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BEGIN TRANSCRIPT:

LAURA GALBREATH: Good day everyone, and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions Webinar on Understanding the Disease of Addiction and Process of Recovery for Healthcare Clinicians and Staff. Today's webinar is in partnership with the National Association of Community Health Centers and designed for primary care audiences. My name is Laura Galbreath, Director for the Center for Integrated Health Solutions here at the National Council for Community Behavior Healthcare. Along with William Reedy from NAC we will both serve as your moderator for today's webinar.

Before I turn it over to Bill to welcome our presenter today, I just want to give you some housekeeping updates and let you know that today's webinar is being recorded and that all participants are in a listen-only mode. You can find the call-in number for the webinar on the right-hand side of your screen. Questions may be submitted throughout the webinar by typing your question into the dialog box to the right on your screen and sending it to the organizer. We'll answer as many questions as time allows. *[1:00]* If at any point during the webinar you experience technical difficulties, please call Citrix at (888) 259-8414. Today's webinar slides are currently posted online at integration.samsa.gov under the webinar section. If you would like to go to those quickly and print those, I know a lot of folks like to have those handy during the presentation. Lastly, just a reminder to please take a moment to provide your feedback by completing a short survey at the end of today's webinar. With that I'll turn it over to Bill Reedy.

BILL REEDY: Thank you, Laura. On behalf of the National Association of Community Health Centers I just want to say that we're delighted to partner with the Center for Integrated Health Solutions in the production of these series of webinars targeted to helping improve the health and well being of patients seen in community health centers by expanding the integration of mental health and substitute services. *[2:00]* It's my distinct pleasure to introduce our presenter today, John Gardin. John has over 30 years experience with behavior healthcare and possesses a unique background which blends clinical, administrative and research experience. He's a recognized

expert in the treatment of addictive and co-occurring disorders, as well as integrative care and behavior healthcare management. John regularly consults throughout North America and Europe, and has given countless seminars and workshops on clinical and management issues.

Dr. Gardin is currently the Director of Behavioral Health at ADAPT, a non-profit licensed mental health and substance abuse treatment agency serving the residents of three counties in southern Oregon, and the Administrator for ADAPT's South River Community Health Center, a Federally-Qualified Health Center. *[3:00]* And one of the unique aspects of Dr. Gardin's experience is that, to my knowledge, ADAPT is the only substance abuse treatment agency in the country that has become, or has developed, a Federally-Qualified Health Center. Dr. Gardin founded Pacific Coast Consulting several years ago also, and he and his staff provide psychological services to Veterans' Administration facilities in southern Oregon.

He has played an integral role in bringing addiction research to practice through his involvement in research and grants from the National Institute of Drug Abuse's Clinical Trials Network, the Health Resources and Service Administration, and the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. John is a licensed clinical psychologist both in Oregon and New Mexico as well as California, and is a consultant for CSAT's ongoing technical assistance. In addition to the additional experience that John has is that he serves as a clinical assistant professor at Oregon Health Services University Medical School and is a registered health service provider with psychology. *[4:00]* I'd like to now turn over the program to Dr. Gardin, and we look forward to your presentation. Thank you.

JOHN GARDIN: Thank you Bill and Laura. It's morning where I'm sitting, so I'll say good morning. I think it's probably afternoon where some of you are. I appreciate you attending today's seminar—webinar, and we'll try and make it worth your time as much as we can. I'm pleased to talk on this particular topic. Addiction has been the bulk of my work now going on close to 40 years in both non-profit and for-profit settings, and within the last five years in community health centers in our recently-acquired Federally-Qualified Health Center. *[5:00]* So this whole topic is near and dear to my heart, and I hope that comes through as I'm speaking to you today.

I'll be spending the first part of the presentation on just an overview of addiction. For those of you who are practicing addiction treatment and have been so, this may be a bit of a review—well, I hope it's a bit of a review—and for those of you who are not addiction specialists, I think you'll find the information foundational to then discussing in the second half of the presentation how to address addiction, or ways that addiction is addressed in medical settings.

Congruent with the old adage that one picture is worth a thousand words, here is my picture of addiction's yellow lab, black lab, chocolate lab and meth lab. *[6:00]* Oregon used to have a big meth problem. We don't so much anymore. But I think that kind of says it all. There are many very complicated definitions for addiction; that's always a good place to start is with the definition. Personally I like to keep these very simple. You can all pull out the DSM-IV TR and soon the DSM-V and read what they have to say. But basically, for me, if it causes a problem it's a problem. Addiction comes in all flavors and sizes and shapes, and I think it's important to

remember that. But basically, if somebody's using alcohol and drugs in a way that interferes with their functioning then it becomes a problem.

There is of course a drug use continuum, and I think it's important to keep that in mind, whether you're an addiction treatment professional, or whether you are a physician, or no matter what setting you're in. *[7:00]* Because traditionally, when we start talking about drug problems, we're talking about those at the far right of your screen, people who have alcohol and drug dependency issues, and those are the people with the most severe problems. But the bulk of people with alcohol and drug problems are to the left of dependency. And I think it's important as we hold this discussion today that we keep in mind that people at risky use level suffer some significant problems as a result, and those at the abuse level as well. So I'll be qualifying some of the things that I say around addiction and understanding addiction based on this continuum, because when we're talking about drug and alcohol use and problems with their use, or misuse, we need to remember that not everybody fits in the same box. *[8:00]* I'll also be using drug use and alcohol use interchangeably unless I specify one or the other. Alcohol is a drug, tobacco is a drug. There are a lot of drugs, so if I say "drug use" I'm not implying to exclude legal substances from that use. A drug is a drug.

I think it's important also to keep in mind that not all drugs are created equal. In other words, the risk of addiction is different for different drugs. This data was taken from a book that was printed in 2002, *Neurobiology of Addiction* I believe is the title, and it kind of estimates, based on rates of incidence and rates of presentation for treatment, what the risk of dependency is. *[9:00]* Now, all these numbers like this of course have all sorts of problems with them, but it's important to note that not all drugs react the same with all brains. And you can see that tobacco is at the top of the list; nicotine is arguably the most addictive drug we know that is most widely used. And essentially what these figures would mean, for example with tobacco, is that about a third of the people who try tobacco—pick up and chew, or smoke a cigarette—about a third will develop a dependency with that substance. Whereas with alcohol, about 15 percent of those who drink will, and with cannabis about 9 percent. So it's important to keep these things in mind. *[10:00]* And this is why ads saying that if you experiment with any drug at all you'll become addicted are not real effective, because people know, many people who have experimented with various drugs and they don't become addicted. Please do not [mis]understand me, I'm an abstinence guy. I'm not promoting the social use of any drugs. But I think it's important that we operate in the real world, understanding the effects of alcohol and drugs on people and that it's variable.

