Strategies to prevent emergency visits and hospital stays related to opioid use disorders

July 19, 2023

Objectives

- Screen for various substance use disorders, including opioid use disorder.
- Describe the differences between the various types of opioids, and best practices to support members with different types of substance use disorders (including opioid use disorder).
- Learn about successful strategies to engage and facilitate treatment for substance use disorders, with an emphasis on opioid use disorders.

Rising Emergency Department (ED) Visits and Hospital Stays for Opioid Use Disorder Remain a Concern

In 2018, over **2 million** U.S. residents, 12 years of age and older were **diagnosed with Opioid Use Disorder (OUD).**[1]

Emergency department (ED) visits for opioid-related adverse drug events, resulting in **ED visits for opioid-related presentations more than doubling between 2010 to 2018**.[2]

ED visits for OUD have been **increasing at a higher rate** than alcohol or other substance use disorders **since the beginning of the COVID-19 pandemic**.[3]

OUD hospitalizations have observed a continuing rise, with **a 219% increase in OUD hospitals** comparing OUD hospitalizations from 2015-2016 to OUD hospitalizations from 1998 – 2000.

1. Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.
2. Hawk, K., Hoppe, J., Ketcham, E., LaPietra, A., Moulin, A., Nelson, L., ... & D'Onofrio, G. (2021). Consensus recommendations on the treatment of opioid use disorder in the emergency department. Annals of emergency medicine, 78(3), 434-442.
3. Venkatesh AK, Janke AT, Kinsman J, Rothenberg C, Goyal P, Malicki C, et al. (2022). Emergency department utilization for substance use disorders and mental health conditions during COVID-19. PLoS ONE 17(1): e0262136. https://doi.org/10.1371/journal.pone.0262136.
4. Singh, J. A., & Cleveland, J. D. (2020). National US time-trends in opioid use disorder hospitalizations and associated healthcare utilization and mortality. PLoS One, 15(2), e0229174.

Quality Measures to Help Prevent, Monitor, and Treatment Opioid Use Disorder

Follow up after emergency department visit for substance use within 30 days (FUA)

- The percentage of ED visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of unintentional drug overdose, with a follow up visit within 7 days of the ED visit (8 total days), or 30 days of the ED visit (31 total days).

Pharmacotherapy for Opioid Use Disorder (POD)

- The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.

Use of Opioids at High Dosage (HDO)

- The proportion of members 18 years and older who received prescription opioids at a high dosage (average milligram morphine dose [MME ≥90 mg]) for ≥15 days during the measurement year. A lower rate indicates better performance.

Objective 1: Screening for Substance Use Disorders

Why are screenings important in primary care settings?

- The American Academy of Family Physicians (AAFP) emphasized that Family physicians play a key role in the **diagnosis, treatment, and prevention of opioid use disorder**. The AAFP strongly urges its members to be knowledgeable of and utilize evidence-based strategies to identify and treat OUD in the primary care setting, including medication assisted treatment (MAT).[1]
- The emergency department is rapidly being identified as the "24/7/365" site to combat the opioid crisis.[2]
- The number of patients presenting with OUD in medical clinics, community health centers, and private practices is increasing. Healthcare professionals in these general settings are in an important position to identify, assess, and treat OUD or to refer patients for treatment.[3]
- Patients who are medically and mentally stable can benefit from receiving OUD medications in integrated care settings, where they often have already established therapeutic relationships with their healthcare providers.[3]
- Patients should be screened annually for alcohol, tobacco, prescription drug, and illicit drug use. Given the high prevalence of SUDs in patients visiting primary care settings and the effectiveness of medications to treat OUD specifically, the TIP expert panel recommends screening all patients for opioid misuse. [3]

Sources:

1. AAFP Opioid Use Disorder Screening: https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/oud.html
2. D'Onofrio, G., Edelman, E. J., Hawk, K. F., Pantalon, M. V., Chawarski, M. C., Owens, P. H., ... & Fiellin, D. A. (2019). Implementation facilitation to promote emergency department-initiated buprenorphine for opioid use disorder: protocol for a hybrid type III effectiveness-implementation study (Project ED HEALTH). Implementation Science, 14(1), 1-12.
3. Abuse, S. (2021). TIP 63: Medications for Opioid Use Disorder. Fore Healthcare and Addiction Professionals, Policymakers, Patients and Families.

