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This presentation is part of the Community Rounds Workshop Series

These sessions are provided monthly thanks to the University of Vermont Center on Rural Addiction, the Vermont Center on Behavior and Health, and a grant from the Health Services and Resources Administration.

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Outline: Alcohol Use Disorder in the Primary Care Setting: Best Practices for Rural Communities

10:30-11:00		Christine Chasek, PhD, University of Nebraska Omaha **Alcohol and Ag: Prevalence of Alcohol Use in Rural Populations**
11:00-11:30		John Brooklyn, MD, UVM CORA Clinician **I CAN Treat Alcohol Use Disorder in the Office**
11:30-12:00	 	Denise O'Connell and Mary Lindsey Smith, PhD, Lunder-Dineen **Using a Multi-Pronged Approach to Reduce Organizational and Provider Burdens for Addressing Unhealthy Alcohol Use in Rural Primary Care Practices**
12:00-12:30		Dr. Christine Chasek, Denise O'Connell, Dr. Mary Smith **Questions & Discussion**

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Session Objectives

- Understand the importance of screening in novel ways for mental health and substance use in rural communities.
- Discuss ways rural communities can spread awareness about AUD.
- Understand the biological basis for treating alcohol users with medications in the office.
- Learn how to reframe the message around alcohol ingestion.
- Understand organizational and provider-level barriers to addressing unhealthy alcohol use in rural primary care settings as well as successful strategies that can be implemented to mitigate these challenges.
- Describe the necessary steps to create and coordinate an effective and efficient, team-based practice model for alcohol screening and patient care in rural primary care practices.

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Continuing Education Credits

In support of improving patient care, The Robert Larner College of Medicine at the University of Vermont is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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Disclosures

There is nothing to disclose for this UVM CORA Community Rounds session.

Potential Conflict of Interest (*if applicable*):

All Potential Conflicts of Interest have been resolved prior to the start of this program.

All recommendations involving clinical medicine made during this talk were based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients.

This activity is free from any commercial support.

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Alcohol and Ag:
Prevalence of Alcohol Use in Rural Populations

Christine Chasek, PhD

Associate Professor, Chair of the Counseling Department at the University of Nebraska Omaha, Associate Workforce Director of the Behavioral Healthcare Center of Nebraska

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Where I'm from and What I do

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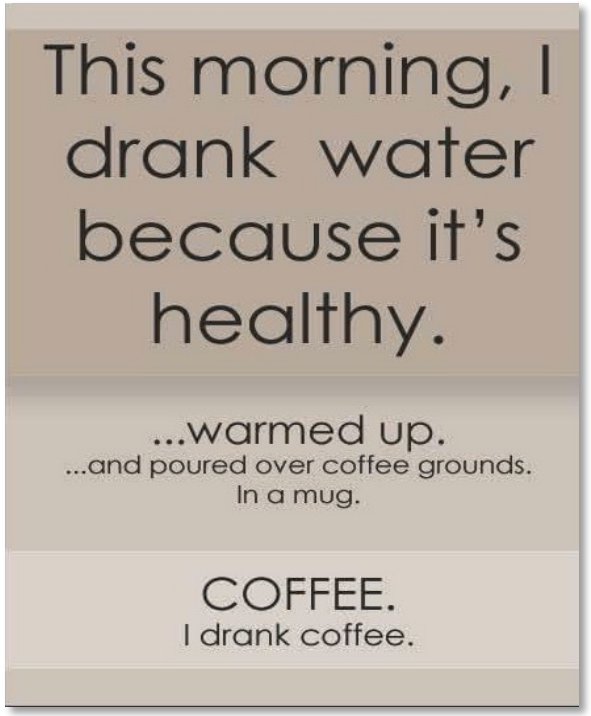

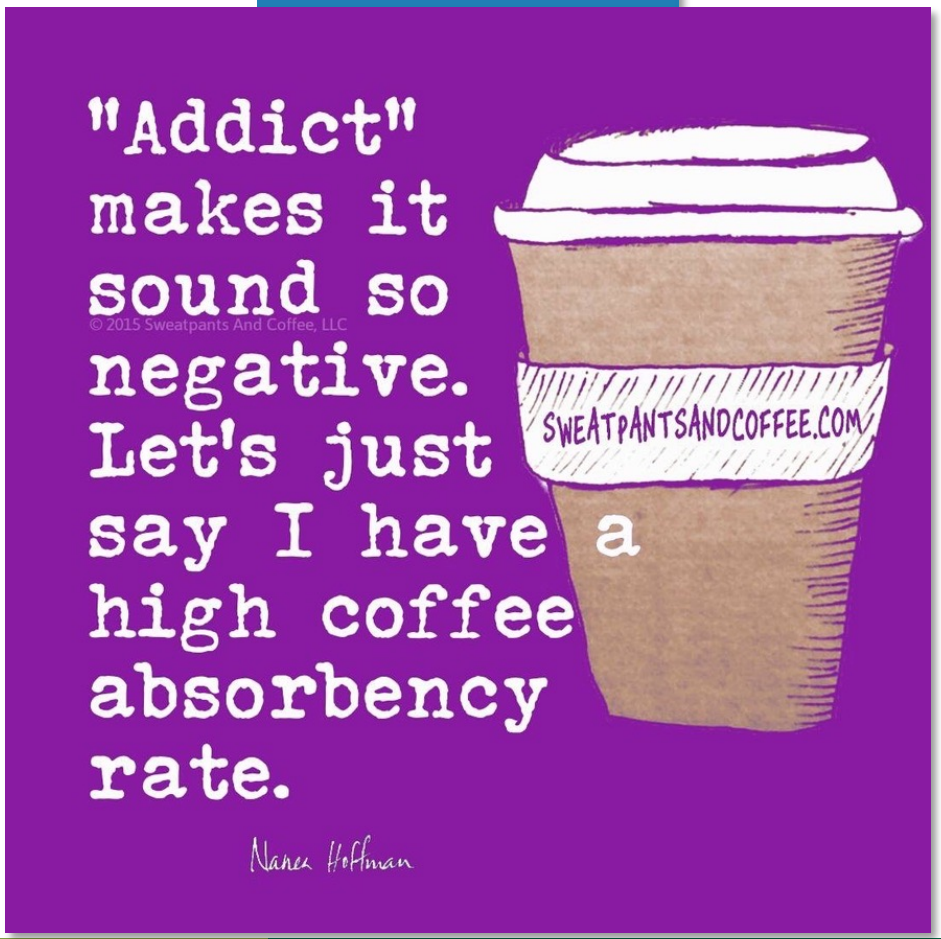

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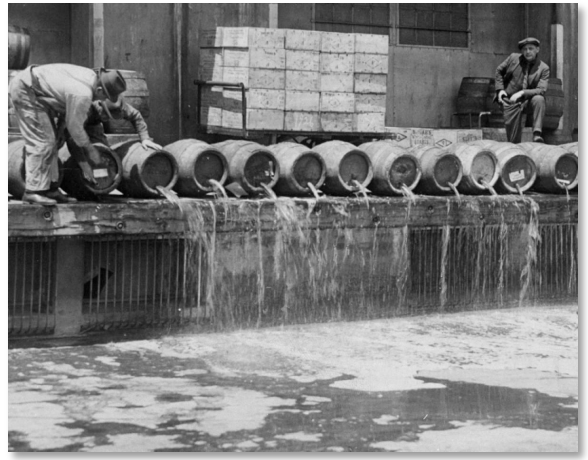

THE AMERICAN

A Saloonless Nation and a Stainless Flag

Volume XXVI — WESTERVILLE, OHIO, JANUARY 25, 1919

U.S. IS VOTED DRY

36th STATE RATIFIES DRY AMENDMENT JAN. 16

Nebraska Noses Out Missouri for Honor of Completing Job of Writing Dry Act Into the Constitution; Wyoming, Wisconsin andMinnesota Right on Their Heels

JANUARY 16, 1919, MOMENTOUS DAY IN WORLD'S HISTORY

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DECEMBER 5, 1933

PROHIBITION ENDS AT LAST!

14 YEAR DRY ERA ENDS TODAY

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What about Rural?