I also think it's very important when we're talking about addiction, as opposed to diabetes, hypertension or other kinds of disorders, that we remember that this is a bio, psychosocial disease and that there are many aspects to the problem. *[11:00]* This is what I think becomes the more complex nature of addiction, is that—and I have not listed all—you could all, each of us, we could have a day-long discussion about the many facets of addiction. But all of these boxes and many, many more come to play in whether a person will develop an abuse or dependency problem with alcohol and other drugs and whether they don't. And likewise, once they develop a problem the arrows will go the other way to affect these and many other areas of the person's life. So that the bottom line of this disease is that it's extraordinarily complex. It's important that we appreciate that as we move forward talking about what to do about it, because there are no simple solutions when we're talking about substance abuse disorders, as those of you who are

actively involved in the treatment of substance abuse disorders know. *[12:00]* This is not a simple disorder to treat.

Another aspect of substance abuse disorders that's very, very important to understand—again, I apologize for some of you if this is repetitious, but those who are not in addictive disorder treatment per se often miss the fact that this is a chronic disease, it's not an acute episode. In the early days—and I began alcohol and drug treatment in the Seventies—my goodness, that's a while ago—and back then we really saw substance abuse disorders overwhelmingly as an acute episode. In other words, if we can deal with it quickly one time well then we're done. As opposed to a chronic model which requires ongoing treatment, intervention and support. *[13:00]* So I want to go through some of the parts of viewing substance abuse disorders as chronic diseases, which leads us to that conclusion.

And one is that chronic disorders are usually acquired earlier in life, and the severe symptoms present much later in life, unlike a trauma. My wife and I were recently in a motorcycle accident, and my wife was thrown to the ground and she kind of hurt her back. That's an acute trauma which has acute treatment and will heal I hope relatively quickly. As opposed to a bad diet over many years which will create obesity, or which will create diabetes, or which will create hypertension. Those don't occur overnight, they take a long time, as does a substance abuse disorder. It takes time to develop. *[14:00]* Which plays into the whole—another reason why substance abuse disorders are so difficult to treat, because in the early stages it doesn't necessarily look like a developing problem.

Another facet of chronic disease is that the progression is very individualized. Early on—if there are some people listening who have been working with addictions for any length of time like I have—early on we put everybody in the same bucket when we treated addictions, and the progression was always the same. You drink abusively, you become dependent, and it's the same progression for everyone. And we know that that's not actually the case at all, that everybody's drinking pattern is very individualized, it's very difficult to predict where that pattern will go, what it'll lead to, and that is very common with other chronic diseases. *[15:00]* As I've mentioned earlier, the causes of chronic diseases are complex, there is not one thing that usually creates a chronic disease.

As to treatment, as with all chronic diseases, the more behaviorally-oriented approaches to treating those diseases seem to work the best. The behaviorally-oriented approaches with high blood pressure for instance work very, very well, or with diabetes. And I'm not saying they don't need medical treatment at all, but we need to deal with the behavior in addition to whatever intervention we're going to do. Interestingly, all chronic diseases, we put them in a bucket, and I'll show you a slide in a minute. Again, those of you who are in addiction are well aware of this, that Tom McClellan shared these insights with us a few years ago, is that the relapse rates for chronic diseases are very, very similar. *[16:00]* Another issue around chronic diseases is that all of them—diabetes, hypertension, asthma, substance abuse disorders, obesity—have extremely poor treatment compliance. A lot of people start, many people don't—in fact most don't, but those that do tend not to do well in treatment.

And it is also true that chronic diseases—all chronic diseases—seem to have an excessive amount of psychiatric co-morbidities. In other words, there are a lot of other mental and emotional issues that overlap with the chronic disease in question, and addictions is no different. This is the slide I mentioned just a moment ago that was in a slide very similar to it that Tom McClellan originally published, and as you can see, the relapse comparison between drug addiction, type II diabetes, hypertension and asthma, if you look at the percentage of relapse, very, very similar. *[17:00]* This slide was used by Dr. McClellan to show that, gosh, we think of relapse as a drug addiction problem; it's not, it's a chronic disease problem. Relapse is the rule, not the exception in chronic diseases. And I think the message again is that we need to look at and understand substance abuse as a chronic disease. For those of you in the addiction field we all know that, but those who are not miss this part, and this is extremely important to understand.

So how big of a problem is substance misuse? You know, understanding addiction is a very ambitious undertaking today. In an hour we're certainly not going to touch on every facet of it, but I want to give you a quick highlight. *[18:00]* So we know that about 6 percent—and I frankly think these figures are grossly underestimating what's actually the case, but we'll go with them anyhow. Six percent of those 12 or older abuse elicit drugs, 16 percent of those 12 or older abuse alcohol, and somewhere in the neighborhood of less than 25 percent of those who should get care and need care get that care. Now, that data has been used to make the argument that there is sufficient treatment. The reality is that all of those people who need care, only about somewhere between 50 percent and 70 percent actively seek care, or are open to care. And that number too varies quite a bit. *[19:00]* So the incidence of alcohol and drug abuse is a significant proportion, percentage of our population. And those are the sources of that information.

To give you one other facet of how big this problem is, this is a chart that came out of another book that William Miller wrote in 2002, looking at alcohol and drug abuse in healthcare settings, and I think it's extremely interesting. If you look at problem drinkers, and where do they present, where are they, you can see that 42 percent of them present in primary care, and 41 percent present in criminal justice settings. Four percent—one-tenth of the people in other settings—show up in the specialty alcohol treatment clinic. That's how my agency started in 1971. *[20:00]* Two percent—less than half of that—present in drug treatment clinics, and three percent present in mental health clinics. So the lesson here is—and as you go across, I'm not going to go through all of these, the same is true for alcohol dependent individuals and daily drug use individuals. The vast majority of these people who have these problems present in settings other than specialty clinics. Specialty clinics are where we have spent years training to deal with individual. They don't come to us; most of them go other places. Hence the importance of integrated care of course. But it's also important just to realize that the folks who have the problems aren't coming to us, they go to other places. And that has very far-reaching implications for training and application. *[21:00]*

Specifically in primary care, we need to understand, again, that less than 10 percent of those with a substance abuse disorder actually get help. And this number is a difficult number to actually put a finger on, but there are various estimates that 25 percent or more of the patients seen in primary care have some issue with alcohol or other drugs. We also know that patients with substance abuse disorders—SUD [sic] is substance abuse disorders—really mess with the medical practice. The environment in the medical practice—for those of you who are in medical

settings you already know, you work in that setting—it's very different than a clinical setting primarily designed to work with mental health and substance abuse issues. *[22:00]* It's a much more high-pressure setting, work production expectations are much higher. There is always the potential for emergent urgent situation to present themselves. It's a very different environment. And when you throw in patients with problems with substance use disorder problems it can really put a fly in the ointment. Not only do these patients complicate the delivery of medical care to them—because they're not compliant, because they tend to abuse the medications they're given, because they tend to be high need—but they also just disrupt the structure of a clinic. They can be complaining, paying patients who are abusing medications are extremely difficult to manage. They present administrative headaches galore. *[23:00]* So wouldn't it be nice if there were some way to deal with these folks in a manner in a medical setting that would somehow diffuse some of these and address the needs that they present? If there are any medical providers—

LAURA GALBREATH: I'm sorry.

JOHN GARDIN: Yes?

LAURA GALBREATH: Can I interrupt for one second? Back on the former slide, a couple people were asking what ETOH is.

JOHN GARDIN: Oh, I'm sorry. ETOH is ethyl alcohol. It's just an abbreviation for alcohol, because I got too lazy to—it's fewer letters. So ETOH is alcohol.

LAURA GALBREATH: No problem, thank you.

JOHN GARDIN: Thanks for asking. So this slide is merely meant to represent that a medical professional—I got this person with a stethoscope in his pocket, I'm not quite sure what that means. But I think that it's often the case that our medical professional really doesn't want information that they don't know what to do with, and so really don't want to go somewhere that they cannot provide a solution for. *[24:00]* Because they're trained to take care of stuff, and substance abuse disorders are not easy things to take care of. The take-away to all of this is that substance abuse disorders permeate the medical setting and are important factors in the lives of our patients that we must address, especially in the current environment of medical home and collaborative care which is now evolving throughout our country.

So, if we accept now that a substance abuse disorder is a disease, it's a chronic disease that's extremely prevalent, so the issue then becomes, what do we do about it in the treatment world? Never mind in the medical world, what do we do about it in the treatment world? *[25:00]* Let me show you the drug abuse—or we'd love if drug abuse worked this way—and again, I'm talking about drug abuse—all drugs, alcohol, everything else. A person presents with a drug problem, we put them into drug treatment, and they leave with no drug problem. That's the ideal treatment experience. And I'm assuming if we were face to face there would be some chuckles in the audience, because it never works that way. But that would be wonderful, wouldn't it, if life were that simple?

Where is treatment provided? Where do people actually go to help? As you can see from these percentages—and these are not exclusive percentages, by the way—many people in residential and substance abuse disorder clinics also go to self-help groups, so these numbers are overlapping. *[26:00]* But in general, we can see that when somebody does go to treatment—and again, these are the people who are actually seeking treatment, as opposed to just they have a problem and they show up somewhere—that they're still coming in large numbers to out patient medical care—that's 22 percent, 16 percent to emergency rooms, 23 percent in hospitals. So we have a large number of people that are presenting in medical settings for problems directly related to their substance abuse disorder.

So again, treatment is provided in a variety of settings, and the effectiveness of that treatment varies depending on that setting as well. The actual way that treatment works reminds me of a sign that I came across in Canada when I was giving a seminar. Actually there was only one or two arrows going to the left, so I think they could have simplified this sign. But it's just very confusing. *[27:00]* Treatment has so many options and so many shapes and sizes that the treatment experience for those not in the treatment world, as well as those who are, can be like, "Are you kidding me? How do you even decide what to do?"

What we know about effective treatments is that there are a core of treatments that have shown repeated effectiveness in clinical trials. We call these evidence-based practices, or evidence-based treatments. Now, I don't want to—this could be a whole topic in and of itself. Evidence-based treatments have a research background. That doesn't mean that treatments that do not have an evidence base are not also effective. What it means is that somebody has taken the time to evaluate them in a research setting. Many if not most of these treatment approaches are behaviorally-oriented, because that's the easiest to measure, and research is all about measurement. *[28:00]* You can go to the National Registry of Evidence-Based Programs, or Practices—that's NREPP, if you Google that, the Samsa website—and there will be over 240 models of treatment that you can identify there. States sometimes have their own registry. Oregon does have a registry of evidence-based practices. And for those of us in the field, if you go down the list you'll see some that you'll really wonder how they ever got on that list. But another discussion.

So there are evidence-based treatments which have been shown to be more effective than others. That's usually how comparison works. When you're looking for an effective treatment program you want to be able to ask them, "What is your treatment approach?" and hear an answer that makes sense back. If they cannot describe their treatment approach then you probably want to go to option B. *[29:00]* A key element that we now know for effective treatment is that that treatment must be individualized. That may sound, for those of you who have come into addiction treatment within the last decade or two, like a no-brainer, but for those of us who have been around for a long time, this was eye opening. It was a one-size-fits-all when addiction treatment was first started in the streets in any kind of measure in the late 40's and early 50's, and then into the 60's and even in the 70's. It was, you know, here's what you're going to do, and it was usually with the 12-step program, and everybody needed to do it.

We know now that, of course—as common sense would tell us, I don't know how come I was so thick back then, but common sense would tell us that treatment needs to be individually centered

to the patient. *[30:00]* And what we call that now is "adaptive care" or "stepped care," so that we provide the least intrusive care which is the most effective for this individual, and we have ways of modifying that care as we go along. We obviously want to involve the patient in setting those goals, and we want to involve people around them for the most effective treatment. We want significant others involved. I put this in here, "Involvement of significant others," because it is a keystone in an effective program, and because most treatment programs, mine included, do a poor job of this particular point. And we can talk about that, but it's a very important point. *[31:00]*

Additionally, when you're dealing with substance abuse disorders, it is key that you involve the big picture in the treatment—their work, their health issues, the psychiatric issues—and of course it's very important that we use medications. Medication assistant treatment—MAT, you can Google that as well—is a burgeoning field in addiction. Medication assistant treatment basically means employing a medication that has direct effects upon the brain of the substance-dependent person. We do not use medicated assisted treatment for earlier or lesser forms of substance abuse disorders. In other words, we're talking—that slide with the arrow that went to the right—we're talking about substance-dependent individuals. These are the folks that evidence a whole series of symptoms that may include increasing tolerance and may include withdrawal effects, but they don't have to include those to become substance dependent. *[32:00]* But their use is such that the cravings for that drug interfere with their ability to function, and absolutely interfere with the treatment process.

