

Prevention in the Context of Care: Opportunities for Collaboration

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CHUCK KLEVGAARD: So that will be somewhat of a review for some of you. And, again, it'll be kind of catching everybody up and getting on the same page with some information, and that will be about twenty, thirty minutes of the first part of today's webinar.

Then we're going to spend the majority of time, right in the middle, talking about your experiences, your successes and challenges with collaboration. And, again, we've, both Kimberly LaGesse and I have spoken directly with many of you and heard, I think, a great number of successes. So we're going to invite you to talk about those. So you'll see a slide that your name might be quoted on, and we'll invite you into the conversation to elaborate on what's happened in your county, or with your coalition, or with that relationship with primary care.

We'll also, then, spend some time talking about challenges that some of you are having. And, again, inviting John and your state association folks to respond to the ways in which you can address some of those challenges you're experiencing in that collaborative effort.

Finally, we'll spend the last twenty minutes today really looking at practical tools for engaging primary care, getting the conversation started. So, things, again, such as examples of screening tools, or even talking points that you might use when working with or talking or reaching out to health center staff or to pediatricians.

So that's the agenda today. So without further ado, you'll know that by the end of today, you'll have some sense in this first part about health related effects. You'll also be able to think about some strategies for working collaboratively. Or even some barrier busters, as we might call them. So then moving forward, we're going to get, at this point go ahead and offer you one more sort of piece of information that CSAP is in full recognition that screening and referral are a part of prevention, and that the priority is often to fund primary prevention. But both are important. So we're making that statement as we get started. I think that that's an important sort of foundation.

All right. Turning this over to our speaker for today, Dr. John Knight.

DR. JOHN KNIGHT: So good morning, everybody. I'm going to move quickly through the slides because my anticipation is that many of you have heard this before. You heard it a year ago, and even if you haven't, you're like the children of Lake Wobegon who are all above average.

So our topic is adolescent substance use, and new research-based strategies for early identification and intervention. And I would like to dedicate this to Ryan Whitney, who grew up in my neighborhood in Milton, Massachusetts. On August 1, 1998, he disappeared from the edge of Lyon's Quarry, where he and a few friends had gone to drink. Divers recovered his body four hours later. Ryan was 19. Ryan's father—Dr. Dick Whitney—was a neighbor of mine, and our families had a lot in common, including the fact that I had a son close to Ryan's age. And I knew that if it could happen to a nice family like the Whitneys, it could happen to any family, including mine. And that changed my career. And as a result, I'm here today.

There is a golden window, in terms of intervention for adolescent alcohol and drug use. And, in general, the brain structure and function continues to undergo critical development into the mid-twenties; perhaps even later. And phenotype, or the expression of genes, which would be like developing an alcohol or drug disorder, is a complex function that involves genetic predisposition and environment exposures at specific points in the developmental time. And so if you have a genetic predisposition and you expose your brain for the first time to alcohol or cannabis or tobacco before the age of 14, you're, essentially, wiring your future. Your brain will have an altered structure and function, and your chances of becoming addicted later in life quadruple. And your chances of having major depression, or an anxiety disorder, or psychotic thinking—including schizophrenia—go anywhere from doubling up to six times the rate they would, otherwise, be.

There are other substance-related health effects. The immediate ones are the ones that we worry about the most—the injuries, the overdose, the hospitalization, assaults, pregnancy, STI's, including HIV. And then lifetime: brain damage, learning disorders, psychiatric disorders, etcetera. It's the alphabet soup of DSM-V.

This just illustrates what happens in the brain. If you look at the photo on the right, you'll see that this bundle of axons here, which looks kind of unassuming, is the right superior long fascicle. But it's actually one of the brain's superhighways. So that there are so many fibers that cross in this area. And your function as an adult, like your ability to do college work and solve complicated problems, or even to plan the rest of your life, is based on how fast your brain can bring together various centers and coordinate their activity to solve a big problem. And when that speed gets slowed down, when it's trying to get through this intersection and the intersection is not formed the right way, then you're slower, and you're not going to be the best that you can be. And you might not get into college, or finish a really competitive college. Perhaps you settle for community college. Today's youth are focused on success. The number one goal of youth in high school surveys is to be famous. And if that's what they

wish to have, then as purveyors of medical information, we can tell them that alcohol and drugs are only going to interfere.

So pediatricians are an interesting group. I'm among them, and I'm proud to be a pediatrician. We provide about half of the adolescent visits in health care. The other half are provided by family physicians. I would anticipate that Michigan is probably similar to Massachusetts, and that in the urban areas you have pediatricians delivering health care. And in the rural areas, I would guess maybe in the Upper Peninsula, you have more family physicians.

Pediatricians are the lowest paid of all medical specialties. Their practice overhead is 50 percent. And they have no procedures. We have no fiber optic scopes, and we have no minor surgical procedures or anything else. And so the only way to keep your head above water is to have high volume, and that's 4–8 patients an hour. Anything that slows down the pace of the office becomes a financial threat. So the specialty was, traditionally, male. Females now comprise greater than 80 percent of new graduates. And so my specialty is changing.

In fact, Dr. Lia Gaggino, who is the president of the Michigan Chapter of the American Academy of Pediatrics, told me that their state chapter is 60 percent women. And I have to tell you that even though I'm a man and, therefore, by definition a dinosaur in my specialty, I approve of the change. Pediatricians are the most mentally healthy of all [Laugh] specialists. We have the lowest rates of depression, substance abuse and suicide, divorce, right down the list. Psychosocial problems are rare in pediatrics, yet far more common in other specialties. And so my peers are [motivated] less by money, more by making a difference in child health. And this is meant to encourage you so that even though they can't have procedures that slow down the patient flow in their busy offices, they are motivated by making a difference. My experience has been that they will welcome screening and brief advice if it can be done in 2–3 minutes, that's as much time as they can devote to it. And I've spent my life's career conducting research in real life pediatric offices so that we can do it in 2–3 minutes.

There was one thing that Dr. Gaggino mentioned to me that I have to mention now. That's that pediatricians also have more fun. We are the fun specialty. When we go to pediatric meetings, there are lots of laughs and, you know, stupid childhood jokes, and we like to laugh and have a good time. When we go with our adults colleagues, they're really kind of stiff and not as much fun. In any case, keep that in mind when you visit pediatrician offices that you're probably going to leave with a smile on your face.

So the American Academy of Pediatrics and the AMA both recommend annual screening for substance abuse as part of routine care. But the provider adherence is low. Less than 50 percent screen all adolescents; less than 25 percent screen for substance-related driving risks, which are the leading cause of death in this age group. And less than 12.5 percent use a structured tool. And if you're not using a structured tool, you're probably going to miss a lot of the cases.

This is the CRAFFT Screen. It came out of actually the first study I ever conducted. And it was an unfunded [Laugh] study unless you count funding from Bruegger's Bagels. They

gave us certificates for three free bagels for the teens that volunteered for the study. But it was the most important of my career because it defined the six CRAFFT Questions, and I'm assuming that you've seen these before. And if not, they'll be available to you at any time to look at.

The criterion validity of the CRAFFT is high. The sensitivity is 80 percent; specificity is 86. That means that it identifies, correctly, 80 percent of the positive cases, 86 percent of the negative cases. For a brief screen, those are very good numbers.

But we found in our second CRAFFT study, which was done in our own adolescent clinic, that of 75 youth who screened positive for safety purposes, the procedure was that the research assistant notified the primary care provider—the pediatrician—who then referred the teen to a clinic social worker, and they got an appointment in less than two weeks. And the social worker worked in the clinic. Same site referral. Seventy-five kids triggered the safety protocol; 75 received the social worker appointment; zero kept the appointment.

So there are barriers to adolescent screening. And this is a game that you can all play. There's a key word in each of the barriers that begins with the letter T. So the first one is that they don't know what the tools are for screening. Not everyone's familiar with the CRAFFT.

There are tenacious parents—parents who just won't leave the room for that confidential conversation. The standard of care that at age 12 you ask the parents to leave the room for a few minutes so that you can ask confidential questions.

Treatment resources are lacking. And that's, actually, a major barrier to screening.

And they have to triage competing problems, like the young person might've come in because they've got a burning question about acne or birth control pills, and substance use is really not on their radar screen.

And they're not trained in how to manage positive tests.

And then the number one reason you've probably all guessed is time is insufficient.

But time, lack of training in positives and lack of treatment resources are the three that tend to run together. And those are the ones that we have to find a way to interrupt if we're going to improve screening practices. This is just to show that if you don't use a structured screening like the CRAFFT, you're going to miss the important cases.

So this shows that we compared the doctors' impressions in the adolescent clinic. These are highly-trained adolescent specialists. So we compared their clinical impressions of substance use severity with a research assistant interview—a structured psychiatric diagnostic interview—known as the ADI.

Of 101 cases that had problem use, the providers correctly identified 18. Of 50 [Background Conversation] of 50 cases that had abuse, 10 were correctly identified. And of 36 kids that

had dependence, none were correctly identified. So if you're not using a structured screening as a pediatrician, you'll miss the cases.

This shows the breakdown among 12–18 year olds. This was over 2,000 kids. They were all in New England. But they were a wide variety of practices. There were nine offices, including pediatricians, family doctors, including rural practices up in Vermont, school-based health centers, and then an adolescent clinic, a very busy pediatrician-owned practice in central Massachusetts and Cambridge pediatrics, as well. But the average, overall, is that 57 percent of these kids coming for routine care were abstinent during the past 12 months. About 20 percent had use of alcohol or drugs, but didn't report any problems. And it really was this other core tile. It's a little bit less than 25 percent that it turns out had problematic use, abuse or dependence, and those are the kids that we really need to offer some kind of intervention.

What are the follow-up plans that providers have? Well, what's notable is for problem use and abuse or dependence, they almost never notified parents. Five or 6 percent are notifying parents, which just means that greater than 90 percent of the pediatricians are not telling parents about it. But what they do—if they do anything—is to ask the child to come back for a return visit. Greater than 50 percent for problems use; abuse or dependence 42. And then refer to counseling, only one in five. And one of the reasons is that you have to break confidentiality in order to refer. And so our work has been about equipping pediatricians so they can do a better job with counseling on return visits.

DR. CYNTHIA STATLER: Dr. Knight, I am here just to let you know.

DR. J. KNIGHT: Okay. So oh, great. That was Cindy?

DR. C. STATLER: Yes, it was. Hello.

DR. J. KNIGHT: All right. Hi. So I'm welcoming Dr. Cindy Statler onto the call, and she's going to be available for questions in a moment.

But Cindy Statler is actually standing in for Lia Gaggino today, who is the President of the Michigan Chapter. Cindy is chair of one of the key committees, and she can tell you about that in a moment. She's here, I have to tell you that both Lia and Cindy were highly enthusiastic about meeting all of you prevention folks on this call. And by the way, Cindy, I want you to know I've already told them all the things about pediatricians. And I did add what Lia said I should add that we're a group of people that love to have fun—

DR. C. STATLER: Good.

DR. J. KNIGHT: —and so they should be prepared to come away from those meetings with a smile. And so they're primed, and I want to welcome you and thank you for coming on the call. And I think you're going to get a lot of questions in just a few minutes.

DR. C. STATLER: Okay.

DR. J. KNIGHT: In focus groups, we asked adolescents what kind of information could you hear from your doctor that would influence your decisions about alcohol and drug use. And over 15 years it was highly consistent. There were two things that they said would help them to make decisions. And I call it the one-two punch of brief interventions.

Science. Don't tell us what to do. Just give us the facts and trust us to make the right decisions. That was the theme that came up over and over again.

And the second one. Stories. True life stories. Put a human face on it to drive the message home.

And so science and stories are what we use in our brief intervention. So I'm just going to tell you, as I close, about our last published study; this is Computer-facilitated Screening and Brief Advice (or cSBA) to Reduce Teen Substance Use. It was published in the *Journal of Pediatrics* that goes to 60,000 pediatricians in the U. S. By the way, the family medicine folks also read *Pediatrics*. And they follow the same guidelines that come up from the American Academy. They're like our cousins, in terms of providers. They're not quite as mentally healthy as we are, and they don't have quite as much fun as we do. But they're still a pretty good group, and I love my colleagues in family practice.

So this is what happened at three and twelve months. Based on a program that you're going to see in a moment, you'll see what it looked like on the computer. So we found at three months that TAU—is treatment as usual—their rate of drinking was almost 23 percent, while the cSBA group was only 15 percent. So, statistically, that results in an adjusted relative risk ratio of 54. So that's almost a 50 percent drop in drinking at three [Inaudible Phrase]. This is based on two to three minutes of the pediatrician's time. It also included five minutes on a computer program. So the computer program is administered before the visit with the pediatrician. It's the screening test, based on the CRAFFT. They get their score, immediately, and you'll see what it looks like. It gets their attention. We call it the two by four upside the head when they actually see their color-coded level of risk being high. And then they get 10 pages of scientific information and true life stories that illustrate the hazards of substance use.

And then the doctor gets a report of the screen. And they get a list of talking points that really reinforce what the children have already seen on the computer. And by the way, teen drinking—so this is a year later, if you look at the two bars on the right. Treatment as usual was getting up to 40 percent with the computerized screening and brief advice [Inaudible Phrase] it was 30 percent. But that still is an adjusted relative risk ratio of greater than 25 percent. I'll tell you as somebody who's made [Inaudible Phrase] conduct behavioral [Inaudible Phrase] most behavioral interventions don't work. And those that do, if you get an effect, immediately, of 20-25 percent, you declare victory. [Inaudible] interventions are almost never as powerful as [Inaudible] therapies.

But here we have two to three minutes of pediatrician time, resulting in an almost 50 percent change. And without reinforcement, the residual is greater than 25 percent [Inaudible] a year. That's a lot of bang for the buck.

So I do want to mention TeenSafe. And I had hoped to put a screen shot in. I don't think that that happened, but I'm not going to click on the link now to bring you out of the Webinar, because when I did it to myself, I couldn't [Laugh] get back in. So I just want you to know that if you go to TeenSafe, this is a site for parents. And it's a site that pediatricians can refer parents to. It's also, a site, there you go. Here's the mock up. So thank you, whoever brought that up. We use this in schools. And I, actually, this morning was meeting with the principal of Milton High School—Milton is the town that I live in in Massachusetts—and telling him that TeenSafe was ready to be rolled out. He's going to send a letter to all of the parents in the school, asking them to go log on and take this 15 minute course, before the end of the school year. And the system, if your school is in there, generates an email that goes to the principal's office. So then he'll know if parents completed it, and he's looking for a 100 percent participation. There's no threat; no penalty. But this is a 15 minute course that presents true life stories. What you see there on the right is a picture of the Whitney family, telling about Ryan's tragedy. And then on the left you see a science page, where we're giving brain function and how that's affected by drugs and alcohol. Again, the one-two punch, and this is highly effective for reducing alcohol and drug-related tragedies around prom graduation and summer vacation.

So I believe that's it for my presentation now. I think I'm coming back to talk about what's in the toolkit. Is that correct?

C. KLEVGAAARD: It is, John. And we're going to keep inviting you back into the conversation to talk about successes and challenges, as well. And as John mentioned a moment ago, Cynthia's with us as well. So, Cynthia, in a moment we'll begin looking at grantee experiences and invite the grantees, themselves, to speak a little bit about what the last year has been like for them. Some of them have been doing this longer than that, of course. Many of them engaged, in terms of trying to reach out to and engage primary care pediatricians or health center folks in the last six months. So we're going to hear a little bit about their success, so kind of catching us up on where they've been since a year ago. So we're going to look at grantees' stories by inviting you all to speak. So if a slide comes up with your name on it, we'd really like and invite you to elaborate a little on what it is that's been your experience with this. And then, again, we'll invite John to comment, or Cynthia. And then after hearing a few successes, we'll move on to some challenges. And then, again, grantees will come up in a quote, then we'll hear about a challenge, and then we'll invite you to elaborate on it if it's from your county. And then we'll invite John and Cynthia to kind of say how could we deal with that barrier? How can we get past that?

DR. J. KNIGHT: And Cindy, I'll really need your help with the barriers because you're the person that has experience on-the-spot.

DR. C. STATLER: I can help you with that.

C. KLEVGAAARD: All right. As I mentioned a moment ago, we're going to invite you all to share. So as Kimberly Lagesse and I reached out to many of you, we just took a snippet of a quote about something that we thought sounded like a great success and that we wanted you to share a little bit with the whole group about.

So, Sequida, in order to unmute your phone, you do star pound. And then to mute it, again, you do the same thing. So if you are muted right now, do star pound and unmute your phone. Say hello to everybody, and then tell us a little bit about what's happening with your FQHC [federally qualified health center] in that prevention component.

SEQUIDA FOSTER: Okay. I'm sorry. I was not on the phone because I was listening to everything from my computer. So I just had to call in real quick.

C. KLEVGAARD: Okay. Well, thank you.

S. FOSTER: But, overall, our FQHC has a prevention component. They've had this prevention component for several years, now, where they worked in the community, and they do prevention activities. You know with the school system. They work with HIV. They work with some of our treatment agencies with integrating prevention into the realm of the recovery process. So we haven't had that much of a problem with the FQHC as a whole. But as far as some of the primary care physicians, that's where some of the challenges have come in. But, overall, it's been a success for us because we're already acclimated with them.

C. KLEVGAARD: So part of that relationship is really firmly in place, so it's kind of engaging individual primary care folks or pediatricians has been a bigger issue. So I wanted to also re-invite everybody back in. Anybody that wants to comment as we move through this section, feel free to unmute your phone to answer, share a comment or a question. Or, again, in the chat it will bring you back in that way if you want to just type a question in for one of the grantees who's telling their county story. You're welcome to do that.

So, again, John or Cynthia, if you have comments here about what your sense is about FQHC's engaged in prevention, feel free to chime in.

DR. J. KNIGHT: I have a question for Sequida. So you're supposed to be this success story, but you said there have been some challenges with the primary care providers. So, what have the challenges been?

S. FOSTER: The challenges is actually getting the primary care doctors to the meetings.

DR. J. KNIGHT: Okay. Cindy, do you have any advice to add? How do you get pediatricians to come to a meeting?

DR. C. STATLER: Some of it is, some of them are more likely to show up if the meeting's like at seven o'clock in the morning before office hours. I'm a part-time pediatrician, so I get to go to those meetings on my off days. I know not everybody has that flexibility.

Doing after hours [Inaudible Phrase] as far as those of us who do call, that makes it, you know, they may show up; they may not. So you're going to get less participation scheduling it after hours.

S. FOSTER: Okay.

DR. J. KNIGHT: I'll just add to that. I think the windows of opportunity are seven a. m., sometimes at noon if there's no travel that's involved.

DR. C. STATLER: Right.

DR. J. KNIGHT: And then the evening is really like, probably the worst time because many pediatricians have children.

DR. C. STATLER: Yep.

DR. J. KNIGHT: And one of the reasons we're mentally healthy and we have intact marriages and that our children do well is that we're there for them. And so you don't want to pull pediatricians away from their own families in the evening.

You can bring them in, sometimes, by conference call. And that's better than not having them participate at all. And so when I have evening meetings, they're almost always conference calls. They're not a face-to-face, and I try to minimize any evening meetings because I know it interferes with family life. And so I only have a meeting when it's really important. So if you're asking pediatricians to come to a single meeting and you can do it in the morning, I think you'll get better participation.

The only other tip that I would offer is that understanding the way the brain works can really help you. I always offer food, like for seven a. m. meetings. And at other times with meetings, I might not order a mouth-watering breakfast, but I always bring like dark chocolate candies because it stimulates the reward pathway. And then people have a positive association. You know, reward pathway stimulation is like good thing. And then they implant the memory in the amygdala, so that they always associate *me* with that reward from the dark chocolate. And so it's like I'm using their own brains to build the alliance. And it really works. Try it. Dark chocolates.

DR. C. STATLER: Okay.

DR. J. KNIGHT: In fact, you might visit their office and bring some with you. And I've done that strategy, too. And it's highly effective.

WOMAN: I have to apologize. We were not doing any of the FACQ things up here, as far as I know. Do you have any idea how many of those are happening around Michigan? Anybody?

DR. J. KNIGHT: How many folks that are on this call are from Federally Qualified Health Centers?

BRITTANY BEARD: This is Brittany Beard. I'm with the Michigan Primary Care Association, the member association for FQHC's. But I missed the question.

DR. J. KNIGHT: We were wondering how many Federally Qualified Health Centers there are in Michigan.

B. BEARD: There are 39 FQHC's, and there are about 230 different delivery sites.

[Overlapping Voices]

C. KLEVGAARD: Many of the Partnership for Success counties are working directly with an FQHC. Some are working with health centers, or tribal health centers, or other kinds of medical kind of entities of one sort or another. So I think the majority of the folks on today's call are in some way associated with an FQHC. So you'll hear more about that as we move through success stories.

We also wanted to invite Marie to share a little bit about working with a rural healthcare network.

DR. J. KNIGHT: Is this the, oh, there we go.

C. KLEVGAARD: Marie, remember to unmute your phone, you star pound. And, again, we'd love to hear a little bit about that network.

The next slide that you'll see as we're waiting to come on has, I think, three different examples of counties that were successful in getting some type of medical professional person to join their coalition meetings. So we'll hold onto that thought [Inaudible] we will come back to it in a minute. But at this point we want to, again, invite Marie into the conversation.

I see that Marie is typing, which may mean that she's not on the phone with us, but only on her computer.

