

## SBIRT Workgroup

September, 2014

### Notes

#### Attending

Pamela Bosa, Graham Bouldin, Stuart Bradley, Hanten Day, Sarah Dryfoos, Lindsey Hopper, Andy Jacob, Alison Johnson, Peg King, Angela Leach, Lynnea Lindsey-Pengelly, Milena Malone, Cindi McElhaney, Carla McKelvey, Jetta Moriniti, Christine Seals, Jared Juett, Ariel Singer, Debbie Standridge, Dan Thoma, Jim Winkle, Ruth Goldster

OHA staff: Sarah Bartelmann, Bill Bouska, Stefanie Murray, Michael Oyster, Shanna Werdebaug

#### Welcome and Introductions

We introduced the webinar format to our meeting structure. There are several advantages to this process:

- Sharing presentation slides; today we have two presentations
- Promoting more interaction, such as survey's, texting questions, and voice interaction
- Control over individual audio lines so individuals can be unmuted while everyone else is muted, allowing the speaker to present without interruption

Michael gave an overview of the webinar-style of meeting process and reviewed the essential protocols:

- Do not place call on hold or the group cannot hear the speaker over your hold music
- State your name before speaking to avoid confusion

#### Metrics Report from Sarah Bartelmann

There were a few metrics elements to report:

- Adolescent incentive measures will be added for 2015 in January
  - The adolescent measure will be combined into one composite rate instead of a benchmark and preferences of making adjustments to this combined benchmark will be reviewed
  - Reporting for adolescent and adult rates will be separated for quality improvement and monitoring purposes based on birthdate
  - There is essentially no differences between pediatric and family clinics
    - If there is a qualifying appointment, then the patient is placed into the denominator and if an SBIRT service is delivered then that is placed in the numerator
  - Further discussion of metric specifications will continue at October Technical Workgroup Meeting, and the Metrics and Scoring Committee
- Documentation and Timing
  - The drafts specifications for adolescent SBIRT is still being developed and will be collecting feedback in October and November
  - Goal is to publish the finalized 2015 specifications in December for use by January

#### Proposed Standing Meeting

Michael reported that he has had several requests to have the meeting on a regular time and date so that the meeting can be prioritized and worked around as scheduled solidify. There was discussion about this issue and

agreed upon by the group present to have the meeting on the last Friday of each month from 9:00 – 10:30 a.m.

- Michael will email the entire SBIRT Workgroup member and ask if this time will work for everyone
- For now, the next meeting is scheduled for October 31, 9:00 – 10:30 a.m.

### Adolescent SBIRT Presentation

Stefanie Murray and Peg King (OHA Public Health), and Jim Winkle (OHSU) presented what OHA Public Health has facilitated through their START program within School-Based Health Centers (SBHCs) during Adolescent Wellness Visits (AWV). Project Partners:

- Public Health and Addictions & Mental Health, divisions of Oregon Health Authority
- Oregon Pediatric Society (OPS), START Program
- Oregon Pediatric Improvement Partnership (OPIP)

Presentation points:

- The public health impact of alcohol use, as well as other substance, among adolescents is significant
  - Alcohol exceed tobacco and other illicit drug use
    - 31% of 11<sup>th</sup> graders and 14% of 8<sup>th</sup> graders used alcohol in the past month
  - Major contributor to leading cause of death for adolescents
    - motor vehicle crashes, suicides, homicides
  - Is associated with death or serious injury for adolescents due to:
    - poisoning, falls, burns, drown, unwanted/unplanned unprotected sexual activity, violence, and school failure
  - Impact on brain development
    - the use of alcohol for ages 14 and under four times more likely to experience dependence during their lifetime compared to those who start drinking at 19
    - For these reasons, reducing alcohol use among youth was identified as a state priority measure for the Title V Maternal & Child Health Block Grant
  - The evidence for adolescent SBIRT is still accumulating
    - SBIRT for Alcohol use has an “A” rating from the US Preventative Services Task Force and an “I” rating for adolescent for incomplete
  - SAMHSA and American Academy of Pediatrics (AAP) recommend SBIRT within context of routine adolescent health care, with appropriate tools and strategies
    - AAP recommends ensuring appropriate confidentiality screening with a validated tool at every visit with patients 11 and older and responding with brief interventions and referrals when indicated
- Project of this partnership called START (Screening Tools & Referral Training)
  - Goal
    - Increase universal screening, brief interventions, and referral to treatment for depression and substance abuse within the context of an AWV through performance improvement projects among adolescent providers across Oregon

