FAST PTO Touchbase

Wednesday June 23, 2021 9:00AM

Call Instructions:

Please

- Mute your phone, microphone, and speakers on your computer/device
- *Enter your name, organization, and preferred pronouns in the chat box*
- *We encourage active participation via Chat or audio*
  - Submit questions via the chat box feature
    - *Questions will be answered as submitted*
  - *Unmute yourself to ask question and participate in discussions*
  - *Time to ask questions via audio will be offered for those on the phone*
    - *6 - Toggle mute/un-mute
    - *9 - Toggle raise/lower hand

Agenda

+ Check In & Follow up from May call
+ Education
+ Q&A
+ Reminders/Upcoming Events/Wrap Up

Check In

- What materials have you been bringing back to your clinics?
- Are there any special requests/adaptations for practice sites to support their different populations?
- Are you seeing a difference in practice engagement by role type?

Operational

Operational Updates

- Reminder: Invoice and W-9, prompt practices to submit invoices
- Budget year ends Sept 30th. Need PTO and practice invoices

- Peer Assistance materials: posters, pocket and wallet cards, etc. Email Jennifer or Bonnie with materials and quantities you'd like to receive.

Session 7 – Assessments Due

+ Monitor
+ SBIRT/MAT Implementation Checklist
+ Final Field Note
+ UAU Measure
+ HIT UAU Measure Submission


Education

Trauma-Informed Brief Interventions for Unhealthy Alcohol Use

Carolyn Swenson

FAST Consultant

FAST Check-In: June 23, 2021

Goals

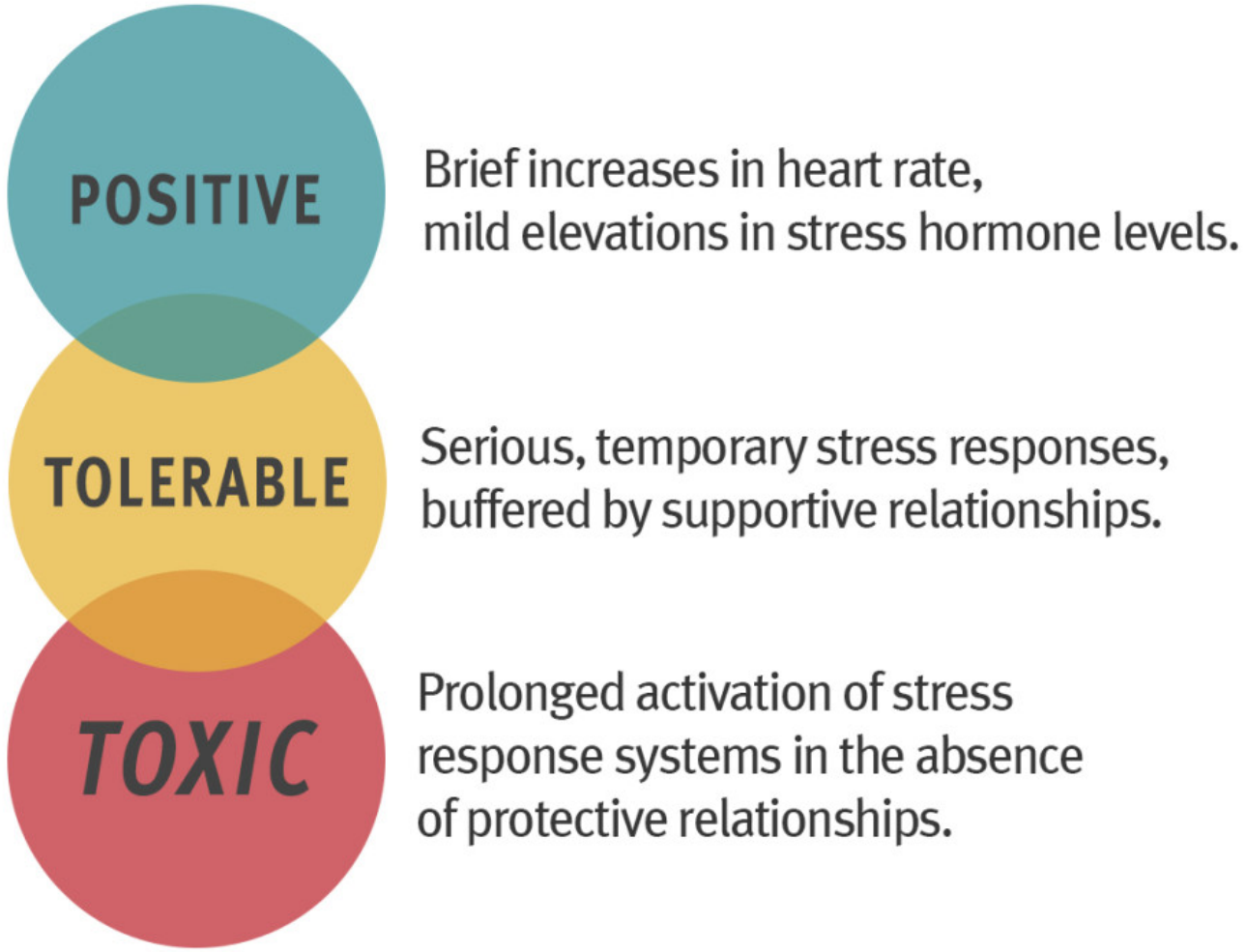
1. Explore how unhealthy alcohol (UAU) use is related to trauma.
2. Introduce approaches to addressing trauma as part of SBIRT.
3. Discuss opportunities and challenges related trauma-informed SBIRT.


A story

Trauma

+ Adverse childhood experiences (ACEs)
+ Historical trauma
+ Intergenerational trauma
+ Traumatic stress across the lifespan that is intense, frequent, or prolonged (Examples: poverty, racism, homophobia/transphobia, community violence, interpersonal violence, natural disasters, war, displacement and migration, *global pandemic*)

Stress


POSITIVE
Brief increases in heart rate, mild elevations in stress hormone levels.
TOLERABLE
Serious, temporary stress responses, buffered by supportive relationships.
TOXIC
Prolonged activation of stress response systems in the absence of protective relationships.

Research

- **The Adverse Childhood Experiences Study (CDC-Kaiser Permanente; 1995):** Epidemiological study of 17,000+ individuals from the U.S. that analyzed long-term effects of childhood and adolescent traumatic experiences on adult health, mental health, healthcare costs, and life expectancy.
- **Coronary Artery Risk Development in Young Adults Study (NHLBI/U-Alabama Birmingham; 1983)** Includes 5,000+ black and white adults who were aged 18-30 in 1985-86; Aims to identify factors that begin in young adulthood that contribute to future risk of cardiovascular disease, and better understand the natural history of cardiovascular disease.
- **The Women, Co-Occurring Disorders and Violence Study (SAMHSA; 1998)** Large multisite study focused on the role of interpersonal and other traumatic stressors among women; the interrelatedness of trauma, violence, and co-occurring substance use and mental disorders; and the incorporation of trauma-informed and trauma-specific principles, models, and services.

Health effects of ACEs

+ Interaction of behavioral, neuroendocrine, and epigenetic (social and environmental) factors
+ Increased sympathetic nervous system activity: increased adrenaline, cortisol, other stress hormones
+ Disrupted brain and other organ development (prenatal; infancy; childhood; adolescence)

LEADING TO INCREASED RISK FOR:

+ Chronic mental and physical health conditions, increased suicide and other injury risk
+ Unhealthy behaviors: unhealthy alcohol use, tobacco or drug abuse, and others
+ Impaired immune function
+ Cognitive impairment
+ Premature death

Mediators of trauma and toxic stress

+ Supportive and protective relationships (especially during childhood)
+ Resilience: ability to respond effectively (cope) to mitigate negative effects
+ Mental health and social support services

Trauma & unhealthy alcohol use (UAU)

Unhealthy alcohol, tobacco & other drug use may be:

- A coping strategy
- A learned behavior related to family or other environmental influences

Research:

- 33-60% of individuals who develop an alcohol or other substance use disorder have history of trauma
- Risk greater in those with co-occurring mental illness
- In women, often a history of physical and/or sexual violence in childhood and/or adulthood
- Suicide is the leading cause of death in individuals with alcohol or another substance use disorder

Trauma-Informed Care: Guiding Principles

1. Safety (emotional and physical)
2. Choice
3. Collaboration
4. Trustworthiness
5. Empowerment

Pause for discussion

1. In your experience, how familiar are primary care practices with the health effects of ACEs and traumatic stress?

2. In your experience, how often are primary care practices identifying and responding to ACEs and traumatic stress?

Screening for trauma in primary care

1. Trauma History Screen (National Center for PTSD)
2. Primary Care PTSD Screen for DSM-5 (National Center for PTSD)
3. ACE screening (pediatric or adult settings)

Trauma History Screen

The events below may or may not have happened to you. Circle "YES" if that kind of thing has happened to you or circle "NO" if that kind of thing has not happened to you. **If you circle "YES" for any events:** put a number in the blank next to it to show how many times something like that happened.

Event	Circle "YES" if that kind of thing has happened to you	Circle "NO" if that kind of thing has not happened to you	Number of times something like this has happened
A. A really bad car, boat, train, or airplane accident	YES	NO	_____ times
B. A really bad accident at work or home	YES	NO	_____ times
C. A hurricane, flood, earthquake, tornado, or fire	YES	NO	_____ times
D. Hit or kicked hard enough to injure - as a child	YES	NO	_____ times
E. Hit or kicked hard enough to injure - as an adult	YES	NO	_____ times
F. Forced or made to have sexual contact - as a child	YES	NO	_____ times
G. Forced or made to have sexual contact - as an adult	YES	NO	_____ times
H. Attack with a gun, knife, or weapon	YES	NO	_____ times
I. During military service - seeing something horrible or being badly scared	YES	NO	_____ times
J. Sudden death of close family or friend	YES	NO	_____ times
K. Seeing someone die suddenly or get badly hurt or killed	YES	NO	_____ times
L. Some other sudden event that made you feel very scared, helpless, or horrified	YES	NO	_____ times
M. Sudden move or loss of home and possessions	YES	NO	_____ times
N. Suddenly abandoned by spouse, partner, parent, or family	YES	NO	_____ times

Did any of these things really bother you emotionally? NO YES

If you answered "YES", fill out one or more of the boxes on the next pages to tell about EVERY event that really bothered you.

ID # _____

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you...

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

   YES NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

   YES NO

3. been constantly on guard, watchful, or easily startled?

   YES NO

4. felt numb or detached from people, activities, or your surroundings?

   YES NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

   YES NO

Trauma-SBIRT feasibility study (T-SBIRT)

Complementing SBIRT for Alcohol Misuse with SBIRT for Trauma: A Feasibility Study (2017)

- Research question: In SBIRT research the “RT” step of SBIRT is less effective. Could this partly be a result of not linking trauma and UAU?
- “Self-medication theory”: difficult to eliminate UAU or other unhealthy coping strategies without addressing trauma exposure
- Focus of this study: **current** effects of trauma exposure and traumatic stress
- UAU and trauma scores positively correlated
- 62.5% with UAU + trauma history accepted a behavioral or mental health referral
- Higher level of UAU associated with higher acceptance of referral to treatment for AUD
- Patient acceptability of trauma screening and conversations was high

T-SBIRT Protocol

- University WI Milwaukee
- https://uwm.edu/icfw/t-sbirt/

T-SBIRT protocol

When delivering T-SBIRT, service providers complete the protocol with their clients in the following sequence:

1. **Make a brief statement** about known connections between stress, trauma and poor life outcomes.

2. **Ask permission** to screen for and discuss issues of stress and trauma.

3. **Ask about sources** of current life stressors using open-ended questions.

4. **Screen for exposure** to traumatic events using the Trauma History Screen[7] or other validated tool.

5. **Assess for current symptoms** with the Primary Care Post-Traumatic Stress Disorder (PC-PTSD) screen.[8]

6. **Ask about** "positive" and "unhelpful" strategies used to cope with trauma memories and symptoms.

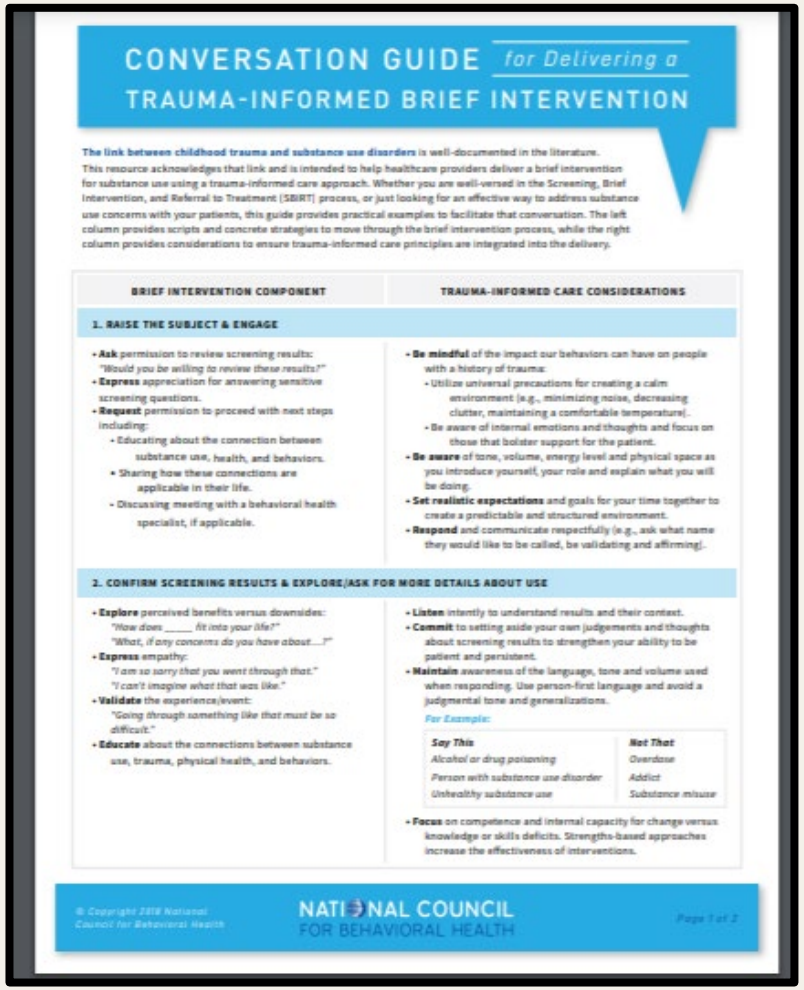
7. **Inform clients** that it can be difficult to eliminate substance misuse or other unhelpful coping strategies without simultaneously addressing trauma.

8. **Gauge and enhance motivation** to pursue behavioral or mental health services.

9. **Make a referral to treatment** when indicated following best referral practices.

10. **Offer an educational booklet** on post-traumatic stress, published by the federal government.[9]

11. **Implement an evidence-based** calming exercise if necessary.



CONVERSATION GUIDE *for Delivering a* TRAUMA-INFORMED BRIEF INTERVENTION

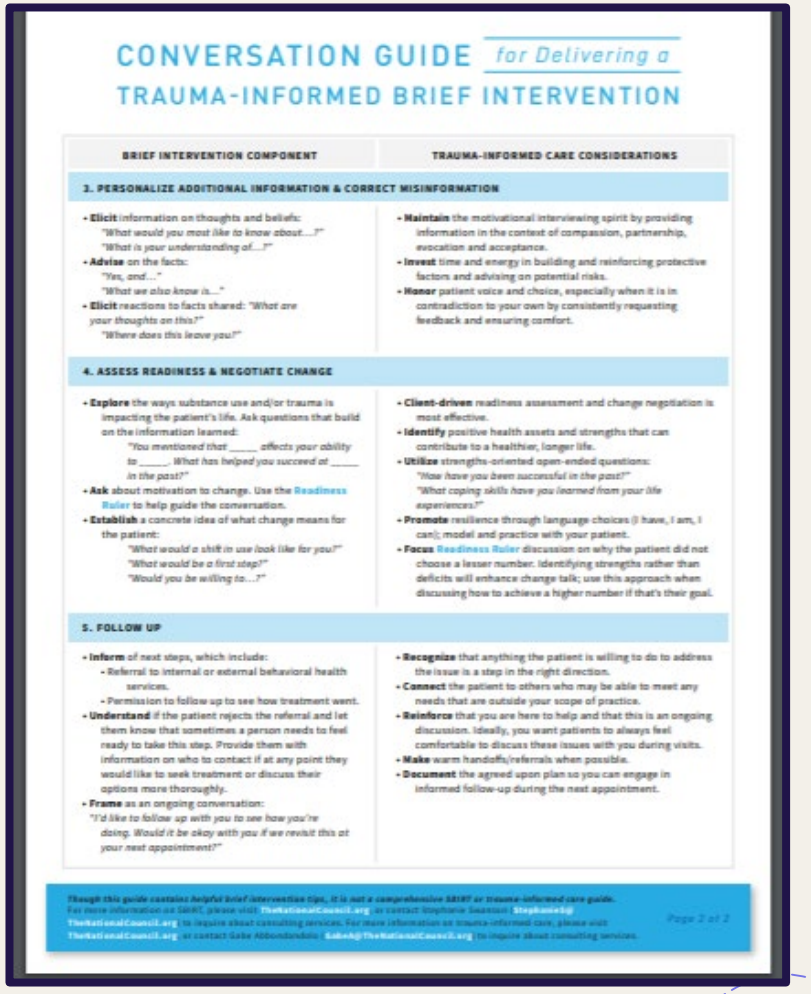
The link between childhood trauma and substance use disorders is well-documented in the literature. This resource acknowledges that link and is intended to help healthcare providers deliver a brief intervention for substance use using a trauma-informed care approach. Whether you are well-versed in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process, or just looking for an effective way to address substance use concerns with your patients, this guide provides practical examples to facilitate that conversation. The left column provides scripts and concrete strategies to move through the brief intervention process, while the right column provides considerations to ensure trauma-informed care principles are integrated into the delivery.

BRIEF INTERVENTION COMPONENT	TRAUMA-INFORMED CARE CONSIDERATIONS
1. RAISE THE SUBJECT & ENGAGE	

• **Ask** permission to review screening results:
"Would you be willing to review these results?"
• **Express** appreciation for answering sensitive screening questions.
• **Request** permission to proceed with next steps including:
  ◦ Educating about the connection between substance use, health, and behaviors.
  ◦ Sharing how these connections are applicable in their life.
  ◦ Discussing meeting with a behavioral health specialist, if applicable.
	• **Be mindful** of the impact our behaviors can have on people with a history of trauma:
	  ◦ Utilize universal precautions for creating a calm environment (e.g., minimizing noise, decreasing clutter, maintaining a comfortable temperature).
	  ◦ Be aware of internal emotions and thoughts and focus on those that bolster support for the patient.
	• **Be aware** of tone, volume, energy level and physical space as you introduce yourself, your role and explain what you will be doing.
	• **Set realistic expectations** and goals for your time together to create a predictable and structured environment.
	• **Respond** and communicate respectfully (e.g., ask what name they would like to be called, be validating and affirming).

2. CONFIRM SCREENING RESULTS & EXPLORE/ASK FOR MORE DETAILS ABOUT USE	
• **Explore** perceived benefits versus downsides: *"How does _____ fit into your life?"* *"What, if any concerns do you have about…?"* • **Express** empathy: *"I am so sorry that you went through that."* *"I can't imagine what that was like."* • **Validate** the experience/event: *"Going through something like that must be so difficult."* • **Educate** about the connections between substance use, trauma, physical health, and behaviors.	• **Listen** intently to understand results and their context. • **Commit** to setting aside your own judgements and thoughts about screening results to strengthen your ability to be patient and persistent. • **Maintain** awareness of the language, tone and volume used when responding. Use person-first language and avoid a judgmental tone and generalizations. *For Example:* ***Say This*** / ***Not That*** *Alcohol or drug poisoning* / *Overdose* *Person with substance use disorder* / *Addict* *Unhealthy substance use* / *Substance misuse* • **Focus** on competence and internal capacity for change versus knowledge or skills deficits. Strengths-based approaches increase the effectiveness of interventions.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH



CONVERSATION GUIDE *for Delivering a* TRAUMA-INFORMED BRIEF INTERVENTION

BRIEF INTERVENTION COMPONENT	TRAUMA-INFORMED CARE CONSIDERATIONS
3. PERSONALIZE ADDITIONAL INFORMATION & CORRECT MISINFORMATION	
• **Elicit** information on thoughts and beliefs: *"What would you most like to know about…?"* *"What is your understanding of…?"* • **Advise** on the facts: *"Yes, and…"* *"What we also know is…"* • **Elicit** reactions to facts shared: *"What are your thoughts on this?"* *"Where does this leave you?"*	• **Maintain** the motivational interviewing spirit by providing information in the context of compassion, partnership, evocation and acceptance. • **Invest** time and energy in building and reinforcing protective factors and advising on potential risks. • **Honor** patient voice and choice, especially when it is in contradiction to your own by consistently requesting feedback and ensuring comfort.
4. ASSESS READINESS & NEGOTIATE CHANGE	
• **Explore** the ways substance use and/or trauma is impacting the patient's life. Ask questions that build on the information learned: *"You mentioned that _____ affects your ability to _____. What has helped you succeed at _____ in the past?"* • **Ask** about motivation to change. Use the Readiness Ruler to help guide the conversation. • **Establish** a concrete idea of what change means for the patient: *"What would a shift in use look like for you?"* *"What would be a first step?"* *"Would you be willing to…?"*	• **Client-driven** readiness assessment and change negotiation is most effective. • **Identify** positive health assets and strengths that can contribute to a healthier, longer life. • **Utilize** strengths-oriented open-ended questions: *"How have you been successful in the past?"* *"What coping skills have you learned from your life experiences?"* • **Promote** resilience through language choices (I have, I am, I can); model and practice with your patient. • **Focus** Readiness Ruler discussion on why the patient did not choose a lesser number. Identifying strengths rather than deficits will enhance change talk; use this approach when discussing how to achieve a higher number if that's their goal.
5. FOLLOW UP	

• **Inform** of next steps, which include:
  ◦ Referral to internal or external behavioral health services.
  ◦ Permission to follow up to see how treatment went.
• **Understand** if the patient rejects the referral and let them know that sometimes a person needs to feel ready to take this step. Provide them with information on who to contact if at any point they would like to seek treatment or discuss their options more thoroughly.
• **Frame** as an ongoing conversation:
"I'd like to follow up with you to see how you're doing. Would it be okay with you if we revisit this at your next appointment?"
	• **Recognize** that anything the patient is willing to do to address the issue is a step in the right direction.
	• **Connect** the patient to others who may be able to meet any needs that are outside your scope of practice.
	• **Reinforce** that you are here to help and that this is an ongoing discussion. Ideally, you want patients to always feel comfortable to discuss these issues with you during visits.
	• **Make** warm handoffs/referrals when possible.
	• **Document** the agreed upon plan so you can engage in informed follow-up during the next appointment.

Though this guide contains helpful brief intervention tips, it is not a comprehensive SBIRT or trauma-informed care guide. For more information on SBIRT, please visit TheNationalCouncil.org or contact Stephanie Seaman (Stephanie@TheNationalCouncil.org) to inquire about consulting services. For more information on trauma-informed care, please visit TheNationalCouncil.org or contact Gabe Abbondandolo (GabeA@TheNationalCouncil.org) to inquire about consulting services.

Trauma-Informed Brief Intervention (1)

1. **Raise the subject:**

+ Be mindful of how provider behaviors can affect patients with a history of trauma.
+ Aim for a calm environment. Consider tone, volume, energy level.
+ Focus on having a predictable, structured interaction; e.g., agree on an agenda.
+ Set realistic expectations and goals.
+ Affirm and validate the patient's willingness to discuss sensitive topics.

Trauma-Informed Brief Intervention (2)

2. Confirm screening results & ask for more details about alcohol use

+ Listen intently to genuinely try to understand context of alcohol use.
+ Explore patient insights into how use relates to difficult life experiences.
+ Set aside personal judgments and opinions.
+ React calmly and compassionately to information shared by the patient.
+ Use person-first language (a *person with unhealthy alcohol use or AUD*).
+ Focus on competence and capacity for change.
+ Focus *less* on knowledge or skills deficits.

Trauma-Informed Brief Intervention (3)

3. Personalize additional information & correct misinformation

+ Ask open-ended questions: *What is your understanding of…?*; *What information would be most helpful to you?*
+ Emphasize partnership with the patient.
+ Always ask what the patient thinks about the information.
+ Explore protective factors and supports.
+ Introduce harm reduction strategies.
+ Honor patient choice/affirm autonomy.
+ Assure patient of ongoing support and care regardless of next steps chosen.

Trauma-Informed Brief Intervention (4)

4. Assess readiness and negotiate change

+ Explore how alcohol use and/or trauma responses are affecting the patient's life.
+ Identify positive health assets and strengths that can contribute to a healthier, longer life.
+ Focus readiness response on why the patient did not choose a lower number.
+ Explore what a change in alcohol use might look like. Ask about the first step that seems like a good idea and possible.

Trauma-Informed Brief Intervention (5)

5. Follow-up

+ Recognize and affirm that any steps the patient is willing to take.
+ Accept any unwillingness to pursue a referral and note that a person needs to feel ready to take the next step.
+ Connect the patient to supports that are outside your scope of practice.
+ Reinforce your willingness to revisit the issue and continue the conversation.
+ Affirm the patient’s insight into next steps that make the most sense for them.
+ Establish a concrete follow-up plan.

Trauma-Informed Alcohol Brief Interventions: Key Points

1. Cultivate a practice environment that recognizes the relationship between trauma and health (including UAU).
2. Identify practice and community supports and services to address trauma.
3. Offer feedback to patients on how stress and trauma affect health (including UAU).
4. Invite patients to reflect on current life stressors and how they may relate to UAU.
5. Ask patients about current helpful and unhelpful coping strategies.
6. Ask patients what information and supports would be most helpful.
7. Inform patients that addressing trauma and UAU simultaneously supports change.
8. Recognize that identifying trauma in patients with an AUD may increase receptivity to treatment.

Questions and Discussion

1. Questions? Comments?
2. What aspects of trauma-informed are most important to introduce to FAST practices?
3. What resources related to trauma and UAU are practices most likely to find helpful?

THANK YOU VERY MUCH!

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Questions & Answers

Upcoming FAST Due Dates

Assessment	Date
PF Field Notes	Field Notes Are to be completed by the 8th of the Month
Baseline Assessments: • Monitor • SBIRT/MAT • Baseline UAU Metrics • Baseline HIT Metrics	Completed as part of the First Session with the Practice
UAU Metrics	Last day of the month following the end of the third month. An example is: If the end of the three-month period ends April 30 the Metrics are due May 31

Future Events

- July PF Learning Network and FAST PF Touch Base meetings are cancelled.
- Reach out to the team if we can help.
- See you again in August!

University Practice Innovation Team Contact Information

+ Practice Transformation – Stephanie.Kirchner@cuanschutz.edu
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+ FAST Faculty – cjswenson57@gmail.com
+ SPLIT – Help Desk

PRACTICE INNOVATION PROGRAM COLORADO

University of Colorado Anschutz Medical Campus

Resources

- Practice Innovation Program Colorado: http://www.practiceinnovationco.org/
- Events: http://www.practiceinnovationco.org/events/
- Facilitating Alcohol Referral & Treatment (FAST): https://www.practiceinnovationco.org/alcohol/
- e-Learning: https://cuelearning.org/
- AHRQ UAU Initiative: https://integrationacademy.ahrq.gov/about/opioids-substance-use/ahrq-alcohol-initiative

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