Live Well Nebraska

Nebraska has one of the nation's highest binge drinking rates

CHRIS DUNKER and MOLLY HUNTER Lee Enterprises Dec 29, 2020 Updated Nov 7, 2021 0

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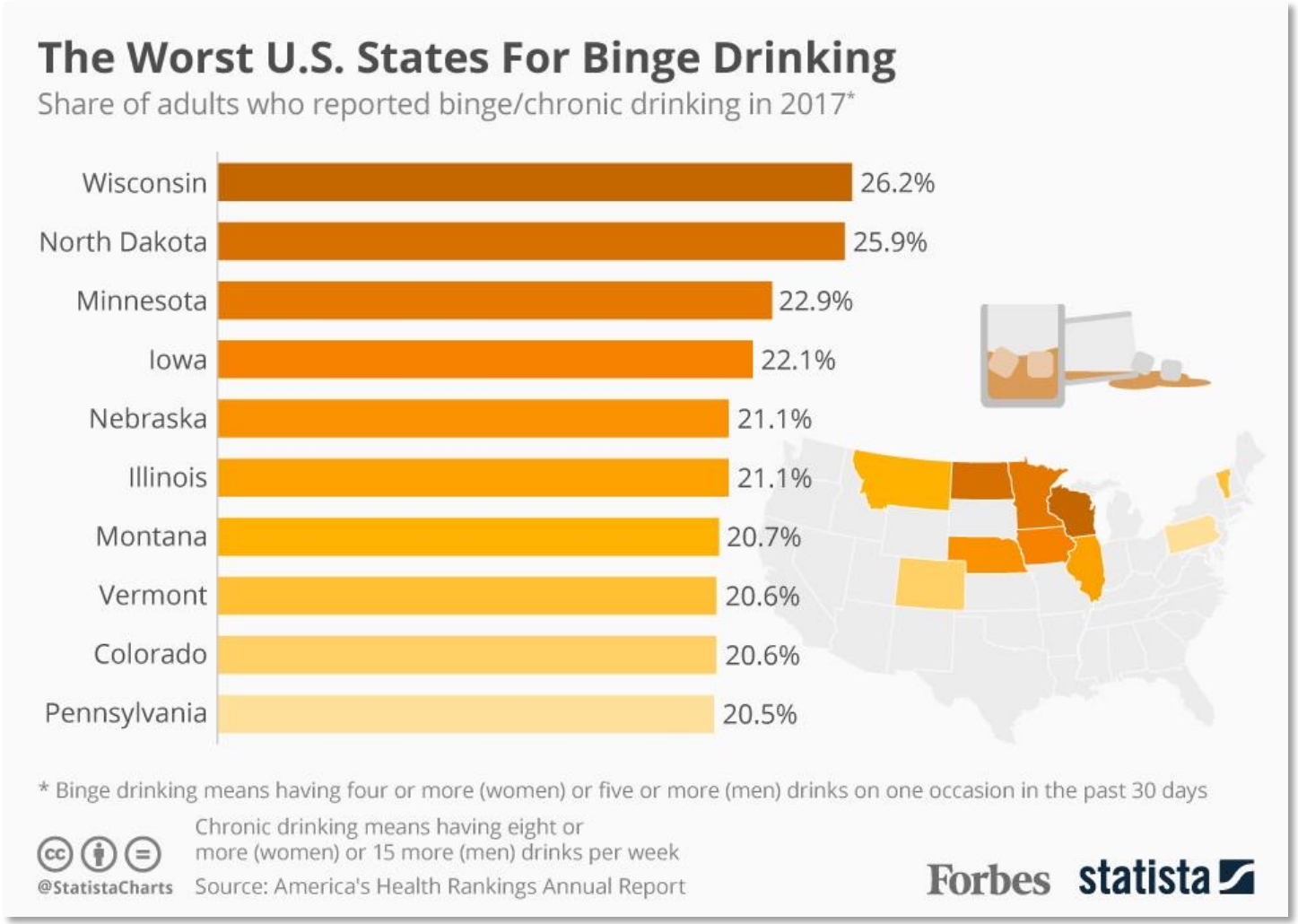

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The Personal Nature of Agriculture

- Characteristics of Agricultural Communities and Culture
- Strong Core Values

- Behavioral Healthcare Issues Specific to Agricultural populations

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3 Research Studies

- Scoping Review
- Health Disparity Research
  SBIRT Project in Lexington NE
  Medical Clinic
- Project AG Aware
  SBIRT in the Field

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Scoping Review

Review > J Rural Health. 2022 Jan;38(1):129-150. doi: 10.1111/jrh.12575. Epub 2021 May 6.

Substance use disorders in the farming population: Scoping review

Shinobu Watanabe-Galloway [1], Christine Chasek [2], Aaron M Yoder [3], Jesse E Bell [3]

Affiliations + expand

PMID: 33955045 DOI: 10.1111/jrh.12575

Abstract

Purpose: The purpose of this scoping review is to summarize the current knowledge base in order to make recommendations for prevention and treatment of substance use disorders among the farming populations.

Methods: We conducted a scoping review of peer-reviewed articles published between January 1989 and September 2019. The search yielded 3,426 citations and the final review was conducted on 42 articles. The full review was conducted by 4 authors to extract information about the target population, data collection methods, and main results.

Findings: There were 21 articles on farmers and 21 articles on farmworkers. The majority of the articles were about alcohol. Overall, farmers had higher prevalence of risky alcohol consumption patterns than nonfarmers. The prevalence of risky alcohol consumption was also high among farmworkers compared to the general population. Risk factors for risky alcohol consumption included male gender, lower socioeconomic status, and psychological problems (eg, depression). Recommendations for prevention and intervention of alcohol disorders included policy development and implementation to curb alcohol access by taxation, screening of alcohol-related problems, and alternative means of recreation instead of alcohol consumption.

Conclusions: This review confirmed that alcohol-related problems are prevalent among farmers and farmworkers. More population-based research is called for to understand the additional risk factors of alcohol disorders and the prevalence of other substance-related disorders. Also,

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Health Disparity Project Partners

- Dr. Christine Tina Chasek, LIMHP, LADC
- UNK Associate Professor

- Dr. Shinobu Watanabe-Galloway
- Professor and Vice-Chair
- Department of Epidemiology
- University of Nebraska Medical Center

- Jason Dillard, PLMHP, PLADC Plum Creek Medical Group
- Sarah Bradley, UNK Graduate Student

- University of Nebraska at Kearney
- Behavioral Health Education Center of Nebraska
- University of Nebraska Medical Center
- Plum Creek Medical Center

- A Pilot Study Investigating Opioid and Alcohol Risk and Misuse Among Rural Agricultural Workers, IRB#046-19-EP

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Lexington, Nebraska

Population: 10,230

Demographics:

- Caucasian-58%
- African American: 10%
- Native American: 1%
- Hispanic of any race: 60%

Largest Employer: Tyson Foods Inc.

Median Household Income: $43,000

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SBIRT

- SBIRT is an evidenced-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
- Easy to implement in medical settings
- Endorsements:
  - Institute of Medicine
  - SAMHSA-HRSA Center for Integrated Health Solutions
  - Medicare and Medicaid
  - American Medical Association

https://www.integration.samhsa.gov/clinical-practice/sbirt

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Why SBIRT in Rural Clinics?

- Many healthcare providers report that **addressing alcohol** and other drug problems is one of the **most challenging areas of their practice**.
- Providers are **unsure how to address** these issues and yet they are in a **prime position** to reduce the negative outcomes related to substance misuse.
- Behavioral Health Counselors can partner with these providers to implement **cost-effective screening, brief intervention, and referral practices** that help identify and get patients the services they need.
- *This is a win, win, win situation* for the healthcare provider, behavioral health counselor, and **mostly importantly the patient.**

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Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.

Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.

Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

SBIRT:
Screening, Brief Intervention, and Referral to Treatment

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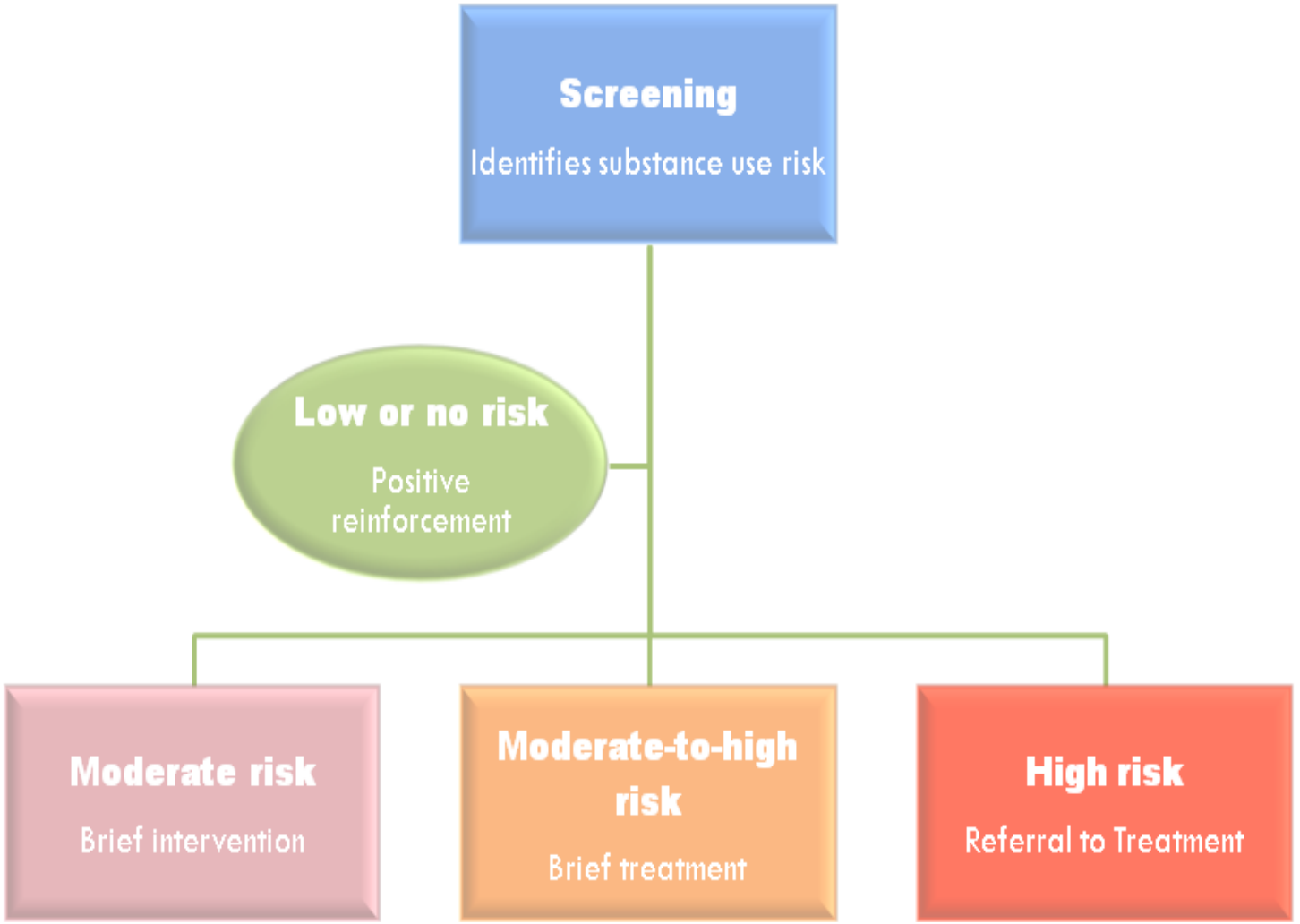
SBIRT: Core Components



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Scores and Intervention

TABLE 1 | ASSIST risk score and associated risk level and intervention

Alcohol	All other substances[a]	Risk level	Intervention
0 - 10	0 - 3	Lower risk	▌General health advice
11 - 26	4 - 26	Moderate risk	▌Brief intervention ▌Take home booklet & information
27+	27+	High risk	▌Brief intervention ▌Take home booklet & information ▌Referral to specialist assessment and treatment
Injected drugs in last 3 months		Moderate and High risk[b]	▌Risks of injecting card ▌Brief intervention ▌Take home booklet & information ▌Referral to testing for BBVs[c] ▌Referral to specialist assessment and treatment

[a] Tobacco products, cannabis, cocaine, ATS, sedatives, hallucinogens, inhalants, opioids and 'other drugs'.

[b] Need to determine pattern of injecting – Injecting more than 4 times per month (average) over the last 3 months is an indicator of dependence requiring further assessment and treatment.

[c] Bloodborne viruses including HIV and hepatitis B and C.

SBIRT

Research Findings and Implementation

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Patient Sample Description

- Adults 18 years or older only
- Total n = 4,674
- Sex: 53% Male
- Race: 87% White, 9% Black
- Ethnicity: 39% Hispanic
- Marital status: 55% Married, 33% Single
- Employment: 58% works full time, 13% unemployed
- Insurance: 67% Private, 24% Medicare, 5% Medicaid

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Screening Results

- SBIRT (n = 65):
  - Alcohol: 38%
  - Tobacco: 37%
  - Marijuana: 29%
  - Stimulants: 37%
  - Opioids: 35%

Comorbidities present:

Depression: 26%

Anxiety: 6%

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A Preliminary Analysis of Project Ag Aware

SBIRT in Agricultural Work Settings

- Dr. Chasek
- Dr. Shinobu Watanabe-Galloway
- Ashley Olson, UNK Grant Coordinators
- Rachel Rutt, BSPH
  - Department of Epidemiology

- Grant: NU System

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Background

Project Ag Aware

- The long-term objectives:
  - Increase knowledge of substance use and misuse through outreach, education, and prevention
  - Determine the risk level of opioid and alcohol misuse among adults in agricultural communities in Nebraska and surrounding rural states

Methods

Population: males and females, aged 19-90 involved in the agricultural industry: NE, IA, KS

Dillman Survey Method[1] used: 12,000 surveys mailed in April-May, September-October 2020, March-April 2021

Options of online or paper survey

- Surveys included
  - Demographics
  - The Alcohol Use Disorder Identification Test (AUDIT)
  - The Generalized Anxiety Disorder Screener (GAD-2)
  - The Drug Abuse Screening Test (DAST-1)

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Results

- Received 2,421 surveys back (20% response rate)
- Majority of participants were male (78.5%)
- Majority of participants were older adults M=61
  - Ages 40-64 (47.%)
  - Ages 65 or older (43.3%)
- Married (80.5%)
- Caucasian (98.3%)
- Occupation:
  - 65% of respondents identified as direct agricultural workers (farmer/rancher, farm hand/ranch hand, agribusiness)
  - 34.5% of respondents identified as indirect agricultural workers (bookkeeper, farm manager, retired)

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Results

- Most respondents did not use opioids, illegal drugs, or prescription pills for non-prescription purposes (97.4%)
- Most respondents were low-risk for anxiety disorders (84.1%)
- Most respondents were low-risk for alcohol a disorders (90.6%)

