Substance Use Disorders (SUDs) occur when the recurrent use of alcohol or other drugs (or both) causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Presbyterian strives for consistent and compassionate management of patients with SUDs using evidence-based practices that address the patient’s specific needs.

**Essentials**

- As many as 188,000 New Mexicans report having substance dependence or abuse. These individuals often go untreated.

- Within targeted PHS hospitals, the Integrated Addiction Medicine Consult Liaison Team provides consultation for hospitalized individuals with substance use disorders, co-occurring behavioral health conditions, and complex medical co-morbidities – including chronic pain.

- Presbyterian’s integrated care model for evaluating and treating SUDs targets opioid dependence and alcohol use disorders.

- Robust clinical education strategy ensures access to evidence-based practice guidelines, supports Physician and APC experience, increases treatment efficacy, standardizes clinical approach, and improves patient outcomes.

- Presbyterian’s Pain, Addiction, and Mental Health ECHO clinic develops the clinical expertise of providers and clinicians throughout all regions and settings of our care delivery system.

**Impact**

Since 1997, New Mexico has had the highest alcohol-related death rate in the United States. One in six deaths among working age adults (age 20-64) in NM is attributable to alcohol (compared to 1 in 10 nationally). Moreover, alcohol related death is decreasing nationally but increasing statewide. The negative consequences of excessive alcohol use are not limited to death; they also include domestic violence, crime, poverty, unemployment, chronic liver disease, car accidents, other injuries, mental illness, and a host of other medical issues.

In 2015, New Mexico had the eighth highest drug overdose death rate in the nation. NMDOH reports that the most common drugs causing unintentional overdose deaths are prescription opioids (e.g., methadone, oxycodone, morphine; 47%) and heroin (37%). In addition to death (unintentional and suicide), drug use is associated with societal problems including crime, violence, homelessness, loss of productivity, and the spread of bloodborne diseases, such as HIV and hepatitis.
Per capita, Rio Arriba County leads the nation in the highest rate of substance abuse, overdose, and the highest alcohol-related deaths. In New Mexico between 2010 and 2015, the rate of opioid overdose related emergency department (OOR-ED) visits increased by almost 10%.

Presbyterian’s data analysts estimate that the average direct cost (i.e., labor, supplies, diagnostics, etc.) of a substance abuse episode at a Presbyterian hospital is approximately $8,000. As many as 1,000 individual patients are treated annually, most of whom experience multiple episodes. Furthermore, the Espanola Hospital administrator estimates these patients occupy up to one-third of their hospital beds on most days.

PHS Success

The number of hospitalized patients receiving specialty addiction medicine consultation services has increased; as many as 910 patients have benefitted from these services since the service launched on May 2, 2017.

Presbyterian has been increasing capacity for caring for patients with SUDs; in 2017, as many as 371 Physicians, APCs, Nurses, and other clinicians attended trainings.

Other capacity increases include: an opioid stewardship program (initiated in 2017); ED Bupenorphine Initiation Program (initiated in 2017), the Pain, Addiction, and Mental Health ECHO clinic (launched January 4, 2018); and motivational interviewing skills training, offered to clinical and non-clinical staff to support patients toward recovery. In addition, a resource guide is available on The Campus website which includes a directory of statewide recovery services.

What We Know About Substance Use Disorder

What is SUD?

According to the 5th edition of the Diagnostic and Statistical Manual (DSM-5), a “substance use disorder describes a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress.” In order for a person to be diagnosed with a disorder due to a substance, they must display 2 of the following 11 criteria within 12 months:

- Consuming more alcohol or other substance than originally planned
- Worrying about stopping or consistently failed efforts to control one’s use
- Spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
- Use of the substance results in failure to “fulfill major role obligations” such as at home, work, or school
- “Craving” the substance (alcohol or drug)
- Continuing the use of a substance despite health problems caused or worsened by it. This can be in the domain of mental health (psychological problems may include depressed mood, sleep disturbance, anxiety, or “blackouts”) or physical health
- Continuing the use of a substance despite its having negative effects on relationships with others (e.g., using even though it leads to fights or despite people’s objecting to it)
- Repeatedly using the substance in a dangerous situation (e.g., when having to operate heavy machinery, when driving a car)
• Giving up or reducing activities in a person’s life because of the drug/alcohol use
• Building up a tolerance to the alcohol or drug*
• Experiencing withdrawal symptoms after stopping use; these symptoms can include anxiety, irritability, fatigue, nausea/vomiting, hand tremor, or seizure*

(*These two criteria can only be applied if the substance in question is not prescribed, or not taken as prescribed.)

