

**ADDICTIONS AND MENTAL HEALTH DIVISION (AMH)**

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

November 21, 2014 ♦ 9 – 10:30 a.m. (354)

**Minutes - DRAFT**

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

**Webinar & Phone Participants:** *Graham Bouldin, Dwight Bowles, Lesa Dixon-Gray, Debi Dobkins, Stephanie Graham, Cyndi Kallstrom, Lynnea Lindsey-Pengelly, Tammie Metzler, Jetta Moriniti, Traci Rieckmann, Ariel Singer, Scott Smith, Debbie Standridge, Dan Thoma, Denna Vandersloot, Jim Winkle, Joell Archibald, Bill Bouska, Beth Brenner, Dominique Buhl, Sarah Dryfoos, Estela Gomez, Jeri LaPoint, Denise Taray, Coco Yackley*

**Presenters:** Michael Oyster, Sarah Bartelmann

TOPIC	KEY DISCUSSION	ACTION/TASK /DECISION	RESPONSIBLE	DUE DATE
<b>INTRODUCTION</b> (MICHAEL OYSTER)	<ul style="list-style-type: none"> <li>• Brief review of webinar functions and features and conference line muting and unmuting.</li> <li>• Reminders:               <ol style="list-style-type: none"> <li>1. Only unmute when needing to speak.</li> <li>2. Do not place call on hold or the group cannot hear the speaker over the hold music.</li> <li>3. State your name before speaking to avoid confusion.</li> </ol> </li> </ul>		<b>Michael and audience</b>	
<b>METRICS UPDATE</b> (SARAH BARTELMANN)	<ul style="list-style-type: none"> <li>• Updates/Review on Specifications &amp; Benchmarks:               <ul style="list-style-type: none"> <li>• SBIRT will continue as an incentive measure in 2015</li> <li>• Will continue to be “claims-based” with the inclusion of <i>adolescents ages 12 and up</i> to the measures</li> <li>• The 2015 benchmark is 12% and reflects the inclusion of adolescents.</li> </ul> </li> </ul>	<b>Email Sarah any other suggestions</b>  <b>Share draft at Oct &amp; Nov SBIRT.</b>	<b>Sarah</b>	

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	<p>Rates will be reported to CCOs for adults and adolescents separately, but the quality pool will be paid based on the combined rate.</p> <ul style="list-style-type: none"> <li>Last review of 2015 draft specifications with the Metrics TAG will be Monday, <b>11-24-14</b> and will be finalized in December and posted on-line then</li> </ul> <p>Will report on emergency department process and metrics at next meeting.</p>	<p><b>Finalize and publish in Dec.</b></p>	<p><b>Sara Kleinschmit</b></p> <p><b>Sarah</b></p>	
<p><b>FUTURE MEETING SCHEDULE/FORMAT</b> (MICHAEL OYSTER)</p>	<ul style="list-style-type: none"> <li>Meetings on the 4<sup>th</sup> Thursday of the month will begin in January, 2015.</li> </ul>		<p><b>Michael</b></p>	
<p><b>OVERVIEW OF THEMES OF CCO SUCCESSES &amp; EVOLVING SOLUTIONS</b></p>	<p>Explained the graphs and pointed out successes of SBIRT to date.</p> <p>How the CCOs were able to meet the metric this last year:</p> <ul style="list-style-type: none"> <li>➤ For primary care</li> <li>➤ Will review forms that will help providers implement SBIRT program</li> <li>➤ Reviewed graphs and maps of the system as it is currently</li> </ul> <p>Graph from June of 2014 showed: CCOs that met improvement targets of 3% toward the benchmark of 13%: Umpqua, Willamette Valley, Health Alliance and Pacific Source; others came close: Columbia Pacific, Western Oregon Advanced Health</p>		<p><b>Michael</b></p>	

