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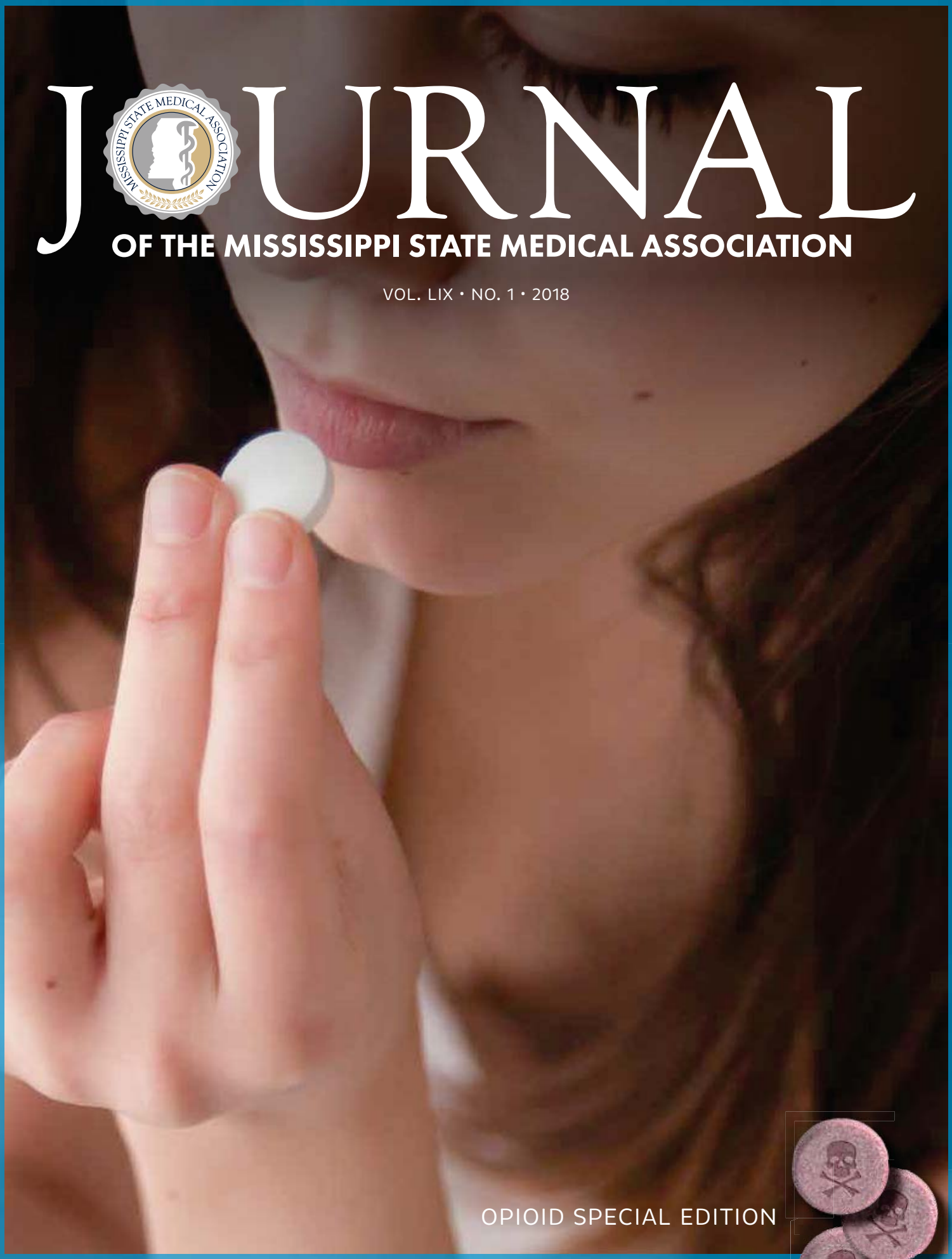

OPIOID SPECIAL EDITION

How Primary-Care Physicians Can Integrate Addiction Screening, Referrals into their Practices

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When you refuse to refill a patient's OxyContin prescription, the response is screaming, threats, or even physical damage to your office.

Have you just witnessed a manic swing from bipolar disorder? Or is there something else going on?

Embarassing scenes like that are a red flag for addiction, but many physicians would not recognize it as such or know what to do to help the patient. For most doctors and surgeons, mental healthcare and addiction were not part of their education and training. Those fields have been largely segregated from the broader healthcare system and from hospital-based physician networks, making the gap even wider.

As the opioid epidemic arrives in Mississippi, however, physicians in this state are finding themselves on the front lines of the crisis. All primary-care practices now need to consider whether they are equipped to help their patients avoid or recover from addiction.

Fortunately, this does not require becoming an expert in treating addiction and co-occurring mental health disorders. Your practice can make a significant difference by adding small steps to the systems you already have in place to screen patients for potential problems and to refer them out for specialized care.

Here are three steps we recommend:

1. UNDERSTAND THE PREVALENCE. According to the National Institute on Drug Abuse, an estimated 8.6 percent of Americans are in need of treatment for problems related to drugs or alcohol.

Particularly in the case of the current opioid epidemic, we have seen that addiction spans all social classes without discrimination. No matter the makeup of your particular practice, consider that one out of every 10 to 12 patients you see has a problem with drugs or alcohol. Ask your office manager how many patients you currently have in your practice, and do the math. The figure may be hard for you to believe, but those struggling with drugs or alcohol often hide it well, at least for a while.

Your practice also includes people who have not yet developed a substance use disorder, but who are vulnerable to addiction due to a genetic, physiological or psychological predisposition.

Consider this: A treatment path that may be medically appropriate and effective for 90 percent of patients can accelerate chemical dependency issues for the remaining 10 percent, due to existing substance use disorders or addiction vulnerability. For that reason, to routinely prescribe Xanax for anxiety or Lortab for pain, without considering certain patients' vulnerability to addiction, will cause problems for them and for your practice.

2. SCREEN AND ENGAGE PATIENTS. Despite the stakes, it can seem extraneous and time-consuming to engage patients on the subject of their drug or alcohol use when they have come to your office for medical care.

To streamline the process, introduce a screening tool into the paperwork that patients already complete during check-in. Choose one for your practice by reviewing the forms provided in the Clinical Practice section of the SAMHSA-HRSA Center for Integrated Health Solutions website.

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The DAST-10 screening tool, for example, is only 10 questions long and can be completed in minutes. It asks patients whether they have ever used more than one drug at a time, whether they've experienced blackouts or withdrawals, and whether their family members have ever complained about their drug use.

By utilizing a simple check-in screening tool, physicians have a better chance of determining whether drugs or alcohol might be causing problems in a patient's life – before a new prescription potentially sends them deeper into dependency.

3. DEVELOP REFERRAL RESOURCES. Of course, the catch in trying to determine whether patients have a problem with drugs or alcohol is, what are you going to do with that information?

Primary-care practices need to build out their referral resources in the areas of mental and behavioral health, especially in communities where those fields are still isolated from broader healthcare systems. When a patient admits to having a drug problem, or when a patient throws a fit in full-blown denial, you don't want to have to make 10 different calls to find someone who can help.

To identify quality treatment centers, look for appropriate licensing and credentials. A center should be certified by the Department of Mental Health and be accredited by the Joint Commission or CARF.

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Referrals for treatment should be made within the context of each patient's access to care. If they have a current insurance plan, reach out to the insurance company's provider service network and ask for a referral for substance use disorders and/or mental health issues. Many practices routinely use insurers' services to refer patients to in-network providers for a range of medical problems; physicians may not realize the same service can also help them refer out for mental and behavioral healthcare.

Addiction and co-occurring disorders are closely linked to physical wellbeing. Patients struggling in theses area many times present with

medical complaints that are not clearly defined and also do not respond to treatment interventions. This may lead to frequent return visits.

This is a good time to consider addiction and co-occurring disorders and integration of treatment for these with your patients. This will help your patients return to good health and stay healthy. ■

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