

ADDICTIONS AND MENTAL HEALTH DIVISION (AMH)

**SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT (SBIRT)
WORKGROUP WEBINAR**

January 30, 2015

Minutes - DRAFT

AMH Participants: Michael Oyster (AMH), Patricia Alderson (AMH)

Webinar & Phone Participants: Laura Andrich, Graham Bouldin, Emileigh Canales, Nick Curteman, Kirk Dantzman, Debi Dobkins, Luda Kohanevych, Lynnea Lindsey-Pengelly, Jetta Moriniti, Stefanie Murray, Julie Oyemaja, Jennifer Stubbs, Ariel Singer, Debbie Standridge, Denise Taray, Megan Underwood, Nikki Vlandis, Laura Walker, Melissa Weddle, Jim Winkle,

Presenters: Michael Oyster

Absent: Sarah Bartelmann and Sara Kleinschmit

TOPIC	KEY DISCUSSION	ACTION/TASK/DECISION	RESPONSIBLE	DUE DATE
INTRODUCTION (MICHAEL OYSTER)	<ul style="list-style-type: none"> • Brief review of webinar functions and features and conference line muting and unmuting. • Reminders: <ol style="list-style-type: none"> 1. Only unmute when needing to speak. 2. Do not place call on hold or the group cannot hear the speaker over the hold music. 3. State your name before speaking to avoid confusion. 		Michael and audience	
UPDATES/FOLLOW UP TOPICS (MICHAEL OYSTER)	<p>No Metrics updates for hospitals to report-Sarah Bartelmann on vacation; Sara Kleinschmit not available.</p> <p>Michael reviewed two attachments with the group: 1) the SBIRT Project Plan 2014-2015 and 2) the SBIRT expansion plan form.</p> <p>SBIRT Project Plan 2014-15 Review & Approval</p>			

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	<p>brief intervention G0396 (15-29 minutes) or G0397 for 30 minutes or greater. This is unique for Medicare; in Medicaid, providers only use one code.</p> <p>Question: MDs and DOs can deliver SBIRT services for Medicare patients, correct? Response: There are certain licensing requirements that are typical to Medicare. Only certain licensed practitioners can bill for each, so MDs and DOs can bill for SBIRT, as well as licensed Psychologists and Licensed Clinical Social Workers.</p> <ul style="list-style-type: none"> ❖ Michael Working on a simplified workflow for Incident-to Medicare billing ❖ Michael will post this document on the AMH SBIRT website for everyone to reference. <p><u>Metrics category update:</u> Issue: How do we end up not competing for SBIRT encounters between primary care and the hospitals? Response: There can be a system flag to indicate that SBIRT has been done and that there is a screening in the system from primary care, however, this could be an issue when the hospital wants to do their own SBIRT process. Question: Has anyone experienced this? Response: When you come across this, there are some solutions for this:</p> <ol style="list-style-type: none"> 1. For a full screen, the emergency department staff could bring up the plan in the EHR, refine it with the patient (which could count toward screening) as well as refining the plan about 	<p>Michael will post the simplified workflow document for Medicare on the AMH SBIRT website. Give Michael any feedback about anything that isn't working in your SBIRT system.</p> <p>Email Michael with your experiences with competition over SBIRT metrics so he can problem solve with you</p>	<p>Michael</p> <p>Michael</p>	

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	<p>what the patient plans to do to reduce or stop their substance use.</p> <p>2. When patient re-visits primary care doc, this encounter should come up in their record for follow up services.</p>			
FORGOTTEN UPDATES & ANNOUNCEMENTS	None to report		Michael	
OTHER DISCUSSION TOPICS	<p>Challenges with adolescent implementation?</p> <ul style="list-style-type: none"> ❖ Pediatricians have been doing these substance use screenings routinely and it is part of their training. ❖ Need to figure out how to get it to ‘count’ count this screening work toward the metric through using the SBIRT codes ❖ SBIRT is a 2-step process, brief annual and a full screen where indicated, but it can be a single step process for specialized populations (perhaps adolescents and chronic pain) or for specific patients the provider is wanting to screen due to medical symptoms or behavior patterns. <p>So, there are exceptions that a clinic or provider can make to give a full screen to a patient, whether a brief annual screening was positive or not:</p> <ul style="list-style-type: none"> ❖ It is reasonable to do a full screen on any population when it is clinically indicated due to history of A&D issue or patients with chronic pain, taking high levels of addictive medication, or have high consequences to substance use (such as pregnant patients) ❖ Billing for a full screen requires the provider to go over the results of a full screening with the patient in relation to their specific medical condition; this needs to be reflected in the medical record 			