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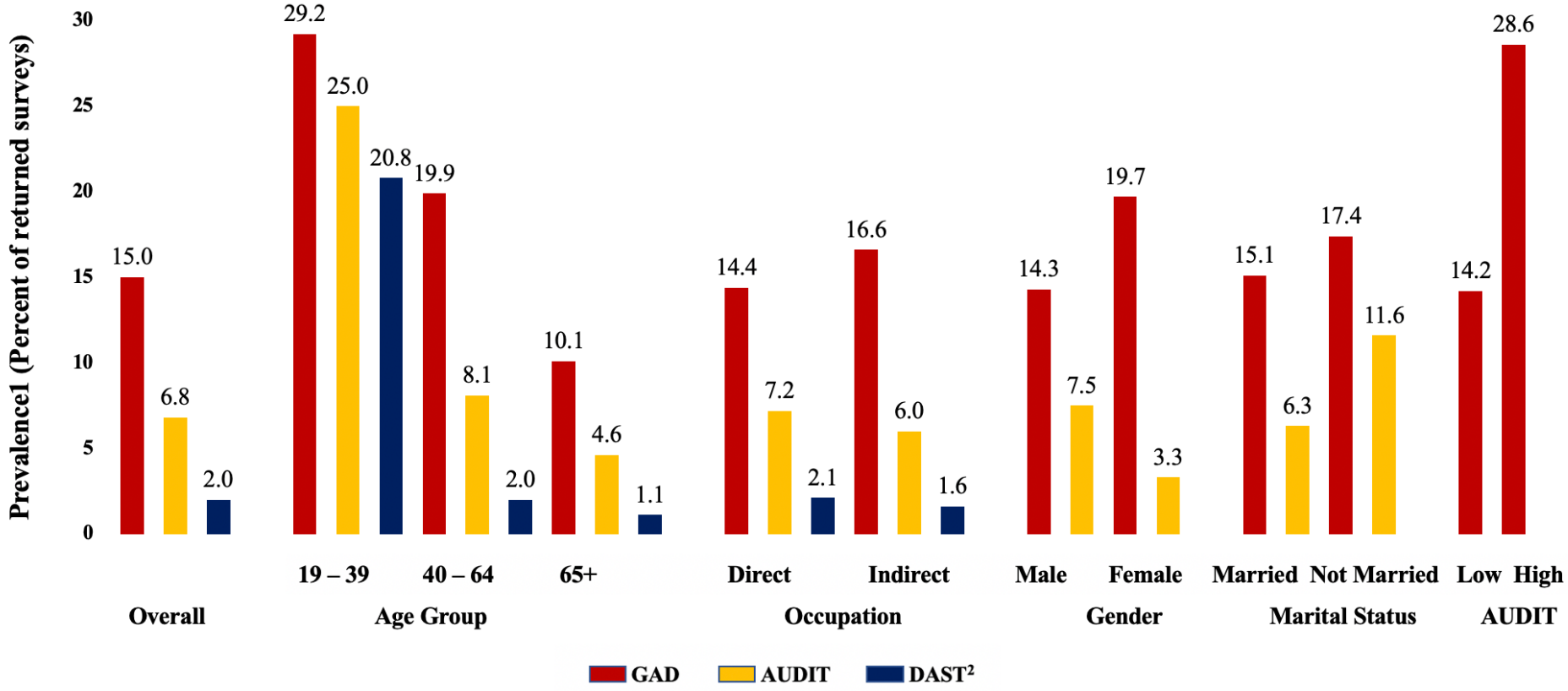
Results: Alcohol, Other Drugs, and Anxiety

- The youngest respondents (aged 19-39) had the highest prevalence of **high-risk alcohol use at 28.2%**
- The youngest respondents (aged 19-39) had the highest prevalence of **other drug use at 7.9%**
- The youngest respondents (aged 19-39) had the highest prevalence of **anxiety at 25.0%**

Figure 1. Prevalence of GAD, AUDIT, and DAST Categories by Sociodemographic and Occupational Groups



[1] Cut points for high risk were as follows: a score of 3 or higher on the GAD, a score of 8 or higher on the AUDIT, and a score of 1 on the DAST-1

[2] DAST was not reported for marital status and gender due to low frequency/cell counts

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Implications

- The youngest age group (ages 19 to 39), had the highest prevalence for all three outcomes:
  - GAD (25.0%)
  - AUDIT (28.2%)
  - DAST (7.9%)
- Anxiety prevalence in agricultural workers compared to the general U.S. population:
  - Agricultural workers with anxiety disorder 35.9% [5]
  - General U.S. population with anxiety disorder 18.1% [5]

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Summary

Alcohol Use Disorder:

- Gender (Males)
- Marital Status (Not Married)
- Age (19-39)
- Anxiety (High risk)
- DAST (Opioids)
- Occupation Type (Direct Ag Worker)

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I CAN Treat Alcohol Use Disorder in the Office

John R. Brooklyn, MD

Clinical Associate Professor, Family Medicine and Psychiatry, University of Vermont, Burlington, VT

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Rural Alcohol Use

- One of the most **common substances** seen in Primary Care

- Rural practices are ideally equipped to assess and treat with medications

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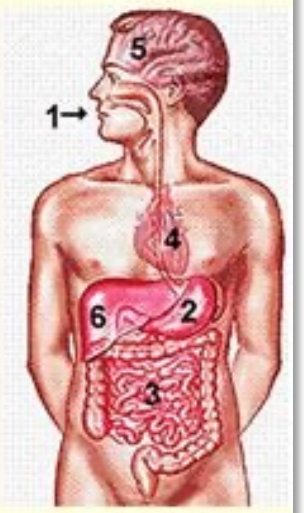
Pathway

The path of alcohol in the body

1. Mouth: alcohol enters the body.
2. Stomach: some alcohol gets into the bloodstream in the stomach, but most goes on to the small intestine.
3. Small Intestine: alcohol enters the bloodstream through the walls of the small intestine.
4. Heart: pumps alcohol throughout the body.
5. Brain: alcohol reaches the brain.
6. Liver: alcohol is oxidized by the liver at a rate of about 0.5 oz per hour.

- Alcohol is converted into water, carbon dioxide and energy.



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Receptors in the Brain

- Opiate receptors
- Serotonin
- GABA
- Dopamine
- Glutamate

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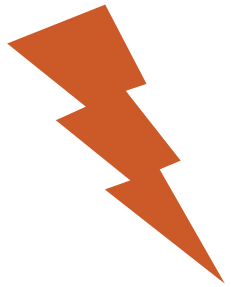
Within 5 Minutes of Consumption

- Initially feel euphoria/giddy, relaxed-reward system



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Endorphin (opiate)

- Euphoria (FEEL GOOD neurons)

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Serotonin

- Euphoria (FEEL GOOD neurons)

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Dopamine

- Reinforcing (REWARD neurons)

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Inhibition

- Continued alcohol reduces cognition
- Then coordination
- Then emotions swing

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GABA GOES up

- Inhibitory (STOP neurons)

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Glutamate GOES DOWN

- Excitatory (GO neurons)

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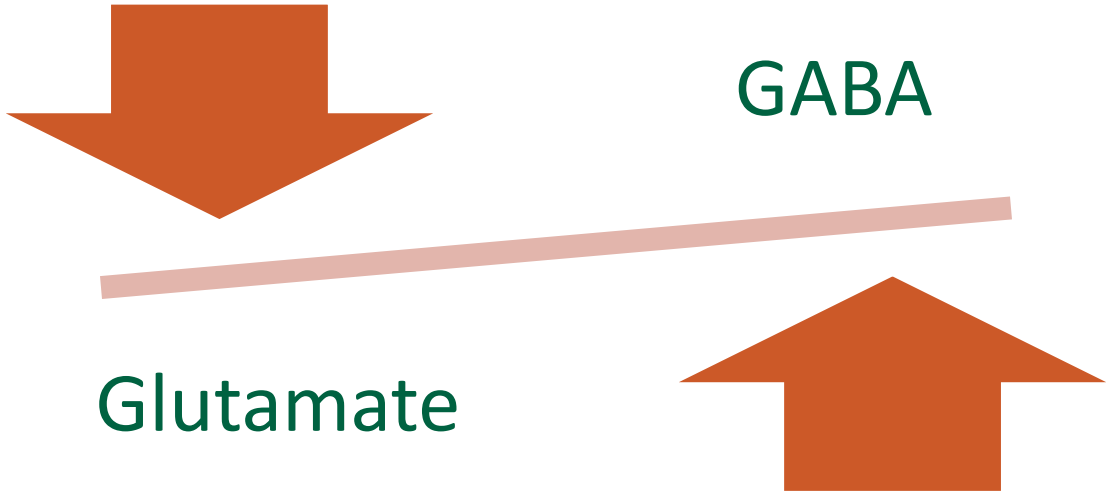
Ethanol in the Brain