Standardized Behavioral Health Screenings and Tools

Condition	Screening Name	Special populations	Tips on Administering	Interpreting Results
Alcohol https://auditscreen.org/	Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument https://pubs.niaaa.nih.gov/publications/audit.htm	• Primary care and emergency room patients, psychiatric patients • Employees in employee assistance programs and industrial settings • Individuals in jail, court, prison, or Armed forces	• Free with an interactive audit at https://auditscreen.org/about/fags/ • Considered highly suitable for primary care and other healthcare settings	• Positive finding: Total Score ≥8 • Score of 8 to 14 suggests hazardous or harmful alcohol consumption • Score of 15+ indicates likelihood of alcohol dependence
	Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument	• Validated for primary care settings	• Both AUDIT-C and Single-question screen can equally detect unhealthy alcohol use and current alcohol use disorders (American Family Physician) • Single- question can be on intake questionnaire or asked verbally • Patients who score positive on single-question should then receive full AUDIT to determine level of risk (Centers for Disease Control & Prevention)	Positive finding: Total Score ≥4 for men Total Score ≥3 for women
	Single-Question Screen: "How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?"	• Validated for primary care settings		Positive finding: Total Score ≥1

Standardized Behavioral Health Screenings and Tools

Condition	Screening Name	Special populations	Tips on Administering	Interpreting Results
Substance Use	National Institute on Drug Abuse Quick Screen[1] (4 questions about use of alcohol, tobacco, nonmedical use of prescription drugs, and illegal drugs in the past year)	• May be more suitable for busy primary care settings	• Screening personnel may want to offer reading the questions in a private setting and complete the form for the patient. • Given the patient's response to the Quick Screen, the patient should not indicate "NO" for all drugs in the initial question. • Apply a protective sheet to preserve confidentiality prior to placing questionnaire in the member's record.	• If patient says "no" for all drugs in the quick screen, reinforce abstinence. No further action needed. • If patient says "yes" to use of illegal drugs or prescription drugs for non-medical reasons, proceed to Question 1 of the NIDA-Modified ASSIST.
	Tobacco, Alcohol, Prescription Medication, and Other Substance Use[2] (TAPS) • 2 stage brief assessment adapted from the National Institute on Drug Abuse (NIDA) quick screen and brief assessment (adapted ASSIST-lite)	• An instrument designed to screen and assess adult primary care patients for tobacco, alcohol, prescription drug, and drug use and problems related to their use • The TAPS tool screens for clinically relevant misuse (using DSM-5 SUD criteria)	• Can either re self administered or done through interview. Online version available. • Patients with positive screens for heroin or prescription opioid misuse need more in-depth assessment. • Combines screening and brief assessment for commonly used substances, eliminating need for multiple screening & assessments.	• Endorsement of any substance use during the initial screening phase (TAPS-1) prompts a few questions through the brief assessment (TAPS-2). • A score of 0 means no use in the past 3 months • A score of 1 indicates problem use • A score of 2+ indicates higher risk.

1. National Institute of Health NIDA Quick Screen: https://nida.nih.gov/sites/default/files/pdf/nmassist.pdf
2. National Institute of Health NIDA TAPS: https://nida.nih.gov/taps2/; Tool available here: https://cde.nida.nih.gov/instrument/29b23e2e-e266-f095-e050-bb89ad43472f

Standardized Behavioral Health Screenings and Tools

Condition	Screening Name	Special populations	Tips on Administering	Interpreting Results
Risk for Opioid Use Disorder[1] (https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/opioid-risk-tool-oud-ort-oud	Opioid Risk Tool	• For adults in primary care populations to assess the potential for opioid-related aberrant drug-related behaviors (ADRB)	• This tool should be administered to patients upon an initial visit prior to beginning or continuing opioid therapy for pain management. • This is an 9-item questionnaire and can take a minute to administer.[2]	• A score of 3 or lower indicates low risk for future opioid use disorder • A score of 4 to 7 indicates moderate risk for opioid use disorder. • A score of 8+ indicates high risk for opioid abuse.
Other Substance Use	Please refer to the National Institute on Drug Abuse for a "Screening and Assessment Tools Chart," available at https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools			

1. Cheatle M, Compton P, Dhingra L, Wasser T, O'Brien. Development of the Revised Opioid Risk Tool to Predict Opioid Use Disorder in Patients with Chronic Non-Malignant Pain. Journal of Pain. 20 (7): 842-851, 2019.
2. Brott NR, Peterson E, Cascella M. Opioid, Risk Tool. [Updated 2022 Nov 25]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK553147/

Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

General Instructions

The Alcohol Use Disorders Identification Test-Concise (AUDIT-C) is a brief alcohol screening instrument. Please give a response for each question.

Segment: _ _

Visit Number: _ _

1. **How often do you have a drink containing alcohol?**
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2-4 times a month
   - ☐ 2-3 times a week
   - ☐ 4 or more times a week
2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ 1 or 2
   - ☐ 3 to 4
   - ☐ 5 to 6
   - ☐ 7 to 9
   - ☐ 10 or more
3. **How often do you have six or more drinks on one occasion?**
   - ☐ Daily or almost daily
   - ☐ Weekly
   - ☐ Monthly
   - ☐ Less than monthly
   - ☐ Never

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 1

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only be females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

Segment:
Visit number:

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 2

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 2 is a brief assessment for tobacco, alcohol, and illicit substance use and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answer choices- either yes or no. Check the box to select your answer.

1. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, did you usually smoke more than 10 cigarettes each day? ☐ Yes ☐ No
   b. In the PAST 3 MONTHS, did you usually smoke within 30 minutes after waking? ☐ Yes ☐ No

2. In the PAST 3 MONTHS, did you have a drink containing alcohol? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, did you have 4 or more drinks containing alcohol in a day?* (Note: This question should only be answered by females). ☐ Yes ☐ No
   b. In the PAST 3 MONTHS, did you have 5 or more drinks containing alcohol in a day?* (Note: This question should only be answered by males). ☐ Yes ☐ No

*One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.
   c. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop drinking? ☐ Yes ☐ No
   d. In the PAST 3 MONTHS, has anyone expressed concern about your drinking? ☐ Yes ☐ No

3. In the PAST 3 MONTHS, did you use marijuana (hash, weed)? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, have you had a strong desire or urge to use marijuana at least once a week or more often? ☐ Yes ☐ No
   b. In the PAST 3 MONTHS, has anyone expressed concern about your use of marijuana? ☐ Yes ☐ No

4. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ☐ Yes ☐ No
   b. In the PAST 3 MONTHS, has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

5. In the PAST 3 MONTHS, did you use heroin? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin? ☐ Yes ☐ No

Opioid Risk Tool

https://nida.nih.gov/sites/default/files/opioidrisktool.pdf

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Additional Screening Tools from The Advancing Drug and Opioid Prevention and Treatment (ADOPT) Project funded by SAMHSA[1]

ADOPT — *Advancing Drug and Opioid Prevention and Treatment*

A collaborative, multidisciplinary training initiative to address the opioid epidemic using medication-assisted treatments
https://adopt.ucsf.edu

Screening and Diagnosis of Opioid Use Disorder

An expert panel of the Substance Abuse and Mental Health Services (SAMHSA) Treatment Improvement Protocols (TIP) recommends universal screening for opioid use disorder[1]; similarly, the U.S. Preventive Services Task Force (USPSTF) released a draft recommendation to routinely screen adults 18 and older for illicit drug use including prescription opioid misuse.[2]

A single question screener can be used to efficiently screen for opioid misuse[1]:

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

Any response other than zero is considered a positive screen that should be followed by identification of the substance(s) used. A positive single question screen for opioid misuse should be followed by an assessment using a validated screening instrument for opioid use disorder (OUD).[1]

Opioid Use Disorder Screening Tools

Some options for validated opioid use disorder screening and assessment tools include are shown in the following table:

Tool	Patient Age		Administration	
	Adults	Adolescents	Self	Clinician
Screening to Brief Intervention (S2BI)[3]		X	X	X
Brief Screener for Alcohol, Tobacco and Other Drugs (BSTAD)[4]		X	X	X
Tobacco, Alcohol, Prescription Medication and Other Substance Use (TAPS)[5]	X		X	X
NIDA Drug Use Screening Tool (NM ASSIST)[6]	X	APA Adapted NM Assist Tool	APA Adapted NM Assist Tool	X
Opioid Risk Tool (ORT)[7]	X		X	
Rapid Opioid Dependence Screen (RODS)[8]	X			X
Current Opioid Misuse Measure (COMM)[9]	X		X	
CAGE-AID[10]	X			X
CRAFFT[11]		X	X	X
Drug Abuse Screening Test-10[12]	X		X	X
Drug Abuse Screening Test-Adolescent[13]		X	X	X
Clinical Opiate Withdrawal Scale (COWS)[14]	X	X		X
Addiction Severity Index (ASI)[15]	X		X	

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PDF Link:

https://opioidpreventionandtreatment.ucsf.edu/sites/g/files/tkssra506/f/wysiwyg/ScreenersPamphlet_10_21_19%20.pdf

1. Project Advancing Drug and Opioid Prevention and Treatment (ADOPT) is a collaborative, multidisciplinary training initiative that includes physicians, nurse practitioners, and psychologists at 3 distinct universities and over 300 Northern California training clinics. ADOPT will be administered through the UCSF School of Medicine (SOM) with Co-I's at USF and SSU Schools of Nursing. For more information, click here: https://opioidpreventionandtreatment.ucsf.edu/

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Determining the Need for and Extent of Assessment[1]

Assess patients for OUD if

- They screen positive for opioid misuse
- Patient discloses opioid misuse
- Patient presents with symptoms of opioid misuse

Extent of Assessment

- Contingent upon provider's ability to directly treat patient
- If medication is not offered, focus should be on assessment, diagnosis of OUD, and patient safety, with motivational brief interventions, education, and in-person follow-up

Setting the stage for successful assessment

- Open-ended questions to encourage patients to explore their own experiences (e.g., "In what ways has oxycodone affected your life?"
- Explore patient ambivalence and highlight problem areas to identify motivations for change
- Take complete history of medical, mental health, substance use, and SUD treatment histories

1. Abuse, S. (2021). TIP 63: Medications for Opioid Use Disorder. Fore Healthcare and Addiction Professionals, Policymakers, Patients and Families.