We have a variety of drugs—I do not have a slide on drugs. This field is constantly changing. The number of drugs that we have available at this time is extremely limited. As a quick tangent here, we started off with the term a "disease" of addiction. Most of us in this field believe that addiction is a brain disease at its core with significant bio, psychosocial, spiritual dimensions. That said, we don't do a whole lot about the brain disease aspect of addiction. *[33:00]* These drugs that I'm going to mention are limited attempts so far at addressing what happens at a neurochemical level in the brain. We have a small set of drugs that have shown some usefulness with those addicted to opiates, whether they are using street opiates such as heroin, or whether they're addicted to prescription opiates such as Oxycodone. These drugs have shown some utility. None of them are a magic bullet.

We have Naltrexone, also known as Vivitrol or Revia, methadone and Buprenorphine. All of them have shown good results, none of them have shown great results. They all seemed—especially Naltrexone with opiates has shown great results when a person is highly motivated (go figure that out) but not so great results when a person is not so greatly motivated. *[34:00]* Amazing, and we all just can't quite get past that. Methadone of course is the most widely-used medication for opiates because it's cheap. There is a lot of controversy around methadone, in that in reality methadone is a more difficult opiate to get off of than even heroin; methadone withdrawal is even worse. And I'm not even going to discuss medication maintenance and harm reduction, that's not the purpose of today's discussion.

Those are drugs that are used with opiates. We have used Buprenorphine in our program, because we're part of the largest clinical trial as one of the investigators of Buprenorphine with pain patients who are addicted to their medication. *[35:00]* And I'll tell you that, while it is good,

it's not great. Again, it's not a magic bullet. With alcohol, we have again a small set of drugs that have shown to have some use. Back when I got started disulfiram or Antabuse was widely used, it's not so widely used now. It got, in my opinion, a bad rap. It should never be used with people who don't want to stop drinking, but it is incredibly helpful for those who do. Disulfiram essentially makes you very, very sick if you use alcohol—any form of alcohol, which is one of the bad parts of it. But if you drink on disulfiram, you'll feel like you're going to die, and you would wish you were going to die, but you won't.

We have also used Naltrexone and Acamprosate and even Topiramate, which is a whole different class of drug, with some limited effects with alcohol. *[36:00]* Unfortunately again, these drugs, Naltrexone, Acamprosate and Topiramate, are more about the cravings and trying to control the cravings, and again, for people who are highly motivated they seem to work well. You'll notice I've mentioned Naltrexone twice. Naltrexone was developed to use with opiates, but we discovered that, gosh, people who are taking this for opiate addiction appear to also have decreased cravings for alcohol, so that's how we found out about that. We are looking at, we've used BuSpar (buspirone hydrochloride), which is an anti-anxiety drug, a non-addicting anti-anxiety drug, which is typically used as generalized anxiety disorder, for cocaine. And we're having decent results with that. There are ongoing clinical trials with this drug, so we're still looking closely at that.

We are looking at drugs for methamphetamine dependency, we're looking at Naltrexone and Bupropion— Bupropion you'll recognize as Wellbutrin—but again this is at clinical trial stages. There is some evidence that acetylcholine, which is a naturally-occurring drug in the body, taken in sufficient doses helps with cocaine cravings—or I'm sorry, cannabis cravings—and there are ongoing clinical trials with that. The bottom line with medically assisted treatment is that there is much research to be done. There is some interesting research around employing the use of amino acids in very high doses and intravenously that also holds great promise. So—and I'll get back to the medically assisted treatment in a moment. *[38:00]*

The take-home message is that substance use treatment is a complex process, and like all chronic disease treatment it involves behavior change. And that's why it doesn't work so well. It is not because we're dealing with an addiction, it's because we're dealing with behavior change. The brain disease part, yes, that's a very difficult aspect of treatment, but the real problem is that you have to change a whole constellation of behaviors to get an effective treatment. If we were in a all-day seminar or two-day seminar—I've done this for years—we'd all agree on a simple path that everyone would agree on before you left today. And tomorrow morning I would ask you how many had done it. A simple thing that I often do is I have people agree that they're going to get up and put their other leg in their pants tomorrow morning. *[39:00]* And nobody can get that done. Behavior change is very difficult. Behavior change when you have your act together and your life is going well is difficult. Behavior change when you're losing your family, might have just been fired from your job, are in jail, any other of the massively negative consequences of severe alcohol and drug dependency, behavior change then, extremely difficult.

So I'd like to take—I don't want to take much of a break or I'm not going to get through the application part here. If there are any questions on this part I'd be happy to take a couple. I really don't want to spend a lot of time on that though, I want to spend most of the remaining time

talking about, okay, so what do we do in a medical setting? But if you have a question, Laura, maybe now would be a time to address issues on addiction proper. *[41:00]* I'm going to get to what to do about it, so don't ask those questions, but if you have any questions on what we've already talked about I'm happy to answer those. Is there anything, Laura?

LAURA GALBREATH: Thank you. We have some points of clarification that we've provided via e-mail, in terms of some references to the website and some of the evidence-based practices that you have referenced. So we've addressed those. I think there was one question that I think we could address. What is the risk of addiction with the use of prescription opiods or opiates like Oxycodone?

JOHN GARDIN: Yeah, that's an excellent question. We're still actually researching that. It's not a clear cut answer. It appears though, in clinical practice, there are no—I should preface it with, there are no good studies that look at this clearly. But in clinical practice, in pain clinics, it appears to be about a third of your patients in a pain clinic, if you are a pain-specific clinic, which of course you're going to be using pain medication. *[41:00]* Yeah, about a third of them will be abusing their opiate medication. There are some guidelines, or some indicators, for misuse of pain medication. One of them is use of other illicit drugs, including cannabis. So if you have a pain patient who is abusing or using other illicit drugs, that's a very high indicator that they will abuse or misuse their pain medication.

We also know that with pain patients—and this was part of the clinical trial with Buprenorphine that I was one of the investigators on—we also know that pain patients have a different motivation for seeking to abuse their medication than typical opiate abusers, and their motivation is, unbelievably, to stop the pain. *[42:00]* And we're not real good at either intervening with pain or providing comprehensive pain clinics to areas such as where I live, out in the middle of nowhere, a very rural setting. So there's no good answer for that, but as best we know I would say that a good benchmark would be about a third of those who are taking pain medication will develop a problem in some way.

LAURA GALBREATH: Great. Well, we have I think one comment that I'd like to share before you start your next slide, and then encourage people to siphon their questions as we go into this next section for the Q&A portion of today's webinar. But I think this is a nice comment as we transition to your next section, which is, "Behavior change is difficult only when one expects it to occur instantly. The nature of behavior change is transitional, it occurs over time." So I think that was a good comment from a webinar participant to share."