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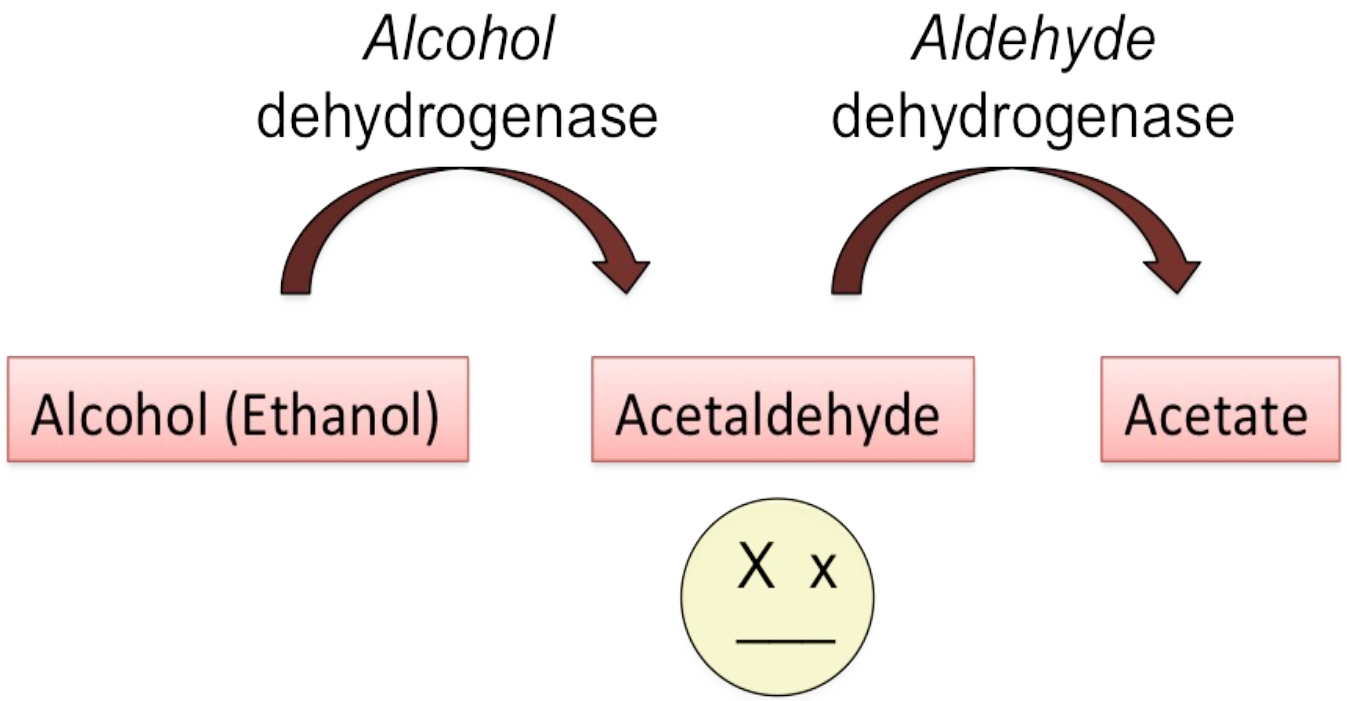

“hangover”

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Alcohol Treatment

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Why Should We Care?

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What is at Risk Drinking?

For healthy **men up to age 65**—

- no more than **4** drinks in a **day** AND
- no more than **14** drinks in a **week**

For healthy **women** (and healthy **men over age 65**)—

- no more than **3** drinks in a **day** AND
- no more than **7** drinks in a **week**

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Natural History of Alcohol Use Disorder

Event	Age
1st drink	13
1st drunk	15
1st problem	18
1st dependence	25-40
Death	60

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2 Questions

- When was the last time you drank?

- How much does it take to get a BUZZ?

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Important Definitions

- **Tolerance**
- **Withdrawal**
- **Physiological Dependence**
- **Cross Tolerance & Cross Dependence-** similar effects from different drugs at the same receptor, ex. **Alcohol and BZD**

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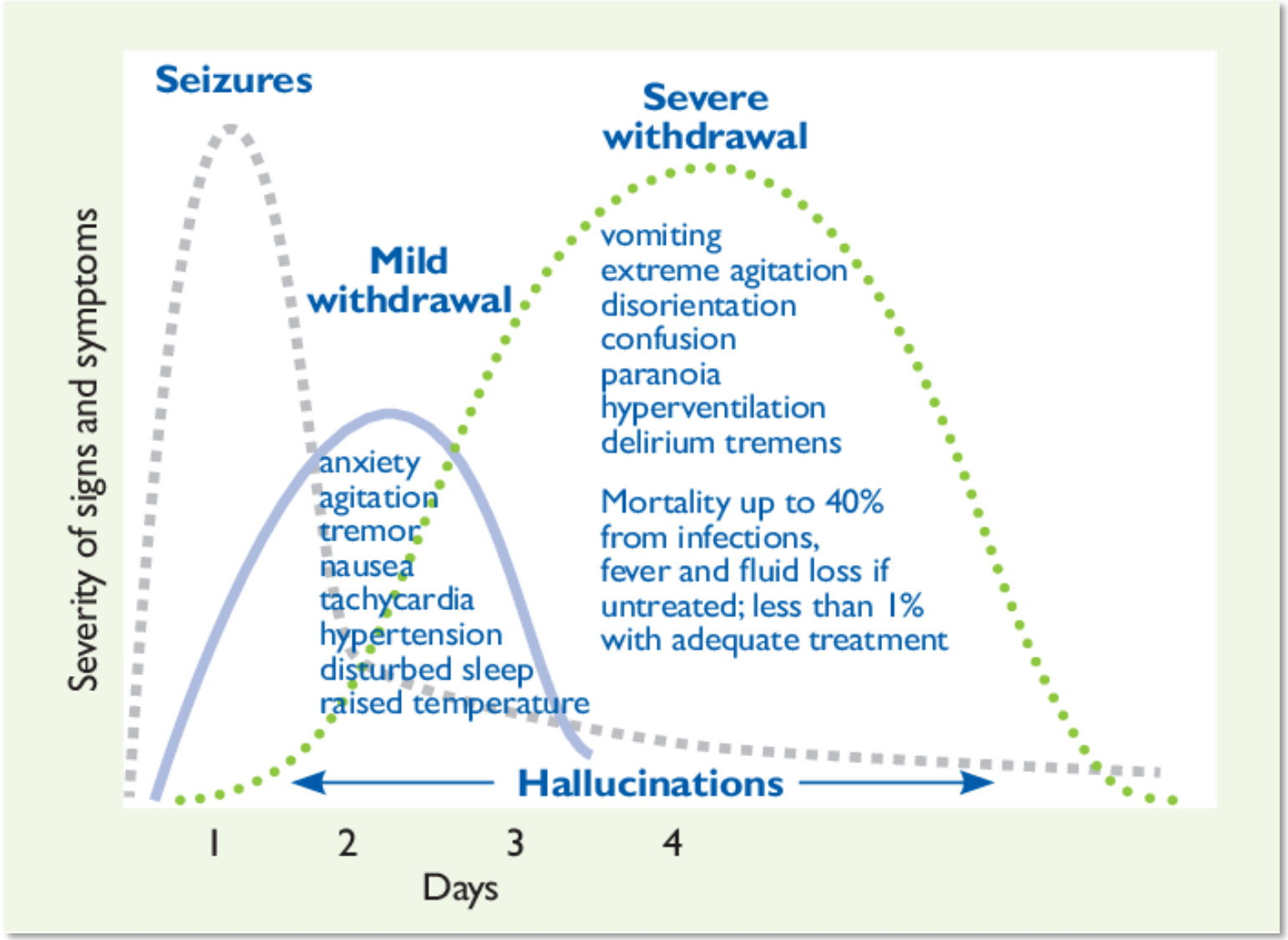

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Treatment

- Acute
  - Hospital or other setting

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Predictors of Severity

- Predictors of Alcohol Withdrawal severity:
  - Older age
  - Severity drinking/tolerance
  - BAL>250 and pt appears coherent
  - Prior AW (“kindling”)
  - Major medical/surgical problems
  - Sedative/hypnotic use

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Who Needs Inpatient Treatment?