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- While also seeking to improve care coordination across health, mental health, and substance abuse sectors to achieve the ultimate goal of improving adolescent health in Oregon
- Description
  - 2 cohorts of 6-8 clinic sites
  - A variety of clinics were included: pediatric, family medicine, and SBHCs from diverse geographic regions
- Training Model
  - Train entire clinic staff on quality improvement, the science behind the screening tool, and how to use the screening tool
  - Discuss PDSA cycles, work flow and specific goals for practice change, and follow up with clinic staff after training
- Training Context
  - Overview of best practices in AWW
  - Use and scoring of screening tools (CRAFFT and PHQ-A)
  - Brief intervention techniques
  - Implementation/workflows
  - Billing
  - Action planning
  - Face-to-face time with referral entities in the community
- Current Status
  - Training completed for 4 geographic regions and now moving to the learning communities for the next couple of months
    - North Bend Medical, Sisters High School SBHC (St. Charles), Bay Clinic LLC, Siskiyou Pediatric Clinic, Baker High School SBHC, La Pine High School SBHC (La Pine Community Health Center), Crater High School SBHC (La Clínica del Valle), and Treasure Valley Pediatrics.
  - High level of interest and attendance
    - Total Trained: 108 PCPs, 65 clinic staff, and 32 interested clinics and community partners who were also invited to attend
- In Process
  - Prep for the second cohort (*maybe spring 2015*)
  - Focusing on the I-5 Corridor and maybe also in Linn, Benton and Lincoln County
- Challenges and things to consider for second cohort
  - The chart audit was determined the best option for an objective measure, because of the challenges experienced by using billing codes
  - The number of AWWs done last year varied
    - Some practices had very few (lowest was 63 for last year)
  - From the office report tool, it was discovered that many clinics do not have the ability to track scores on screens or get feedback from referral entities

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- This is why the SBHCs only collected the number of screens conducted, because many clinics were also not documenting brief interventions in a standardized way
- Observed Barriers to adolescent SBIRT (similar to adult)
  - Lack of familiarity with screening tools and scoring
  - Lack of training in treatment of substance abuse
  - Lack of knowledge about referral providers in community
  - Concerns around confidentiality (especially with youth)
  - Lack of training in identifying adolescents who are at risk for substance abuse
  - Few sites have standardized, universal procedures for providing one-to-one time with providers during an AWV, as well as screening, referral, and follow-up
  - No sites were able to sort or query EHR data by substance use screening scores
  - Adolescent screening tools (e.g. CRAFFT) not built into OCHIN Epic SBIRT template
- Post-Survey Responses
  - People mentioned what they really want is training around conducting a brief intervention with adolescents
    - 34 clinics contacted them requesting them to come out and do a training session
- Provider perspective (Dr. Carla McKelvey):
  - What is a success?
    - Electronic versions of CRAFFT and PHQ9 are now imbedded into all AWVs
  - What has been a challenge?
    - Biggest barriers were incorporating it into their electronic medical records (EMR)
    - Went back and pulled charts to see the % who were actually doing the screenings
      - The number of those doing screenings was very high (many went from 0% to 70%), but with the exception of the pediatricians, none of them were billing for it, so the billing data documentation was inadequate to identify if the screenings had been done
      - They reemphasized that the best way to communicate is through the billing data
      - Collaborating with IT, working with pediatricians, and reemphasizing what was done in the training
    - Change in progress
      - Create a transition plan, so that as kids are getting older, both they and their parents are prepared for the visits to soon be just between the pediatrician and the patient
        - They are still working on getting this into writing
      - Paper forms are given out in the waiting rooms so they can be on the chart when the pediatricians come in
        - We need to look at this process and try to have those things happen in the room when the patient is by themselves

