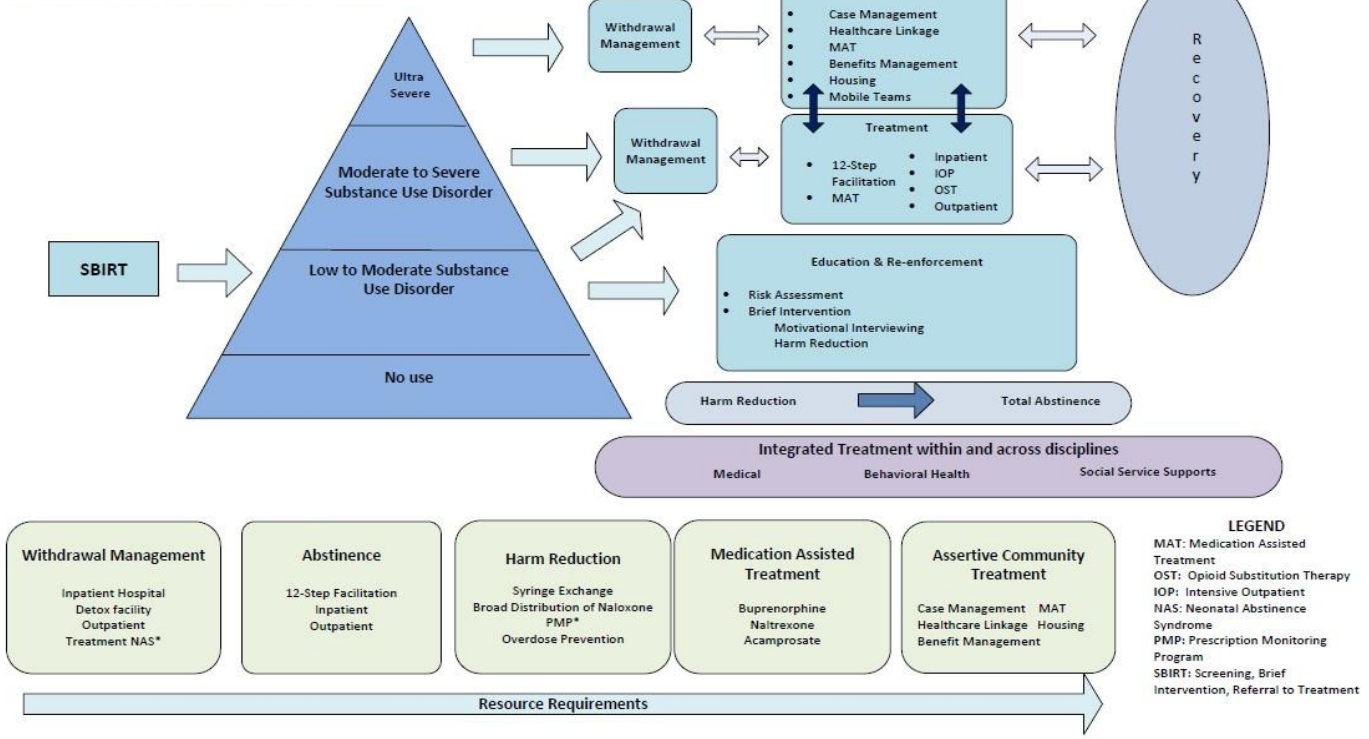
- Is brief
- Universally screens all patients for a specific issue (e.g., alcohol and other drug misuse)
- Occurs in a non-chemical dependency treatment setting (e.g., primary care, hospital)
- Includes a seamless transition between screening, brief intervention, brief treatment, and referral to specialty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



Commented [ess9]: NAS is mentioned on this diagram without any other mention in this document. This is a critical missing piece in this report. Drug-affected babies needs to be a topic in the report; treatment capacity, protocols, no licensed facilities to manage withdrawing newborns.

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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**:''

Focus Area	Specific strategies
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, including pregnancy 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 • Manage pregnant women collaboratively between addiction, obstetric specialists, and pediatric providers.
4. **Decrease barriers for facilitating referrals to appropriate treatment facilities**	• Enhance ability to triage patients to appropriate level of care if not improving • Increase accessibility of consulting with qualified behavioral health providers • 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 • Manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if possible
5. **Address the opioid addiction epidemic**	• Increase chemical dependency resources sufficient to facilitate successful patient rehabilitation for public and privately insured individuals. • ~~Increase chemical dependency resources sufficient to facilitate successful patient rehabilitation~~ • 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-

Commented [ess12]: What about the issues of wait lists and not enough treatment capacity in WA state?
Issues of reimbursement for providers, CDPs, and facilities may need to be addressed.