- 10 -20% of patients:
  - Previous history of DTs and / or seizures.
  - Major medical-Cirrhosis, COPD, CAD
  - Major psychiatric and/or drug problems
  - Poor support, homelessness
  - Pregnancy

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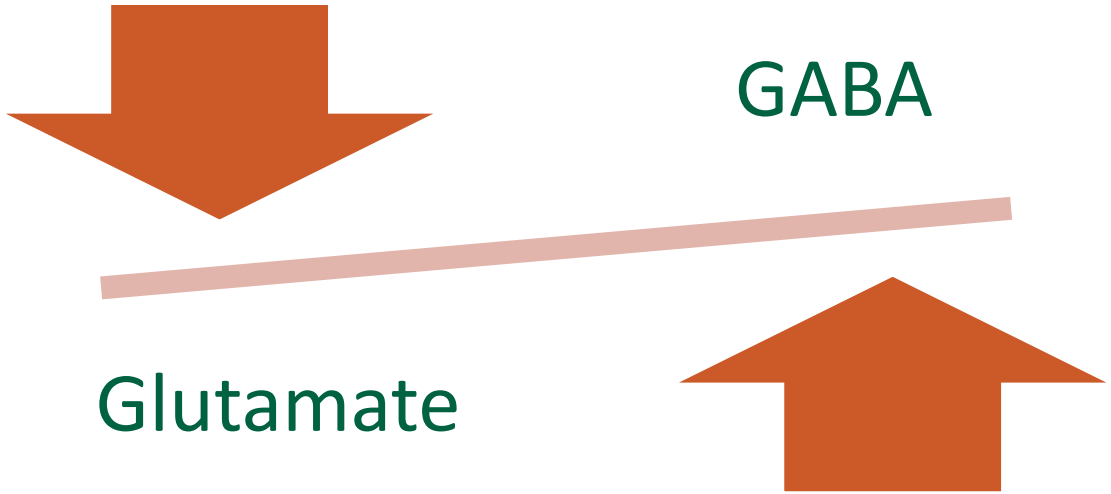
Ethanol in the Brain



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Clinical Institute Withdrawal Assessment (CIWA-Ar)

- Standardized assessment of AW symptoms
  - ↑ Autonomic activity (e.g. sweating or pulse > 100)
  - Hand tremor
  - Insomnia
  - Nausea or vomiting
  - hallucinations or illusions
  - agitation
  - Anxiety
  - Grand mal seizures

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Rural-Based Treatment

- Or when there is “nowhere else to turn” - because rural communities are often resource-poor
  - Distance is barrier
  - Lack of community hospital or inpatient, residential treatment
  - Primarily office-based
- Hubs (in Vermont) can provide addiction consultation to rural providers for alcohol related treatment questions

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Treatment

- After the acute period
- Medications
- Recovery activities

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Drugs Used for Treatment of Alcohol Dependence

- Disulfiram (Antabuse)
- Naltrexone
- Acamprosate (Campral)
- Topiramate (Topamax)
- Baclofen
- Gabapentin (Neurontin)

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Chemicals in the Brain

- Endorphins
- Serotonin
- GABA
- Dopamine
- Glutamate

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Disulfiram (Antabuse)

- Aversive therapy

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Naltrexone (Vivitrol)

- Opioid antagonist
- Blocks opioid receptors (reward system)
- Reducing craving for alcohol
- Medic alert bracelet

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Acamprosate

- Glutamate analog

- Reduces craving by preventing excitation of glutamate receptors

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Anti Seizure Drugs

- Topiramate and Gabapentin

- Investigational

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Alcoholic Anonymous Related Helping

- “Helper therapy principle ”
- One’s own problems diminish through the process of helping others
- Spiritually based-12 steps/ Self Help

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Alcoholic Anonymous Related Helping

“the sublime paradox of strength coming out of weakness”

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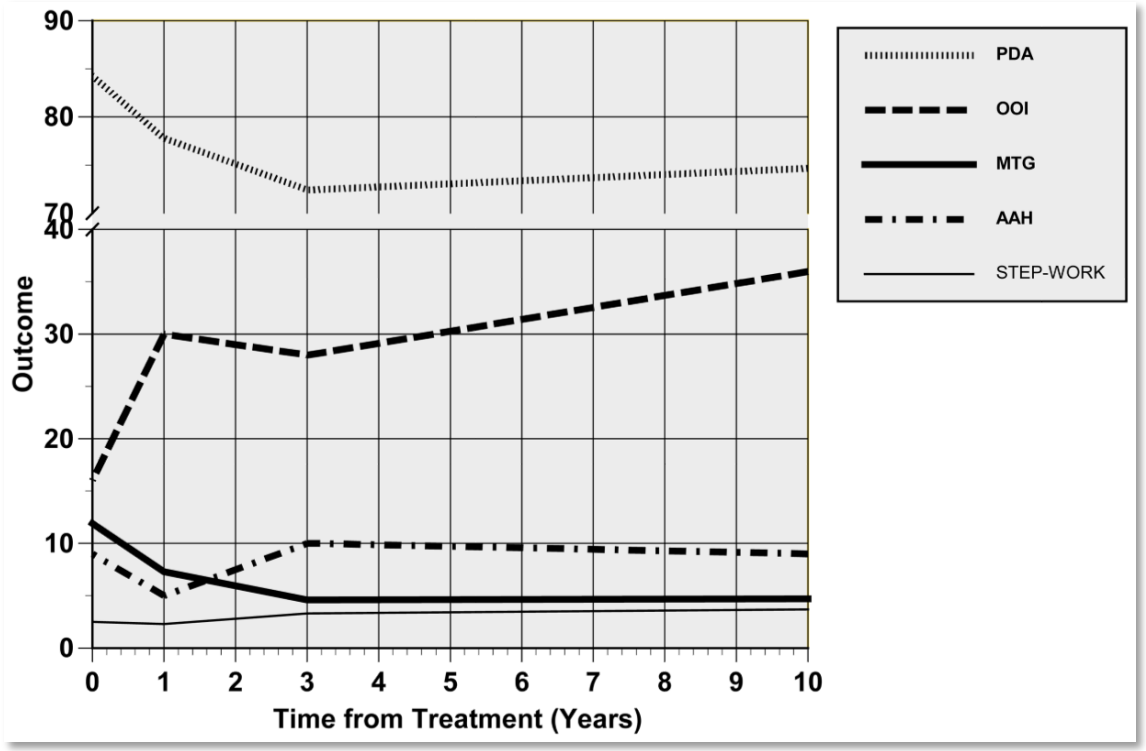
Project MATCH



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Recovery Options

- Support meetings can be important for recovery and are available **even in rural communities**
- SMART recovery-Self Management and Recovery Training
- Rational Recovery-Addictive Voice Recognition Technique

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Summary

- Alcohol use disorders are managed primarily with medications
- Naltrexone has the best evidence for efficacy in reducing alcohol use
- Rural communities often are resource-poor due to distance and lack of community hospital or inpatient, residential treatment
- Hubs (in Vermont) can provide addiction consultation to rural providers for alcohol related treatment questions
- Support meetings can be important for recovery and are available even in rural communities

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Using A Multi-Pronged Approach To Reduce Organizational and Provider Burdens For Addressing Unhealthy Alcohol Use In Rural Primary Care Practices

Mary Lindsey Smith, PhD, MSW, Director Substance Use Research and Evaluation
Cutler Institute for Health and Social Policy, University of Southern Maine
Denise O'Connell, MSW, LCSW, CCM, Associate Director
Lunder-Dineen Health Education Alliance of Maine

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Learning Objectives

- Understand organizational and provider-level barriers to addressing unhealthy alcohol use in rural primary care settings as well as successful strategies that can be implemented to mitigate these challenges.
- Describe the necessary steps to create and coordinate an effective and efficient, team-based practice model for alcohol screening and patient care in rural primary care practices.