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- Adolescent vs. Adult SBIRT: What's the difference?
  - Screening tools and administration:
    - Where will adolescent fill out screen?
    - Is private time with the provider standard for each well visit?
  - Brief Intervention:
    - Drinking is legal for adults over 21.
    - Directive on recommendation to not use at all, but leaving the decision with the youth
  - Lack of substance abuse services for adolescents in many communities
  - Billing and coding
    - Same challenges as adult population related to measurement
    - Added layer of confidentiality issues; patient confidentiality can be broken by Explanation of Benefit, MyChart, or other visit communication sent to member
- Recommendations for successful adolescent SBIRT:
  - Practices should have standard policies/practices related to AWV
    - Private time with provider
    - Clear confidentiality statements
  - Providers need training and support to implement SBIRT workflows
  - Practices must work in close concert with referral entities
    - Face-to-face time during training has been some of the most beneficial work.
  - Adolescent screening tools should be integrated into EHR systems
  - Practices should have the ability to suppress member communications and to modify online portals to protect information related to substance use screening that could jeopardize confidentiality
- For questions or more information, contact:
  - Liz Thorne, Adolescent Health Policy & Assessment Specialist, Public Health division:
    - Email: [Elizabeth.k.thorne@state.or.us](mailto:Elizabeth.k.thorne@state.or.us)
    - Phone: 971-673-0377
  - Stefanie Murray, School Mental Health Specialist, Public Health division:
    - Email: [Stefanie.l.murray@state.or.us](mailto:Stefanie.l.murray@state.or.us)
    - Phone: 971-673-1088
  - Peg King, START Program Manager, OPS:
    - Email: [Margaret.king@oraap.org](mailto:Margaret.king@oraap.org)
    - Phone: 503-334-1591x101

#### Discussion:

The group discussed paring the SBIRT and depression screening with the AWVs, and how this services is a good time to screen. Although this work has been done in many ways throughout the years, capturing the screening services in a way that reflects that work is a challenge. It was highlighted that the adolescent workflow will most likely be different from adult workflows. Getting adolescents to follow through with entering into treatment has especially been difficult, although adults too have a difficult time following through with referrals.

We also discussed the evidence supporting adolescent SBIRT services that is still incomplete, with few studies supporting it right now and yet promoting the value of screening because of the health issues at stake. Issues such as confidentiality, privacy, and access to records are continuing challenges to determine clear solutions.

### **Umpqua Health Alliance SBIRT Electronic Medical Record Example**

After studying the tools needed and interviewing area providers about their workflows, Umpqua developed a EHR that embedded the SBIRT process within it. They combined four areas of screening into the nurse's intake form that highlights in yellow if the screening is coming up and in red if it is due or overdue:

- Tobacco
- Alcohol
- Drugs
- Depression

Some elements that they incorporated into this process are:

- Graphics of drinks in color
  - Beer, wine and martini symbols that draws attention to the screening section
  - This was significant because the section was being missed before the graphics were added
- If yes was answered to brief screening, then the full screen would pop-up for each area
  - Only information that is needed is shown and only one element is shown at a time
  - Potentially, each workflow is shaped a little differently for each patient depending on what area of concern is needing further screening
  - If patients completed the screening before, the previous screen's scores pop-up as a historical reference and comparison
  - If a referral needs to be facilitated, a release pops-up
  - Billing pop-ups occurs depending on what the service was and how long, with reminders of diagnostic choices in reference to the screen
- A variety of staff facilitate the screening process, from physicians to medical assistants
- Adolescent SBIRT workflows are still being worked out, although much of the information is in the EMR
  - Another adolescent screening process is in the EMR right now but the CRAFFT is being developed
- Implementation challenges and resolutions
  - Initially, some physicians were hesitant but are growing to see the screeners and behavioral health clinicians has resources
  - Physicians are getting a lot of "no" answers to questions
    - Training is being considered to help physicians with asking screening questions
    - Strategies about how to ask about opiate medication misuse

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- Physicians are ending up seeking out behavioral health specialists more often because of their effectiveness
  - At times, the behaviorist is being pulled into the exam room before the physician gets there due to triggers in the screening process
    - Whether this is due to general indicators or to specific results from the screening process is unknown
- Systemically, their region has an Alcohol Awareness Month in December
  - This made it easier to ask screening questions because it was the program driving it

Discussion:

The group discussed how some EMRs are being developed with this type of cascading forms and prompts but it largely depends on IT departments supporting these additions and edits, which takes resources in personnel and money for programming. There are challenges in various regions when there are a number of different EMRs, so standardizing a process or an EMR form becomes challenging.

**Action Plan Summary**

- **Michael** will
  - email the group meeting day/time options to reach decision on a consistent meeting schedule for future work group sessions
  - welcomes any who are interested in developing their EMR to better support SBIRT
  - will explore how to edit the webinar recording for possible archiving of today's presentations
- **Jim** will
  - email the group the link to the SBIRT Oregon website to view the forms
  - ask OCHIN for permission to share the manual
  - follow up with John on any other information that he can share with the group
- All can call **Michael or Sarah** with questions

**Next meeting will most likely be October 31 from 9:00 – 10:30 a.m. and will be announced when the notes are sent out.**