Substances for which a person can establish a substance use disorder include alcohol, cannabis, phencyclidine, hallucinogens, inhalants, opioids, sedative/hypnotic/anxiolytics, stimulants (e.g., amphetamine or cocaine), tobacco, or other (unknown).

Disorders involving use of alcohol and drugs range in severity; a person can be diagnosed with a “mild,” “moderate,” or “severe” form. Mild is characterized by a person meeting 2 to 3 of the above 11 criteria; moderate is meeting 4 to 5 criteria; and severe is meeting 6 criteria or more.

Severity can change over time with the person either reducing or increasing the symptoms for which they meet. In the case that an individual no longer meets criteria for a substance use disorder, “in early remission” (3-12 months), “in sustained remission,” (greater than 12 months), “on maintenance therapy,” or “in a controlled environment” may be added to the diagnosis (e.g., alcohol use disorder in sustained remission).

Prevalence
A 2014 national survey by the Substance Abuse and Mental Health Services Administration (SAMHSA) showed that an estimated 21.5 million Americans aged 12 or older had SUDs in the past year, including 17.0 million people with an alcohol use disorder and 7.1 million people with an illicit drug use disorder.

SAMHSA also reported that an estimated 117,000 New Mexicans aged 12 or older (6.82%) have had an alcohol use disorder in the past year (2015). See table below.

Table 1. Alcohol and Selected Drug Use in New Mexico by Age Group: Estimated Annual Averages

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numbers of New Mexicans (in Thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALL</td>
</tr>
<tr>
<td>ALCOHOL</td>
<td></td>
</tr>
<tr>
<td>Past Month Alcohol Use</td>
<td>807</td>
</tr>
<tr>
<td>Past Month Alcohol Use (Individuals Aged 12 to 20)¹</td>
<td>48</td>
</tr>
<tr>
<td>Past year Alcohol Dependence</td>
<td>69</td>
</tr>
<tr>
<td>Past Year Alcohol Use Disorder²</td>
<td>117</td>
</tr>
<tr>
<td>TOBACCO PRODUCTS</td>
<td></td>
</tr>
<tr>
<td>Past Month Tobacco Product Use³</td>
<td>414</td>
</tr>
<tr>
<td>Past Month Cigarette Use</td>
<td>349</td>
</tr>
<tr>
<td>ILLICIT DRUGS</td>
<td></td>
</tr>
<tr>
<td>Past Year Marijuana Use</td>
<td>253</td>
</tr>
<tr>
<td>Past Year Cocaine Use</td>
<td>33</td>
</tr>
<tr>
<td>Past Year Heroin Use</td>
<td>3</td>
</tr>
</tbody>
</table>

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach. Estimated numbers appearing as 0 in this table mean that the estimate is greater than 0 but less than 500 (because estimated numbers are shown in thousands). 1) Underage drinking is defined for individuals aged 12
to 20; therefore, the “12+” estimate reflects that age group and not individuals aged 12 or older. 2) Alcohol Use Disorder is defined as meeting criteria for alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). 3) Tobacco Products include cigarettes, smokeless tobacco (i.e., snuff, dip, chewing tobacco, or "snus"), cigars, or pipe tobacco. Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014 and 2015.

Furthermore, 2015 survey data indicate that 21.7 million Americans aged 12 or older needed substance use disorder treatment in the past year, while only 10.8% of those people received treatment. Moreover, accumulated data (NSDUH, 2010 to 2014) show that in New Mexico, among the estimated 131,579 individuals aged 12 or older with alcohol use disorder, only about 10,000 individuals (7.6%) per year received treatment; among the 56,910 New Mexicans aged 12 or older with illicit drug use disorder, about 7,000 individuals (12.3%) per year received treatment.