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Barriers to Addressing Unhealthy Alcohol Use in Rural Primary Care Practices

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Organizational-Level Barriers to Addressing Unhealthy Alcohol Use

- Competing priorities
- Organizational Culture
- Challenges with collection & tracking in health record
- Training Coordination
- Workflows
- Leadership and staff turnover

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Organizational-Level Barriers to Addressing Unhealthy Alcohol Use in Rural Settings

Rural primary care organizations often:

- Face greater challenges with staff retention
- Have less HIT infrastructure
- Have competing organizational and patient demands that make training and supporting quality improvement efforts difficult

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Provider-Level Barriers to Addressing Unhealthy Alcohol Use

- Lack of provider education on the topic
- Provider ambivalence about screening
- Lack of external resources for referrals for higher level of care
- Lack of provider confidence and comfort
- Patients
  - Concerns over privacy and trust
  - Lack of rapport

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Provider-Level Barriers to Addressing Unhealthy Alcohol Use in Rural Settings

Rural practices face difficulties connecting individuals with external resources, such as:

- specialty addiction care services
- behavioral health providers
- recovery supports
- other social supports are not available in many rural communities

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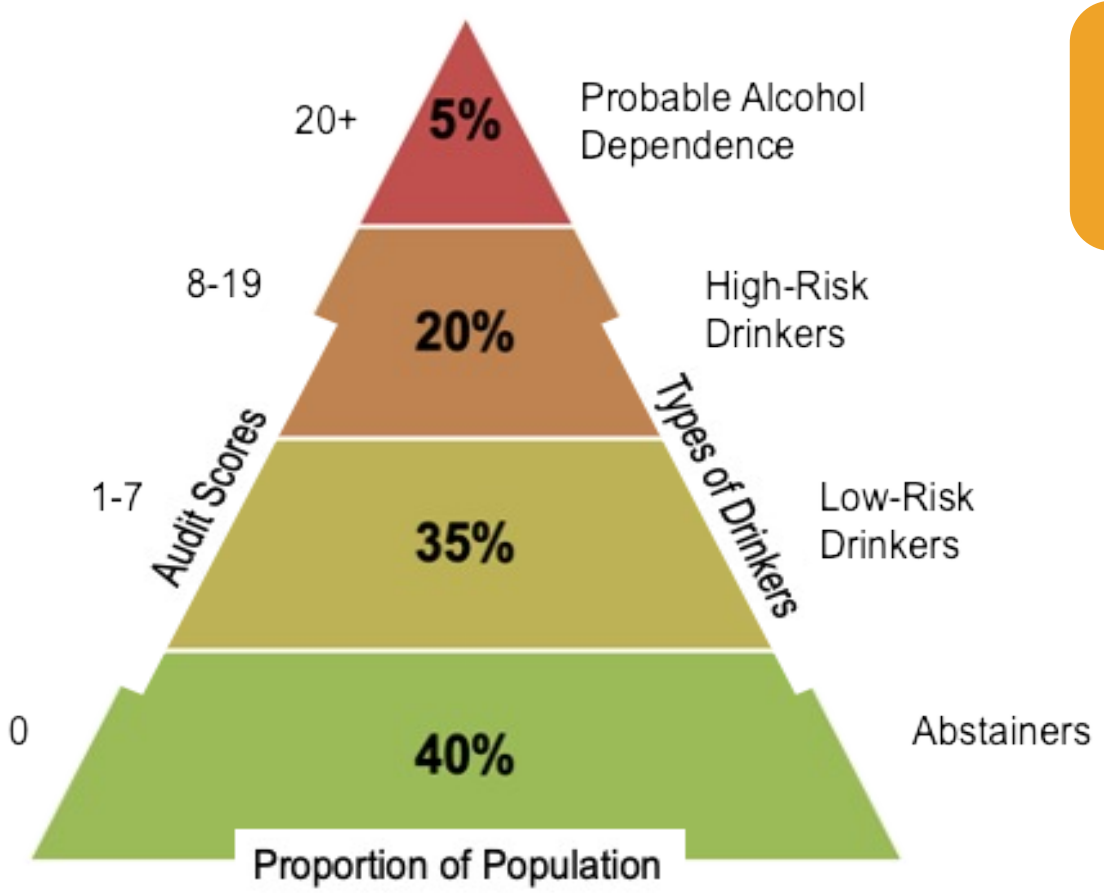
Provider-Level Barriers to Addressing Unhealthy Alcohol Use



While **most individuals** identified as at risk for or exhibiting unhealthy alcohol use **will not meet the criteria for AUD**, the **primary concern** cited by providers for not wanting to screen for alcohol use is **uncovering a significant number of patients with AUD**.

Although 25% of the population will score 8 or Above on Audit, 90% of those people do not meet the definition for alcohol use disorder.

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Facilitators for Addressing Unhealthy Alcohol Use in Rural Communities

- Organizational leadership engagement and support
- Comprehensive planning
- Organizational Champions / Early Adopters
- Feedback loop
- Use of interprofessional teams
- Peer supports and ongoing training
- The use of **organizational champions** to gain provider buy-in as well as peer supports for ongoing consultation has been shown to help expand capacity in rural areas for addressing SUD
- **Interprofessional teams** also help to distribute the burden of incorporating enhanced screening, monitoring and treatment of alcohol use in busy rural primary care practices where providers are frequently overburdened

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Strategies for Addressing Unhealthy Alcohol Use in Rural Primary Care Settings

The Time to Ask Model

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Health Education is Powerful Medicine

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Time to Ask BluePrint

Designed as:

- An educational and quality-improvement program
- An interprofessional, blended learning program consisting of on-line learning modules and a live teaching session
- On site practice support to help apply what is being learned
- Access to experts
- An academic and practice partnership utilizing best practices for 21st century learning

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Responding to Rural Practice Barriers

- Free on-site Education and Training
- Practice Support
- Access to Experts for peer-support
- Reasonably paced program implemented over time
- Flexible and organizationally-centered that responds to the needs of the practice

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Time to Ask

Implementation Strategies

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Supporting Interprofessional Collaborative Practice

- Implementing alcohol screening in primary care extends the benefit of having an interprofessional team of care providers in place. When using this model, each team member is able to contribute to patient care at the top of their scope of practice.

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Interprofessional Team Based Practice

Interprofessional Collaborative Practice is:
"When multiple health care workers from different professional backgrounds work together with patients, families and communities to deliver the highest quality of care."

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Education and Training Learning Modules

The Time to Ask Training includes three online modules:

1. Alcohol Use in Every Day
2. The Art and Science of Conversation
3. Addressing Unhealthy Alcohol Use and Alcohol Use Disorder

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Practice Facilitation

The practice facilitation component is critical for rural practices and involves **regular onsite consultation** with practice staff to: **understanding gaps** in current alcohol screening policies; updating **practice workflows** to increase alcohol screening rates; **developing tools** for providers to use in clinical practice; and working with health informatics staff to promote the **use of clinical data**

Practice Facilitation
• Forming a committee of Champions • Monthly onsite/virtual meetings to work on implementation of the TTA Manual to meet site specific needs • Defining staff roles and responsibilities • Updating workflows • Standardization of data collection protocols and use to support data-driven decision making • Exploration of EMR capabilities

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Expert Consultation

The expert consultation component of the program is to provide learners with the opportunity for engagement with expertise in the field on topics of interest including topics such as: Medication Assisted Treatment for AUD and Motivational interviewing.

Expert Consultation
• Provide onsite and/or virtual trainings on the use of medications to treat AUD • Supplemental module on motivational interviewing (CME credits available) • New individualized in-depth training on motivational interview beginning • Work with TTA Practices to create specific tools to support SBIRT such as waiting room videos, pocket guides and other training/education materials