Commented [ess13]: Still need to address other issues such as over prescribing of benzodiazapines

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.[27] 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.[28]

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.[29] 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.[28,30] 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.[30] Screening alone has also been shown to reduce alcohol misuse, potentially due to increased self-awareness and self-monitoring.[31,]32 The screening tools validated for use during pregnancy include Audit-C, CRAFFT, 4Ps plus, T-ACE, TWEAK, and Substance Use Risk Profile Scale.

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.[33] 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.[34,35] 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.[36,37]

Single Item AUDIT Screener: How many times in the past year have you had (4 for women, 5 for men) or more drinks in a day? Answers: Never, Less than monthly, Monthly, Weekly, Daily or almost daily

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.[38] 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.[39] 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.[39,40] 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.)[41,42]

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.[43] 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.[44] 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.)"[45] 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.[46,47] 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?"[45]

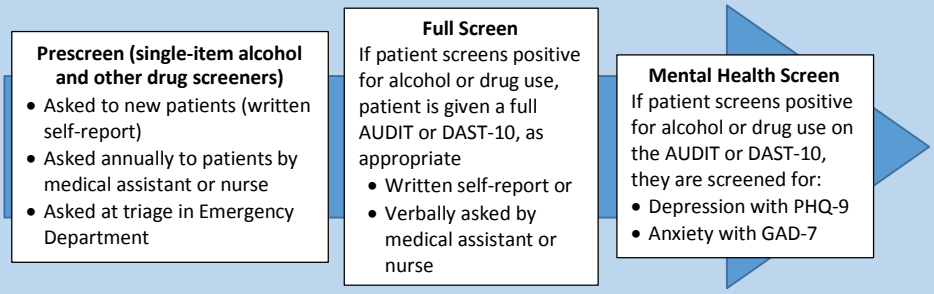
Other validated screeners include the **CAGE**, also a mnemonic acronym of key words within the four questions (Cut down, Annoyed, Guilty, and Eye-opener) to which patients answer yes or no. The CAGE has been adopted to assess drug use, called the CAGE-AID. Two positive responses are considered a positive test and indicate that further assessment is warranted.[48] A systematic review found an average sensitivity of 0.71 and specificity of 1.90.49 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.[47]

Case Study: Washington Screening, Brief Intervention, and Referral to Treatment Primary Care Integration[50]

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
    - Brief intervention and referral to chemical dependency treatment.

Screening and brief intervention took approximately 15 minutes per patient.[51] 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.[9,52] 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.[53]

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.[51]

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."[12]

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."[54] Many guidelines exist outlining brief interventions. The WA-SBIRT program limits reimbursement for brief interventions to four per client, per provider annually.[50]

WA-SBIRT suggests the following for brief interventions[50]

- **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

Examples can be found on the SAMHSA website, here: www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions.

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.[45] The contract for life, available here: 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.[45]

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:[45]

- 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.[55] 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.[56] 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.[57] 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.[58,59] 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.

Commented [ess14]: I think there are more resources that could be added here.

However, a discussion on the barriers to getting folks into treatment needs to be added. This includes some post-mortem analysis on why the treatment expansion consistently underspent and did not meet targets for treatment admissions.

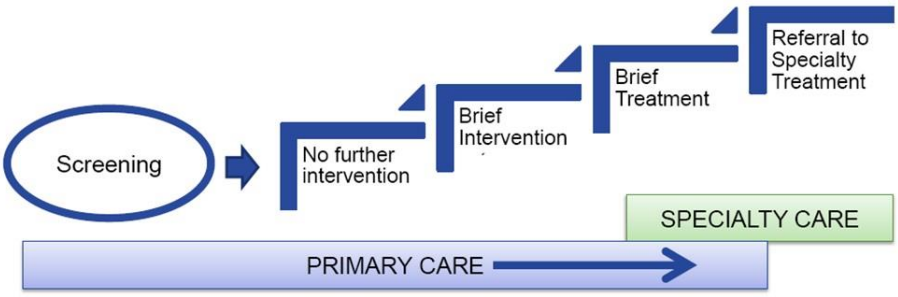
These recommendations seek to increase the number of patients screened for drug use prior to patients encountering the treatment system for other reasons and prior to developing drug-use associated problems. Additionally, a growing body of evidence is showing positive effects from brief intervention for drug use in primary care and emergency rooms.[60,61] The National Institute on Drug Abuse and many other organizations recommend brief intervention for non-medical prescription drug use.[62]

The National Institute on Drug Use suggests five A's for brief intervention[62]

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.

Figure 10: Expanded Role of Primary Care to Provide Brief Treatment[63]



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.[26] 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."[26] 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.[54]

> While brief interventions have been shown to be effective for alcohol misuse and marijuana misuse, in many cases, brief treatment may be more appropriate for those misusing other drugs or who are severely dependent on alcohol.[54]

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."[64] 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.[51] 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.

Commented [ess15]: Need to consider that there was a reimbursement methodology that was available to support this effort. Without infusion of $$s these initiatives cannot work.

Commented [ess16]: Need a reimbursement pathway….

Key Recommendations for Integrating Brief Treatment:[63]

- 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.[65] 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.[56] 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.*"[66]

Commented [ess17]: System capacity is an ongoing issue. The state certifies; low payment causes folks to leave the field

SAMHSA recommends four transdisciplinary foundations for addiction professionals:[67]

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

The Washington State Department of Health ~~licenses~~ certifies chemical dependency professionals based on meeting specific requirements including having postsecondary education.[68]

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.[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.[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."[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:[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.[45] Primary care and emergency room settings are recommended to manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if available.

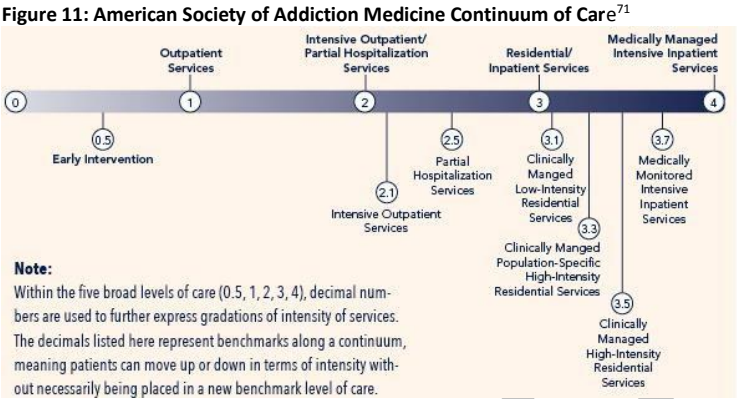
- WA-SBIRT suggests how to make good referrals through familiarization with treatment options and having a good relationship with local treatment centers. More information, here: www.wasbirt.com/content/referrals-treatment
- SAMHSA provides a behavioral health services treatment locator, here: http://findtreatment.samhsa.gov/

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.

Commented [ess18]: Who maintains the waiting lists; central referral and tracking needs to be funded;

Private insurance requires co-payments and what about access to treatment and out-of-state treatment? Need to add more here about the OIC work around CD

Figure 11: American Society of Addiction Medicine Continuum of Care[71]



American Society of Addiction Medicine. What is the ASAM criteria? Copyright 2014. Accessed: October 2014. Available: www.asam.org/publications/the-asam-criteria/about/.

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.

Commented [ess19]: How would this happen? There is not any reimbursement for these services? It would work in an outpatient hospital setting because they get facility fees which allow for some more flexible use of staff time but for a small independent facility, there is not staff to support this

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.[72] 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.[21]

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

Pregnant women need specialized in-patient and outpatient specialized services geared toward pregnant and parenting women.

Evidence shows that pregnant women who are provided intensive case management and support services are better able to maintain sobriety and improve family health and capabilities. Parent Child Assistance Program (PCAP), and Safe Babies Safe Moms (SBSM) are examples of such programs in Washington State.

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, including pregnancy 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
- Manage pregnant women collaboratively, with obstetrics, addictions and pediatric providers.
- Establish and maintain working relationships with chemical dependency treatment ~~faculties~~ facilities 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

- Women of child bearing age should be encouraged to use evidence based birth control while still using.
- **Primary** care professional should provide family planning services.

- Screen, treat, or refer for comorbid conditions such as violence and mental illness.
- [need to add something about what medical professionals learn in their basic training]

Commented [ess20]: How does the collaborative consider the work of school-based health centers?

Commented [ess21]: Need EMRs that support this = $$

Commented [BStein22]: Good resource from DOH- http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy/?searchterm=substance

Hospitals – also add Urgent Care Centers and Clinics

- 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
- Manage newborns who are withdrawing according to hospital NAS protocol.
- Manage pregnant women during labor/delivery according to appropriate protocol.

Commented [TP(23]: Link to be posted on waperinatal.org

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
- Provide birth control information and connect to family planning services.

Commented [ess24]: Who does this, how is it paid?

Health Plans

- Reimburse for screening, brief intervention, and referral to treatment (SBIRT) services; Medicaid reimburses trained and qualified providers for this; what about the private market and plans certified through the OIC and marketed through the health benefits exchange
- 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

- Reimburse for long term intensive case management and home visiting services to support sobriety, and family health.

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
    - Reduce or eliminate co-payments
- 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
- Insure that employers hold jobs when people go to treatment
-

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.[73]

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: **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment 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.

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Appendix A: Bree Collaborative Members

Member	Title	Organization
Susie Dade MS	Deputy Director	Washington Health Alliance
John Espinola MD, MPH	Vice President, Quality and Medical Management and Provider Engagement	Premera Blue Cross
Gary Franklin MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed MD	Medical Director	Wenatchee Valley Medical Center
Tom Fritz	Chief Executive Officer	Inland Northwest Health Services, Spokane
Joe Gifford MD	Chief Executive, ACO of Washington	Providence Health and Services
Richard Goss MD	Medical Director	Harborview Medical Center – University of Washington
Steve Hill (Chair)	Retired	Previously Director, Department of Retirement Systems, and Chair, Puget Sound Health Alliance
Christopher Kodama MD	Medical Vice President, Clinical Operations	MultiCare Health System
MaryAnne Lindeblad RN, MPH	Director, Medicaid Program	Health Care Authority
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Robert Mecklenburg MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kimberly Moore MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden MD	Family Physician	Pacific Crest Family Medicine, Yakima
Mary Kay O'Neill MD, MBA	Executive Medical Director	Regence Blue Shield
John Robinson MD, SM	Chief Medical Officer	First Choice Health
Terry Rogers MD (Vice Chair)	Chief Executive Officer	Foundation for Health Care Quality
Jeanne Rupert DO, PhD	Director of Medical Education	Skagit Valley Hospital
Kerry Schaefer	Strategic Planner for Employee Health	King County
Bruce Smith MD	Associate Medical Director, Strategy Deployment	Group Health Physicians
Lani Spencer RN, MHA	Vice President, Health Care Management Services	Amerigroup
Jay Tihinen	Assistant Vice President Benefits	Costco Wholesale
Carol Wagner RN, MBA	Senior Vice President for Patient Safety	The Washington State Hospital Association
Shawn West MD	Family Physician	Edmonds Family Medicine

Appendix B: Addiction and Dependence Treatment Workgroup Charter

Problem Statement

The total financial cost of drug use disorders to the United State is estimated to be $180 billion. The economic costs of alcohol abuse were $184.6 billion in 1998.[i] 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

Name	Title	Organization
Tom Fritz *(Chair)*	Chief Executive Officer, Bree Member	Inland Northwest Health Services
Charissa Fotinos, MD, MS	Deputy Chief Medical Officer	Health Care Authority
Linda Grant, MS, CDP	Director	Evergreen Manor
Tim Holmes, MHA	Vice President of Outreach Services and Behavioral Health Administration	MultiCare
Ray Chih-Jui Hsiao, MD	Co-Director, Adolescent Substance Abuse Program, First Vice President of the WSMA	Seattle Children's Hospital
Scott Munson	Executive Director	Sundown M Ranch
Rick Ries, MD	Associate Director	University of Washington Addiction Psychiatry Residency Program
Terry Rogers, MD	CEO, Bree Member	Foundation for Health Care Quality
Ken Stark	Director	Snohomish County Human Services Department
Jim Walsh, MD	Addiction Medicine, Family Medicine w/Obstetrics	Swedish
Workgroup Staff		
Steve Hill	Chair	Bree Collaborative
Ginny Weir	Program Director	Bree Collaborative, Foundation for Health Care Quality