At PHS from May through December 2017, among the 808 patients referred for addiction services, opiates and alcohol were the most prevalent SUDs.

**Treatment**

The substance use disorder recovery process is highly personal and occurs via many pathways. For most people, this recovery process occurs in the outpatient setting, while others may access treatment at specialty facilities, such as a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or an outpatient), or a mental health center. Accumulating research supports reinforcing positive changes rather than a punishment approach for treating addiction.

Several strategies have been shown effective at treating substance use disorders:

- **ENGAGEMENT.** Research studies and evaluations have shown that recovery and better outcomes are more likely for people who remain engaged with SUD treatment services for 90 days or longer.
- **THERAPY OPTIONS.** SUD treatment can include behavioral therapy (e.g., individual and group counseling, cognitive therapy, or psychotherapy), medications, or their combination. Treatment can happen in the outpatient, inpatient, residential, or intensive outpatient care settings. In addition, case or care management and referral to recovery support services and other medical, psychological, and social services are beneficial components of treatment for many people.
- **SCREENING AND BRIEF INTERVENTION.** Several systematic reviews have shown that screening and brief intervention (SBI) is effective in helping at-risk alcohol drinkers (men and women; in both primary care and ED settings).
• **MEDICATION-ASSISTED TREATMENT (MAT).** MAT combines pharmacological interventions with counseling and behavioral therapies to treat certain substance use disorders. MAT is an evidence-based approach to the treatment of tobacco use disorder, alcohol use disorder, and opioid use disorder.

• **ACCESS TO NALOXONE.** Naloxone can reverse opioid overdose and prevent deaths if administered in time and followed up appropriately.

Among all these strategies, the best practice shown to achieve successful outcomes is one in which services are integrated and coordinated; providers work closely with community partners and stakeholders to determine the appropriate treatment for the individual. Proactive, patient-centered models that offer multiple treatment options are most effective. Effective treatment attends to multiple needs of the individual, not just his or her substance use; it also addresses any associated medical, psychological, social, vocational, and legal problems. Moreover, integrating mental health and substance use disorder treatment into primary care and the patient-centered medical home (PCMH) model is a strategy for long-term success.

**PHS’ Approach to Addressing Substance Use Disorders**

An extension of Presbyterian’s Behavioral Health services, Addiction Services are being expanded through the 2017 Integrated Substance Use Disorder and Community Collaborative Initiative. This initiative serves to improve the health outcomes of patients and members affected by substance use disorders and addictions, using a scalable, integrated care model that provides access to a wide range of physical health, mental health, and substance use prevention, treatment, and recovery services. This approach has a population health focus; employs innovative and evidence-based care; maintains protocols for managing referral of patients at any point of entry into a healthcare delivery system; provides seamless transitions between acute care, primary care, and the recovery community; and utilizes community supports, wrap-around services, and funding channels.

This integrated approach includes a variety of interventions, including:

• Specialized consultative/liaison clinical team dedicated to identifying and treating hospitalized patients
• Clinical education regarding prevention, early identification, and treatment
• Presbyterian’s Pain, Addiction, and Mental Health ECHO clinic (offered weekly) to mentor and support providers throughout the central and regional delivery system
• Increasing providers’ SUD expertise to facilitate engagement and better connect patients to resources
• Peer-engagement and support to link patients with community services (e.g., housing, employment, etc.) and medical follow up
• Triage/referral process to route patients to the appropriate level of care both within PDS and into the greater recovery community
• Universal screening tool to identify problematic use of tobacco, alcohol, and opioids
• Evidence-based treatment recommendations to guide the Provider’s clinical practice
• Opioid stewardship to support standardized, evidence-based use of opioid medications
• Alternative, lower-cost models of care for medically ill patients with insecure housing
• Partnerships with community organizations, that support patients through recovery
• An integrated health insurance plan (PHP) that removes barriers to access and collaborates on innovative reimbursement strategies/models
The goals are to sustain a replicable model of care that compassionately identifies, engages, and treats patients with SUDs; to improve the patient’s physical health, mental health, and quality of life; to reduce harm; to reduce recidivism; and to avoid unnecessary costs related to care.