JOHN GARDIN: Yes, that's absolutely true. And of course, life goes on. So it's difficult. *[43:00]* Whether it occurs today or it occurs over the next ten years, it's hard. There's no easy way to change behavior, that was the point. Whether it takes a long time or a short time, behavior change is a big deal.

So when we talk about next steps—okay, so that's addiction. That was geared towards people who really don't know anything about addiction but are working in the medical setting, that's like kind of the basement level. So now what do we do with all that information? You're in a medical clinic. The first thing that I tell everyone to do is contact your local addiction treatment

agency. There is somebody in your community, if you are an FQHC or CHD in the medical clinic at all, there's someone in your area that treats addiction, that's their job. I am intimately involved with clinical treatment programs all over the United States as part of the clinical trials network with the National Institute on Drug Abuse. I'm the Chair of the clinical treatment programs, about 240, 250 of them across the United States. *[44:00]* And overwhelmingly what they say is, "Gosh, we'd love to be involved with FQHCs or CHDs, but we can't find a way in the door. They don't want to really talk to us."

I would urge you, if you're in a medical setting, don't try and reinvent the wheel, call up a local agency and get them involved with you in addressing this issue. So everything I'm going to say from this point forward assumes that you do that. That's step number one. None of this meant to, "Okay, now you're an FQHC, you're a CHD, you can just go do your own thing with addiction." Bad idea. So the good idea is contact that agency. Once you have contacted that agency you're going to have all sorts of decision points about, how would we incorporate what they do treating addiction in our setting? The converse is also true: how would they incorporate medical services in their setting? *[45:00]* And there are a variety of models. This presentation isn't really—the purpose of this presentation isn't to go into models of integration. But you'll need to decide how structurally this should happen best.

There are many ways to cut the pie, and again, I'm not going to go into that. But one model I definitely want to address is what is called SBIrT—Screening, Brief Intervention, Referral and Treatment. It's a model that has received a lot of attention in research and is widely used. Now, it's not a typo. "SBIRT" with the big "R" and the "SBIrT" with a small "r", that's intentional. *[45:00]* SPIRT is a very interesting model. Essentially this model as developed in the literature is training medical personnel—that would be nurses or providers—to screen patients, do a brief intervention with them, mostly motivational interviewing-ish, some kind of a brief intervention— and then refer them for treatment somewhere else, usually. That was the way the model was developed.

I have many problems with that model. And again, this is just me talking. Number one is, I run a medical clinic. I don't have time for my providers to spend five or ten or fifteen minutes in addition to what they're doing as a provider screening people for addictive disorders and using motivational techniques to intervene with them. Not only don't they have the time to do that, motivational interviewing is a very complex process. *[47:00]* Motivational interviewing is the Aikido of interventions, and it requires a lot of training and a high level of skill to do appropriately. There are many people that think it's a slam dunk. Not so. Very, very difficult. So I have a problem with redefining the workforce to do this.

The second big problem I have with SBIRT is that referral doesn't work. If you refer people across the hall, or across town, or across the street for alcohol and drug treatment, they don't get there. It doesn't work. So even through we can identify people in a medical setting with this particular model, it works best if we modify it, and that's what the small "r" means, and I'll talk about that modification in a little bit.

With any integration issue, if we're going to move addiction treatment into a medical clinic, or medical services into an addiction clinic, we need to address these three issues at a minimum.

[48:00] And again, we're not here to discuss those, but these are factors that all need to be addressed. What are we actually going to do? How will the care be provided? And how much is it going to cost, is it good value? There are many good treatments. I can think of some very complex and high-intensity treatments for addiction that involve multiple interveners in a family system—some of you know what I'm talking about—totally impractical in the real world. Way too expensive, way to time-intensive. Yes, it does help that one family, but we have hundreds of families to help, thousands, hundreds of thousands. That's just not a good use of resources. And again, all of that is up for debate, but again that's not the purpose of today's discussion. But anything that we're going to talk about when we move addiction into medical care needs to address those issues. *[49:00]*

There are many clinical issues that also need to be addressed when we're talking about integrating addiction treatment into medical care or vice versa. And again, I don't mean to imply just treatment for those who are dependent. Again, the bulk of people with alcohol and drug problems are not addicted, they're—it's problematic use, it's risky use, it's abusive use, and a small number are dependent use. So one of the real good ways of identifying people with risky and abusive use, and also putting boundaries on those who are going to be severe abusers of the system and be dependent users, is to have controlled substances and medication contracts. *[50:00]*

And substance abuse agencies are excellent resources in how to develop those contracts that really define what kind of use of a controlled substance indicates a problem and what are we going to do about it. There are many screening tools available for administration to find people with alcohol and drug problems. The AUDIT is one such tool, the DUDIT, which is—the AUDIT is for alcohol, the DUDIT is for other drugs—are often used. I've got to be real honest that those tools have shown good results in research, and I've read other studies where they seem to work. In our population they were pretty useless. They did not really identify users. *[51:00]* The way we interviewed, we discovered people with alcohol and drug problems, was with a very brief intervention with a non-medical person. Once again, we'll talk about our experience in a moment. But again, you'll need to decide that in your own setting. Perhaps screening tools would work, and there are some screening tools that are even electronic in nature, where you can have a patient utilize a computer or some little electronic tablet to take whatever kind of a screening tool you might want to employ.

Pain patients are a huge issue. That would be a whole other seminar, is how to—we talked about that with an earlier question, but pain patients are a huge clinical issue. They take up a lot of time in a medical clinic, they're extremely difficult to manage. Most rural or suburban settings do not have bona fide pain clinics. *[52:00]* Although that's available in urban settings, in large cities, it's not so much other places, and so there's no real place to deal with these folks. An integrated system around alcohol and drug and mental health issues for these folks is a home run, because they are so demanding and so difficult.

Where exactly will you provide the treatment, and how will you provide it around mental health, addiction and behavioral medicine? Which is the catch-all. Behavioral medicine really captures issues related to a medical diagnosis that can be addressed with psychological interventions. We know, for instance, that hypertension has a stress component. It's not a huge component, the

literature's really clear on that, but it's not insignificant. It can account for anywhere from 10 to maybe 25 or even 30 percent of the hypertension dynamics. *[53:00]* But that percentage can be enough to limit the amount of medication the person needs, or even eliminate the amount of medication they need, by teaching them stress management techniques and relaxation techniques. So behavioral medicine is a burgeoning new field. So who's going to provide these, and where will they be provided?

