Engaging Primary Care and Prevention: Four Case Studies

• Lessons learned from four communities that engaged in whirlwind, 6-month pilot projects to increase connections between primary care and local prevention efforts.
Goal of the Project.....

To develop capacity to work with primary care providers for the purpose of integrating and expanding capacity to offer prevention services to clients served in a primary health care setting.
Goal of the Project.....

• The integration of health care and prevention is essential to the reduction of costs for health care in America.
  
  – Integrating medical resources and community prevention will reduce demand for services and improve health outcomes.

  – DBHR is committed to ensuring the prevention field is ready for participation in the future of Health Care Reform.
This two part project offered ..... 

- $25,000 through a competitive process to four (4) PRI coalitions. Six month projects supporting the development and documentation of innovative connections and strategies between Coalitions and PHCP.

- $3,000 to recruit Primary Health Care Providers (PHCP) to join Prevention Redesign Initiative (PRI) Coalitions and participate in at least one media engagement or public presentation as spokesperson for the Coalition by the completion of the grant on July 31, 2012.
Primary Care Integration Demonstration Projects ..... 

- **Chelan County** - Wenatchee Coalition - Renee Hunter 
- **Okanogan County** - Okanogan Community Coalition - Megan Azzano & Andi Ervin 
- **Snohomish County** - Darrington Prevention Intervention Community Coalition - Joe Neigel 
- **Whatcom County** - Shuksan PRI Coalition - Joe Fuller & Geoff Morgan
Part 1:
Four Demonstration Projects were conducted

Wenatchee Substance Abuse Coalition

Darrington Prevention Intervention Community Coalition

Shuksan Community Network

Okanogan County Community Coalition
Omak Triple P

- Okanogan County
- Rural and Remote (County population 40,000)
- Most services centralized in Omak (population 4,700)
Omak Triple P
What is Triple P?

Breadth of reach

Intensive family intervention

- Level 5

Broad focused parenting skills training

- Level 4

Narrow focus parenting skills training

- Level 3

Brief parenting advice

- Level 2

Communications strategy

- Level 1

Intensity of intervention
Omak Triple P

• Focus of Triple P
  – Self-sufficiency
  – Self-efficacy
  – Self-management
  – Personal Agency
  – Problem solving

No more – no less

Providing parents with support ~ in the dosage they need ~ is cost effective and efficient
Omak Triple P

Why Triple P?

- Identified in September 2011 by the Coalition’s ACE Subcommittee as a program of interest.
  - Data indicating reduction in child maltreatment and out of home placement.
  - Exploratory efforts to retain funding began during the next 6 months (led by Public Defender and CPS Supervisor).

Triple P identified as a potentially sustainable prevention program
Omak Triple P

• 18 people participated in the 2-day Triple P Training.

• 9 of those participants were Primary Health Care Providers

• Fifteen Omak Triple P practitioners completed the accreditation process to be recognized by Triple P America as "Accredited Primary Care Triple P Practitioners" on May 9 and 10.

• We have retained 14 accredited practitioners – we lost one when she relocated out of the area
Omak Triple P

Who was trained?

Prof. Category

Agency Type

40%
Omak Triple P

**Successes**

- Agency administrators willing to identify “correct” people for training
- Agency administrators willing to explore options for full implementation.
- Good participation in both training and accreditation
- 13 different agencies sent staff for training
- **Community Support - “buy-in”**

**Barriers**

- Funding: Training is EXPENSIVE!
- Parents often need higher level of services than Primary Care Triple P
- Capacity within organizations to deliver the program
- Did I say FUNDING?
Omak Triple P

Where are we now?

• Omak is one of 3 pilot communities in a new DBHR-funded Triple P demonstration project levels 1-4

Includes training for...

✓ PHCP from Family Health Centers (Level 2/3)
✓ Additional Level 2/3 training for para-professionals
✓ More intense Level 4 Practitioners
Omak Triple P

Most exciting part...?

Potential development of evaluation tool to be used for local evaluation of efficacy.

Capacity built within community

Billing codes established by Healthcare Authority!
Demonstration Project #2
Wenatchee Substance Abuse Coalition

Physicians Partner for Prevention:

• **Secured drop-boxes** for disposal of unused prescription and over-the-counter medications.