DR. J. KNIGHT: C. KLEVGAARD, I wonder if it might be a good idea to just tell folks, again, that if they're going to have, if they'd like to join the conversation, or if they're going to be invited that they should call in and then do the-

C. KLEVGAARD: Yeah, that's a good reminder. So if you're listening through your computer speakers and you actually have a quote in today's presentation, you'll want to call into the number, and that's 888-876-9656, rather than just listening through your computer speakers, so you won't be able to speak in that way. So why don't we [33:49.6] go on to the next slide. We'll kind of come back to Marie if we can. If Marie you can call in in the meantime, that'd be great.

DR. J. KNIGHT: One further suggestion. Could you say the number again, slowly, for the call in.

C. KLEVGAARD: It's on the left-hand side of your screen. So on the bottom left, you're going to see a phone number that you can use, in lieu of listening to your computer speakers. Again, it's 888-876-9656. So we have a number of other folks who are going to talk about those experiences of getting a school-based health center, or another kind of professional involved in their group.

So Jennifer or Quran, we invite you into the conversation.

QURAN GRIFFIN: Hello? This is Quran. I am in Lake County, which is in the Lower Peninsula, but more northern. We're north of Grand Rapids, about seventy miles. We have a FQHC in our community. However, we're mostly involved with their school-based health centers. They have a youth advisory council, in which we use in our Communities that Care program. We also have their physician has been involved in the past. Their entire staff is very supportive of our Communities that Care Coalition.

DR. J. KNIGHT: This is Dr. John. I wonder if you could just share with folks that are having more trouble how you were successful in bringing in the medical professionals—primary care providers. How did you do it? I'm assuming it wasn't with dark chocolate, so [Laughter] you must've had another method.

Q. GRIFFIN: I actually was a former employee, so that helps a lot. I had great relationships with the staff. I had an amazing relationship with the school. So it was a happy marriage.

C. KLEVGAARD: It sounds like the key there is working from a relationship. I think that says a great deal about how well that might work.

I think we had another example of a lot of school activity from Roscommon County, but I'm not sure we have Marie yet.

MARIE HELVESTON: Uhhh, I think you do.

C. KLEVGAARD: Great. [Inaudible Phrase] Marie. Go ahead.

M. HELVESTON: Hooray. Just a small success, but worthy to report. If we wanted to—are you going to scroll back to where we were—

KIM LAGESSE: Yes. We can do that.

M. HELVESTON: —in the first quote? Or—

K. LAGESSE: Go back to the.

M. HELVESTON: —shall we move on?

K. LAGESSE: Here we go.

M. HELVESTON: Okay. You know, I don't want this quote to be misunderstood because we are a 30-county region coordinating agency. And I'm speaking on behalf of our grant providers in- prevention providers in Clare and Gladwin Counties who are not on the call. But they have been working, there is one FQHC in Gladwin County, and Clare has a medical practice that they work with—Mid Michigan Medical Practice, which kind of serves as the rural health partner there. And between the two of them, they have this network where they collaborate and where in the formation of a substance abuse coalition—which has been operating under grant funding for the past two years—they have incorporated the health professionals, at least one from each of those facilities in their assessment and planning process. So even though both of those health centers have been engaged with the prevention services and treatment services in the area, it hasn't been as formal a relationship as we would like to make it. So to do that the coalitions are engaging them as community partners to be part of that planning process so that the planning is really not *imposed* upon the health centers, but it is being driven by the community coalition, and the health partners are part of that coalition.

DR. J. KNIGHT: So do you have strategies that you can share? How did you go about it? How did you get healthcare providers to come to the table?

M. HELVESTON: Well, the healthcare providers already knew that substance abuse and prevention are issues in both counties. There is abundant data from youth surveys that have been conducted over the years that have been made, they have been brought into community awareness. And then plus from the clientele, the clients at the health centers, it's an obvious connection that there's health issues related to substance abuse going on. So when there was a general effort to form these coalitions they were, readily, wanting to get on board. Let's put it that way.

They had been making informal referrals on the basis of folks that they felt needed to seek treatment, or youth that were in crisis on that level, but not, necessarily, in primary prevention efforts so much. So knowing what the problems are that evolved, they really wanted to get on board with primary prevention.

DR. J. KNIGHT: There is one thing that I would like to share with the group, overall. I actually, my meeting this morning with the high school principal in Milton just reminded me of a lot of things. I had emailed him several times, and we had not gotten a response. And I felt very hypocritical because my inbox has more than a hundred new messages a day, and most of them expect a reply. And I just can't keep up with them, anymore.

And Melissa, who's the center coordinator, triages my inbox and will tell me if I get one from a high school principal, like I should respond, or another doctor. But it's an imperfect system, and sometimes falls through the cracks. And when I then met with Mr. Jette and we were talking about follow-up, I said, "Well, you know, can you text message on your cellphone?" He said, "Oh yeah, I can do that." So I sent a text and actually brought Melissa in. So now I don't get a hundred texts a day. I get a fewer number. So that's like a viable way to communicate. So if there's anyone on the call and you're sending emails out to healthcare providers and you're not getting any response, it may not be that they're ever seeing the

emails. Some people don't go into their inboxes anymore it's like because there's only pain waiting there [Laugh]. You know? Several hundred messages and nobody's got hours that they want to waste in the evening, again, taking time away from their family just to do emails. So phone calls, sometimes, are better than emails with pediatricians.

And the pop in visit, it rules the roost. I'll just tell you that if you pop in, especially like around noon time. Sometimes you have to ask the person at the desk when the doctor will be there and might have just two minutes, introduce yourself, bring some chocolates or something else. It's like that personal connection is the way that you build coalitions. There's no substitute for it.

C. KLEVGAAARD: Thank you Marie and John for all of those examples.

I see in the chat today that we have Karra, who's representing Detroit and wonder if you'd say something a little bit about Detroit's experience with FQHC. It sounds like you've had involvement with healthcare folks since the beginning of your Partnerships for Success. But I'm guessing there are other both unique challenges, or unique sort of opportunities that might exist in Detroit, or in Wayne County. So Karra, if you'd be willing to unmute and say a little bit about Detroit's experience, that would be great.

KARRA: [Inaudible Phrase] anything about our experiences. [Inaudible Phrase] challenges to begin with. We had great representation, even as we tran- in our transition, continue with transition. We are still growing. The coalition has been doing a lot throughout the community that is involving the FQHC, which I mentioned [Inaudible Phrase] Troy Community Health Connection. [Inaudible Phrase] from its inception. So we've had them at the table.

And then most recently in the past couple of months, I've noted Nancy Lewis, which organization VODI, is also considered under the health services as [Inaudible Phrase] recently involved as our pharmacist in helping us get the connection with the pharmacy, as well as [Inaudible Phrase] the doctors because she is a also a doctor, as well. Dr. Lewis. I didn't mention that she was a doctor, a pharmacist, a doctor of pharmacy. So we are doing so much, but we are also, you know, specific successes with the FQHC is what you asked. But the coalition is the one that is leading, which is [Inaudible Phrase] coalition which takes the lead in contacting and doing the collaborations with those agencies. [Overlapping Voices]

DR. J. KNIGHT: Do you have pediatricians in the coalition?