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	<p>documentation</p> <ul style="list-style-type: none"> ❖ What doesn't meet the code is for a provider to do a full screen, see that the score is low, and not bring it up to patient at all; there are ethical issues involved with giving a screening tool and then not reporting to a patient about its results. Plus, there are legal issues for not reviewing the results with the patient but billing for the service ❖ Pediatricians want to do full screenings with all of their patients, so even though this is an increased workload, they are wanting to do this; which works. For family practice providers, doing a full screening on their adolescent patients may be overloading, so they are more likely follow a 2-step process ❖ Bottom-line is that the SBIRT process is typically a 2-step process but providers can chose, based on clinical judgment, when to give a full screen, no matter if the brief annual has been positive or not. <p>Marijuana screening and Intervention Changes:</p> <ul style="list-style-type: none"> ❖ Provides challenges for screeners now that marijuana is legal when addressing this issue with patients regarding their health, much like alcohol and tobacco ❖ In addition, marijuana use may be connected with chronic pain management, which will require further assessment, medication reactions, etc. ❖ If marijuana is lumped in with illegal drugs as a part of the DAST, do we need a section of its own for marijuana as a recreational drug? What would be the benchmarks, recreational drug vs. other drugs that are being abused? 			

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	<ul style="list-style-type: none"> ❖ SBIRT screening program may run the risk of losing credibility if marijuana screening is not dealt with properly, yet there is no national research on this issue that we are aware of at this time ❖ There are several risks associated with the recreational use of marijuana: inhaling smoke, lack of concentration, lower executive functioning, and possible interactions with medications ❖ We need to have a discussion with patients regarding the risks (marijuana is not a benign substance, even though it is legal) ❖ Michael will research what other states, such as Colorado, are doing with legalized marijuana <p>Question for Ariel Singer (Director at NWATTC): At NWATTC, has there been a discussion regarding a screening tool for recreational marijuana?</p> <p>Response:</p> <ul style="list-style-type: none"> ❖ Risk is higher for adolescents. ❖ Want to create <i>awareness</i> on this, but there is no screening tool currently for this, and a screening tool probably won't be available by the time it is legal (summer 2015) ❖ Need to have a way of discussing with patient the risks without being judgmental about the issue ❖ Need to consider methods of ingesting and overall risks ❖ Need some <u>education-based</u> awareness for patients on this issue now and in the future as more information is known ❖ NWATTC is working on developing these materials for providers and patients 	<p>Ariel Singer will send Michael an email with resources that he can add to the SBIRT information on the AMH website.</p>	<p>Ariel Singer & Michael</p>	

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	<p>❖ University of Washington has a great website for consumers on cannabis that is science-based for teens, adults, etc</p> <p>Question for Lynnea Lindsey-Pengelly, PhD (Medical Director at Trillium): How do we screen for <i>disruptive</i> marijuana use?</p> <p>Response: Cannabis use screening can be normalized in the same way we do for alcohol and/or tobacco use. Method of ingestion (such as eating it instead of smoking it), is the patient using cannabis for pain management or other medically diagnosed condition, is the patient experiencing any current cognitive impairment, or experiencing any learning impairment and other bio-psycho-social factors are important considerations; specific language needs to be developed for this type of screening.</p> <p>Question: What is Trillium doing for this screening?</p> <p>Response: There is high incidence of cannabis use in Lane County, and some medical professionals consider it to be normative behavior. This differs from many of the substance use disorders providers. One opioid treatment provider in Lane County has been doing some work around harm reduction for cannabis use.</p> <p>Some things to consider for the future screening tool:</p> <ul style="list-style-type: none"> ❖ On the one hand, SBIRT needs to establish a standard around the state regarding how cannabis is screened ❖ But then, screenings will have to have flexibility regarding norms for marijuana use, much like 	<p>Email Michael if you have any input or questions on this marijuana screening for future consideration by the workgroup</p>	<p>Michael, & workgroup participants</p>	

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	<p>alcohol, to identify when it is having a negative effect on health and not just identify that merely use of marijuana is damaging</p> <p>Michael would like everyone to be thinking about how to address making marijuana screening a standard around the state.</p> <p>Audience would like continued conversation on this important topic around state and region over the next several years.</p> <p>Email Michael about any resources, etc. that you would like to share with the group, and feel free to send to group anything you would like to share.</p>			
FUTURE TOPICS FOR WORKGROUP?	<ul style="list-style-type: none"> • Email your future topic ideas to Michael as soon as possible - - thank you! 	Email Michael with your agenda ideas	all	
NEXT MEETING	<ul style="list-style-type: none"> <input type="checkbox"/> Meetings are the last Friday of the month starting Jan. 2015 <input type="checkbox"/> Next meeting: February 27, 2015, 9-10:30 a.m. (webinar format) 			