Screen member with a standardized screening tool

- Patient directly fills out or staff verbally asks questions (depending on questionnaire)
- Ensure patient's consent forms are signed for care coordination purposes

Communicate and interpret results with the patient

- Trained clinicians and/or provider shares screening results with the patient
- Employ OARS and READS to communicate results with the patient

Act on the positive screening

- OARS and READS to educate patient about the importance and benefits of treatment
- Inform patient they have treatment options through MHN, their BH benefit administrator
- You and/or staff, with the patient, call MHN Customer Service to help the patient find a provider of their choice
- Once identified, immediately share screening results with the patient's chosen provider

Objective 2: Strategies for Evidence-Based Treatment

Suspect Opioid Use Disorder?

- Discuss your concern with your patient
- Provide an opportunity for your patient to disclose concerns
- Assess for opioid use disorder and arrange for treatment
- Do not dismiss patients from care. Use the opportunity to provide potentially life saving information and interventions

DSM-5: Opioid Use Disorder

- Taking larger amounts or taking over a longer period than intended.
- Persistent desire or unsuccessful efforts to cut down or control opioid use.
- Spending a great deal of time obtaining or using the opioid or recovering from its effects.
- Craving, or a strong desire or urge to use opioids
- Problems fulfilling obligations at work, school or home.
- Continued opioid use despite having recurring social or interpersonal problems.
- Giving up or reducing activities because of opioid use.
- Using opioids in physically hazardous situations.
- Continued opioid use despite ongoing physical or psychological problem likely to have been caused or worsened by opioids.
- Tolerance (i.e., need for increased amounts or diminished effect with continued use of the same amount)
- Experiencing withdrawal (opioid withdrawal syndrome) or taking opioids (or a closely related substance) to relieve or avoid withdrawal symptoms

DSM-5: Diagnostic and Statistical Manual of Mental Disorders- 5th edition https://www.psychiatry.org/patients-families/addiction/opioid-use-disorder/opioid-use-disorder

Know the Risk Factors for OUD

- Personal and family history of substance abuse
- Age (16-45 at highest risk)
- Comorbid psychiatric illness: mood disorders, anxiety, PTSD, personality disorder, and suicide behavior/attempts
- More prevalent in uninsured, unemployed, and low income
- Significant history of legal problems or incarceration
- Recent completion of inpatient treatment

http://www.californiaopioidsafetynetwork.org.ca opioid dashboard, Edlund MJ, et al. Pain. 2007;129(3):355-362; Liebschutz JM, et al. J Pain. 2010;11(11):1047-1055; Webster LR. Anesth Analg. 2017;125(5):1741-1748.

How to talk about behavioral health with patients

- How you talk about behavioral health can shape the patient's decisions and feelings about treatment
- There is no quick solution or "fix" for emotional distress
- Be present with patients, listen without interruption or judgment

Tips	Examples
Focus on the issue or concern you are observing, and avoid labels or psychiatric diagnoses	*You mentioned you have lost your appetite and not sleeping well since you lost your job.*
Normalize emotions and express empathy, concern	*It is common to have strong feelings after the loss of a loved one. You may feel angry, confused, sad, or lost. I can see you in a lot of pain.*

CAHPS Tip: How you talk to your patients can impact their perception on their access to care

Source: Sherman, M.D., Miller, L.W., Keuler, M., Trump, L., & Mandrich, M. (2017). Managing Behavioral Health Issues in Primary Care: Six Five-Minute Tools. *Family Practice Management. 24*(2).30-35. Retrieved from https://www.aafp.org/fpm/2017/0300/p30.html

How to talk about behavioral health with patients

Tips	Examples
Mention how mental health is related to physical health concerns	*I wonder if your stress is making your headache or nausea worse. Are you noticing these symptoms or pain when you are stressed?*
Emphasize you are there for support and that you are both a team	*You do not have to go through this alone. I'm here to support you during this difficult time.*
Educate the patient that they have behavioral health treatment options available to them	*We believe it's important to address how you're feeling, and your mental health, as part of your overall wellness.* ***Did you know you have behavioral health treatment options through MHN? We can call them together and help you find a provider.***
Increase patient awareness and knowledge that treatment helps	*I have had other patients experience your loss, or have been in your situation. I have recommended counseling and other treatment options. Others have found talking to a therapist can be helpful. How would you feel about that?*