Programs and Services

<table>
<thead>
<tr>
<th>CARE SETTINGS</th>
<th>Primary Care and Outpatient Speciality</th>
<th>Hospital/Inpatient Care</th>
<th>Post Acute Care</th>
<th>Home-Based Care</th>
<th>Emergent Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Community Programs</td>
<td>Addictions Consult Liaison Service</td>
<td></td>
<td></td>
<td>ED Buprenorphine Initiation Program</td>
</tr>
<tr>
<td></td>
<td>Individual SUD Therapy</td>
<td>Medical Detoxification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intensive Outpatient Program (IOP)</td>
<td>Medication-Assisted Treatments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAT (Methadone)</td>
<td>Peer Engagement, Support, and Coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Prevention</td>
<td>Universal Screening</td>
<td></td>
<td></td>
<td>Universal Screening</td>
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<td></td>
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</tbody>
</table>

**Addictions Consult Liaison Service**
A team of specialists (including an Addictions Medicine Specialist and a Peer Support Specialist/Care Coordinator) is on call for Inpatient Providers whose patients have an SUD and would like direct assistance with determining an appropriate course of treatment for the SUD.

**Community Programs**
Presbyterian partners with community organizations (e.g., 12 step mutual help groups, faith-based organizations) that offer recovery support services. Presbyterian provides these groups with education as well as meeting spaces.

**Emergency Department Buprenorphine Initiation Program**
Patients identified in the CDS emergency department with opioid use disorder will be offered initiation of treatment with buprenorphine and access to an ambulatory provider to continue treatment.
**Individual SUD Therapy**
A Behavioral Health Clinician (BHC) co-located in the patient’s medical home (a PMG primary care clinic) can provide one-to-one counseling for adults and adolescents (age 13 and up), such as brief cognitive-behavioral therapy (CBT) and community reinforcement approach (CRA) brief therapy. In addition, Behavioral Health offers one-to-one therapy, family therapy, and group therapy.

**Intensive Outpatient Program (IOP)**
Licensed therapists conduct these group therapy sessions (24 sessions over 8 weeks), offering adults the opportunity to explore the biological and emotional dimensions of addiction and to learn new coping skills for sobriety. Suboxone therapy for opioid use disorders and other MAT for alcohol use disorders are available to those enrolled in this program. Psychiatric treatment for co-occurring mental illness is also available.

**Medical Detoxification**
In hospital and ambulatory care settings, PHS has implemented evidence-based protocols for safely managing the acute physical symptoms of withdrawal associated with stopping drug and alcohol use.

**Medication-Assisted Treatments (MAT)**
Presbyterian offers evidence based medication treatments in addition to supportive therapy for tobacco, alcohol, and opioid use disorders in all care settings. Methadone maintenance therapy is supported in community settings.

**Peer Engagement, Support, and Coordination**
The “Emissaries of care” program focuses on training non-clinical staff regarding engagement and service linkage. Within the care delivery network, ancillaries to care (e.g., Care Coordinators, Navigators, Chaplains, etc.) bring together patients, providers, and community resources.

**Prevention**
PHS’ core Community Health priorities are: Healthy Eating, Active Living, and Prevention of Unhealthy Substance Use. PHS’ opioid stewardship program targets the prevention of accidental lethal opioid overdose, by establishing standards of care to reduce variation in opioid prescribing, monitoring opioid practice patterns, and provide feedback to providers that reinforces evidence-based practice.

**Universal Screening**
Throughout the PHS care delivery system, patients are universally screened for Tobacco Use Disorder, Alcohol Use Disorder, Opioid Use Disorder, and Injection Drug Use.
STAGES OF CHANGE

The “Stages of Change” are a well-defined model of behavior modification. The programs and services described above offer intervention strategies that are appropriate for treating a patient in specific stages of readiness. The diagram below illustrates how an array of interventions can meet the patient wherever he or she may be on the path to recovery.