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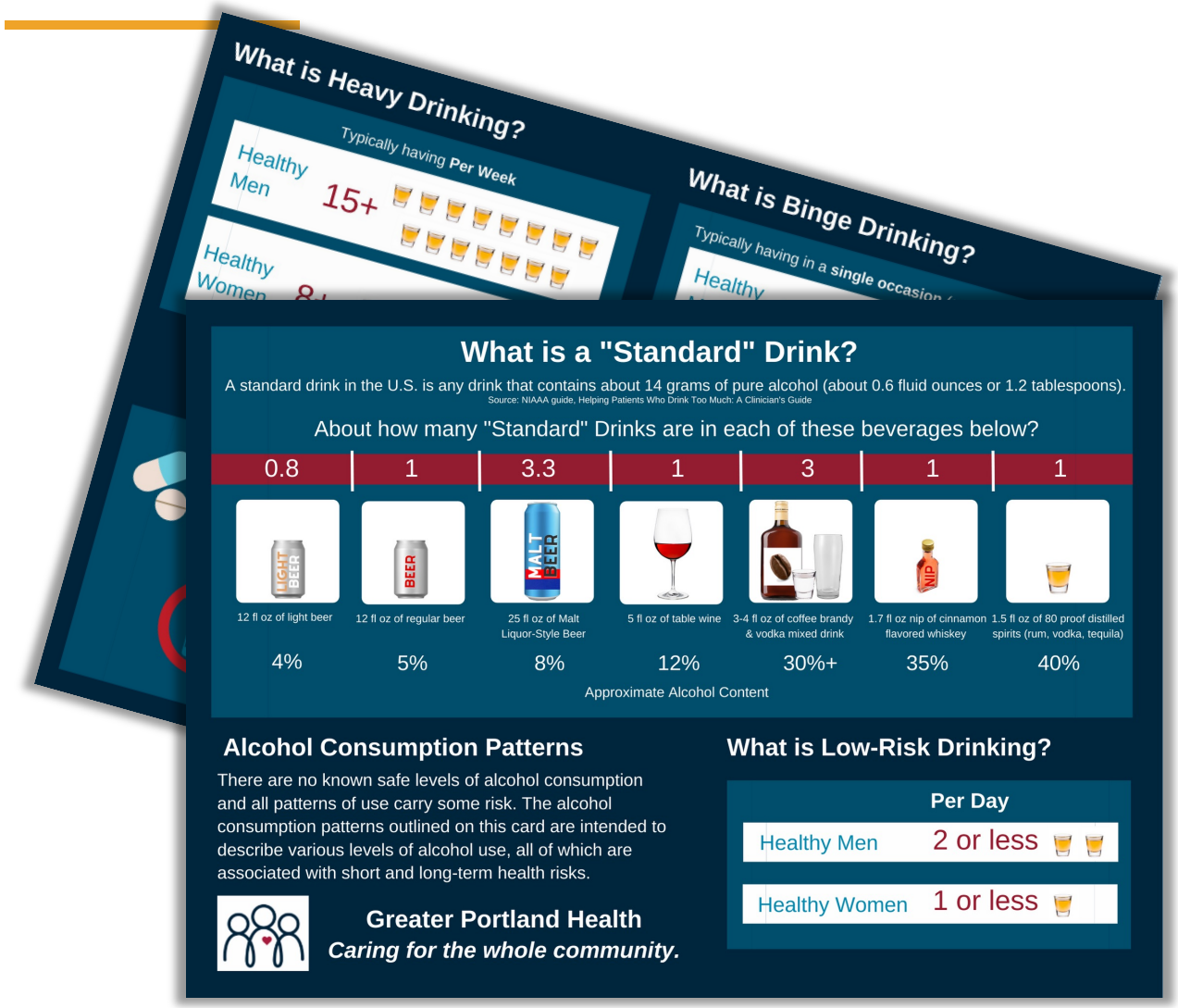
Patient Teaching Pocket Guide



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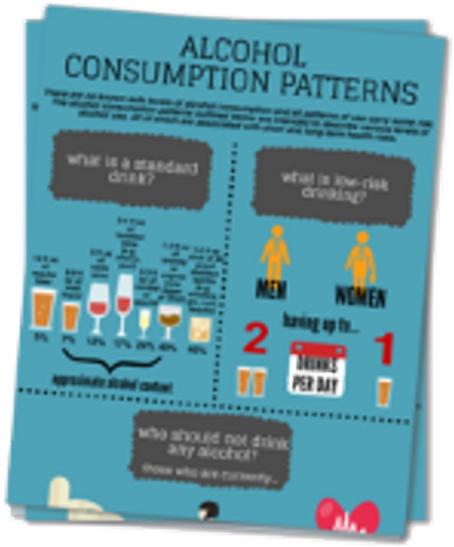
Time To Ask Toolkit



https://lunderdineen.org/alcohol-use-time-ask

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Waiting Room Video

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Motivational Interviewing Training

This opportunity has been made possible by a three-way collaboration: the Health Education & Training Institute (HETI), Lunder-Dineen and the Addiction Technology Transfer Center Network (ATTC) with additional funding provided by a grant of the Welch Charitable Fund.

VIRTUAL MOTIVATIONAL INTERVIEWING PRACTICE OPPORTUNITY

A TIME TO ASK EDUCATION BOOSTER

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We heard you! Time to Ask (TTA) program graduates asked us for additional training and opportunities to practice how to hold efficient, effective and compassionate conversations with patients about alcohol so that they can make informed decisions.

Motivational Interviewing (MI) is a collaborative conversational style for strengthening a person's motivation to deal with the struggle of managing health and risk factors while finding their own strength, hope and resiliency.MI sprung out of the substance use treatment field and has become widely used by many health professionals as an effective tool and approach for discussing difficult chronic health challenges with patients. "MI is the most widely researched and disseminated motivational counseling approach in SUD treatment."

This training opportunity centers on advancing MI skills for primary care health professionals with a focus on enhancing a person's motivation to change by exploring and resolving ambivalence around alcohol use.

We are offering this unique pilot as an opportunity to learn and practice virtually with others in Maine who've completed the TTA program or are about to. This MI practice program will be specifically tailored to the TTA audience but will also help you as you hold other difficult conversations with patients. Woven into the MI content will be shared decision making, diversity, equity and inclusion and recovery conversations.

By completing the program, you'll join your colleagues across the state by becoming Time to Ask MI champions at your organizations.

We've enlisted the help of a highly regarded Maine-based expert MI trainer, Stephen Andrew, LCSW, LADC, CCS, CGP and his faculty who have extensive experience working with interprofessional health care teams. https://www.hetimaine.org/stephen-andrew

This opportunity has been made possible by a three way collaboration: the Health Education & Training Institute (HETI), Lunder-Dineen and the Addiction Technology Transfer Center Network (ATTC) with additional funding provided by a grant of the Welch Charitable Fund.

PROGRAM DETAILS

A 5-month program that meets every other week during lunch* beginning **September 22: 12-2pm (a full schedule of dates can be found on the website: https://lunderdineen.org/motivational-interviewing-heti**

Participants will receive a gift card to purchase lunch.

The program consists of three virtual components:

- Basic Training
- Practice and Reflection
- Coaching, coding and master class

Who can Participate?

- 2 slots are available per practice site.
- The program is open to patient-facing licensed and unlicensed staff who are involved in screening and/or brief intervention and referral to treatment including medical assistants.

More Info?
denise@lunderdineen.org

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Footprint Across Maine

Footprint Across the State

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Participating Organizations

- Bucksport Regional Health Center
- Four Seasons Family Practice
- Katahdin Valley Health Center
  - Ashland Clinic
  - Patten Clinic
  - Houlton Clinic
  - Millinocket Clinic
  - Brownville Clinic
- Greater Portland Health*
- St. Croix Regional Family Health Center

*Red pin indicates urban site

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Programmatic Outcomes

Content relevant to interprofessional learners

Content was well received by health care professionals; although individuals entered the training with varied levels of exposure to individuals with AUDs, most participants gained new knowledge and skills to apply to their role

Positive impact on provider knowledge, attitudes, and behaviors

Education had a positive impact on provider attitudes and behaviors. Participants reported they would change behavior by screening patients for unhealthy alcohol use; promoting collaboration within the care team; and changing their interaction with patients to be less stigmatizing and more patient-centered

Leveraging statewide expertise to enhance provider capacity

Health care professionals indicated overwhelmingly that the peer support they received as part of the expert consultation was one of the most valuable components of the program.

Expanded organizational capacity for SBIRT

Onsite consultative practice support by Lunder-Dineen played a key role in promoting enhanced alcohol screening polices, expanding the use of brief interventions and medications to treat alcohol use disorder as well as referrals to higher levels of specialty care when appropriate.

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Key Steps for Establishing a Team Based Model of Care for Addressing Unhealthy Alcohol

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Establishing Systems: What to Consider

Define an organizational policy that clearly establishes the clinical pathways or protocols for alcohol screening, diagnosis, treatment and referral. Things to consider when developing the policy include:

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Establishing Systems: Best Practices

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Summary

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Key Takeaways

Using multi-dimensional approaches to addressing unhealthy alcohol use in rural primary care settings that promote changes in both **organizational** and **provider** behaviors is fundamental to overcoming barriers to expanding strategies to enhance screening, brief interventions, treatment and referrals pathways in rural primary care practices.

- Utilize on site practice facilitation to promote organizational culture change and imbed mechanisms to address unhealthy alcohol use into practice workflows and staff roles
- Leverage local champions as well as experts in the field to provide peer support and build provider capacity to address unhealthy alcohol use
- Provide training and professional development opportunities that are relevant to a diverse group of learners to support the use of interprofessional care teams in addressing unhealthy alcohol use
- Provide ongoing education and training to enhance provider knowledge and motivation as well as skills related to addressing unhealthy alcohol use

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Questions & Discussion

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