Source: Sherman, M.D., Miller, L.W., Keuler, M., Trump, L., & Mandrich, M. (2017). Managing Behavioral Health Issues in Primary Care: Six Five-Minute Tools. *Family Practice Management. 24*(2).30-35. Retrieved from https://www.aafp.org/fpm/2017/0300/p30.html

Motivational Interviewing (MI) Techniques to Help Screen and Refer Patients (OARS)

"MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." (Miller & Rollnick, 2013, p. 29)

Skill	Example
Ask **O**pen-Ended Questions	"I understand you have some concerns about your drinking. Can you tell me about them."
Make **A**ffirmations	"I appreciate that it took a lot of courage for you to discuss your concerns with me today." "Thank you for hanging out in here with me. I appreciate this is not easy for you to hear."
Use **R**eflections	"You enjoy the effects of alcohol in terms of how it helps you unwind with friends, but you are beginning to worry about the impact of your drinking, is that right?"
Use **S**ummarizing	"If is okay with you, just let me check that I understand everything we've discussed. You have been worrying about how much you have been drinking and experienced some health concerns."

Source: Hall, K., Gibbie, T., & & Lubman, D. (2012). Motivational interviewing techniques - facilitating behaviour change in the general practice setting. *Australian Family Physician. 41*(9). 660-7. Retrieved from: https://www.mcgill.ca/familymed/files/familymed/motivational_counseling.pdf

Motivational Interviewing Principles

Principle	Description
R – Roll with resistance	Reframe and reflect but do not actively confront patients with their resistance to behavior change. Explore with them the negative and positive consequences of not changing their behavior.
E—Express empathy	For example, if you told a friend you were in a car accident yesterday but did not sustain major injuries, they would not first ask whether you had been speeding or whose fault it was. Neither would they say that everything will be fine or talk about their own accident a few months earlier. None of these comments would make you feel better.
A—Avoid argumentation	This is easier when asking questions rather than making declarative statements. Techs should also avoid questions that are condescending or leading.
D—Develop discrepancy	Help patients come to their own realization of the discrepancy that exists between their behaviors and goals.
S—Support self-efficacy	Inspire patients with confidence that they can make changes.

Source: Mifsud, J. L., Galea, J., Garside, J., Stephenson, J., & Astin, F. (2020). Motivational interviewing to support modifiable risk factor change in individuals at increased risk of cardiovascular disease: A systematic review and meta-analysis. *PloS one, 15*(11), e0241193.

Can Opioid Use Disorder be Treated? YES!

- There are medications for treatment of opioid dependency such as:
  - **Buprenorphine**
  - **Methadone**
  - **Naltrexone**

- Medication Assisted Treatment (MAT has proven to be very effective as part of an evidence-based treatment program that includes behavioral, cognitive and other recovery-oriented interventions, treatment agreements, UDT, and PDMP).

Pharmacotherapy for Opioid Use Disorder

- Estimates suggest that less than 40% of U.S. residents over 12 with an OUD diagnosis receive pharmacotherapy.[1]
- Encouraging pharmacotherapy is critical because individuals with OUD who engage in treatment with pharmacotherapy are less likely to exhibit withdrawal or craving symptoms and use illicit opioids, and are more likely to remain in treatment and engage in mental health therapy.[2,3]

1. Wu, L.T., H. Zhu, and M.S. Swartz. 2016. "Treatment Utilization Among Persons With Opioid Use Disorder in the United States." Drug and Alcohol Dependence 169, 117–27.
2. NIDA. 2016. Effective Treatments for Opioid Addiction. https://www.drugabuse.gov/effective-treatments-opioid-addiction-0
3. Connery, H.S. 2015. "Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions." Harvard Review of Psychiatry 23(2):63–75. doi: 10.1097/HRP.0000000000000075.

Medication Assisted Treatment (MAT) Resources

Resource	Website
Project ADAPT Medication-Assisted Treatment (MAT)	**https://opioidpreventionandtreatment.ucsf.edu/resources**
SAMHSA Waiver Elimination (MAT Act): All practitioners who have a current DEA registration that includes Schedule III authority, may now prescribe buprenorphine for Opioid Use Disorder in their practice if permitted by applicable state law and SAMHSA encourages them to do so.	https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act
SAMHSA Medications for Substance Use Disorders	https://www.samhsa.gov/medications-substance-use-disorders
From Project ADAPT: Prescribing MAT in the Outpatient Setting	https://opioidpreventionandtreatment.ucsf.edu/sites/g/files/tkssra506/f/wysiwyg/BCMJ_Vol60_No8_suboxone_guide.pdf
American Society of Addiction Medicine: National Practice Guideline 2020 Focused Update	https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline
National Institute of Health, Management of Opioid Use Disorders: A National Clinical Practice Guideline	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5837873/