<table>
<thead>
<tr>
<th>Pre-contemplation</th>
<th>Contemplation</th>
<th>Preparation</th>
<th>Action</th>
<th>Maintenance</th>
<th>Relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>“My drinking isn’t a problem.”</td>
<td>“I need to change, but now is not the right time.”</td>
<td>“I want to make a change, but I’m not sure how to do it.”</td>
<td>“I am ready to make a change.”</td>
<td>“I am living better.”</td>
<td>“I slipped.”</td>
</tr>
</tbody>
</table>

Patient Education and Shared Decision Making

Shared decision-making (SDM) helps people in treatment and recovery have informed, meaningful, and collaborative discussions with providers about their healthcare services. During the SDM process, clinicians contribute evidence-based medical knowledge, experiences, and attitudes while patients share their individual perspectives, expectations, and goals as well as information regarding needs, values, and their daily lifestyles. Then a decision on a subsequent treatment is drawn within the framework of both evidence-based medicine and individual patient preferences. This strategy empowers patients to be actively engaged in their own treatment.

One example of a SDM tool that Presbyterian service providers may use is **Decisions in Recovery: Treatment for Opioid Use Disorder**, developed by SAMSHA, an innovative decision support tool for people in or seeking recovery from opioid use disorder. Patients use this website to: 1) Learn about MAT; 2) Compare treatment options, and; 3) Discuss preferences with a treatment provider

**Key Tools**

Epic contains a list of order sets, including: inpatient alcohol withdrawal, inpatient opioid withdrawal, inpatient tobacco withdrawal, inpatient buprenorphine induction, ambulatory alcohol detoxification, ambulatory opioid detoxification, ambulatory benzodiazepine detoxification, outpatient MAT for alcohol use disorder, outpatient MAT for opioid use disorder, and outpatient MAT for tobacco use disorder.

In addition PDS is deploying a universal screening tool for patients in all care settings to identify problematic use of tobacco, opioids, alcohol, and IV drug use.
Clinician Training

Presbyterian offers a variety of educational forums regarding SUDs:

- Case-based learning, support, and telementoring (ECHO model)
- Provider training (up to 8 CME) in Chronic Opioid Therapy Guidelines and Opioid Alternatives for Chronic Pain, and Suboxone Certification (Data 2000 Waiver), quarterly
- Online training modules for Physicians, APCs, and staff (in development)
- Training for ancillary staff, including Addiction 101, MAT for Inpatient Providers, MAT for Outpatient Providers, Weaning Opioids and Benzodiazepines, Patient Engagement, Motivational Interviewing, and Community Reinforcement Approach

Leadership

| Process Owners | Jane Keeports – Administrator, Behavioral Health Services, CDS  
Daniel Duhigg, DO, MBA – Medical Director, Addiction Services  
Lisa K. Jackson, MA, LPCC, MPH – Director, Integrated SUD Initiative |
| Clinical Champions | Daniel Duhigg, DO, MBA – Medical Director, Addiction Services  
Patti Pade, MD – Consult Liaison, Addiction Services |
| Governance Bodies | Integrated Substance Use Disorder and Community Collaborative Initiative  
Presbyterian Integrated Leadership Team (PILT) |

Integrated Substance Use Disorder and Community Collaborative Initiative

| Core Team | Daniel Duhigg, DO, MBA - Medical Director, Addiction Services  
Lisa K. Jackson, MA, LPCC, MPH - Director, Integrated Substance Use Disorder Initiative  
Laurie Kerr – Project Manager  
Doyle Boykin - Administrator, Kaseman Hospital  
Elizabeth Lacouture - Executive Director, Behavioral Health, PHP  
Gray Clarke, MD - Medical Director, Behavioral Health, PHP  
Mary Eden - Vice President, Government Programs, PHP |
| Executive Sponsors | Sandy Podley – Vice President of Operations, CDS  
Brandon Fryar – President, PHP |
| Other Participants | Fernando Jumalon, MD - Medical Director, Pres Acute Care, PH  
Jill Slominski, MD - Hospitalist, Skilled Nursing Facility, PKH  
Marie Hopper - Finance Manager for CDS  
Michael Hsu, MD - Medical Director Assistant for ER, PKH  
Randle Adair, MD - Hospitalist for Pres Acute Care, PH  
Sandra Mulligan, MD - Medical Director, IP Utilization Review for Care Coordination, PH  
Marti Martienssen - Director, Practice Operations, Market Business Dev., PKH  
Christina Vigil - Associate General Counsel, Legal Services  
Jennifer Ellis - Director of Nursing, Infusion Center  
Arand Pierce, MD - Pathology Associates of Albuquerque PA |
Measures of Success

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Aligns with Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the physical and mental health of the SUD population;</td>
<td>number of patients screened for SUDs</td>
<td>Better Health</td>
</tr>
<tr>
<td>Reduce harm;</td>
<td>number of patients prescribed naloxone</td>
<td></td>
</tr>
<tr>
<td>Reduce recidivism</td>
<td>number of hospitalized patients served by addictions consultation-liaison service</td>
<td></td>
</tr>
<tr>
<td>Improve the quality of life of SUD patients</td>
<td>access to addiction specialty services (rate)</td>
<td>Exceptional Experience</td>
</tr>
<tr>
<td></td>
<td>use of tobacco products (rate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>problematic alcohol use (rate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>follow up (after ED visit) rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>number of recovery-oriented community partnerships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>number of prescribers offering MAT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>response time to connect patient with SUD services</td>
<td></td>
</tr>
<tr>
<td>Avoid unnecessary cost</td>
<td>Number of episodes; cost per episode</td>
<td>Cost Leadership</td>
</tr>
<tr>
<td></td>
<td>Number of ED visits, admissions; length of stay</td>
<td></td>
</tr>
<tr>
<td>Develop the capacity for care of the medical home &amp; medical neighborhood</td>
<td>Number of hours of physicians, APCs, and nurses educated in SUD treatment</td>
<td>Better Health</td>
</tr>
<tr>
<td></td>
<td>Number of physicians and APCs certified (DATA 2000 waiver)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of hours of SUD-specific education to community organizations</td>
<td></td>
</tr>
</tbody>
</table>
**Future Work**

The SUD-related interventions that have been established or are being developed in the Central Delivery System will be expanded to the Regional Delivery System over the next 12-24 months.

Furthermore, some programs and services will be enhanced:

**Education**
Dr. Duhigg is leading the development online training modules for SUDs, addictions, and chronic pain, slated to go live in 2018. In addition, Dr. Duhigg will continue to lead the quarterly trainings and monthly grand rounds. The weekly Pain, Addiction, and Mental Health ECHO clinic will use case-based learning and telementoring to support more Providers who are treating patients with complex chronic pain conditions and/or substance use disorders.

**Consult Liaison Team**
Additional Providers (Physician Assistant and Advanced Nurse Practitioner) will increase the capacity for SUD consultations, enabling wider coverage for hospitals in the central delivery system, as well as tele-consultation for the regional hospitals.

**Prevention**
The SUD Initiative is collaborating with both Community Health and Population Health programs to develop prevention strategies in the community.

**Telehealth**
Telehealth will be expanded to increase a Provider’s ability access recommendations from the Addictions CL Team including MAT and discharge recommendations.

**Transitional Clinic**
Behavioral Health services is leading the planning of a Transitional Clinic, which may be an SUD-focused medical home that will offer care coordination, MAT, and therapy options to complex patients who are discharged from CDS hospitals, in order to then transition them to the primary care setting.

**Opioid Stewardship**
In collaboration with the Pharmacy department, the SUD Initiative will launch an enterprise-wide Opioid Stewardship program in 2018. This program will implement evidence-based guidelines to encourage safer use of opioids, reduce variation in opioid prescribing practices, and increase the use of non-opioid treatments.
Glossary

**cognitive-behavioral therapy (CBT)**
CBT is a therapy modality that is used widely in the treatment of substance use disorders. Derived from both behavioral and cognitive theories, it focuses on learning and practicing a variety of coping skills. CBT tries to change what the client both does and thinks, to help the client identify self-defeating, negative thoughts and behaviors which may often drive addiction. CBT for SUDs focuses on relapse prevention, including: 1) Individualized training in recognizing and coping with cravings, managing thoughts about substance use, problem solving, planning for emergencies, recognizing seemingly irrelevant decisions, and using refusal skills; 2) An examination of the client's cognitive processes related to substance use; 3) The identification and debriefing of past and future high-risk situations; 4) The encouragement and review of extra-session implementation of skills; and 5) Practice of skills within sessions.