KARRA: Yes. I'm sorry. I'm, at this time, I'm sorry, no, we don't have pediatricians in the coalition. I'm sorry, I'm thinking of the pharmacist. So no pediatrician is present, as of yet. But we have been reaching out. We have multiple hospitals in the zones that we had to specify where the greatest need was. And we're servicing two [Inaudible Phrase]. And Saint John's Hospital is the one that is in one of the specific [Inaudible Phrase] that we are providing most of the services for PSFII funding, for one of the two locations. No [Inaudible] pediatricians yet.

DR. J. KNIGHT: So for Detroit, I have a special tip that I'm going to give. And that's that, in terms of not just any dark chocolates, the ones that I find work the best are Ghirardelli's. And the Ghirardelli's have these little bite-sized, individually wrapped packets that have like Evening Dream that's 60 percent cacao. And then there's one that's like 75 percent Twilight Delight, it's actually 72 percent. So I'm partial to those. And they really work wonders.

KARRA: You'll have to spell that for me.

DR. J. KNIGHT: But I want to ask Cindy to do a truth check about the pop in. So, is there a time in your very busy practice that you wouldn't mind taking just four or five minutes to meet somebody from a community coalition? And when would that be? What would be the window that somebody should aim for?

DR. C. STATLER: Lunch time.

DR. J. KNIGHT: There you go. So, maybe not just chocolates. Bring a sandwich or something.

DR. C. STATLER: Can anybody comment about whether any of the FQHC's have done any attempts to try to link up with the juvenile court systems that are scattered throughout the state?

I sit on the Charlevoix team, and we actually meet once a week with the judge, the probation officers, the prosecuting and the defense attorneys, the school liaison, the school police officer. And there's a program in place to track some of these kids. Has anyone linked into that group at all?

B. BEARD: This is Brittany, again, from MPCA. And I am not sure about that. But I can follow up if this group would like some more information on that.

DR. C. STATLER: I can tell you that Charlevoix County is the only one in our state that has a physician sitting on the team. But I have made multiple comments at state meetings about other people considering being involved in that. But [Overlapping Voices] it might be nice to work from the top down, as well as the bottom up.

B. BEARD: Yeah. Do you have information on how to get involved that you could send my way?

DR. C. STATLER: Absolutely.

B. BEARD: Awesome. I can go ahead and type in my email right now.

DR. C. STATLER: I haven't been able to log on to the actual live program. It told me that it was already discontinued. So

B. BEARD: Well, it's real easy. I can do it over the phone.

DR. C. STATLER: Okay.

B. BEARD: B as in Brad or Brittany. That was pretty bad.

DR. C. STATLER: Yeah. Yeah.

B. BEARD: And then my last name Beard, as in the facial hair.

DR. C. STATLER: Okay.

B. BEARD: At M-P-C-A, so Michigan Primary Care Association, dot net.

DR. C. STATLER: Okay.

B. BEARD: Thanks!

DR. C. STATLER: Yeah.

DR. J. KNIGHT: I would also add that Dr. Gaggino, who could not be on the call, had said that she would welcome folks contacting her, and that her office would try to facilitate introductions to pediatricians in various communities. So you've got strong leadership with the Michigan chapter, and I would say Cindy can also help too, is the, what's the name of the committee, Cindy, that you chair?

DR. C. STATLER: Oh, the Behavioral Developmental Mental Health Committee.

DR. J. KNIGHT: Yeah. So in that capacity, again, this is something that would, I think, be of great interest to her. So Cindy, I'm assuming that you would welcome folks contacting you.

DR. C. STATLER: Absolutely.

DR. J. KNIGHT: And you could tell them how to do that, what's the best way for them to contact you.

DR. C. STATLER: Yep. My email address is C like in cat, statler S like in Sam, T like in Tom, A like in Apple, T like in Tom, L like in Larry, E like in elephant, and then R like in raindrop, at CharterMI for Charter Michigan dot net.

DR. J. KNIGHT: See? I told you pediatricians were a fun lot. [Laughter] And because Lia's not on the call, we can volunteer her for all kinds of stuff. She can, she'll help like hold hands and bring you together.

DR. C. STATLER: She's actually the president for the Michigan Chapter of the American Academy of Pediatrics. And we meet once a year. That meeting is coming up in September.

So if you've got anything that you might want to have to come to a booth, or if you want to be involved in a presentation, or get a handout available to people to hand out in our entry packets, or there's all kinds of creative ways to get the information out to the, at least the people that'll show up to that conference.

But then there's an electronic base—email wise—that you'd be able to access, as well, for getting information out. There's a monthly newsletter that goes out on the computer, as well as hardcopy if you want a hardcopy. It's a matter of just trying to think outside the box.

DR. J. KNIGHT: Community prevention, folks. You've just been offered something that I'll just tell you is pure gold. And of the choices, I think you really want to be at the meeting. You want to have something to present at the meeting about what you do, what is a prevention expert, what comes under your purview, why is it that you'd like to work with pediatricians, talk about your coalitions, where they are, have print information that people can pick up. Be an exhibitor, and at the booth have those Ghirardelli chocolates there because people will stop by a booth to get a chocolate. That's just how life works. And you'll have handshakes, and you'll set relationships in motion that will last for decades. The other stuff is fine. It's fine to have electronic connections and web sites. That's a nice add on, but it's no substitute for meeting people in person.

C. KLEVGAAARD: Thank you, John. I think we have a couple more counties that we're going to share successes, and then we're going to move into challenges.

So we invite Lisa or Kara Steinke to share a little bit about what's happened, either in Roscommon or Genesee. So either one of you want to go first? Kara Steinke are you able to unmute and tell us a little bit about how you guys got brief screening motivational interviewing going in the school-based health clinic?

KARA STEINKE: Sure. Can you hear me?

C. KLEVGAAARD: We can.

K. STEINKE: Okay. We're, actually, we have a presence in two different school districts in Roscommon through a Federally Qualified Health Clinic providing motivational interviewing. And I couldn't agree more that developing those relationships with those physicians goes a long ways. We're there partnering with them because they love our prevention person, solely. [Laugh] And she does motivational interviewing, more than a brief screening. Just being available to them for them to send the kid out of the school-based clinic that they suspect may be abusing substances or having family issues. It's a good alliance, in its infancy, for sure.

B. BEARD: I think that was a good point—Brittany Beard, again—because a lot of times there are challenges with folks being [Inaudible Phrase] being reimbursed for either screenings, themselves, or some of the great substance abuse work that you folks do. So if a lot of it can be done through the formal contract or the partnerships and stuff like that, if we

can help identify it and then have that relationship to pass off to the experts who can help the population the best that's really, really beneficial.

C. KLEVGAAARD: Perfect comments. Again, thank you both, Brittany and Kara. Lisa, are you able to unmute and tell us a little bit about the FQHC that you all are workin' on gettin' started with?

LISA COLEMAN: Sure. What we did, I work for Genesee Health system, and it's actually formerly Genesee County Community Mental Health. As we looked at the integration of mental health and substance abuse with primary care, we seen that there was a huge need in our community. We do have one Federally Qualified Health Center already in existence, in Flint. But the need was so great that we knew that another one would just add to the resources that community members have.

So we actually, originally, received a one-year planning grant. And then after the one year planning grant, we applied to become a Federally Qualified Health Center and we received that. So we have a couple of sites that we're working.

One site is already opened in downtown Flint, Michigan. And we're seeing clients Monday through Friday. And our focus is on the homeless population, although anybody can come in and be served, receive services through that clinic.

Our second site that we're actually in the process of working on right now, because of many different factors, it's been delayed. But we are trying to open up a second site at one of our Flint housing complexes and where we're actually going to take one of the apartment buildings and turn it in then into a clinic so that we can not only service the individuals through that housing complex, but others throughout the community.

MAN: [Inaudible Phrase] totally different.

C. KLEVGAAARD: All right. So moving on, I think we were about to move into challenges. And, again, feel free to let the dialogue continue in whatever ways as you talk about successes and challenges.

We heard a key challenge show up with many of you, as we reached out. And that is that often times screened youth may not, they might not need a full blown evaluation for substance abuse. [Inaudible] there's not enough problematic behavior there, but also feeling like maybe a single shot patient education also doesn't feel like quite enough. So we invite anybody who shared that concern to elaborate, but want to, again, also invite Cynthia and John in to think about how do you deal with that situation where you have kids kind of falling in the middle, in terms of what they need?

[Overlapping Voices]

M. HELVESTON: This is Marie Helveston. And can you hear me?

C. KLEVGAARD: Yes.

M. HELVESTON: Okay. Well, there's a gap there. There's no doubt. It's invaluable or there to be an intervention during the medical visit at that particular time. But as stated, it's not always enough. And then, again, there are youth that need more than that, but they really don't need an evaluation for treatment at that point. Either they've experimented once, or they've been at a party where there's been use. They're around the issue, not quite needing treatment evaluation at that point. So what do you do with them? If they're young enough, it really makes sense to have parents involved in the education. And if it can't be done at the office, itself, which usually is not primary to most health care centers, then it should be referred to a parenting program and where there can be an [Inaudible] of youth.

DR. J. KNIGHT: This is Dr. John, again. C. KLEVGAARD, can we bring up the toolkit?

[Automated Recording when phoning into chat line]

DR. C. STATLER: The phone's asking for a password and pressing pound. Is anyone else hearing that?

[Overlapping Voices]

DR. C. STATLER: Do we have a password?

C. KLEVGAARD: You shouldn't need to enter anything at this point. I think we're just hearing somebody else's static.

So John, Francine has opened the toolkit.

DR. J. KNIGHT: Okay.

C. KLEVGAARD: So let us know where you'd like to go inside of it, and we'll bring it up.

DR. J. KNIGHT: All right. I can start at the beginning, the beginning of the TeenSafe cards. No, go right up to the top, actually. Let me start at the top.

Okay. So what I'd like to do is to just show you what our computer program looks like, and then to let you know that in the toolkit we've actually put screenshots. So this is Adobe Acrobat file, PDF file that you can take to a printer and you can have color prints made of this. And I would suggest that what you do is then have them put in a spiral notebook that you can use like a little flipchart. And these are intended for pediatricians, but I think any pediatric healthcare provider could use them with teenagers. And this is how you can do a very effective brief intervention.

So when you say that the brief counseling might not be enough—oh, Cindy says can I send her the toolkit? Absolutely will get it to you. Melissa, if you can send her as an email

attachment, I think would really help her because she's not able to see what's on the computer screen.

But in any case, after the screening questions are done, this is the page that the young people see. And we call this the two by four upside the head because if you have a score two or higher on the CRAFFT Test—there are six questions, each answer is one point. So the threshold is low.

And the first question on CRAFFT is, *Have you ridden in a car driven by someone, including yourself, that was high or had been using alcohol or drugs?* So that's a very common behavior. And by the way, also of the youth that say yes, in terms of riding in a car greater than 30 percent of the time, it turns out it's Mom or Dad. It's like a parent or adult caregiver that's placing them at risk. And I'll talk about the brief intervention for that in a moment. But they're seeing this as high risk, and so this gets their attention. And once you have their attention, then let's scroll down here, then next we go into 10 pages of science and true life stories. So this is an example of the science page. And on the computer, there's a little bit of interactivity. When you move your cursor around, different sections will light up. But the interactivity is minimal because we didn't want to slow down pediatrician offices. So they can play with it a little bit, but they spend just really a few seconds on each page. They get through the whole thing in five minutes, so it will work just as well with the card, you know, in a little flip book. And so this tells them about how alcohol and drugs affect the developing brain, and how they can lose their edge.

This is an example of a nicotine slide that shows how rapidly you can become addicted to nicotine. And this is showing, actually, rat brains [Laugh] after single dose of nicotine. And then after five days. The bottom line is nicotine addiction is it's very, it's almost instantaneous, so that when somebody just starts to smoke, they become addicted within a short period of time. It takes longer to get addicted to opioids than it does to nicotine.

This one I really like. I have to confess that I've got a little bit of pride on this one because we wanted to show that smoke drugs—whether it's tobacco or marijuana—can hurt your lungs. The problem is most teenagers don't care about their lungs. You know, it's like they won't get COPD, or lung cancer until their 40's or 50's. And when you're 16, you're never going to become that old. But there's the teeth. And so we're looking the healthy teeth, and these are the nasty, stained teeth. And if you lose your sex appeal as a teenager, it's like a death sentence. So this always gets their attention, it's like oh, whoa, nasty.

And then this is about the liver. And they may or may not really care that much about their livers, but that's healthy and diseased.

But this is fetal brain. There are girls who become pregnant, or who actually have multiple pregnancies during their teenage years. We see it in Boston in some of the Latino populations where being a single mom is a cause for celebration. It's not shameful. But the liability is that the boyfriends don't last. And when you lose your boyfriend and you get a new one, the new boyfriend will accept your first child as long as you have one by him. If you don't have one by him, then it makes him look like not so macho. And so girls will have two or three babies

during their teen years. And they really do care about having healthy babies. So the brain slides, I think, can actually get their attention, as well.

And then there's substance abuse and sexual risk.

And then this shows the effect of marijuana on the developing brain. And this just shows that if you use marijuana even once, what can happen to your level of risk, and then what can happen if you use it 50 times or more. And the increase in risk is huge. There's a lot of misinformation. I'm not sure what the law is in Michigan, but Massachusetts decriminalized marijuana use, little over two years ago. And then this past fall, in a referendum, they voted in medicinal marijuana. And so the message has gotten to youth that there's no legal penalty anymore, and by the way, it's medicine. We're having problems with opioid dependence because of kids taking OxyContin and Percocet and then getting rapidly hooked, and graduating to heroin. And now we're going to see the same thing with marijuana. And the teens and their parents don't understand what a toxic drug this is for a developing brain. So we're making the point. And by the way, there's even more information in TeenSafe on this. So you can use that with your parents.

And then this is an example of a true life story. And we're actually upgrading the information on here because it turns out that if you read the story, Jennelle and Kristin were killed in the car after it hit a tree. And by the way, neither of them had been drinking. These were girls that went to a party, thinking that it would be a sober party. And when they saw everybody getting drunk, they decided they would leave, and they didn't have a ride. And a young man offered them a ride, and he was 19 and he was drunk and they didn't realize it. And he was, actually, on his way out to buy some beer and bring it back. And he hit a tree and they were killed. And the boy wound up getting five years. And I'll tell you that three lives were destroyed that day because of a bad decision on the part of the host that had that party. And so many lives were impacted. The parents' lives will never be the same for any of these three children.

And then this is about marijuana because there's a myth that it doesn't impair driving the way that alcohol does. And of course it's total myth. It is every bit as impairing, and it lasts much longer.

And then this is about prescription drugs. And we're actually updating Julie's story to make it a little more succinct. Julie was actually in Wisconsin, so closer to your neck of the woods, than to ours. But I've met the moms of all of these kids. And one of the few things I can offer for bereaved moms and dads is an opportunity to use the pain that they've suffered to help others. And folks are just incredible about wanting to do that. And Julie's mom was no exception. So this is her story there. And by the way, if you look at the last line, "Her parents, brothers, little sister, and many friends will always miss her and will never completely get over her senseless death." The reason that's there is because we've found that adolescents are not scared to die. They either think it's exciting if there's a risk of death and it can never happen to them, OR once they get into drug use, they become depressed and it's like I don't care if I die. But the way that you reach them is that you talk about how their friends and

family will ache forever if they die, because they'll resonate to that. They don't wish to hurt the people that are closest to them.

And that's why the last slide that we have for the computerized screening and brief advice is about the roadside memorial and showing the friends that will, forever, be hurting because of the deaths, the senseless deaths. So there you go. And you can use these. Print it up in your own practice. And it's something that you might bring to pediatrician offices and show them. Also in the toolkit there's a whole section with scientific reprints. And among them is the study that we published in *Pediatrics*, showing that what a significant and profound effect this had with only two minutes of the doctor's time.

We're also providing you with copies of the CRAFFT Screening Questionnaire so you can print these up. And the questionnaire is designed to be completed by the adolescent in a private place. You can't give it to them to take in a waiting room where their [Laugh] parents are lurking around. But as long as you have some private location, they can check off the boxes.

You notice that there's no place to put their name on it because you want to keep their answers confidential, and I don't think that these forms should be put into a medical record. And if people would like more information on how you record positive screens in a medical record, I'm happy to answer that. It's a very important question because you don't want to damage our adolescents' futures with too much information.

And this is the interview. The interview is meant to be administered by a clinician. So the instructions. You know, "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential." And then you would read the questions and check the boxes. So it can be done as an interview or a questionnaire.

And then these are the scoring instructions. And you can see that scores run one through six. It's a screen, really, it's not meant to be a scale or an index, but it does have scale-like properties. This shows you the probability of having an abuse or dependent diagnosis. This is from DSM-IV. And DSM-V it would be the probability of having any substance use disorder, of any severity. And we haven't, yet, done a study where I can tell you what the cut is for severity, but I can tell you pretty much that it's going to be right around between three and four; that this would be, four five and six, this would be the severe disorders. And you can actually use this with the patient. We have these printed up on little red cards that are laminated and when I use them in a patient interaction, I would ask the questions and then flip the card over and say, "Well, your score was three, so you'd be in this bar here. So that means that wow, there's greater than 60 percent probability that you have some kind of substance use disorder." [Inaudible Phrase] 40 percent or less than 40 percent chance that they don't, and they can flip it that way. But I've found that if you just present facts, if you just present, "Your score was three. It correlates with that bar," you don't get into a lot of arguments. If you say to a teenager, "Well, I think you have a substance use problem," they'll say, "Well, no, I don't." They get resistant. But you can say, "This was your score. That's the level of risk."

And then, you know, again, this is from DSM-IV. We're going to be updating this to DSM-V. Those are the criteria. And there'll be another one that we'll add for DSM-V, which will be craving. The references are on there. And by the way, there are citations that are on the science pages. And the reason for that is that the teens ask for them. They, it was important for them to know that these all come from scientific papers. And some of the teens actually look them up. You know, everything's available online. So the Internet can do harm, in that it gives teens instant access to the latest things to get high on and things like Internet pornography. But it also gives them access to scientific studies. And they can get the papers and, at least, read the abstracts. And some of them do, and I find that to be very positive.

So you've got the CRAFFT. You've got the scoring. And then this is actually an example of what we would give to clinicians, based on the computer program.

And this would be the score that they would get when they've completed the screening ahead of time. In a pediatric office if you're going to use the paper version, somebody else in the office would give the young person the questionnaire form. And then they would then check the boxes. They would do the scoring and then give the scoring to the pediatrician.

And then these are the talking points. And you'll see that for No Use it's Not using drugs and alcohol is a smart decision. You should be proud of yourself. If it ever changes, I hope you'll trust me enough so that we could talk about it. So it's positive reinforcement, praise and encouragement.

And then leaving the door open. You don't want to brand yourself as the no drug and alcohol person because then if they ever decide to use it, they're not going to come to you.

So all of these statements have been, scientifically, vetted. And this comes from qualitative research and quantitative.

So these are the bullets that will make a big difference. And you can see that you don't have to do all of them with every patient. But emphasizing some of them. These are the same points where it says always mention the health effects. They've already seen these. So you just want to reinforce whichever ones you think might be most meaningful for your patient if they're pregnant, or have a child that would be the last one. If it's a boy, you're not going to do that one at all.

And then for the driving risk, or riding with an intoxicated driver, we recommend giving out the Contract for Life, which is available online from SADD. SADD online, S-A-D-D. That's Students Against Destructive Decisions. In our study, we gave out contracts for life and asked the teens to take them home—this is what the pediatrician did—discuss it with their parents, and to come back or call if they had any questions. And that minimal intervention resulted in significant drops in riding with intoxicated drivers, including parents. There was a greater than 30 percent drop in riding at three months. It was extinguished at 12, but at least for three months those kids were protected with a simple intervention like the Contract for Life.

So I lost my toolkit. I don't see it. I think I've covered most of the things that are in there. I don't think we put in the motivational enhancement therapy manual and tools, but that's something that's available if there are clinicians that are doing motivational enhancement therapy, or would like to see science-based tools that are developmentally appropriate for adolescents, that's something that we can provide to you.

C. KLEVGAAARD: John, thank you so much for doing the tools with folks and know that that stuff is going to be available. If you didn't get it in advance of today's Webinar, we're also going to bring it up in just a few moments and you can download it, directly, from the Webinar to your laptop. So it's for those of you who stay on.

We wanted to take a minute and open the floor to anybody who hasn't spoken yet, or somebody who has who has an additional challenge you'd like to have the group talk through, with John and Cynthia's help.

And as we do that, we wanted to kind of let you know who, again, we have a slide showing what Cynthia looks like, so we're going to go there and invite her to say something more about the organization in a way that she can support you all. And then we're going to take more questions.

DR. C. STATLER: [Overlapping Voices] Oh, this is Cynthia Statler talking. I, continually find it absolutely amazing how normal these kids who abuse drugs and alcohol, how normal they think it is. It just is mind boggling every single time I ask one of them. I've gotten to the point now where once they admit to any use, then I switch over to my drug use questionnaire where I ask them what drug, first use, maximum amount of use, and the last time they used. And they will rattle off inhalants, other prescription pills, alcohol [Inaudible], mucinex over the counter. They'll tell you as if they were talking about having an Oreo cookie at lunch time. So we've got to get to the prevention piece. We've got to get to the screening and identifying these kids, up front 'cause it's a whole culture we have to change for them.

DR. J. KNIGHT: Cindy, there's one thing I'd like to add. And we've actually documented this in research. My colleague, Dr. Sian Harris is an expert in measurement or survey development for adolescents. And she's developed something called the Youth to Provider Connectedness Scale. And the bottom line is that young people have very strong connections to their pediatrician. Some pediatricians have known their adolescent patients for five years, 10 years, or their whole lives.

When I was in pediatric practice—I'm now research based—but when I was, I had kids who came to me that I remembered when they were babies. And I would start my brief advice by saying, "I've known you for your whole life. The first time I saw you I could almost hold you in one hand. I would hate it if something happened to you. It would be like losing a member of my family. Please stay away from drugs and alcohol. You're an incredible kid. You've got so much promise. You could change the world, so don't get sidetracked, please. Stay away from that stuff, all right? You heard it from Dr. John." That took me about 30 seconds to say, but it's very, very powerful. It's as powerful as if they heard it from a parent. And what parents say also has an impact. It's just that the adolescents are never going to give you the

feedback like well, thanks. I really loved hearing that from you, Dr. John. No, it's like, yeah, whatever, you know? But it has an impact. It really does. It works.

C. KLEVGAAARD: John, it looks like we have another challenge from Luce County. We have Gery, who's joined us. And wonder, Gery, can you say a little bit about the fee-for-service sort of challenge that you all have experienced? I think that's not unique to your county, but if you could elaborate a little and we could invite John and Cynthia to share any ideas about that issue.

GERY SHELAFOE: Yes, this is Gery. What we're finding is that most often physicians and all of the services they provide are fee-for-service. And what's happening is there is a little bit of resistance to doing things that are not going to be billable. Does that make sense?

DR. J. KNIGHT: It does. I'll just tell you that screening and brief advice *is* billable.

DR. C. STATLER: Yep.

DR. J. KNIGHT: It was, federally, enacted, but I can't tell you what the codes are and so on. Cindy, maybe you could help with this.

DR. C. STATLER: Ummm.

DR. J. KNIGHT: And if you don't know, then we can find the answer. If Michigan has like a finance committee, we can try to find the answer. But there are codes that you can—it's not a lot, but you can get extra money for doing screening and brief advice. In Massachusetts, I know what the codes are. You can get like about fifteen dollars. But that's extra, on top of your visit. And I'll just tell you that even though if it's fee-for-service—and I mentioned before 50 percent overhead—so pediatricians are reluctant to do something that will slow down the practice. But if you can show them evidence that what they can say in two minutes will impact their teenage patients—these are good people. Pediatricians are doing this because they love the children and adolescents that they serve. And they'll do it because they *have* two minutes. I know that they do because I ask them. All of my research was conducted in real life practices. And I asked them before I designed this, "How much time can you give me?" And they said, "Two minutes; maybe three." And, actually, you can do it in 30 seconds to a minute, if you heard what I said for that model brief intervention. That has an impact like a ton of bricks. Again, you're talking about people that have very close relationships. And it doesn't take long for them to change the course of an adolescent life.

C. KLEVGAAARD: John I see one more question coming through the chat. Thank you for that, first of all, about handling a local pediatrician who feels it's okay for youths to drink in their own homes, as long as they're with their parents. Probably an attitude that's not just Michigan, but how might you deal with that?

DR. J. KNIGHT: Tell'em to go to TeenSafe and to take the course. At TeenSafe, they're going to first see a three-minute interview with the Whitney family. And no person that deals with teenagers can go without being strongly impacted when you hear in their own words

what it's like to lose a child because of an alcohol-related tragedy. Completely senseless and totally preventable.

And then it goes on from there and it will give the pediatrician, as well as parents, the information that adolescent brains are still developing, and there is no safe level of alcohol for teenagers. And there's no safe use of cannabis for teenagers. Children and teens are not little adults. They're developmentally distinct. So when people feel that way that it's okay for them to do it, they just don't have the latest scientific information. And the impact we had with TeenSafe, by the way, we got, there were almost 300 parents in our first year that went to the site, from one high school, and took the course. And all of the feedback that we got was incredibly positive. And almost 80 people took time to write things and said, "I just didn't know." "This science is astounding to me." "Why don't more people know about this?" "Why isn't anyone telling us these things?" And so we have to get the word out. And everybody on this call, you can help. Get the word out to the people who don't know. Let them see the science. And I think it will persuade them. The science will speak for itself.

DR. C. STATLER: And don't wait until you get all the other adults that you know on board. Start working with the kids that you know and move forward. If you wait until everybody else agrees with you, you're going to miss your opportunity to have an impact.

DR. J. KNIGHT: Amen. Absolutely. Yeah. If you can save—

C. KLEVGAARD: One final question, from Gery and Jim, about a student who's at a 1 or a 2. And I think some of the information in your brief and screening toolkit was super helpful. [Inaudible] additional comments. And that will be our last question for today. Any thoughts about a student who shows up at a 1 or a 2, what you might do, as a pediatrician?

DR. J. KNIGHT: You talking about on the CRAFFT? A score of 1 or 2 on the CRAFFT?

C. KLEVGAARD: Yeah, and I think that question's coming from Gery and Jim. So jump in and elaborate, Gery or Jim, if that's what you're talking about.

Yes, it's from the CRAFFT.

DR. J. KNIGHT: Okay. So a 2 is a positive CRAFFT. It's 2 or greater is a positive. So you want to just give advice. For any kid who's using, if they've said that they're using, then the brief advice needs to be, 'It would be better for your health if you didn't use at all.' That's the advice that you give. It's standard. It's 'the best thing for your health is not to use.' 'There's no safe level of alcohol or cannabis use when your brain is still developing.' That's the message.

For a 1, these may be kids who are riding in a car with an intoxicated driver, but haven't used drugs or alcohol, themselves. And this is a group that may die before the next time you see them. Contract for Life. Ask them to take it home. Discuss it with their parents. And, again, the advice from the clinician is if you've got a good relationship with them, say, "I would hate it if you died in a car crash." And talk about ways that they could extricate themselves

from a car when there's an intoxicated driver. And there's one way that's foolproof. I'm just going to tell you—and this has been scientifically derived—is if the person who's the passenger, sometimes intoxicated drivers won't stop for anything. But there's one thing they'll stop for. If the kid says, "I'm gonna throw up!" They'll stop the car, no matter how drunk they are. Nobody wants throw up in their car. And so that's the ticket. That's the thing that'll get the driver to stop and let them out.

C. KLEVGAARD: We'd like to pause and say thank you to all who participated today. Thank you to Dr. Knight and to Cynthia Statler. That was amazing, sort of relevant just in time. Kind of service from the state of Michigan association.

Wanted to remind folks today that the tools today are available for download. They're on your screen right now. And all you need to do is click on the tool that you want, and click download file and it'll be on your own desktop in moments.

Again, we wanted to also remind folks that there will be an evaluation today. So you'll get an email from us. So if you have not, yet; if you were participating but didn't register today and we don't have your email, please type it into the chat now, and we'll make sure you'll get an email, again, inviting you to evaluate today's conversation.

Again, we want to just amazing thank you to Dr. Knight and to Cynthia, and invite everybody to have a fabulous afternoon. I, myself, am heading out to get some chocolate. Thank you, John.

DR. J. KNIGHT: By the way, I have to confess that when I wasn't talking, I had the chocolates in front of me.

[END OF AUDIO]