Implementation of Ohio SBIRT in an Integrated Health Center: Panel Discussion

All Ohio Institute on Community Psychiatry
March 25, 2017
SBIRT Panelists: Introduction

• Ellen Augsperger – Director of Ohio SBIRT Program
• Alan Hejduk, LISW-S – Dual Diagnosis Therapist and SBIRT Team Leader, Circle Health Services
• Farah Munir, DO – UH/CWRU Faculty and CMO, Circle Health Services
• Monica Tone, MD, MPH – PGY-5 UH/CWRU Fellow
• Lisa Zapotocky, MD – Associate Medical Director, Circle Health Services
Objectives

- Describe the Ohio SBIRT Project and evidence for preventive screening in primary care settings.
- Learn about the SBIRT implementation process at a local federally qualified health center (FQHC), including challenges and lessons learned.
- Panel discussion and questions: focus on strategies for SBIRT implementation in the community.
Introduction to the Ohio SBIRT Project

Ellen Augspurger, Director of Ohio SBIRT
What is the Ohio SBIRT Project?

5 year, $10 million cooperative agreement between Ohio MHAS and SAMSHA

Implement screening, brief intervention and referral to treatment in medical settings

Collect data on substance use and depression across populations
What is SBIRT?

Validated, routine screening using standardized tools to identify potential problems.

Evidence based brief intervention if a potential problem is identified.

Referral to appropriate treatment services as needed for those willing to engage.
What is SBIRT?

- Routinely Screen
- Provide preventative services
- Delay or preclude

Potential problems
Prior to the onset of acute symptoms
Development of chronic conditions
## Who is doing SBIRT?

<table>
<thead>
<tr>
<th>Past Funded Partners</th>
<th>Present Funded Partners</th>
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<tbody>
<tr>
<td>Health Partners of Western Ohio – Lima, Kenton, New Carlisle, Bryan</td>
<td>Mercy Health – Cincinnati, Mt. Orab, Clermont County, Lima, Springfield</td>
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<tr>
<td>Wood County Health District – Bowling Green</td>
<td>Third St Family Health - Mansfield</td>
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<td>Compass Community Health - Portsmouth</td>
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<td>Circle Health Services - Cleveland</td>
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<td>Firelands Counseling &amp; Recovery – Sandusky region</td>
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</table>
What does the data tell us?

**Overall Service Level Distribution (N = 41,295)**

- **SF (n = 35,238)**
- **BI (n = 3,947)**
- **BT (n = 696)**
- **RT (n = 1,414)**

- 85.3%
- 9.6%
- 3.4%
- 1.7%
What does the data tell us?

Change in 30 Day Substance Use from Baseline to Follow-up (n=328)

- Alcohol Use
  - Baseline: 6
  - Follow-up: 4
- Illegal Drug Use
  - Baseline: 7
  - Follow-up: 5

* Indicates significant difference.
What does the data tell us?

Change in Mental Health from Baseline to Follow-up (n=112)

Number of Days

<table>
<thead>
<tr>
<th>Condition</th>
<th>Baseline</th>
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<td>Suicide</td>
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</table>

* Denotes significant change
1970-1974
The House on Cornell Rd

The Free Medical Clinic of Greater Cleveland
Health care is a right, not a privilege.
1974 – 2002

The Free Medical Clinic of Greater Cleveland

Health care is a right, not a privilege.
2002-2016

The Free Medical Clinic of Greater Cleveland
Health care is a right, not a privilege.
Circle Health Services

- Free Clinic from 1970-2012, Name change in 2016
- Co-located BH and Primary Care Services since 1970’s
- Community Mental Health Center – AOD & MH Services
- Federally Qualified Health Center
- Patients are low-income, minority
- All are served regardless of ability to pay
Circle Health: Patient Race/Ethnicity

- Asian: 3%
- Black: 1%
- White: 21%
- Hispanic: 2%
- Other: 68%
Circle Health: Patient Demographics

- Below 200% FPL: 96.3%
- Below 100% FPL: 76.9%
- Uninsured: 40%
- Homeless: 7.7%
Circle Health Clinical Services

• Adult and pediatric **Primary Care**

• **Behavioral Health**
  – Psychotherapy/counseling (group and individual)
  – Psychiatry
  – Substance Abuse Intensive Outpatient Treatment

• HIV outreach/testing/treatment

• Dental Clinic

• Volunteer medical specialty clinics (derm, ophthalmology, Physical therapy, etc)
Circle Health Other Programs and Services

• Syringe Exchange Program (van and on-site)
• Project DAWN (deaths avoided with naloxone)
• Assistance with applying for Medicaid and private insurance plans
• Chronic disease self-management and health literacy education
• Assistance with transportation, housing, food stamps, RTA discount passes, etc.
Patient-Centered Medical Home (PCMH)
The Past to Present: from Co-Location and shared EMR to Partial Integration