**community reinforcement approach (CRA)**
Based on the principles of operant learning, CRA is a therapy modality used in the treatment of substance use disorders, the goal of which is to increase the likelihood of continued abstinence from alcohol or drugs by reorganizing the client's environment. Specifically, CRA attempts to weaken the influence of reinforcement received by substance use by increasing the availability and frequency of reinforcement derived from alternative activities, particularly those vocational, family, social, and recreational activities that are incompatible with substance use, which are referred to as prosocial activities. These alternative interpersonal and social sources of reinforcement are available when the person is not intoxicated, but unavailable if the person drinks or uses. CRA also incorporates motivational interviewing and CBT relapse prevention. The CRA model has been modified into the Community Reinforcement and Family Training procedure (CRAFT), in which the client's significant other and family members receive training in behavior modification and enhancing motivation. CRAFT seeks to reduce or stop substance use by working through non-using family and friends.

**engagement**
In treating substance use disorders (SUD), engagement is defined as initiation of intensive treatment as soon as possible after receiving a diagnosis.

**evidence-based care**
(Evidence-based Medicine) The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

**illicit drugs**
Illicit drugs include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, and others as well as prescription-type drugs used nonmedically, as defined in SAMHSA’s National Survey on Drug Use and Health (NSDUH).

**medical detoxification**
Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug or alcohol use. However, medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug or alcohol use. Although detoxification alone is rarely sufficient to help people achieve long-term abstinence, for some individuals it is a necessary precursor to effective drug and alcohol addiction treatment.
Patient-Centered Medical Home (PCMH)  The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication. Medical homes can lead to higher quality and lower costs, and can improve patients’ and providers’ experience of care.

Population Health  The identification and improvement of health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Stages of Change  A series of phases that people move through when modifying their behavior, the Stages of Change (precontemplation, contemplation, preparation, action, maintenance, and relapse) are described in the Transtheoretical Model (Prochaska & DiClemente), a comprehensive, integrative, biopsychosocial model to conceptualize the process of intentional behavior change. For each stage, specific intervention strategies are most effective at advancing the person to the next stage and ultimately to a changed behavior.

Substance use disorder (SUD)  Substance use disorder describes a problematic pattern of using alcohol or another substance (legal and/or illegal drugs) that results in impairment in daily life or noticeable distress. The term encompasses a range of severity levels, from problem use/misuse to dependence and addiction. The diagnosis is based on fulfilling diagnostic criteria as defined by the Diagnostic and Statistical Manual, 5th edition (DSM-5).

Additional References

Clinical Care Model
- Patient-Centered Medical Home (PCMH)
- Primary Care Behavioral Health (PCBH)
- Telehealth

Resources: PHS Login Required
- BH Substance Abuse and Dependence Assessment Content Outline BEH.CDS.205
- Community Health Investment Report 2016
- Substance Use Disorder Resources (PHS Campus)
- Substance Abuse Resources: Statewide Services
- Training: Data 2000 Waiver: Suboxone Certification
- Training: Ground Rounds: Complex Pain and Opioid Management
- Training: Pain Management and Opioid Therapy
- Training: Pain, Addiction, and Mental Health ECHO Clinic

Additional Resources
- Alcohol Screening and Brief Intervention Manual (APHA)
- Behavioral Health Trends in the US: Results from the 2014 National Survey on Drug Use and Health (SAMHSA)
- Decisions in Recovery: Treatment for Opioid Use Disorders
- ECHO Model
- New Mexico Substance Abuse Epidemiology
- Rethinking Drinking (NIAAA)