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	<ul style="list-style-type: none"> <li>➤ Willamette Valley met their improvement target because one clinic screened all patients with a full screen</li> <li>➤ Need to get billing information out to the clinics, and how to problem solve the process with them</li> <li>➤ CCOs and their SBIRT promotion have caught the attention of many clinics via a vast amount of investment in the process</li> </ul> <p><b>What did CCOs do to meet the metric?</b></p> <p><u>Workflow:</u></p> <ul style="list-style-type: none"> <li>➤ Need regular, frequent meetings to avoid <i>drifting</i> of clinics in the SBIRT process and maintenance is also important for the process</li> <li>➤ How to make the transfer process smooth from one clinician to another is important</li> <li>➤ Using <i>Motivational Interviewing</i> techniques for the process is important</li> <li>➤ Identifying training needs for staff is important</li> <li>➤ Michael has links to online resources for both in-person trainers as well as online training - let him know if you would like this information</li> <li>➤ Billing: need enough information to bill and encounter this information-process being refined and is important for good clinical care</li> <li>➤ Validating the billing process with the service process is critical and needs to be done regularly (weekly vs. monthly)</li> </ul> <p><u>Clarifying the process:</u></p> <ul style="list-style-type: none"> <li>➤ Workflow issue-clarify who the SBIRT screener is</li> <li>➤ Documentation of work: needs to be clear for the provider</li> </ul>			

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	<ul style="list-style-type: none"> <li>➤ Using smart phrases and limited drop down menus</li> <li>➤ Feedback is given to I.T. Dept. to develop the E.H.R. to make it work for the provider (CCO)</li> <li>➤ Funding would be nice to have for developing E.H.R.'s but current CCOs did it w/out extra \$ (using internal resource costs) <ul style="list-style-type: none"> <li>○ Michael has had requests for this help and will research this possibility</li> </ul> </li> <li>➤ Both Physician and Behaviorist involved in screening-need input to make the screenings happen</li> <li>➤ Behaviorists need flexibility, as well as procedure balancing, that needs to happen to make the screenings work, as well as physician endorsement at the very least, to realize SBIRT screening success</li> </ul> <p><u>CCO Roles:</u></p> <ul style="list-style-type: none"> <li>➤ Being a resource for partnership</li> <li>➤ Being a center to problem solve together</li> <li>➤ Developing events to promote SBIRT awareness such as <i>screening month</i> which gives those clinics that are behind a chance to catch up with no blame</li> <li>➤ E.H.R. development: how to turn on the forms within the E.H.R. if that hasn't happened yet</li> <li>➤ Can provide oversight, and clarifying any processes; offering feedback on billing data and any snags that are happening along the way</li> <li>➤ CCOs are taking up the SBIRT challenge even if they aren't getting paid for it (such as during dental visits) just because it is good care (figuring out encounters is a little tricky though)</li> <li>➤ Several behavioral health clinics doing SBIRT screenings also-giving them some structure. Also need physical health integration within the behavioral</li> </ul>			

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	<p>health settings particularly with high end mental health patients: bipolar, schizophrenia, depression, and P.T.S.D.</p> <ul style="list-style-type: none"> <li>○ Sometimes called “reverse integration” but this is not an accurate term because it leads to ideas of separation or fragmentation -- more like physical health into behavioral health integration</li> <li>➤ Mental Health already doing SBIRT-like screens in the E.R.’s on patients seen for crisis psychiatric assessments</li> <li>➤ A lot of clinics already doing screenings w/out getting paid because it is good care but Michael has been providing technical assistance on this so that billing is understood more clearly and assuring that encounters are occurring</li> </ul> <p><u>Future Challenges:</u></p> <ul style="list-style-type: none"> <li>➤ <i>Annual re-screening process:</i> some have been doing this, but some have been confused on the process. Need to have a tickler system in place to alert the need it is time to do it again. Systems are needing clarification on this process</li> <li>➤ <i>Referral process for treatment:</i> warm hand off process sometimes challenging due to limited resources of local providers; timely admissions also a challenge; <i>coordination of treatment</i> (who is suppose to talk to whom?): Coordinator role is critical for the medical home to provide for the client</li> <li>➤ <i>Dually-covered client:</i> seems like the most needy, and most covered (via Medicaid &amp; Medicare) are the least served due to difficulty meshing the multiple insurance coverages-they have specific standards that</li> </ul>			

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	<p>don't include substance abuse treatment providers- there are solutions for these challenges -- Michael will work on a clarification document for this population</p> <ul style="list-style-type: none"> <li>➤ <i>Treatment services need to re-tool</i>: need more practice serving <i>mild or medium</i> cases-motivational interviewing techniques need to be refined for this client population when they are having a hard time changing behavior patterns; good preparation from primary care for the warm hand off-utilizing more collaboration within the system</li> <li>➤ <i>Residential Treatment Providers</i>: most favor local community but will treat anyone throughout the state; aftercare needs tight coordination when patient is ready to be sent back to local community for their aftercare: stabilization services process needs to be practiced by client's local community through intensive outpatient services</li> <li>➤ <i>Developing all levels of care</i>: in many communities, level 2.1 intensive outpatient is there (with the notable exception of the metro area); level 2.5, or day treatment, is not often used, but there are some throughout the state, and is a great segue way to or from residential or prevention treatment, to keep them in the community and to learn relevant skills</li> <li>➤ <i>Improved coordination</i> for better triage upfront &amp; ongoing through a variety of levels of care: detox, E.R. dept., psychiatric hospitals, A&amp;D residential; other issues can be uncovered in these settings and there should be smooth coordination to get clients other needed services</li> <li>➤ <i>Billing system caught up to pay providers</i>: specific licensed providers are being hired in primary care, and</li> </ul>	<p><b>Medicare / Medicaid clarification document</b></p>	<p><b>Michael</b></p>	<p><b>Jan 30, 2015</b></p>

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	<p>need to be able to get paid for their services; a program is being developed, and is close to being finished to accomplish this-process just needs a little more “<i>polishing</i>”</p> <p><b>In Summary:</b> Implementation is more than just training-requires regular problem solving meetings, implementing in waves, workflow requires coordinated service process, need physician endorsement and behaviorist flexibility, CCOs have a role to provide vision and resources to make the SBIRT process possible, to problem solve on mutual issues with clinics and providers, using metrics to measure progress but not curtail creative solutions.</p> <p><b>Future Challenges:</b></p> <ul style="list-style-type: none"> <li>➤ Annual rescreening</li> <li>➤ Refining referral process, and clarifying the dually covered patients</li> <li>➤ Treatment providers need to retool: for engaging internal motivation, making referrals back into the referring community smooth, and developing whole systems and levels of care to have smooth coordination</li> </ul> <p><b>Questions or Comments:</b> Very comprehensive, useful presentation. Will the slides be sent out to everyone? <b>Response:</b> Yes, later today by Michael.</p> <p><b>Question:</b> Will the improvement target be modified in 2015? <b>Response:</b> (Sarah) Will be talked about on Monday, <b>11-24</b>, with the Metrics technical workgroup, using the 2014 data.</p>	<p><b>Send Michael your feedback on these forms</b></p>		



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<b>TELEHEALTH FOR SBIRT: WHAT DO THE CCOS NEED?</b>	<ul style="list-style-type: none"> <li>○ Telehealth came up with the rural CCOs as a possible solution since inception of SBIRT and CCO implementation (such as Skype or FaceTime but more secure to meet HIPAA standards)</li> <li>○ Current AMH and DMAP OARs are antiquated around this technology-Michael working with the two offices to implement updated OARs</li> <li>○ What kind of resources are needed to connect providers and clients?</li> <li>○ Michael open to any and all ideas for future implementation.</li> </ul>	<b>Email Michael with your ideas</b>	<b>all</b>	
<b>FUTURE TOPICS FOR WORKGROUP?</b>	<ul style="list-style-type: none"> <li>● Let Michael know if the group wants to meet in December</li> <li>● It would just be mostly an open forum</li> <li>● Meeting adjourned at 10:16 a.m.</li> </ul>	<b>Email Michael with your preference</b>	<b>all</b>	
<b>NEXT MEETING</b>	<input type="checkbox"/> <b>December 19, 2014 - 9-10:30 a.m. (webinar format)</b>			