Primary Care

Behavioral Health

Primary Care

Behavioral Health
Current Model: Circle Health

- Close Collaboration in a unified system:
  - Shared Facility, administration & billing
  - Shared EMR, co-Management & care plans
  - Patient-Centered, Team Based Care Model
  - Full array of BH services on site
Our Integrated Care Model: Care Coordination

- Care Management for risk-stratified populations
- Patient Navigator manages transitions of care and tracks internal and external referrals from BH and Primary Care
- Co-Management relationships between providers
- Daily interdisciplinary team huddles
Team Huddle
Other Staff Involved in Care Coordination

- **Patient Navigator** - transitions of care, referral tracking
- **RN** – population health registries, same day triage for referred BH and Primary Care patients
- **Pharmacist** - Medication Therapy Monitoring (MTM)
- **HIV Case Managers** (LISW and LSW)
- **BH Care Manager** (LPCC) – psychiatry only clients
- **BH Providers** (therapists, psychiatrists) – “warm handoffs”, direct collaboration and co-management
Team Collaboration and Communication

- Weekly leadership team meetings
- Monthly integrated care case conferences
- Quarterly clinical in-service days
- Shared record and treatment plans
Outreach and Referrals

• Patient Navigator tracks internal referrals
• Care Management is offered to all patients with comorbid chronic primary care and MH diagnoses
• Warm Handoffs wherever possible
Follow up for + Depression Screens in Primary Care

Percent of all patients

- 2014: 26%
- 2015: 30.2%
- 2016: 53%
What’s Missing?

- Systematic identification and follow up for substance abuse disorders
- Motivational interviewing
Clinical Quality Improvement

• Goal—identification of depression and substance use disorders in Primary Care patients

• Funding support - Ohio SBIRT Program

• Skill development: Motivational Interviewing (MI)

• SBIRT team support, ongoing training and education
Making the Investment: Trainings and Education

• 2 full-day trainings for all clinical staff

• SBIRT Team
  – Education about substance use disorders and MI for RNs, MAs, DAs

• Centers for Evidence-Based Practice
  – for all primary care, dental and BH providers in October, 2016 and January, 2017.
Motivational Interviewing Training
QI: Plan-Do-Study-Act

• Multidisciplinary SBIRT team participates in peer network webinars
• Patient Navigator tracks internal referrals resulting from positive screens
• Improved engagement and show-rates
• Incentives for patients who complete the lengthy data collection interview
SBIRT IMPLEMENTATION AT CIRCLE HEALTH SERVICES
Primary Care SBIRT Team

- Primary Care Provider
- Medical Assistant
- SBIRT Behavioral Health staff embedded in medical department
- Nursing
- Patient Navigator
Stepwise Implementation of SBIRT into Clinic Workflow

- November 2016: one physician/medical assistant team began screening two full clinic days weekly
- Mid-December 2016: expansion to include all full time adult primary care providers
Stepwise Implementation of SBIRT into Clinic Workflow

• Initial exclusion criteria:
  - patients under 18
  - walk-in clinic sessions
  - HIV chronic care patients
  - active CHS Behavioral Health/Psychiatry patients
  - non-English-speaking patients
  - nurse visits
Stepwise Implementation of SBIRT into Clinic Workflow

- March 2017: education on SBIRT/GPRA expanded to RN staff
- HIV case managers will be undergoing SBIRT/GPRA training for HIV chronic care patients
- Short-term expansion to include our urgent walk-in clinics twice weekly, including a significant number of STD/HIV testing visits.
Staff Training

- Two full-day sessions of training for Primary Care and Behavioral Health staff on SBIRT and motivational interviewing
- GPRA training for BH SBIRT support staff
  - All MAs, RNs, Patient Navigator
- SBIRT lead MA provides peer training/feedback
- Training on use of EMR for SBIRT tracking/standardized documentation, inclusive of appropriate billing codes for screening and brief intervention
Collaborative SBIRT Team

• Composed of:
  – Psychiatry (Drs. Munir and Tone)
  – BH liaison/SBIRT Team Leader (Alan Hejduk, LISW-S)
  – Medical Liaison/SBIRT MA Lead (Briaune Williams)
  – Primary Care Physician (Dr. Zapotocky)

• Team meets weekly and is responsible for problem-solving, data collection, education/training, status updates, support and motivation to Medical and BH teams, and accountability to Ohio SBIRT Program.
Current Medical Team Workflow

• Pre-visit planning:
  – Identify if SBIRT screening has been done at previous visit or if patient meets exclusion criteria

• Medical Intake (MAs):
  – MAs intake patients for their schedule visit, including vitals, current complaint, and social history.
  – SBIRT screening initiated where appropriate.
    • Negative screens documented and GPRA-A completed by MA in exam room.
    • Positive screens followed with PHQ-9, DAST, AUDIT as indicated
Current Medical Team Workflow

- Motivational Interviewing/Brief Intervention
  - MAs engage patient to assess level of change, offer brief meeting with SBIRT BH team member
  - MA gives brief verbal handoff to PCP and BH staff (if patient amenable)
  - Brief Intervention may occur before OR after provider medical visit, depending on workflow
Current Medical Team Workflow

• If patient agreeable: intake appointment is scheduled with a BH provider or brief intervention is initiated at the visit.

• GPRA performed by SBIRT team member

• Medical provider places an internal referral with SBIRT notation to allow referral tracking, patient assistance with scheduling if needed.
Medical Team Workboard: Real-time Patient/Provider Status

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Room | Time | Provider
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SBIRT Collaborative: Work in Progress

• Expand SBIRT screening to include higher risk populations
  – STD screening, HIV chronic care

• Maintain engagement, comfort level and motivation of staff members, particularly during higher volume or short-staffed clinic days

• Engage patients to: optimize effectiveness of screening and assess willingness to change, enhance likelihood of follow up

• Referral tracking

• Improve capture of GPRA data for Ohio SBIRT project
  – Expanded to include $10 gift certificate as thank you for participating in the full GPRA survey completion
DATA COLLECTION AND ANALYSIS
Screened Patients

Gender Profile (N=66)

- Male: 39.4%
- Female: 60.6%
Screened Patients

Race Profile (N=66)

- African American: 62.1%
- Asian: 21.2%
- White: 9.1%
- Multiracial: 4.5%
- Other/Missing: 3.0%
Screened Patients

Age Group Profile (N=66)

- 18 to 29: 9.1%
- 30 to 45: 33.3%
- 46 to 64: 25.8%
- 65 and over: 31.8%
Screened Patients

Service Level Distribution (N=66)

- SF: 86.4%
- BI: 10.6%
- RT: 3.0%
Positive Screens: n = 9

• Type of substance used
  – 8 reported alcohol use
  – 7 reported marijuana use
  – No positive screens for: cocaine, heroin, benzodiazepines, methamphetamine, illegal Rx drug use

• Number of substances used:
  – 3 reported using one substance
  – 6 reported using two substances
Referral Tracking

- Tracking referrals to behavioral health as well as outcome (no show, initial intake, established care)

- Subjective observation: increase in referrals to behavioral health and an improved show rate
Next Steps

• Goal is to have 3000 patients screened by July 31
• Follow-up interviews conducted Wright State to establish outcome data
• Upcoming Cross-site Evaluation – independent evaluation which can help improve SBIRT process and efficiency
• Continuous Quality Improvement
LESSONS LEARNED
Ongoing Challenges

• Patients declining to participate in GPRA
  – Planning to implement $10 gift card incentives

• Workflow
  – Time needed to perform intervention
  – Small overall staff is heavily impacted by any missing staff
  – Paging system ➔ dedicated SBIRT phone
Ongoing Challenges

• Environment: Physical distance between places MAs are working

• Need to integrate highest risk clinics into SBIRT
  – Busy, walk-in clinics

• Billing and Documentation
  – PCP note vs separate therapy note
  – Training providers to use new billing codes, every time
Ongoing Challenges

• Provider and MA engagement
  – Missed screenings
  – Make sure all have access/passwords, repeat training, discuss patients needing screening in daily huddle

• Sustainability
  – BH therapist SBIRT time grant-funded
What Works

• Staff buy-in for SBIRT
  – Small group of providers with good communication infrastructure
  – Champions for change at multiple levels: administrative, medical and BH providers, lead MA
  – Share success stories

• Dedicated training days
What Works

• Quality Improvement and PDSA cycle model
  – Small, progressive changes
  – Measure performance
  – Tracking behavioral health referral data including initial show rates
  – Anonymous feedback from MAs to improve workflow
What Works

• Workflow
  – Team huddle
  – Pre-screen prior to full screen
  – MAs delivering Screening, +/- Brief Intervention
    • Unique rapport with patients
    • Empowered for intervention through education and peer modeling
What Works

• Co-located behavioral health and substance abuse treatment
  – Warm hand-off; meeting BH provider face-to-face and provided phone number, appointment
  – “Next Appointment” Motivational Interviewing
  – Assessment appointment within 1 week
    • Urgent access to psychiatry and therapy appointment
What Works

• Support from the Ohio SBIRT Project
  – Data collection analysis and support
  – Coaching on implementation
  – Training on Motivational Interviewing and workflow process