

Provider feedback to improve 5A's tobacco cessation in primary care: A cluster randomized clinical trial.

Bentz CJ; Bayley KB; Bonin KE; Fleming L; Hollis JF; Hunt JS et al. *Nicotine & Tobacco Research* 9(3): 341-349, 2007. (42 refs.)

The electronic health record (EHR) may be an effective tool to help clinicians address tobacco use more consistently. To evaluate the impact of EHR-generated practice feedback on rates of referral to a state-level tobacco quitline, we conducted a cluster randomized clinical trial (feedback versus no feedback) within 19 primary care clinics in Oregon. Intervention clinics received provider-specific monthly feedback reports generated from EHR data. The reports rated provider performance in asking, advising, assessing, and assisting with tobacco cessation compared with a clinic average and an achievable benchmark of care. During 12 months of follow-up, EHR-documented rates of advising, assessing, and assisting were significantly improved in the intervention clinics compared with the control clinics ($p < .001$). A higher case-mix index and presence of a clinic champion were associated with higher rates of referral to a state-level quitline. EHR-generated provider feedback improved documentation of assistance with tobacco cessation. Connecting physician offices to a state-level quitline was feasible and well accepted. Copyright 2007, Taylor & Francis.

Long-term opioid contract use for chronic pain management in primary care practice. A five year experience.

Hariharan J; Lamb GC; Neuner JM. *Journal of General Internal Medicine* 22(4): 485-490, 2007. (27 refs.)

BACKGROUND: The use of opioid medications to manage chronic pain is complex and challenging, especially in primary care settings. Medication contracts are increasingly being used to monitor patient adherence, but little is known about the long-term outcomes of such contracts. **OBJECTIVE:** To describe the long-term outcomes of a medication contract agreement for patients receiving opioid medications in a primary care setting. **DESIGN:** Retrospective cohort study. **SUBJECTS:** All patients placed on a contract for opioid medication between

1998 and 2003 in an academic General Internal Medicine teaching clinic. **MEASUREMENTS:** Demographics, diagnoses, opiates prescribed, urine drug screens, and reasons for contract cancellation were recorded. The association of physician contract cancellation with patient factors and medication types were examined using the Chi-square test and multivariate logistic regression. **RESULTS:** A total of 330 patients constituting 4% of the clinic population were placed on contracts during the study period. Seventy percent were on indigent care programs. The majority had low back pain (38%) or fibromyalgia (23%). Contracts were discontinued in 37%. Only 17% were cancelled for substance abuse and noncompliance. Twenty percent discontinued contract voluntarily. Urine toxicology screens were obtained in 42% of patients of whom 38% were positive for illicit substances. **CONCLUSIONS:** Over 60% of patients adhered to the contract agreement for opioids with a median follow-up of 22.5 months. Our experience provides insight into establishing a systematic approach to opioid administration and monitoring in primary care practices. A more structured drug testing strategy is needed to identify nonadherent patients. Copyright 2007, Springer.

On-site medical care in methadone maintenance: Associations with health care use and expenditures.

Gourevitch MN; Chatterji P; Deb N; Schoenbaum EE; Turner BJ. *Journal of Substance Abuse Treatment* 32(2): 143-151, 2007. (34 refs.)

To evaluate whether long-term drug treatment with on-site medical care is associated with diminished inpatient and outpatient service use and expenditures, we linked prospective interview data to concurrent Medicaid claims of drug users in a methadone program with comprehensive medical services. Patient care was classified as follows: long-term (. 6 months) drug treatment with on-site usual source of medical care (linked care), long-term drug treatment only, or neither. Multivariate analyses adjusted for visit clustering within patients (n 423, with 1,161 person-years of observation). After adjustment, linked care participants had more Outpatient visits ($p < .001$), fewer emergency department (ED) visits (24% vs. 33%, $p = .02$) and fewer hospitalizations (27% vs. 40%, $p = .002$) than the "neither" group. Ambulatory care

expenditures in the linked group were increased, whereas expenditures for other services were similar or reduced. Longterm drug treatment with on-site medical care was associated with increased ambulatory care, less ED and inpatient care, and no net increase in expenditures. Copyright 2007, Elsevier Science.

Prevalence, risk factors and treatment for substance abuse in older adults.

Christensen H; Low LF; Anstey KJ. *Current Opinion in Psychiatry* 19(6): 587-592, 2006. (50 refs.)

Purpose of review: This paper briefly outlines new research on the epidemiology of alcohol and drug use in the older population, describes mental and cognitive consequences of substance use and summarizes recent treatment trials for alcohol dependence. Recent findings Cross-sectional and longitudinal studies indicate that alcohol use is less prevalent in older groups, and it decreases over time. Comorbidity (alcohol and other drugs, alcohol with mental health disorders) is high. An inverse-U-shaped curve describes the association between alcohol consumption and cognitive impairment with increased impairment for abstainers and high users as compared with moderate users. Trials of alcohol use in the older population are rare, but they suggest that brief patient education may reduce drinking levels in primary care populations, and that, for some users, integrated primary care may be more useful than referral to specialist care. Summary The basis for higher risk in abstainers is not resolved. More randomized controlled trials are needed, which target alcohol use and dependence and also focus on comorbid disorders. Copyright 2006, Lippincott, Williams & Wilkins

Primary care quality and addiction severity: A prospective cohort study.

Kim TW; Samet JH; Cheng DM; Winter MR; Safran DG; Saitz R. *Health Services Research* 42(2): 755-772, 2007. (45 refs.)

Background. Alcohol and drug use disorders are chronic diseases that require ongoing management of physical, psychiatric, and social consequences. While specific addiction-focused interventions in primary care are efficacious, the influence of overall primary care quality on addiction outcomes has not been studied. The aim of this study was to prospectively examine if higher primary care quality is associated with lower addiction severity among patients with substance use disorders. Study Population. Subjects with alcohol, cocaine, and/or heroin use disorders who initiated primary care after being discharged from an urban residential detoxification program. Measurements. We used the Primary Care Assessment

Survey (PCAS), a well-validated, patient-completed survey that measures defining attributes of primary care named by the Institute of Medicine. Nine summary scales cover two broad areas of primary care quality: the patient-physician relationship (communication, interpersonal treatment, thoroughness of the physical exam, whole-person knowledge, preventive counseling, and trust) and structural/organizational features of care (organizational access, financial access, and visit-based continuity). Each of the three addiction outcomes (alcohol addiction severity (ASI-alc), drug addiction severity (ASI-drug), and any drug or heavy alcohol use) were derived from the Addiction Severity Index and assessed 6-18 months after PCAS administration. Separate longitudinal regression models included a single PCAS scale as the main predictor variable as well as variables known to be associated with addiction outcomes. Main Results. Eight of the nine PCAS scales were associated with lower alcohol addiction severity at follow-up ($p \leq .05$). Two measures of relationship quality (communication and whole-person knowledge of the patient) were associated with the largest decreases in ASI-alc (-0.06). More whole-person knowledge, organizational access, and visit-based continuity predicted lower drug addiction severity (ASI-drug: -0.02). Two PCAS scales (trust and whole-person knowledge of the patient) were associated with lower likelihood of subsequent substance use (adjusted odds ratio, [AOR]=0.76, 95 percent confidence interval [95% CI] =0.60, 0.96 and AOR=0.66, 95 percent CI=0.52, 0.85, respectively). Conclusion. Core features of primary care quality, particularly those reflecting the quality of the physician-patient relationship, were associated with positive addiction outcomes. Our findings suggest that the provision of patient-centered, comprehensive care from a primary care clinician may be an important treatment component for substance use disorders. Copyright 2007, Health Administration Press.

Project CHAT: A brief motivational substance abuse intervention for teens in primary care.

Stern SA; Meredith LS; Gholson J; Gore P; D'Amico EJ. *Journal of Substance Abuse Treatment* 32(2): 153-165, 2007. (64 refs.)

Many adolescents use alcohol and drugs; however, most do not seek help because of stigma or confidentiality concerns. Providing services in settings that teens frequent may decrease barriers. We examined the feasibility of adapting a brief motivational intervention for high-risk adolescents age 12-18 years) in a primary care setting by conducting

small feedback sessions with adolescents, parents, and clinic staff, and pilot testing the motivational intervention with adolescents. Findings from feedback sessions indicated that clinic staff thought teens would not talk about alcohol and drugs use. In contrast, adolescents reported that they would talk about their alcohol and drugs use, however, they were afraid of being judged. Parents were also concerned that the PC provider might be judgmental. Feedback from the motivational intervention pilot indicated that teens were willing to talk about their alcohol and drug use and indicated readiness to change. Findings suggest that providing a brief motivational intervention in a primary care setting is a viable approach for working with high-risk youth. Copyright 2007, Elsevier Science.

The "Six T's": Barriers to screening teens for substance abuse in primary care.

Van Hook S; Harris SK; Brooks T; Carey P; Kossack R; Kulig J; NEPSAR. *Journal of Adolescent Health* 40(5): 456-461, 2007. (40 refs.)

Purpose: To identify barriers to adolescent substance abuse screening in primary care. Methods: Focus groups were held at six primary care sites with a total of 38 providers. Providers brainstormed a list of barriers, collectively grouped similar barriers, and voted to produce a final ranked list. Two investigators qualitatively analyzed field notes and transcripts to triangulate findings, ranked the barriers across all sites by the number of groups identifying the barrier, then calculated a mean ranking (MR) for each. Results: The most commonly identified barrier was insufficient time (MR 1.8). Lack of training in how to manage a positive screen was ranked second (MR 1.7), but was linked to the first. Providers reported they had enough time to administer a short screen, but insufficient time to manage a positive result during the well care visit. The need to triage competing problems (MR 3.0), lack of treatment resources (MR 3.3), tenacious parents who would not leave the room for a confidential discussion (MR 2.5), and unfamiliarity with screening tools (MR 3.0) were also noted by more than one group. Conclusions: Insufficient time and lack of training in how to manage positive screens are the greatest barriers to screening adolescents for substance abuse. This suggests that some providers might differentially avoid screening youth who they suspect will screen positive, yet these patients would benefit most from early recognition. More research is needed on effective ways to manage positive substance abuse screens in primary care. Copyright 2007, Society for Adolescent Medicine.

The 5-Step family intervention in primary care: I. Strengths and limitations according to family members.

Orford J; Templeton L; Patel A; Copello A; Velleman R. *Drugs: Education, Prevention and Policy* 14(1): 29-47, 2007. (41 refs.)

Background: Family members affected by a close relative's substance misuse constitute a large but neglected, high-risk group. Interventions for that group are now being developed and tested in trials. More use should be made of qualitative methods to study process in such interventions. Design: Semi-structured interviews with family members 12 weeks after assignment to a full or brief 5-Step intervention. Both involved a primary care professional giving a self-help manual, and the full version also involved up to five sessions of a psychosocial intervention. Participants: 143 patients of GPs, health visitors and practice nurses in general practices in two areas of England. Patients were the family members of close relatives with drinking or other drug problems. Analysis: Framework analysis and grounded theory analysis of post-interview reports. Results: There was strong support for a form of intervention that involved face-to-face discussion with a primary care professional, and those who received the full intervention were appreciative of being able to talk to a professional who had time to listen and who appeared interested, understanding and caring. The self-help manual itself was reported to contain active ingredients for change, and a number of family members described transformations in their ways of coping with the problem whether they received the full or brief form of intervention. A common constellation of changes included increased consciousness of the nature and extent of the relative's drinking or drug use and its family effects, an acknowledgement of the family member's own needs and rights, a strengthening of resolve to assert plans and expectations, and a calming effect with reduction in stress symptoms. Many participants were unable to describe changes, however, and the following principal limitations of the intervention were described: prior familiarity with the material, perception that the intervention did not go far enough, belief that it was incapable of effecting change for the substance misusing relative, and a perception that sufficient professional expertise or sympathy was not always available in primary care. Conclusions: Findings suggest that the 5-Step family intervention has positive potential in the primary care setting, but has limitations and may need strengthening for family members whose problems are of longer standing or who have already been exposed to relevant information. Copyright 2007, Taylor and Francis.

The 5-step family intervention in primary care: II. The views of primary healthcare professionals.

Orford J; Templeton L; Patel A; Velleman R; Copello A. *Drugs: Education, Prevention and Policy* 14(2): 117-135, 2007. (29 refs.)

Background: This is the second of two papers using qualitative methods from a study of an intervention for family members affected by close relatives' substance misuse problems. **Participants:** 168 primary healthcare professionals (PHCPs: GPs, practice nurses and health visitors) working in general practices in two areas of England, and who took part in the study. **Data sources:** Recruitment and post-session forms completed by PHCPs; telephone interviews with each PHCP 12 weeks after recruitment of a family member; interviews with PHCPs at the end of the study. **Results:** At the end of the project PHCPs were overwhelmingly positive about the family member intervention and about primary care as the appropriate site. Difficulties were encountered, however, in identifying and engaging affected family members, who were often excluded on grounds of the complexity of their problems or the level of their distress. Shortage of PHCP time and other practice-related factors added to the difficulty. Active work by a PHCP was often necessary in order to make the link between presenting symptoms of physical or mental ill-health and the existence of a family substance misuse problem. When family members were identified and recruited, PHCPs were usually positive about what was achieved. Nearly all were in favour of an approach that combined giving a self-help manual with some follow-up contact with a family member as needed. **Conclusions:** Taken in conjunction with statistical outcome findings of significant reductions in symptoms and changes in ways of coping, plus qualitative analysis of the views of family members, the present results encourage the view that a flexible form of this intervention should be developed for use in primary healthcare, and that further work should

build on existing strengths and attempt to overcome weaknesses identified. Copyright 2007, Taylor & Francis.

Treating opioid addiction with buprenorphine-naloxone in community-based primary care settings.

Mintzer IL; Eisenberg M; Terra M; MacVane C; Himmelstein DU; Woolhandler S. *Annals of Family Medicine* 5(2): 146-150, 2007. (14 refs.)

PURPOSE Office-based treatment of opioid addiction with a combination of buprenorphine and naloxone was approved in 2002. Efficacy of this treatment in nonresearch clinical settings has not been studied. We examined the efficacy and practicality of buprenorphine-naloxone treatment in primary care settings. **METHODS** We studied a cohort of 99 consecutive patients enrolled in buprenorphine-naloxone treatment for opioid dependence at 2 urban primary care practices: a hospital-based primary care clinic, and a primary care practice in a free-standing neighborhood health center. The primary outcome measure was sobriety at 6 months as judged by the treating physician based on periodic urine drug tests, as well as frequent physical examinations and questioning of the patients about substance use. **RESULTS** Fifty-four percent of patients were sober at 6 months. There was no significant correlation between sobriety and site of care, drug of choice, neighborhood poverty level, or dose of buprenorphine-naloxone. Sobriety was correlated with private insurance status, older age, length of treatment, and attending self-help meetings. **CONCLUSIONS** Opioid-addicted patients can be safely and effectively treated in nonresearch primary care settings with limited on-site resources. Our findings suggest that greater numbers of patients should have access to buprenorphine-naloxone treatment in nonspecialized settings. Copyright 2007, Annals of Family Medicine