Red Flags for Providers

Components of Addiction (The 3 “Cs”)	Possible expression in patients on chronic opioids
Loss of Control	• Reports lost/stolen medication • Calls for early refills • Seeks opioids from other sources • Withdrawal symptoms noted at appointments
Craving, preoccupation with use	• Recurring requests for increases in opioids • Increasing pain despite lack of progression of disease • Dismissive of non-opioid treatments
Use despite negative Consequences	• Over-sedation/somnolence • Decreases in activity, functioning and/or relationships

Red Flags with Prescriptions

- Forged prescriptions
- Prescription is from outside the immediate geographic area
- Altered prescriptions (e.g., multiple ink colors or handwriting styles)
- Cash payments
- Inconsistent or early fills
- Multiple prescribers

"The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription." (Title 21 Code of Federal Regulations Part 1306.04 (21 C.F.R. ⚕ 1306.04)

Smart Care California Priorities to Combat the Opioid Epidemic

GOAL	EXAMPLES OF DATA SUPPORTING GOAL AND RECOMMENDATIONS
Prevent. Decrease the number of new starts: fewer prescriptions, lower doses, shorter durations.	• Monitor long term opioid use. A large health plan study showed 67% of members taking opioids for 90 days continued regular use two years later. • Risk of prolonged use of opioids increases by 1% per day over 3 days.
Manage. Identify patients on risky regimens (high-dose, or opioids and sedatives) and develop individualized treatment plans, avoiding mandatory tapers.	• The CDC recommends against involuntary tapers; involuntary tapers have been shown to increase illicit drug use6 and suicidal self-harm. • Doses >100 morphine milligram equivalents (MME) per day increase the death rate almost ninefold 3 compared to 1 to 20 mg daily. Thirty percent of opioid overdose deaths include concurrent benzodiazepine use.
Treat. Streamline access to evidence-based treatment for substance use disorder at all points in the health care system.	• Starting buprenorphine in the emergency department doubles retention in treatment at 30 days. • Buprenorphine and methadone decrease rates of death, HIV, and hepatitis, and increase retention in treatment compared to social model treatments.
Stop deaths. Promote data-driven harm reduction strategies, such as naloxone access and syringe exchange. Promote data-driven harm reduction strategies, such as naloxone access and syringe exchange.	• **Co-prescribing of naloxone with chronic opioid prescriptions lowered emergency department visits by 47%.** Communities with increased naloxone availability have lower death rates. • Syringe services programs lower HIV and hepatitis transmission and health care costs.

California Health Care Foundation Smart Care California: https://www.chcf.org/resource/opioid-safety-toolkit/

Goals to Combat the Opioid Epidemic

When to initiate or continue opioids	Opioid selection, dosage, duration, follow up, and discontinuation	Assessing risk and addressing harms of opioid use
• Opioids are not the first line. • Establish treatment goals before starting opioid and a plan if therapy is discontinued. • Continue opioids for patient only if there is clinical improvement in pain and function • Discuss risks and benefits with patient	• Use Immediate-release opioids when starting. • Prescribe the lowest effective dose for short duration, provide no more than needed for the condition. • Follow up and review risks and benefits before and during therapy. • If benefits do not outweigh harms, consider tapering to lower doses and discontinue.	• Offer risk mitigation strategies including naloxone for patients at risk for overdose. • Review CURES before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter. • Perform UDT before and after therapy. • Avoid concurrent prescribing with benzos. • Offer or arrange MAT for patients with OUD.

Objective 3: Strategies to Engage, Facilitate Treatment, and Support Members

Improving Care Coordination

Co-occurring disorders are the expectation, not the exception

Recommendations & Best Practices	
Provider Collaboration	• Use standardized mental health screens to detect and identify if there are co-occurring substance use and/or mental health concerns. • Create linking mechanisms to support collaboration or care coordination. • Share patient information through direct phone, written form/fax, and secure e-mail. • Consider the patient for case management.

Improving Care Coordination

Recommendations and best practices for bi-directional Provider Communication

ACCURATE INFORMATION

- Document evaluation or assessment results to reduce duplicative tests.
- Ensure correct patient and diagnosis information is being shared.

SUFFICIENT DOCUMENTATION

- Share complete information that helps the referring provider with diagnosis and treatment planning.
- Keep in mind the minimum necessary requirements.

Improving Care Coordination

Recommendations and best practices for Provider Communication

TIMELY RECEIPT OR SUBMISSION

- Forward feedback within a week from evaluating the patient.
- If the patient was discharged, forward information the day of discharge.
- Contact the specialist or procedure site to request a copy of the report if the report hasn't arrived within 30 days.

CLEAR INFORMATION

- Direct phone calls are the best-case scenario for conveying information clearly.
- Utilize written forms/fax if providers cannot take phone calls.
- If phone calls or fax are unavailable, send secure e-mails.

Sharing Information to Support Care Coordination

When

- Forward feedback within a week from evaluating the patient
- When the patient is discharged, forward information the day of discharge
- Contact the specialist or procedure site to request a copy of the report if the report hasn't arrived within 30 days

How

- Direct phone calls are the best case scenario for conveying information clearly
- Utilize written forms/fax if providers cannot take phone calls
- If phone calls or fax are unavailable, send secure e-mails or US mail.

What

- Evaluation, assessments, patient diagnosis, patient medications, lab, imaging and test results
- Share information to help the referring provider with diagnosis and treatment planning
- Keep in mind minimum necessary requirements and releases of information

Recommended Actions to Support Members for Timely Follow-Up Care After an ED visit for Mental Illness (FUM) or Substance Use (FUA)

- Telehealth, phone visits, e-visits or virtual check-ins with a principal diagnosis of a mental health (FUM) or any diagnosis or substance use disorder (FUA) support follow-up requirements. The follow-up visit can take place on the day of the ED visit.

- Assign staff or individuals to implement follow-up care procedures to obtain and document proper permissions from the patient. Plus, document the best way to contact the patient.

- If possible, when discharging members, provide an overview of what the member should expect in the next few days and weeks

- If visits cannot take place on the day of the ED visit, consider contacting the member within 24 to 48 hours via phone to assess the member's health status, medications, needed appointments, and what to do if a health or medical problem arises.

Recommended Actions to Support Members for Timely Follow-Up Care After an ED visit for Mental Illness (FUM) or Substance Use (FUA)

- When documenting the follow-up visit, document the follow-up visit either with a principal diagnosis of a mental health disorder, intentional self-harm (FUM), or any diagnosis of substance use or drug overdose (FUA)
- Consider a prompt referral to a behavioral health provider to begin treatment within seven (7) days of patient's diagnosis.

  - Health Net's behavioral health administrator, MHN, administers behavioral health services to Health Net members

  - You may also refer patient to Case Management for more help. Refer to the Provider Operations Manual in the Health Net California Provider Library for more details.

Note for Pain Management Approaches

- Medication reconciliation and motivational interviewing
- Start with a complete baseline assessment
- Be familiar with latest guidelines
- Start low and go slow when prescribing opioids
- Screen patients for mental health, drug abuse and addiction problems
- Counsel patients and caregivers on safe use, including proper storage and disposal
- Emphasize using “one provider & one pharmacy”
- Refer patients to specialists if needed

Most patients have access to mental and behavioral health care through MHN, a Health Net company

BEHAVIORAL HEALTH SERVICES

- Depending on the plan, MHN works with its network providers to deliver medically necessary services for the treatment of mental health conditions, including:
  - ✓ Individual and group mental health evaluation and treatment (psychotherapy);
  - ✓ Psychological and neuropsychological testing when clinically indicated to evaluate a mental health condition;
  - ✓ Psychiatric consultation for medication management; and
  - ✓ Applied behavioral analysis (ABA).
- Unlimited 24/7 telephonic access for routine as well as emergent calls or concerns
- Coordination with Community Resources (non-treatment services such as housing, etc.), Health Plan, Integrated Case Management, and other internal and external entities
- **While providers can contact MHN Customer Service, it's best for a provider and/or staff to call with the patient in the room, to obtain member consent.**
- With the member present, the MHN Customer Service representative will briefly screen the member and help find the appropriate contracted provider.
- The member will receive a list of telehealth providers (via phone or e-mail). If the member is having difficulty finding a provider, they can ask the MHN Customer Service Team for a Provider Availability Check (PAC).

WAYS TO PROMOTE ACCESS TO BH SERVICES

- MHN recommends partnering with the patient to call MHN Customer Service. This allows the member to participate in the process and select a provider of their choice.
  - ➢ *"You have behavioral health services available through MHN. We can call them together and help you find a provider that fits your needs."*
- Encourage patient to call MHN directly through MHN Customer Service
  - ➢ *"You have behavioral health services available through MHN. Their customer service can help you find a behavioral health provider or specialist of your choice."*
- Use the Provider Directory function on MHN (with the patient, or the patient can search on their own).
  - ➢ *"You have behavioral health services available through MHN. Their website also has an option to find a provider of your choice, with telehealth options."*

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MHN Numbers & Resources

MHN Customer Service

- The customer service number may differ by line of business
- The number can be found on the back of the member's ID card
- If the ID card is not available, call (888) 327-0010, press 1 (for member services), press 3 (for benefits and referrals)

MHN Crisis Line

- (800) 322-9707
- This phone number provides MHN support 24/7
- This line is not for medical emergencies. If there is a medical emergency, dial 9-1-1.

Online Provider Directory

- Visit https: https://www.mhn.com/find-a-provider.html
- Check the applicable Health Net Plan (or Check CHW)
- There are 3 search options: "Search by Telehealth," "Search by Distance," or "Search by Provider Attributes and location"

Language Assistance

- (888) 426-0023
- If you need an interpreter or for any other language assistance needs

Supporting Medi-Cal Members through Community Health Workers (CHW's)

- In accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-016, Community Health Worker (CHW) services are considered preventive care services and are **Medi-Cal covered benefits** as of July 1, 2022.
- CHW's are members of the community, such as community health representatives and non-licensed public health workers, including violence prevention professionals.
- CHW services that can engage members and facilitate treatment include:
  - **Health education** – Services that promote health or address barriers to physical and mental health care. This includes providing information on health topics.
  - **Health navigation** – Services providing information, training, referrals or assistance to help members access health care. Examples include increasing member knowledge of the health care delivery system, or how members can engage in their own care.
  - **Screening and assessment** – Providing screening and assessment services that do not require a license, and assisting a Member with connecting to appropriate services to improve their health.
  - **Individual support or advocacy** – Assisting a Member in preventing the onset or exacerbation of a health condition, or preventing injury or violence. This includes peer support as well if not duplicative of other covered benefits.

For more information on Community Health Workers, please visit the CalAIM Resource for Providers page:
https://www.healthnet.com/content/healthnet/en_us/providers/support/calaim-resources.html

Medi-Cal Member Eligibility Criteria for CHW Services

Written Recommendation

CHW services require a written recommendation submitted to the Managed Care Plan (MCP) by a physician or other licensed practitioner of the healing arts within their scope of practice under state law

Other licensed practitioners who can recommend CHW services within their scope of practice include:

- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Podiatrists
- Nurse midwives
- Licensed midwives
- Registered nurses
- Public health nurses
- Psychologists
- Licensed marriage and family therapists
- Licensed clinical social workers
- Licensed professional clinical counselors
- Dentists
- Registered dental hygienists
- Licensed educational psychologists
- licensed vocational nurses
- Pharmacists.

Can not be concurrently enrolled in Enhanced Care Management

Medi-Cal Member Eligibility Criteria for CHW Services
Written Recommendation

The recommending Provider must determine whether a Member meets eligibility criteria for CHW services based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
- Any stressful life event presented via the Adverse Childhood Events screening.
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse
- Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
- One or more visits to a hospital emergency department (ED) within the previous six months.
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
- One or more stays at a detox facility within the previous year.
- Two or more missed medical appointments within the previous six months.
- Member expressed need for support in health system navigation or resource coordination services.
- Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children.

How CHW Services Support Quality Improvement

Covered CHW Services support Healthcare Effectiveness Data Information Set (HEDIS®) performance

- Health plans measure and compare quality of care through Healthcare Effectiveness Data and Information Set (HEDIS®) metrics.
- HEDIS® quality metrics reflect a spectrum of health-related topics and outcomes.
- CHWs can help members use appropriate healthcare services (e.g., have a primary care visit).
- CHW's can provide screening and assessment services (e.g., depression screening) and individual peer support to prevent the onset or exacerbation of a health condition.

CHW services can directly or indirectly close HEDIS® care gaps

- CHW service procedure codes can directly close the HEDIS® care gaps.
- Health navigation and health education can indirectly close care gaps by helping the member receive appropriate services, fill medications, address barriers to disease management, etc.
- CHW's can help collect data necessary to close HEDIS® care gaps.

HEDIS® improvement is critical to complying with Medi-Cal quality requirements

- There are a priority set of HEDIS® measures, known as the Managed Care Accountability Set (MCAS) that are reported to the Department of Healthcare Services.
- Managed Care Plans (MCPs) must meet the minimum performance level (MPL) on the qualifying MCAS metrics.
- CHW services will support the MCAS requirements through HEDIS® improvement.

Educational Resources for Providers

HEDIS TIP SHEETS

Health Net Provider Quality Improvement
https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/quality_imp_tools.html#tipsheets

- On the landing page, scroll down and click on: "Provider Tip Sheets"
- In the alphabetized drop-down menu, locate: "Follow-Up after an Emergency Department Visit for Mental Illness (FUM) / Follow-Up after an Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)"
- Select appropriate tip sheet per Line of Business
- Flyer will open as a PDF in a new browser window

OTHER ONLINE RESOURCES

Health Net Provider Library Microlearnings
https://providerlibrary.healthnetcalifornia.com/

- From landing page, select your "Line of Business"
- Select library topic from left navigation bar: "Education, Training and Other Materials"
- Scroll through alphabetized learnings and select: "Follow-Up Care After a Hospital or Emergency Department Visit for Mental Illness: Optimizing the FUH and FUM HEDIS® measures"