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IAP Medicaid Innovation Accelerator Program

Medicaid Innovation Accelerator Program (IAP)

IAP Learning Collaborative: Substance Use Disorders (SUD)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Primary Care Settings

Targeted Learning Opportunity #4

6/8/15

Logistics Placeholder

Facilitator

- **Cathy Fullerton, MD, MPH**
- Senior Research Leader, Truven Health Analytics

TRI Science Addiction

Speakers (1 of 4)

- **Adam Brooks, PhD**
- Senior Research Scientist, Treatment Research Institute

TRI Science Addiction

Speakers (2 of 4)

- **Peggy Bonneau**
- Director, Health Initiatives, New York State Office of Alcoholism & Substance Abuse Services

Oregon Health Authority

Speakers (3 of 4)

- **Michael Oyster, LPC, CADC III**
- SBIRT Specialist, Oregon Health Authority

Speakers (4 of 4)

- **John Muench, MD, MPH**
- Associate Professor; Director of Behavioral Medicine for the Department of Family Medicine, Oregon Health and Sciences University
- Director, SBIRT Oregon Primary Care Residency Initiative

Agenda

- What is SBIRT?
- Evidence for SBIRT
- Opportunities for increasing SBIRT uptake
- State experience: New York
- State experience: Oregon

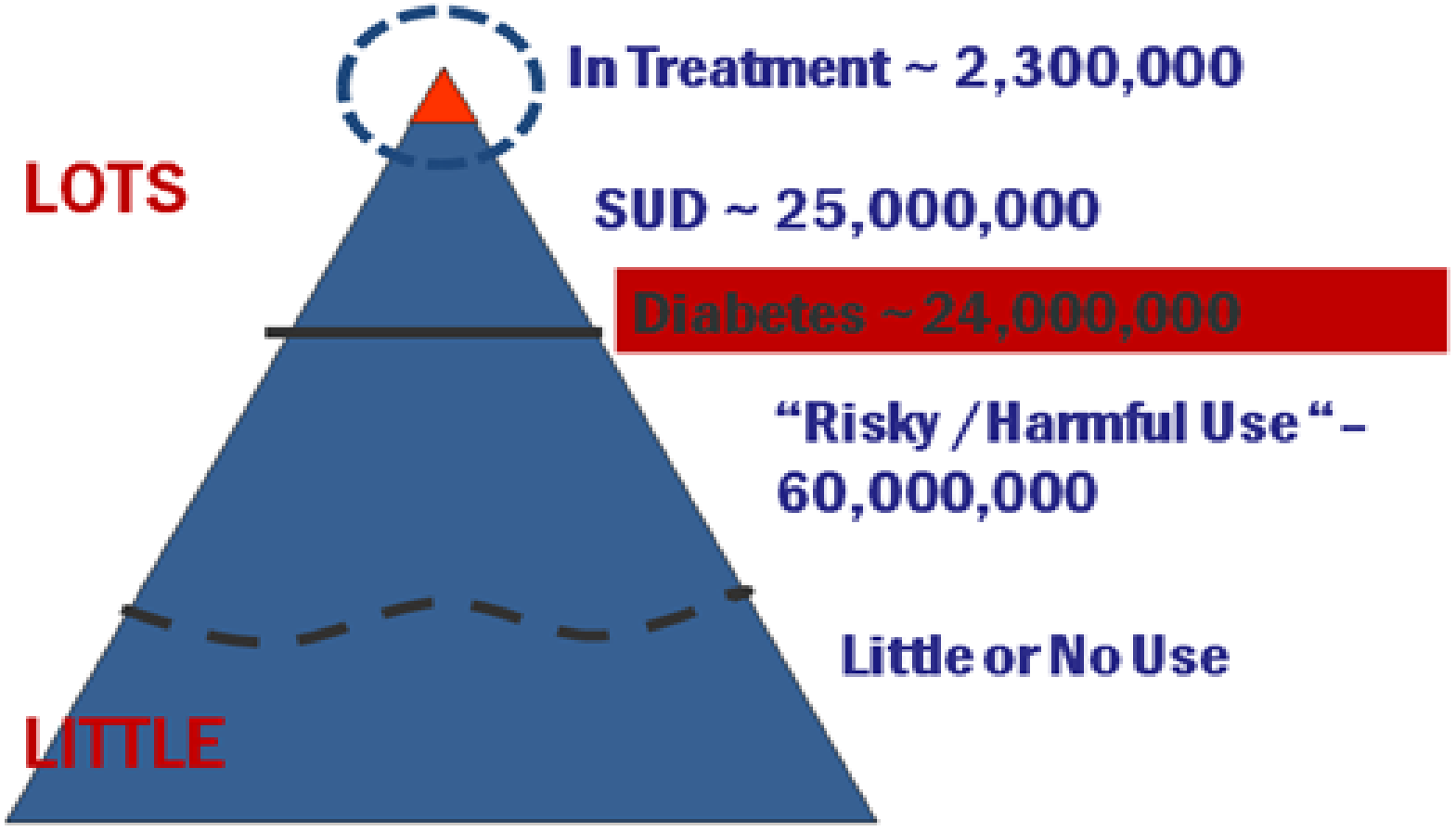
Goals of Webinar

- Participants will better understand how SBIRT can benefit risky alcohol users
- Participants will grasp the evidence limits around SBIRT interventions
- Participants will be lead through a discussion of financial, workflow, and perception barriers of SBIRT
- Participants will examine a case study example of SBIRT implementation in Oregon

Section 1

Overview of SBIRT

Pyramid


In Treatment ~ 2,300,000
LOTS
SUD ~ 25,000,000
Diabetes ~ 24,000,000
"Risky / Harmful Use" – 60,000,000
Little or No Use
LITTLE

U.S. Population Risk Prevalence

No Alcohol Use	42%
Low Risk Alcohol Use	39%
Risky Alcohol Use	14%
High Risk Alcohol Use	3%
Severe Risk Alcohol Use	2%

Screening: Who are We Looking for?

- Not just the “addict”– but the “at risk”, such as:
  - Young adults periodically binging
  - Individuals who are rarely intoxicated but do consume outside safe limits
  - