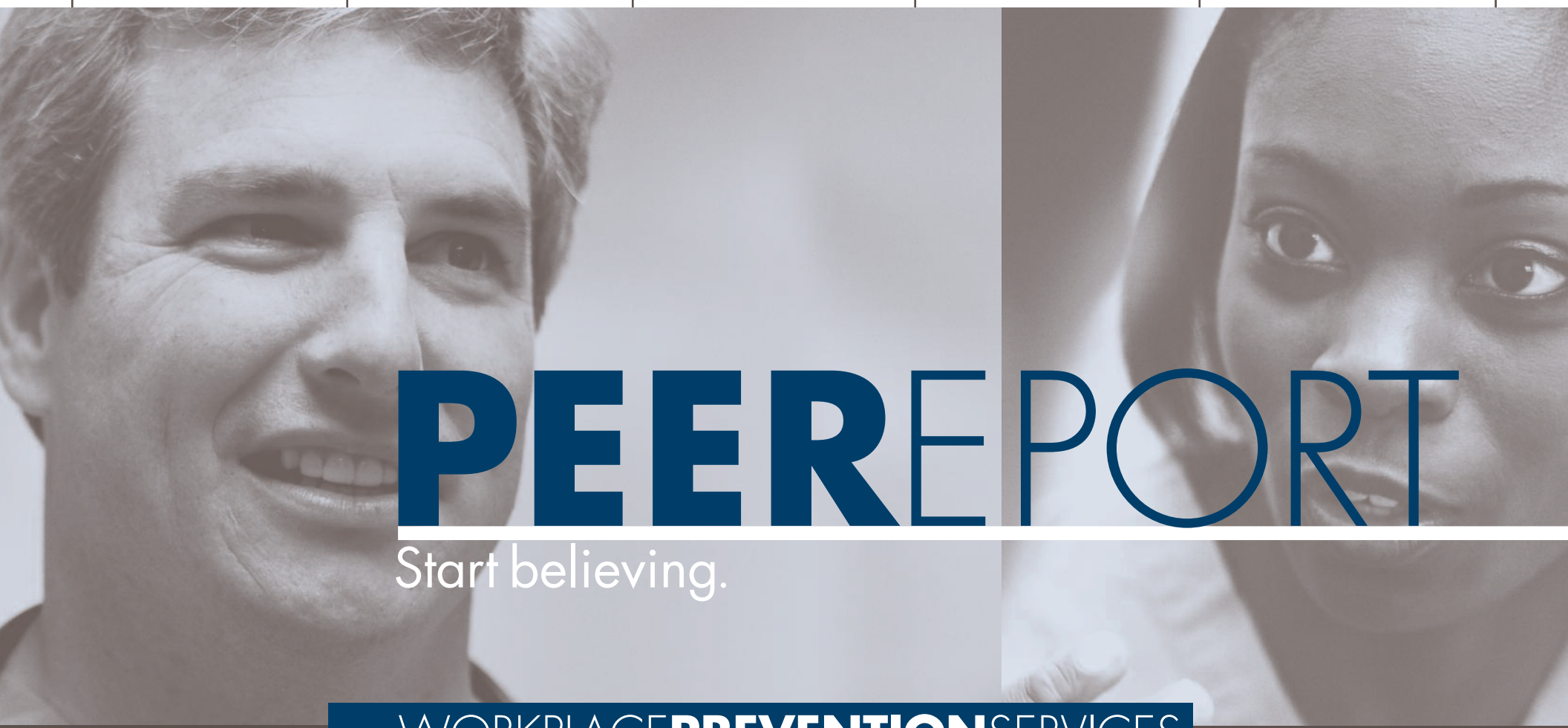


WPS 1	PEER PROGRAMS 2	THE BUZZ 3	SBIRT COLORADO 3	EDUCATION SERIES 4
Report from C-SEAP director on SBIRT implementation in the state EAP	Peer assistance program evaluation results	New employees, awards, calendar of events and more news	Highlights from the SBIRT Colorado/CHA summit	Thanks to all supporters of the Awareness Event, part of the Education Series 2011



PEER REPORT

Start believing.

WORKPLACE PREVENTION SERVICES

SBIRT and EAPs: prevention for life

— BY RANDI C. WOOD, LCSW, DCSW, CEAP, DIRECTOR OF COLORADO STATE EMPLOYEE ASSISTANCE PROGRAM

PROVIDING

QUALITY, ACCESSIBLE

SUBSTANCE ABUSE

PREVENTION AND

INTERVENTION,

IN THE WORKPLACE

AND COMMUNITY

303.369.0039

Toll free 866.369.0039

PeerAssistanceServices.org

The Colorado State Employee Assistance Program (C-SEAP) provides a full range of employee assistance services to Colorado's state government workforce, including counseling, referral, management consultation, crisis intervention, facilitation, mediation, workshops and organizational development. In consultation with the Colorado Business Group on Health and SBIRT Colorado, C-SEAP screens all clients presenting for counseling services to better recognize and assist employees coping with substance abuse and depression. The goal is to identify employees engaging in risky substance use early to stop progression to more serious use, and to increase the

Years ago,
helping professionals
were taught the job
was always the last to go.
Today, the message
is changing to one
of prevention...

likelihood that those at risk for depression or suffering from untreated depression will receive essential support and treatment.

From July 1, 2009 through December 31, 2009, C-SEAP provided services for 5,400 people. Of the 1,230 individuals seen for personal or work-related counseling, 791 were new cases, opened on or after July 1, 2009. On December 31, 2009, C-SEAP completed six months of screening. The results were:

- 26% screened positive for alcohol
- 56% screened positive for depression
- 17% screened positive for tobacco
- 3% screened positive for drugs other than those required for medical reasons

All positive pre-screens were followed by C-SEAP staff using evidence-based screening instruments to determine level of risk; motivational interviewing to assist clients in taking the necessary steps toward positive behavior change; and short-term counseling or referral. The screening tools used were AUDIT for alcohol use, DAST-10 for drug use and PHQ-9 for depression.

For positive tobacco screens, C-SEAP advised users to quit smoking, assessed willingness to quit, and provided behavioral coaching and/or referral to the Colorado QuitLine.

One of the primary goals of an EAP is to help the employer avoid and reduce costs associated with problematic workplace behaviors often associated with health concerns. Substance abuse and mental health issues cost U.S. employers an estimated \$80 to \$100 billion in indirect costs alone. When employees abuse alcohol or other drugs or live with untreated depression, productivity, safety and morale are impacted; healthcare costs rise; and consequences to individuals and families can be devastating. Prevention and early intervention provide the best avenues for tackling this growing concern.

HERE ARE SOME WAYS EAPS CAN MAKE A DIFFERENCE:

1. Teach employees about substance abuse and depression through awareness and prevention training, and let them know where and how to access the EAP.
2. Teach supervisors and managers how to recognize signs of substance abuse and depression, and how to refer employees to the EAP for confidential assistance. Help them understand that loss of concentration, poor decision-making, lack of follow through, errors, breakdowns in communication, conflict and other costly behaviors can be associated with substance abuse and mental health problems.
3. Teach supervisors and managers to address performance issues directly, respectfully and honestly.

continued on page 4



Peer assistance programs evaluation

In the summer of 2010, Peer Assistance Services contracted with a consultant to conduct evaluations of three peer assistance programs: the Nursing Peer Health Assistance/Nurse Alternative to Discipline Program; the Pharmacy Peer Health Assistance Diversion Program; and the Dental Peer Health Assistance Program. While there have been four previous evaluations of the dental and pharmacy programs, this evaluation was the first for the nursing program.

What do the participants and stakeholders in these programs think? Feedback was greatly anticipated by the PAS program staff, intent on delivering the best possible services. The evaluations demonstrated that the programs are perceived as high quality and valued by participants and key stakeholders. Highlights of each evaluation and conclusion are featured here, providing a snapshot of the programs' accomplishments, opportunities and challenges.

Each evaluation consisted of two components:

- 1) an anonymous survey of participants
- 2) interviews with stakeholders including the related regulatory agency, educational institutions and professional organizations.

The participant survey utilized a four-point scale to determine perceptions and evaluate areas where improvements could be made. The areas included:

- helpfulness of services
- aspects of responsiveness of PAS, including timeliness, confidentiality and respondent's involvement with PAS
- aspects of effectiveness
- opportunities for and responsiveness to feedback
- appropriateness and satisfaction with referrals and overall satisfaction
- case manager contact and respect
- appropriateness of contract
- effect of participation on quality of practice and care
- effect of participation on respondent's satisfaction with their profession
- likelihood that respondent would return to PAS if needed and recommend PAS to a friend

RESULTS

NURSING PEER HEALTH ASSISTANCE/NURSE ALTERNATIVE TO DISCIPLINE PROGRAM

The contract between the Colorado State Board of Nursing and Peer Assistance Services, Inc. had been in place for two years at the time of the evaluation.

The program served 441 clients during the evaluation time period of June 1, 2008 through March 31, 2010. The response rate to this survey was 302 responses (69%). Drug use was the most common behavioral problem among survey respondents (60%), followed by alcohol use (45%). Mental health problems were reported by 23%. Opiates were the most common drug abused. 19% of users reported intravenous use.

The majority of respondents thought their problem could have been recognized earlier by themselves, their partner or spouse. The highest rated strategies to prevent behavioral health problems were emphasis on identification of risk factors during professional training, awareness of the program, and awareness of workplace stressors. Barriers to seeking help included

fear, embarrassment, misconception about possible loss of license and confidentiality concerns. Obstacles to maintaining compliance included financial factors, professional employment issues, time and health insurance. Family participation was common and increased effectiveness of services.

The program is generally perceived to be of high quality and valued by participants and key stakeholders. Areas identified for improvement include consistency in timeliness of reports and recommendations, and consistency between the practices of different case managers. Although it was recognized that there may be a need for contracts tailored specifically for participants with particular problems, situations and needs, it is suggested that contracts for participants who have similar problems and needs be consistent.

Issues that need to be addressed to encourage seeking treatment and contract completion include the fear of losing one's license or job and the financial burden of the rehabilitation contract.

PHARMACY PEER HEALTH ASSISTANCE DIVERSION PROGRAM

The response rate to the survey was 69%. Nearly half (48%) of respondents indicated alcohol brought them to PAS; 34% indicated a single drug; 39% reported more than one drug; and 32% reported a mental health problem.

To gain knowledge about how behavioral problems might be prevented or treated earlier, a series of questions was posed about recognition of problems, strategies for prevention, barriers in seeking help for problems and obstacles to maintaining contract compliance. Three-quarters of respondents thought their problem could have been recognized earlier by themselves, their partner or spouse, other family members, a friend, or co-worker. The highest rated strategies to prevent behavioral health problems were emphasis on identification of risk factors during professional training and awareness of workplace stressors. The most common barriers to seeking assistance were embarrassment, fear, misconceptions about loss of license and confidentiality concerns. With respect to overcoming those barriers, the most highly scored items were greater confidentiality, knowledge of ability to maintain the professional license, increased knowledge of treatment services, confrontation or intervention, support of professional colleagues and spouse/partner, and knowledge of program. The most important obstacles to maintaining contract compliance were professional employment issues, financial issues and lack of time. However, none of these obstacles was rated highly. Although uncommon, those who have family involvement indicated it increased the effectiveness of services.

The evaluation shows the program is generally perceived as high quality and valued by participants and key stakeholders. Service areas that could be improved include family counseling and other types of family involvement, urine drug screens or breathalyzers, medication monitoring, and workplace supervision, managerial monitoring, or practice monitoring. Facilitated peer support groups were not viewed as effective as other services, and in fact have been replaced with quarterly participant meetings. Program outcomes might be improved by more attention to contracts tailored to individual needs and circumstances; approaches for enhancing the quality of

pharmacists' practice and patient care; and increasing pharmacists' satisfaction with their profession. There may also be a need to address timeliness and level of detail of compliance reports to the State Board of Pharmacy. Educational efforts could be enhanced through social media and active outreach.

THE DENTAL PEER HEALTH ASSISTANCE PROGRAM

The response rate to this survey was 80%. The majority of respondents indicated that the behavioral problem that brought them to PAS was alcohol (58%) or a single drug (42%). Opiates were the main drug of choice. Ingesting was by far the most frequent method of use (92%).

Two-thirds of respondents thought their problem could have been recognized earlier by themselves, their partner or spouse, other family members, a friend or co-worker. The most commonly reported cues included decreased dependability, repeated absenteeism or tardiness, missing drugs or unaccounted doses and complaints about behavior. The highest rated strategies to prevent behavioral health problems were emphasis on identification of risk factors during professional training, awareness of peer program and awareness of workplace stressors. The reported barriers to seeking help were confidentiality concerns, embarrassment, misconception about loss of licenses, not knowing about the program, and fear. The most highly scored items in overcoming barriers were confrontation or intervention by family or colleagues, increased knowledge of treatment services, knowledge of ability to maintain professional license, support by spouse/partner and colleagues, and increased confidentiality in seeking services. Lack of time was the only obstacle identified to maintaining rehabilitation contract compliance. Family participation was reported to be low; however, for those where it was present, the majority reported that it increased the effectiveness of services.

The evaluation shows the program is generally perceived to be of high quality and valued by participants and key stakeholders. Service areas that could be improved include procedures and timing of drug testing; helping participants stabilize their personal lives; responsiveness of PAS to feedback; enhancing the quality of participants' practice and patient care; increasing participants' satisfaction with their profession; and tailoring contracts based on individual needs and circumstances. There may also be a need to address timeliness and level of detail of compliance reports to the Colorado Board of Dental Examiners. Educational efforts could be enhanced through social media and active outreach approaches. Outreach was suggested to rural and outlying areas where the need may be greater due to isolation, but where the program may be less well known.

Early intervention offers an opportunity to protect the public and to save the career—and many times the life—of the practitioner. It minimizes intangible losses to the individual and the profession, and results in significant cost savings for the employer. The Dental Peer Health Assistance Program, the Pharmacy Peer Health Assistance Diversion Program and the Nursing Peer Health Assistance Program are provided by PAS. If you know someone who could benefit from a referral, please contact us: 303.369.0039 • www.peerassist.org/referral

PROGRAMS: Peer Health Assistance Programs, Mark Merrill, RN, ND, CNS, director

FUNDING: Colorado Board of Nursing, State Board of Pharmacy and Colorado Board of Dental Examiners

Summit: the cost of doing nothing

—BY BRIE REIMANN, SBIRT PROGRAM DIRECTOR

In recognition of the difference prevention can make in the cost of healthcare, SBIRT Colorado and the Colorado Hospital Association chose “The cost of doing nothing—exploring SBIRT as a strategy proven to save money and improve the health of patients” as the theme for its 2011 SBIRT Colorado Summit on February 3 at The Children’s Hospital. The Summit featured perspectives from a number of national experts on the demonstrated value of SBIRT, and drew a diverse audience of more than 130 participants including CHA members, MDs, RNs, educators and behavioral health providers.

Speakers at this year’s Summit included **LARRY GENTILELLO, MD**, professor of surgery, University of Texas Southwestern Medical School; **HOLLY HEDEGAARD, MD, MSPH**, data program manager, Emergency Medical and Trauma Services Section at the Colorado Department of Public Health and Environment; **KERRY BRODERICK, MD**, assistant professor in Emergency Medicine at the University of Colorado, Health Sciences Center, and attending physician at Denver Health Emergency Department; **ERIC GOPLERUD, PHD**, senior vice president, Department of Substance Abuse, Mental Health, and Criminal Justice Studies at the National Opinion Research Center, University of Chicago; **CHRIS DUNN, PHD**, author and instructor, Department of Psychiatry and Behavioral Sciences at Harborview Medical Center, the University of Washington; and **CRAIG FIELD, PHD**, research associate professor of the Health Behavior Research and Training Institute, the University of Texas at Austin, program director of Behavioral Health Services at University Medical Center in Brackenridge, and principal investigator at the National Institutes of Health. The event was moderated by **STEVEN SUMMER**, president and chief executive officer of the Colorado Hospital Association.

It is widely acknowledged that hospitals need to reduce their costs, and that substance use is often the cause of emergency room visits, as well as contributing to over 70 diseases, leading to expensive, long-term health problems. But can it be proved that SBIRT actually makes an impact and reduces healthcare spending? Is there really a return on the investment in SBIRT? How can we add to the tasks of already stretched-to-the-max providers in the hospital? The morning session addressed these questions by making the medical and business case for SBIRT, providing an overview of SBIRT as a standard of care and billable service in healthcare facilities, and demonstrating how SBIRT can make a difference.

DR. GENTILELLO discussed the ease of SBIRT implementation and highlighted that SBIRT could save lives and improve health, as well as resulting in cost savings and reduced alcohol-related trauma visits. Dr. Gentilello illustrated his point: “The way we treat alcohol problems is to wait until it’s malignant substance use and someone has an addiction. It’s as if we didn’t treat high blood pressure until someone had a stroke or a heart attack. ‘Broadening the base,’ in referring to the alcohol pyramid, means that we don’t just look at the top of the pyramid and wait until someone comes to the hospital with ascites or jaundice, but we focus lower on the pyramid when people are just drinking too much. Like high blood pressure, it is simpler, easier to treat and more responsive when you go after it early. It is harder to treat, more expensive and chronic if you wait. And in terms of the evidence of efficacy in brief interventions, there is almost nothing in medicine that has as much evidence behind it.”

Following Dr. Gentilello, **DR. HEDEGAARD** presented data collected in the Colorado State Trauma Registry related to substance use, demonstrating and reinforcing the need for prevention of risky drinking.

As an ardent champion of SBIRT in Colorado, **DR. BRODERICK** discussed the prevalence and impact of substance use on emergency department visits at Denver Health. About her first-hand knowledge of the effectiveness of SBIRT in addressing this issue, Dr. Broderick said, “Obstacles to acceptance of SBIRT can be attitudes toward substance use and also disbelief that brief intervention can really make a difference, much less screening alone. But multiple studies demonstrate that screening—on its own—decreases substance use by individuals. Clinicians see the impact they have on patients when they simply ask about their use of alcohol and other drugs; especially when followed by a brief conversation about the health risks. That conversation can be 30 seconds to ten minutes depending on the department’s pace and the patient’s attitude. Some days I find myself explaining the importance and enormous impact we can have by treating substance use as a true healthcare issue rather than making a character judgment, and I wonder how we can possibly change the thinking and doing of an entire system. But I know that since my days as a nurse when I first witnessed the effect of substance use in the ER, we have made huge strides in introducing this practice.”

DR. GOPLERUD presented the business case for SBIRT, the cost of substance use to hospitals, and the cost-savings for Colorado hospitals when SBIRT is routinely delivered. Dr. Goplerud provided exacting studies on the impact of SBI on health plans and medical cost savings. He interjected a quote from the Institute of Medicine: “Suitable methods of identification and readily learned brief intervention techniques with good evidence of efficacy are now available. The committee recommends...broad deployment of identification and brief intervention,” and remarked that the recommendation was made more than 20 years ago. He then demonstrated why SBIRT is good for hospitals, not only in cost-savings, but in revenue potential. Dr. Goplerud concluded with an update on the Joint Commission SBIRT standards.

A lively and engaging portion of the day, the lunchtime debate on “Screening for risky alcohol use? Not my job!” between **DR. GENTILELLO** and **DR. DUNN**, was moderated by **MR. SUMMER**. Dr. Gentilello advanced his belief that SBIRT should be routinely provided in hospitals, and the reasons why. Dr. Dunn took the opposing view that SBIRT will never be routine in healthcare due to (commonly misperceived) barriers, including the belief that SBIRT is unnecessary, lack of time, limited training for providers and competing demands. Although participants were not officially polled, it was clear that Dr. Gentilello won the day with his reason and thoughtful arguments!

After lunch, participants were offered the opportunity to be trained in delivering quality SBIRT services by national experts **DR. DUNN** and **DR. FIELD**. The training on screening and brief intervention skills encouraged role-playing among participants and demonstrated how SBIRT helps in the quest of delivering improved healthcare.

The 2011 SBIRT Colorado Summit concluded with thanks to the organizers and a reminder that SBIRT Colorado provides support, training and technical assistance to providers interested in implementing SBIRT. *For more information on SBIRT Colorado, or to schedule a SBIRT training call 303.369.0039 x245.*

PROGRAM: SBIRT Colorado, Brie Reimann, MPA, program director
FUNDING: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment

MARK YOUR 2011 CALENDAR

- JUNE 9-11 • COLORADO PHARMACISTS SOCIETY ANNUAL SUMMER MEETING •** www.copharm.org
- JUNE 19-24 • UNIVERSITY OF UTAH SCHOOL ON ALCOHOLISM AND OTHER DRUG DEPENDENCIES •** www.medicine.utah.edu/usa/.org
- AUGUST 18 • AMERICAN DENTAL ASSOCIATION NATIONAL CONFERENCE ON DENTIST HEALTH AND WELLNESS •** www.ada.org
- SEPTEMBER 2011 • RALLY FOR RECOVERY •** www.advocatesforrecovery.org
- SEPTEMBER 2011 • NATIONAL ALCOHOL AND DRUG ADDICTION RECOVERY MONTH •** www.recoverymonth.gov
- SEPTEMBER 7-10 • INTERNATIONAL NURSES SOCIETY ON ADDICTIONS CONFERENCE •** www.intnsa.org
- SEPTEMBER 20-23 • NATIONAL PREVENTION NETWORK CONFERENCE •** www.swpc.ou.edu
- SEPTEMBER 23-25 • SOUTHWEST PHARMACIST RECOVERY NETWORK MEETING •** www.swprn.org
- OCTOBER 21-22 • ANNUAL COLORADO NURSES ASSOCIATION CONVENTION •** www.nurses-co.org
- OCTOBER 26-29 • ANNUAL WORLD EAP CONFERENCE •** www.eapassn.org
- NOVEMBER 3-5 • 2011 AMERSA NATIONAL CONFERENCE •** www.amersa.org

We **CELEBRATE** our staff for years of dedicated service!

- 27 YEARS • ELIZABETH PACE**

- 19 YEARS • JACKIE WESTHOVEN**

- 11 YEARS • KAREN WAGNER**

- 8 YEARS • LEE ANN ADEN • ANITA HOFFMAN**

- 6 YEARS • TRACI HUEY • DAVID JOSLYN • ANTHONY WASH**

- 5 YEARS • CAITLIN KOZICKI**

- 4 YEARS • MEKKA BANKS • DORINDA ROBINSON**

- 3 YEARS • BRYN BROCKLESBY • SUSAN BURGDOFF • MAUREEN CARNEY • MATTHEW PLUMB • PATRICIA STRAWSER • JONATHAN TEISHER**

- 2 YEARS • LISA ANDERSON • JEFF BURGDOFF • TOM CHATFIELD • BRENDAN DELAO • CARLA GARCIA • BEVERLY GMEREK • GINA VAN ORT**

- 1 YEAR • JUSTIN ARNOLD • SUE CHARLES • MARGARET CONNELL • ANNIE KLEIN • CHRISTOPHER KNOEPKE • JILL PETERSON • DUSTIN ROBINSON • TRISHA TAULBEE**

CONGRATS

CAITLIN KOZICKI was promoted to assistant director, Workplace Prevention Services
MYRON BYLES and **JACOB ALFONSO** have been promoted to case managers at Southeast TASC
MELISSA IPPOLITO earned the CEAP credential
BRYN BROCKLESBY earned the CAC I designation
ANDREA SCHMIDT was recently awarded a Master in Social Work, and earned her CAC I
JENNIFER PLACE is now a Certified Nutrition Consultant

WELCOME NEW PAS STAFF!

Agnieszka Baklazec, Susan Bosold, Cathleen Derickson, Travis Furnari, Joe Geary, Mark Merrill, Diane Sanders and Ryan Webber



Peer Assistance Services

2170 South Parker Road, Suite 229
Denver, Colorado 80231

Start believing.

PROGRAMS
Dental Peer Health Assistance Program
Nursing Peer Health Assistance Program/Nurse Alternative to Discipline Program
Pharmacy Peer Health Assistance Diversion Program
Colorado TASC
Western • Northeast • Southeast • Mile High
Healthy Relationships Program
Prescription Drug Abuse Prevention Program
Workplace Prevention Services Program
Paul D. Coverdell Drug-Free Workplace Program
SBIRT Colorado

PA EDUCATION SERIES 2011

Annual Awareness Event

Thanks to all of our supporters for making the 2011 Awareness Event a grand success.

TITLE SPONSOR OF EDUCATION SERIES



SPONSORS OF ANNUAL AWARENESS EVENT

PRESENTING



PARTNER

Centura Health
Elizabeth M. Pace
Robin S. Mower, Pharm.D
USW Local 920, Colorado
Professional Employees,
Chain Staff Pharmacists

PATRON

Center for Dependency, Addiction
and Rehabilitation
Clare & Matt Sandekian
Colorado Dental Association
Connie Robertson, spark communications
Crossroads' Turning Points, Inc.

Harmony Foundation
Lee Ann Aden & Mark Tokheim
National Jewish Health
Sara & Howard Jarrett
Valley Hope Association
Wells Fargo

ADVOCATE

Addiction Research and
Treatment Services
Advocates for Recovery
Benefits & Incentives Group, Inc.
Bridge to Awareness Counseling Center
Box Studios
Collis & Marsha Johnson
Colorado Nurses Association
Colorado Veterinary Medical Association
David & Ann Stuhr
Dilley Printing
F. Robert Murphy

Gail & Robert Boyd
Jane & Annie Klein
Jeff & Jan Downing
Jeffrey & Deborah Astroth
Lola & Red Fehr
Lloyd & Anne Davis
Lynn & Cynthia Koenck
Mary & Jim Newell
Nancy & Dick Downing
Rocky Mountain Health Plans
Sara & Jim Hopfenbeck

WPS

Prevention for life

continued from page 1

- Educate decision makers about the impact of substance abuse and depression on the workplace, particularly with today's do-more-with-less mandates.
- Give employers options for promoting a healthy and drug-free workplace.
- Communicate with physicians. Help them assist employees by sharing pertinent clinical information when we make a referral—with releases, of course. Make sure physicians know about the EAP as a resource for employees.
- Create opportunities for employees to participate in meaningful conversations through their EAP. Foster conversations that will help prevent injury, disease or more severe disorders.
- Screen everyone who walks in the door.

Years ago, helping professionals were taught the job was always the last to go—people could hide addictions and mental health problems at work for decades, and very little could be done about it except to “deal with” severe cases through disciplinary measures and expensive treatment. Today, the message is changing to one of prevention: through awareness, education and employee resources like EAPs, employers can create working environments that recognize employees as human beings who sometimes need help, embrace effective prevention programs and understand the connection between employee health and behavior, and the bottom line. C-SEAP is committed to screening, brief intervention and referral to treatment for substance abuse and depression—on a permanent basis. I invite other EAPs to join us in doing what works.

For information on how your company could benefit from an Employee Assistance Program, please call Workplace Prevention Services Director Jennifer Place, 303.369.0039 x209.

PROGRAM: Workplace Prevention Services, Jennifer Place, MA, LPC, CEAP, CAC III, EA-CS, director
FUNDING: Colorado Division of Behavioral Health