Another issue that is excellent to address around integrated care issues and substance abuse clients are noncompliance. People with alcohol and drug problems are notoriously noncompliant. Not only will they abuse the drugs you give them, sell them to other people, but they won't take them, they're just not compliant with the other instructions relative to their medical care. As are—as we said earlier, as are all patients with chronic illnesses. So how are we going to deal with those people? *[54:00]* And of course, a key clinical issue in any setting, no matter where you are, is to really be mindful of what kind of evidence-based approach you're going to use, and just not throw everything at patients, but something that we really expect to use.

There are some very specific operational issues around treating substance use disorders, or identifying them in medical settings, and one of them is, who is the behavioral healthcare consultant? I mentioned earlier that in the first SBIRT trials, the behavioral healthcare consultant was actually, or usually, a trained RN who knew a lot about medicine and was trained to recognize addiction, and was trained minimally in motivational interviewing. But one of the things you'll have to decide if you decide to address addiction and—substance misuse would be a better word—substance misuse in a medical setting is who is going to be the behavioral healthcare consultant. *[55:00]* What licenses should they have, what skill sets should they have, who's going to be the most effective at doing that? We decided that LCSWs fulfill that bill best for us, Licensed Clinical Social Workers.

There are other operational issues about where that treatment is going to be provided, how it's going to be provided. The more the substance use/substance misuse treatment is integrated into the flow of work in a medical setting, and vice versa, the more the medical care is integrated into the specialty care setting of addiction treatment/substance abuse treatment, the more that integration occurs, the greater efficiencies you'll realize and the more effective they will be. *[56:00]* So collocation is really going to be key to effective integration, in my opinion.

I'm going to skip a couple of these, because we're running out of time and I've got some other things that I want to address. I do want to talk about scheduling issues, it's a huge operational issue dealing with substance misuse in a medical setting. The medical environment, as I mentioned earlier, is a very high-pressure, high outcome environment. You cannot schedule—it's not wise to schedule in my opinion—50-minute therapy sessions in a medical environment for these kind of issues, so you have to modify out-treatment as provided. It becomes brief intervention, brief therapy, and then after a relationship has been developed, then a warm handoff into specialty care if that's needed. *[57:00]*

And a key component of this scheduling issue is what we call the meet and greet, where a behavioral healthcare consultant is able to stick his or her head in the door in the exam room—hopefully when the patient's not in a compromised position—and talk to them about—just

introduce themselves and ask them in a non-invasive, non-confrontational way if there's something they can help them with. So, if they're on pain medication, they can stick their head in the door and say, "I'm part of the medical team here. I noticed that you've got some pain issues. Oftentimes we resort to controlling our pain with other medications or even drugs on the street, alcohol. If you're having any issues with that at all I can help you." And we found that that can be very effective in identifying and intervening with people with substance abuse disorders.

I'm not even going to get into the whole charting and confidentiality issue. Huge. *[58:00]* Most electronic health records are doing a good job regarding charting for mental health in medical settings and vice versa. Not so good around federal confidentiality regulations on drugs. It requires special modifications to electronic health records, and we found disagreement with that. You've got to make sure and address that.

I'd like to talk briefly, and then I'm done, about our experience in creating a model for intervening with substance abuse disorders in a medical setting. We were awarded a HRSA grant about six years ago to create this model. And so we initially thought that we would train a nurse, as I mentioned before. That's a typical model with SBIRT. *[59:00]* We train a nurse—find a nurse, cross-train them in substance abuse disorder identification and basic mental health issues. By the way, in our experience, separating mental health and substance abuse identification is probably very inefficient, because there's such a huge overlap. Roughly a third of those with mental health disorders should have some substance misuse problem, and about 40 percent of those with a substance misuse problem have some kind of mental disorder. So we found it better to deal with both at the same time. But when we went to try and train a nurse to do this we—again, as I mentioned, we're in a rural setting—didn't have good luck with finding someone that we could train.

So I decided to take a couple of my certified alcohol and drug counselors who had a lot of training and experience and put them in the medical clinic. *[1:00:00]* And because they were alcohol and drug counselors, they were not able to identify the mental health issues. It's good to know, to remember, that people with alcohol and drug problems at any level don't really want to be found. Not only do they not want to be found, they don't want to be treated. As opposed to people with mental health issues. They're usually quite open to interventions. As many of you know, with depression and anxiety medical studies, those studies go through the roof, they have incredible identification and compliance and retention issues that you do very, very well. Addiction, not so much. People don't really—it's part of the disease of addiction, that it's just very, very difficult to engage them in treatment. *[1:01:00]*

So we ended up hiring a Licensed Clinical Social Worker who we trained in addictive disorders, substance misuse disorders, and he went into the medical setting, and in our program he would screen—he screened about 2000 patients a year, which was about 20 percent per year. They had about 10,000 patients in this clinic, so we screened about 20 percent of them every year. When he did his screening he was able to identify or engage about 15 percent of them in ongoing treatment. Now, ongoing treatment could be as little as two to five sessions, and it could have been more than five sessions, but that was rare. We tried to keep this a very brief intervention model. In our experience, about half of the people that he saw were Medicaid patients, and those

were the ones that we had data on that I will be sharing with you, just for electronic health records kind of issues. *[1:02:00]*

You'll notice that the mix was, as I said before, about 25 percent substance abuse disorders, 35 percent mental health, and 40 percent both. We found that there were a group of Medicaid patients—because remember, the only ones we have data on are the Medicaid—there was a subgroup in Medicaid—about a third, about 30 percent—that accounted for almost three-fourths of the utilization. We termed them our "high flyers," our "frequent flyers." So in the future we plan on targeting that specific group. *[1:03:00]*

What we found in our interventions—as I've already described, were two sessions to five sessions, and occasionally more than five sessions—is that two-thirds of the people showed significant improvement in both their alcohol or drug use. In other words, in the medical setting we were looking for decreased use—we were not looking for abstinence; even though that's our model, we felt it would be more appropriate to change that a bit—and/or improvement of their mental health symptoms: depression, anxiety or such. We also found that the overall medical utilization for Medicaid patients decreased by about 13 percent. That's a big number. That means a lot to managed care organizations, or in the future community care organizations, and is a good marketing tool. *[1:04:00]* So that, if you're an addiction treatment program, if you're a substance misuse/substance abuse disorder treatment program, that's a selling point to FQHCs and CHCs, is that you can reduce utilization so that they can see more patients instead of seeing more of fewer patients.

But perhaps the most impressive thing we found is that we were able to reduce medical utilization for that frequent flyer group, including visits to the ER, by a third. That's just a huge number. What we learned from our project is that really, in a medical setting—taking substance abuse disorder treatment into a medical setting—that the medical assistants, the CMAs, are what really drive the approach. *[1:05:00]* Providers are important to be onboard, they need to be supportive, but really the medical assistants are the ones that we rely on to help us identify patients who might use our services and to be kind of the hookup point for us as well.

We found that people who come in to see our behavior health consultants had a no-show rate of about 50 percent. Some days we're a little better than others, but it averages still out to about 50 percent, and so work financially we have to book like an airline. We also found that—one of the areas of medically-assisted treatment that I didn't really address because most people don't consider it medically-assisted treatment—I do—is the use of psychotropics. In other words, medication for mental and emotional disorders. *[1:06:00]* As you probably well know, the vast majority of anti-depressants and anxiolytics, anti-anxiety medications, are prescribed in general medical practices, not by psychiatrists. And they do this with as much skill as they've had training to do it in, and they're usually the ones providing the diagnosis as well. What we found is that, by putting our behavioral health consultant in the medical environment, he was able to assist them in appropriate prescribing. Given that a high percentage of our substance abuse disordered patients also have a co-occurring mental, emotional disorder, getting them on the right psychotropic is extremely crucial to their recovery. So we found that this was a great aid to our practitioners, they really appreciate it.

We also—we mentioned pain patients several times, and we were able to help with that significantly. I've already spoken about the session length. These are the behavioral medicines. *[1:07:00]* They're in code. If you're not using them in a medical setting with a mental health or addiction specialist, those are golden. And again, they are codes that relate to providing psychological treatment for a medical disorder, so you don't have to diagnose them with a psychiatric disorder. So if you're not using those, you need to do your research and begin using those.

Addressing substance abuse disorders, with or without mental health disorders, in a medical environment is extremely difficult, because it involves constant retraining of the medical staff in that environment to be aware of the new member to their medical team. If you go into that environment, you have to adapt to the medical environment, and you have to integrate with the medical environment. You shouldn't expect them to adapt to you. *[1:08:00]* But nonetheless, they have to be aware of who you are and what you do, and that's a constant training issue we found that we have to go over and over. There are constant scheduling challenges in the medical environment, again because of the nature of that environment.

There are some scheduling and billing issues around Medicaid and Medicare that make same-day visits for the same-day diagnosis something you can't do. So in other words, if you get somebody in for hypertension and you want to see them for a behavioral medicine code that same day by the behavioral healthcare consultant on some stress management or a related issue, you can't do that on the same day. That's not really a substance abuse disorder issue, but again, because there is such an overlap, sometimes we as a behavior medicine issue, to get our foot in the door with a person who we know has a substance abuse disorder, we'll use whatever door we can get in, quite honestly. *[1:09:00]*

We continue to find however, that identifying, interviewing and treating substance abuse disordered patients in a medical environment is extremely challenging. I don't know of a magic bullet in this environment. I'm aware of many folks that are attempting to do it. I think it's somewhat environment-dependent. In other words, I think the approach has to be modified to deal with the setting involved. But I think it's important to remember that these people don't, as a rule, want to be found. And so it requires a lot of side door approaches, as opposed to direct confrontation. That'll never work. *[1:10:00]* So looking for keys or clues to a substance use disorder, such as mismanagement of their medications, of their scheduled medications, is one way of identifying that group, that then you can intervene with in a productive way. The issues around confidentiality again are just huge, and we continue to work on those issues. And billing issues around substance abuse disorders in a medical setting also, just for pragmatic reasons, it was important to cover.

In short, I think the issue of substance abuse disorders in a medical setting—and medical services in the substance use disorder setting, which I have not really addressed today—are important, very important issues for us to be aware of. If you're a medical provider I strongly again urge you to bring your substance abuse disorder treatment agency into the mix, invite them in, and work out with them how they might help you. *[1:11:00]* I think that's the best way to begin to identify patients in your environment. There is no one model, I don't believe, that works in all settings. So even though nurses didn't work for us, maybe they would work somewhere else.

Even though referral didn't work for us and it doesn't work in a lot of settings, perhaps if you modify the way you do referrals perhaps you would have better luck. But I think it's worth having the dialog to figure out how to find these people and treat these people, because they're there and they need our help. And if you're going to do this, this is my visual [inaudible 1:11:46]. So we have a few minutes for questions. Laura?

LAURA GALBREATH: Yes, thank you. I have cleared the line in terms of folks if they would like, if they've dialed in they can click on the hand icon and I'll be able to open their line. *[1:12:00]* We do have lots of folks that have typed in questions. First of all, I think, you know, around the area of financing, in terms of partnering with specialty addiction treatment programs, I think there's a concern because many escalate fees. Or HRSA-funded health centers have a lot of folks that are uninsured, they don't even have Medicaid. And do you have any advice for that conversation about that population, because maybe they can't afford specialty services because they're uninsured, and how do they get in for treatment if they can't afford that?

JOHN GARDIN: Well, that's an excellent—of course that was one of the issues that I brought up early, is you have to address financial issues. No matter how good the idea is, if you can't pay for it it's not viable. Medicaid—especially of course, since it's state-administered—and Medicare services are key to the survival of an FQHC or a rural health clinic. *[1:13:00]* Billing for those services is really what drives the success of those clinics. Every state handles the billing of treatment for substance abuse disorders and mental and emotional problems differently. In our state, for example, overwhelmingly in each county the county is the sole provider of billable mental health encounters through Medicaid. And the billable encounters for substance abuse disorders is usually contracted to a specialty clinic for substance use disorders, like us.

In addition, if you're an FQHC or an RHC, you can define a change in scope to provide those services in your clinic. *[1:14:00]* Now, once you are allowed that change of scope the substance use disorder billing is usually rather straightforward. The mental health services billing may not be so much. As I mentioned earlier, in our particular situation, even if we changed our scope we couldn't bill for those. But we can bill for substance use disorder treatment in an FQHC, and in fact we do that. That's why I brought up the behavioral medicine codes. The behavioral medicine codes are a way to provide psychological care to patients with mental disorders where other issues may be uncovered. And if those other issues are uncovered, then you have to be very—you have to know in advance how you might be able to bill those productively. And again, in our case, we can bill Medicaid and our FQHC for substance use disorder treatment, but we can't bill mental health. *[1:15:00]* So it varies by state, but mental health and substance abuse disorders are two very billable categories. And if I recall, Laura, I think we put out, the CIHS put out a—I think there's a chart available to folks. I can't now remember the details on the chart, but I think you took state by state and what was billable and what wasn't. Didn't she have something like that?

LAURA GALBREATH: Correct. So if folks visit the integration.samsa.gov, under "Financing" you'll see that we created billing worksheets for individual states, and we're developing one for the District of Columbia, that list the different codes that are available, turned on, as well as who can bill for those codes, including the 9600 series which support behavioral health intervention for people with a primary medical condition. *[1:16:00]*

JOHN GARDIN: Right. And in fact I want to put a plug in for the CIHS. If you'll go to the integrated care part of their website, they've got more resources there for integration than I know of anywhere on the planet. So that will be something you might want to access.

LAURA GALBREATH: Well, thank you very much, I appreciate that. We did have a question about prevention. What does prevention look like in primary care in terms of prevention or a—or, yes, prevention. Let's leave it at that.

JOHN GARDIN: Yeah, a very good question. We, in the past, when there was actually money, we were the provider of prevention services in Oregon, for the state actually, and we continue to have limited prevention services. In the medical setting, our prevention services are really limited to patient educational materials. *[1:17:00]* We have a lot of handouts, we'll have in the very near future videos running that will explain substance use issues, both for adults and adolescents. But there are not—we don't have any particularly specific prevention modules available per se in the medical setting. As some of you may know, in an FQHC and RHC—a Federally-Qualified Health Center or a Rural Health Clinic—the funds for outreach are kind of rolled into your funding, so to speak. And outreach work can include prevention work, and so we can incorporate some in there. *[1:18:00]* But as in most settings, there is just limited to no funding, and so it's really relegated to just educational materials at this point.

LAURA GALBREATH: Great. I have a question or two about workforce that I wanted to ask, and then some statistics around your slides on outcome. On workforce, I think there's really two questions here. One is the use of—when you talked about the behavioral, the BHC. I know because of billing a lot of states limit that to like a licensed social worker or psychologist. And then there was a question about are other staff able to serve in that role, like Licensed Professional Counselors. I think there's another related question that you could also speak to when you're talking about workforce, is the use of individuals in recovery and how you're using them as part of—or do you use them in the primary care setting, or do you typically use them just in your specialty services? *[1:19:00]*

JOHN GARDIN: Yes. Again, a very good question. Medicare is very inflexible around who can provide what kind of services. As far as provision to Medicare patients, we're really limited to Ph.D. psychologists. I'm the only one, and I don't see patients, so we don't provide those services to Medicare patients. Medicaid—again, who can provide Medicaid services, substance abuse or mental health services, varies from state to state. In our state, anybody with the appropriate training and scope of their licensure or certification can provide billable Medicaid services in an FQHC setting. But again, that varies by state. *[1:20:00]* We're able to then use our Certified Drug and Alcohol Counselors—CDACs we call them here. We can use licensed health professional: a Licensed Professional Counselor, a Licensed Clinical Social Worker.

So really in Oregon we're able to use any licensed or certified professional. We're also able to use, in the medical setting for our state Medicaid—and again, this is probably going to vary widely across the United States—peer counselors. We are just moving into this area. It's embarrassing to admit, but the gal that does all the training of peer counselors is my employee, and we have very few peer counselors, and she goes out to other places who have many more

than we do. *[1:21:00]* So we plan on expanding the role of peers and mentors in the medical environment. I'm not sure how the billing will work in the medical environment. We're able to bill in our specialty care environment because that's under a different contracting, but I'm not sure about how that will work in the medical environment.

LAURA GALBREATH: Great, thank you. Yeah, I think that's a growing area in terms of the workforce.

JOHN GARDIN: It's huge.

LAURA GALBREATH: Along with other care professional and allied professionals. So the Center will be exploring that in the coming year and we look forward to bringing more information to folks. Two quick questions about outcome slides. How were outcomes for significant improvement measured?

JOHN GARDIN: Well, we—I don't now how many of you have ever had a HRSA grant. It was a rural health outreach grant, it was a specific funding vehicle. Excellent funding vehicle. *[1:22:00]* If you get an opportunity to apply for one I'd strongly suggest it. There's not a lot of money, but they're extremely flexible and you can—your project can morph as needed to address your areas of concern. And in fact it became the vehicle eventually for establishing our FQHC. With the funding we were able to pretty much decide how we wanted to—what direction we wanted to move in with the rural health outreach grant. And now I forgot where I was going with the outreach grant. I'm sorry, I got lost in another thought. Tell me that question again. *[1:23:00]*

LAURA GALBREATH: No problem. They were just asking about how you had measured significant improvement in your outcome.

JOHN GARDIN: Oh, yeah, yeah, yeah. Okay. Well, so all that to say, we didn't have a lot of money for researchers, statistics. I wasn't able to even hire a statistician. So what we did is we used a simple outcome. We gave individuals the Hospital Anxiety and Depression Scale, the HADS, which has an extensive research background. It's a real quick—I forget how many items exactly, I think there's like twelve items, give or take. And we compared scores when patients first started seeing our behavioral healthcare consultant with the scores that they obtained at the end of treatment for one rating. And then we compared how they said they were using alcohol or drugs at the beginning with how they said they were using, totally self-report, at the end. *[1:24:00]*

LAURA GALBREATH: Great, thank you very much. That's all the time we have for questions today, so I'd like to turn it over back to my co-moderator Bill Reedy from NAC.

BILL REEDY: Thank you, Laura. And thank you John for a wonderful presentation. Very comprehensive, and covered all of the many concerns and considerations that we all need to carefully think about in this area of—an era of change. I greatly appreciate the participation, the questions, and the vigorous discussion that we had about the topics. I'd like to also thank the Center for Integrated Health Solutions for a perfect partnership. NAC is delighted to continue to

work together to promote the bi-directional integration of behavior health and primary care. I do want to highlight a couple of issues that—kind of one that kind of permeated I guess the discussion today is that practice transformation is underway. *[1:25:00]* That, however we approach integration of mental health and substance use services in primary care, it's rare that it's a plug-and-play activity. We can't simply take what we've been doing in one setting and plug it into the other setting. So we're all learning rapidly, and I think the challenge for us is to continue to learn and to share our learning with each other.

To that point, one of the future webinars that NAC is working with the Center to conduct will be in mid- to late-October. I'm sorry, I don't have the exact date available. But it's going to be a webinar focused on patient-centered medical home and the delivery of integrated behavioral health services in the context of the patient-centered medical home. Addressing kind of care coordination and the whole issues of team-based care and population-based approaches. And I think that it's very relevant to the discussions today. *[1:26:00]*

One final point. I would ask that your feedback is very important to us as we kind of plan future sessions and kind of keep thinking about how we can do better in terms of meeting your needs. So please take a moment before you sign off today to fill out our brief questionnaire at the end of the survey to let us know how we did today and any suggestions you have. So again, on behalf of NAC and the Center for Integrated Health Solutions, thank you all for your participation and we're looking forward to having you join us in future webinars. Thank you.

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