• **User-friendly brochures**, developed in English and Spanish, for local medical providers to give patients when prescribing opiate medication.
Accomplishments

• 69 pounds of medications were received on “Take Back Day” in April 2012.

• The Drop Boxes are on back order due to the Colorado fires.

• Brochures were printed in English with information about the location of the drop boxes. Progress is being made toward printing brochures in Spanish.
Accomplishments

• Public service announcements are ready to announce the placement of the "Lock Boxes".

• Presentation will be made to local dentists at their September meeting requesting they distribute brochures to patients when they prescribe opiate medications.
Lessons Learned and Recommendations

• Select a focus that is a shared interest to both parties.

• Plans to place the “Drop-Boxes” at local hospital and clinic failed when Coalition discovered DEA rule: (insert Law here)
Lessons Learned and Recommendations

• Be a good partner.

• Be on time and get to the point.

• Be flexible on your needs and timelines.

• Be organized and ready to present.

• Respond ASAP when contacted by PHCPs.
Demonstration Project #3
Shuksan Community Network

Bridges to Health Initiative:

• **Trainings:**
  – Motivational Interviewing
  – Adverse Childhood Experiences (ACEs)
  – Resilience and Prevention
  – Community Resources

• **Focus Groups:**
  – training attendees assess “what they would do differently based on the information from the training?”

• **Integrated Response:**
  – implemented to share information between primary care providers/school/prevention

• **Patient Screening:**
  – in the PHC clinic using an ACE focused risk and behavioral screening tool
Compared to an individual with 0 ACEs, individuals with 4 or more ACE’s increase the risk of:

- panic reactions: 2.5 fold increase
- anxiety: 4
- depressed affect: 3.6
- hallucinations: 2.7
- sleep disturbance: 2.1
- smoking: 1.8
- alcoholism: 7.2
- illicit drug use: 4.5
- injected drug use: 11.1
- perpetrating intimate partner violence: 5.5

Also, 1.1% lifetime prevalence of at least one suicide attempt (no ACE’s) compared to 35.2% for those who reported seven or more ACEs.
Training

• **Adverse Childhood Experiences:**
  – Ten total training events on topics of ACEs, Resilience, and Prevention & Community Resources

  Highlight:
  – ACE training with Dr. Felitti on the “Impact of ACE’s”
  – ACEs training with Dr. Felitti on “What’s Next?”
    • 81 in attendance/12 primary care

• **Motivational Interviewing (July 21st)**
  – Stephanie Ballasiotes w/ 16 yrs. MI training
    • 15 in attendance/4 primary care

• Total Training Events = 11 reported in PBPS
• Total # Trained = 245 (25 primary care)
Training

• Dr. Felitti’s knowledge and experience as a physician provided a unique ability to discuss applying the ACE information directly in a clinical setting.

• Dr. Felitti shared that while many believe this requires a lengthy discussion about childhood trauma, most of it can be accomplished within 1-3 minutes. The key question to the client is “how has this affected your health later in life?”

• Kaiser physicians appreciated understanding ‘root causes’ of many clients’ health problems. This allowed them look beyond treating a physical symptom resulting from a deeper issue of trauma.
Focus Groups

- Six focus groups found many common themes, including:
  - Use of ACE study results enhance the ability for discuss cross-systems approaches and dialogue among a variety of partners and disciplines.
  - ACE screening results, even within training events, affirmed the impact they have on individuals. They are also common and ‘most of us’ have them. On a professional level, this helps to reduce the judgment that ‘it’s just them.’ Results also highlighted the need for prevention and the need to work together.
  - Categorical thinking around mental health and physical health has created a distinct line between the two. ACE information is helping to reshape how health is framed, and to illustrating the clear connection between them both.
Focus Groups

- Opportunities to expand upon work surrounding ACEs opens the door for new partnerships and resources. Much interest has been generated and is turning into action.
- Enormous pressure exists on health care providers, causing difficulties for them to partner outside of their own field.
- In previous training events Dr. Anda effectively showed the impact of ACEs on larger public health perspective. Dr. Felitti provided a unique view on how the information can be applied on an individual level, and in a clinical setting. Our community now has an improved understanding of the macro and micro impacts.
The response demonstrates how the Coalition, Clinic, and School all contribute to and benefit from an improved functioning of the system that ultimately benefits individuals being served.
Screening Tools

• A handful of screening/evaluation tools were reviewed to see if of the possible use or adaptation.

• During his visit, Dr. Felitti provided a 15-page screening tool that is used in his Obesity clinic at Kaiser, and with success.
Possible Impact on Health Care Providers

• 35% reduction in doctor office visits during the year subsequent to evaluation
  – 11% reduction in Emergency Department (ED) visits and a
## ACE Questions

**Prior to your 18th birthday:**

- Did a parent or other adult in the household **often** swear at you, insult you, put you down, or humiliate you **or** act in a way that made you afraid that you might be physically hurt?

- Did a parent or other adult in the household **often** push, grab, slap, or throw something at you **or ever** hit you so hard that you had marks or were injured?

- Did an adult or person at least 5 years older than you **ever** touch or fondle you or have you touch their body in a sexual way **or** try to or actually have oral, anal, or vaginal sex with you?

- Did you **often** feel that no one in your family loved you or thought you were important or special **or** your family didn’t look out for each other, feel close to each other, or support each other?

- Did you **often** feel that you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you **or** your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

- Were your parents **ever** separated or divorced?

- Was your mother or stepmother **often** pushed, grabbed, slapped, or had something thrown at her **or** **sometimes or often** kicked, bitten, hit with a fist, or hit with something hard **or ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?

- Did you live with anyone who was a problem drinker or alcoholic **or** who used street drugs?

- Was a household member depressed or mentally ill **or** did a household member attempt suicide?

- Did a household member go to prison?
ACE Screening Protocols and Individual Response (clinic and school)

- Directions for engaging, screening, and supporting clients
- Can be initiated and driven from clinic or school point of contact
Tools & Resources

ACE Fact Sheet and School & Community Resources
Screening Results

- Number of screenings: 50 completed (7/11/12 and 7/16/12)
- Number of referrals: 48 (to community or school resources)
- Families co-served: N/A-outside of school year
- Average ACE score: 4
- ACE range (low-high): 0-10
- Gender: 30% Male & 70% Female
- Age:
  - 38% 18-35 years old
  - 36% 36-45 years old
  - 20% 46-60 years old
  - 6% over 60 years old
ACE Dosage among Washington State Adults (by percentage)

Source: Behavioral Risk Factor Surveillance System (BRFSS)
ACE Dosage among Interfaith Clients (by percentage)

- 60% 4 or more ACEs
- 16% 2 ACEs
- 14% 3 ACEs
- 6% 1 ACE
- 4% 0 ACEs

# of ACEs

Washington State Department of Social & Health Services – Division of Behavioral Health and Recovery - SPE
ACEs: WA Adults and Interfaith

- # of ACEs-WA
- Interfaith

- 0: 35
- 1: 22
- 2: 15
- 3: 10
- 4 or more: 18

60
# Type of ACE Experienced

<table>
<thead>
<tr>
<th>Type of ACE Experienced</th>
<th>STATE*</th>
<th>Whatcom*</th>
<th>Interfaith Patients</th>
<th>% Above State</th>
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<td><strong>Family Dysfunction</strong></td>
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<td></td>
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<tr>
<td>Substance Abuse</td>
<td>35%</td>
<td>33%</td>
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<td>+35%</td>
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<tr>
<td>Parental Separation/Divorce</td>
<td>27%</td>
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<tr>
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<td>56%</td>
<td>+32%</td>
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<tr>
<td>Battered Mother/DV</td>
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<td>15%</td>
<td>32%</td>
<td>+15%</td>
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<tr>
<td>Criminal Behavior</td>
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<td>15%</td>
<td>38%</td>
<td>+25%</td>
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<tr>
<td><strong>Neglect</strong></td>
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<tr>
<td>Emotional</td>
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<td>56%</td>
<td>+41%</td>
</tr>
<tr>
<td>Physical</td>
<td>10%</td>
<td></td>
<td>30%</td>
<td>+20%</td>
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*Behavioral Risk Factor Surveillance System (BRFSS)*
Type of ACE Experienced
WA Adults and Interfaith Patients (by percentage)

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<thead>
<tr>
<th>Type of ACE</th>
<th>WA</th>
<th>Interfaith</th>
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<tbody>
<tr>
<td>Substance Abuse</td>
<td>35%</td>
<td>70%</td>
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<tr>
<td>Divorce/Parent Sep.</td>
<td>27%</td>
<td>60%</td>
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<td>Physical Neglect</td>
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Source: Interfaith Screening. Behavioral Risk Factor Surveillance System (BRFSS)
Lessons Learned and Recommendations

- Relationships take time to develop
- Training can reframe the problem/solution and unite professionals across disciplines to build a common language
- The structure of the primary care system may not allow for broad change in a short time (payment structure also needs to be addressed)
- Identify changes that can be made within the current structure that allows clinic staff to work ‘smarter and not harder’
Lessons Learned and Recommendations

- Incentives (training opportunities and funding) can help increase participation from the care providers.

- We did not achieve the full level of participation we had anticipated. We were competing with significant pressures the clinic faced in health care reform.

- Make sure that you have the right staff to make the project happen. While the director may be needed for authority purposes, other key staff are needed for ‘buy-in’.
Lessons Learned and Recommendations

- Learn about the clinic’s service delivery system, their funding and time restrictions, and agency goals and objectives. This can help align services and support efforts that improve their work and their outcomes.

- Understand the differences between the Medical Model, Public Health Model, and various prevention models, including the Strategic Prevention Framework.

- PHCPs limited time with patients is always a concern. This can be alleviated, in part, through training. The result will also be found in a more accurate diagnosis.
Other Accomplishments & Future Plans

Efforts to **Continue** in the Future:

- Continue the to engage professionals and the larger community in the ACEs Network
- Interfaith- using project information to help in integrating maternal health services
- Administer HYS Off-Year Survey with ACEs and school climate questions
- Explore applications of ACE data on a client level and population level
- **CHIP** – project information will support the Comprehensive Behavioral Health Improvement Plan
  - Health Dept. and St. Joseph Hospital facilitate with WAHA, Interfaith, Whatcom Comm. Foundation, etc.
  - ACEs and Substance Abuse have been identified as the primary focus of the plan
Other Accomplishments & Future Plans

Efforts to **Continue** in the Future:

- Use collected ACE data in ongoing planning with the PRI in the Shuksan community
- Foster the BHAP relationship
- Additional training to health care providers, school staff, parents, and the larger community
- Increase consumer likelihood of engaging their physician in discussions about the impact of ACEs on their health
- Continued collection and analysis of ACE information from the Behavioral Risk Factor Surveillance System
- Continue developing partnerships with the medical community and recruit additional representatives for ongoing coalition meetings, as well as for strategic efforts
Future Goals

Efforts to **Begin** in the Future:

- Long-term (work into medical record at Interfaith and other providers)
- Partner with home-visiting nurses at the Health Department and encourage them to integrate ACE-related screening and discussion into the Nurse Family Partnership
- Expand efforts to collect ACE information that would allow for site comparisons over time and an improved profile of the community
Demonstration Project #4
Darrington Prevention Intervention
Community Coalition
Demonstration Project #1
Darrington Prevention Intervention
Community Coalition

Context

• Darrington is a frontier town located in the Cascade foothills of northern Snohomish County
• They have a 30 mile driveway called Highway 530
• Community has experienced sharp economic decline along with the downturn in the timber industry beginning in the 1990’s and continuing through the housing bust and current recession
Demonstration Project #1
Darrington Prevention Intervention
Community Coalition

People

- Community composition primarily Caucasian with some Sauk-Suiattle.
- Social standing significantly based on family longevity in the community, with many residents able to claim “founding family” status.
- Strong Tar Heel culture stretching back to turn of the 20th century “Tar Heel Picnics”
- View others as outsiders - “Flat Landers” - tending to disregard their views
Need

- Darrington was identified by data as one of Snohomish County’s most at-risk communities
Demonstration Project #1
Darrington Prevention Intervention
Community Coalition

The evidence based GAIN-SS (past year version) is designed to identify individuals who are likely to have a substance use or mental health disorder and who should be referred for further assessment or intervention.

- 68% of all 7th graders and 71% of all 9th graders demonstrated need for formal assessment or intervention.
Demonstration Project #1
Darrington Prevention Intervention Community Coalition

Primary Care Integration

- The Coalition worked with Dr. Gary Schillhammer, Darrington’s lone physician, to develop a proposal in response to the SPE solicitation from the State.
- Dr. Schillhammer was very concerned with how youth accessed prevention and healthcare information in the community, as well as the reliability of the information they were getting.
Proposal

• DPICC’s proposal was crafted to coordinate Darrington’s youth serving organizations away from symptom-driven and reactive care, toward protection-building proactive and preventative behavioral interventions.

• The project focuses on health information technology and physician accessibility to achieve an integration of prevention practices across community healthcare domains.
Demonstration Project #1
Darrington Prevention Intervention Community Coalition

Three Prongs

• **Teen Clinic:** Establishing a school-based teen clinic, called the Well Aware Center, where youth had free access to medical consultation.

• **Web Presence:** Developing a locally relevant wellness web and mobile device site where teens could explore reliable health care information and interact with Darrington Clinic staff anonymously.

• **Screening:** Best practice physician screening tool called the Rapid Assessment for Adolescent Preventative Services (RAAPS), to direct the physician’s work.
Demonstration Project #1
Darrington Prevention Intervention Community Coalition

Teen Clinic: Wellness + Awareness = Well Aware

• The Well Aware Center is staffed by Nurse Practitioner Shannon Thom from the Darrington Clinic.
• The Center is open each Thursday from 2-4pm. 2-3pm for scheduled appointments. 3-4pm for drop-ins.
• Uses technology to engage students and validate health messages
• Favors healthcare consultation over provision
Demonstration Project #1
Darrington Prevention Intervention Community Coalition

Accomplishments

• Found space on School District property _mid-year_.
• Over 70 youth served in just 4 months
• Individual and group consultation provided in addition to assessment and referral
• 14 follow-up referrals were made to the primary care clinic, with no costs passed on to youth or families
• The demonstration project literally saved lives
 Demonstration Project #1
 Darrington Prevention Intervention
 Community Coalition

RAAPS Screening

• For youth accessing Well Aware Center
• Developed at the University of Michigan
• Identifies behaviors that put youth at highest risk for serious injury, premature death, and academic and social problems
• Can be completed on Clinic Ipad
www.darringtonwellaware.com

• Darrington Youth Coalition served as primary consultants to the development of the site.
• Optimized for web and mobile devices
• The idea is to provide reliable information to local youth searching for answers to health questions, and to give them a mechanism to ask difficult questions without fear of judgment
• Our intent is to move youth in need of intervention from anonymity to face-to-face contact at the Well Aware Center or the Darrington Clinic.
Demonstration Project #1
Darrington Prevention Intervention
Community Coalition
Demonstration Project #1
Darrington Prevention Intervention Community Coalition

Where we stand TODAY

• Funding for the project expired five weeks ago, on July 31, 2012.
• HOWEVER – All of the players involved with the project recognize the value in continuing it.
• Darrington Clinic will continue to make Shannon Thom available each Thursday afternoon.
• School District will continue to promote the service and provide space for the Well Aware Center
• Cascade Valley Hospitals has offered grant writing support for the program
Demonstration Project #1
Darrington Prevention Intervention
Community Coalition

Where we stand TODAY

• Clinic staff will operate the website and update it regularly.
• County will continue to provide 3g service for Ipads and access to electronic RAAPS database.
• RAAPS database available throughout 2012-2013 school year.
Local Lessons Learned

• Implementing innovative programs with quality takes time.

• School Superintendents are busy and trusting. Make sure they read and understand everything you’re proposing.

• Everything that can go wrong... might. Partners change, time marches on, community culture will impact your efforts, bureaucracy happens and cross-agency collaboration takes time to work through. Did I mention time?
General Lessons Learned

• Technology is an important tool with which to engage youth. Anecdotally, our Nurse Practitioner cited its novelty, flexibility and cultural relevance as benefits.

• Liability and insurance were concerns for the School District and Darrington Clinic.

• Doctors are not contractors.
  – A Doctor’s participation is based on the perceived value of your project weighed against their sense and vision for how to help the community.
  – The PHCP assumes a certain level of political, social, and business risk for participating in a project like this.
Demonstration Project #1
Darrington Prevention Intervention
Community Coalition

Recommendations

• Develop a referral network: ensure that youth serving professionals in the community, including teachers and counselors, understand how and when to refer youth.
• Use technology to engage youth.
• Use a combination of scheduled appointments and walk-ins to maximize the time of the PHCP.
• PHCP requires a liaison at the school for scheduling, promotion and “norming,” or making students feel safe accessing the assigned PHCP.
• Ensure you have enough time for quality.
Demonstration Project #1

Darrington Prevention Intervention

Community Coalition

Questions?
Demonstration Project #1
Darrington Prevention Intervention
Community Coalition

Questions?
Part 2
Incentive Projects ($3,000)

**Goal:** Develop capacity to integrate substance abuse prevention with primary health care providers.

To be successful the Coalition needed to:

1. Ensure the identified Primary Health Care Provider attended 2/3 of the general Coalition meetings between February and July 2012.

2. Ensure the PHCP participated in a media interview/engagement or public presentations in support of the goals of the Coalition.
Successful Incentive Projects were conducted by

- Wenatchee Substance Abuse Coalition
- Shuksan Community Network
- Port Townsend Coalition
- Darrington Prevention/Intervention Community Coalition
- Okanogan County Community Coalition
- Franklin/Pierce Youth First
- Vashon Alliance to Reduce Substance Abuse
Participating Coalitions/Project Managers

- **King County** - Vashon Alliance to Reduce Substance Abuse (VARSA) – Luke McQuillin and Jackie Berganio
- **Pierce County** – Franklin Pierce Youth First - Renee Tinder
- **Jefferson County** – Port Townsend Coalition – Kelly Matlock
- **Chelan County** - Wenatchee Coalition - Renee Hunter
- **Okanogan County** - Okanogan Community Coalition - Megan Azzano & Andi Ervin
- **Snohomish County** - Darrington Prevention Intervention Community Coalition - Joe Neigel
- **Whatcom County** - Shuksan PRI Coalition - Joe Fuller & Geoff Morgan
Accomplishments

Public Presentations by Primary Health Care Providers included:


PHCP for Omak Coalition presented a radio program on "Healthline" for two local radio stations. Topics included prescription drug abuse, misuse, and the coalition's local prevention efforts.
Accomplishments

Public Presentations cont:

presentation was made to the Garfield Business Association to promote the Franklin/Pierce Youth First Coalition and it's work.

Presentation made before health, prevention, and social service professionals highlighting the Shuksan Comm. Network profile sheet, a snapshot of current activities and services and an open invitation to participate in the coalition. She also shared her experience as a coalition member.
Accomplishments

• PHCP for Okanogan County Community Coalition was recently elected to the Coalitions Executive Board.
Incentive Projects ($3,000)

Lessons Learned

• Schedules for meetings are key in engaging PHCPs in coalition work.

• First listen to PHCPs concerns about substance abuse and how in impacts their patients.
Overall Considerations for these Grant Projects

Now is the time for the field to ensure that substance abuse prevention providers find ways to support community-based health centers and be familiar with the medical context in which they operate and bill for services.

- At a minimum, provide referral information and in-services to staff on substance abuse prevention programs and services that serve their patients.
Overall Considerations for these Grant Projects

• From A Purchaser’s Guide to Clinical Preventive Services: Moving Science into Coverage March 2006

  – Alcohol misuse contributes to illnesses and injuries and is the third most common behavior-related cause of death in the United States.
  
  – Alcohol misuse was associated with 75,000 deaths and 2.3 million years of potential life lost (30 years per premature death) in 2001.
• Alcohol misuse results in a variety of adverse health and social outcomes. These include increased risk of unintentional injuries, violence, liver disease, hypertension, certain cancers, and diseases of the central nervous system.

• Alcohol misuse is associated with high costs to employers in the form of increased absenteeism, decreased productivity and lost productivity, and increased employer-sponsored healthcare expenditures.

• Overall, 15.3% of U.S. workers report using or being impaired by alcohol at work at least one time during the previous year, including 9% of workers who report being hung over at work.
Alcohol misuse is costly for health insurers and society. The cost of alcohol misuse in the United States was estimated to be $185 billion in 1998.

• About $16 billion of this amount was spent on medical care for alcohol-related complications (not including fetal alcohol syndrome [FAS]),

• $7.5 billion was spent on specialty alcohol treatment services, and

• $2.9 billion was spent on FAS treatment.

• The remaining costs ($134) billion were due to lost productivity.
Screening and counseling for alcohol misuse reduces both societal and healthcare costs.

• Each $1 invested in screening and brief counseling interventions saves approximately $4 in healthcare costs.

• Coverage for screening and brief counseling is currently offered by only 20% of employer-sponsored health plans, despite the fact that such services are among the most cost-effective clinical preventive services and have a proven impact on health outcomes.

http://www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf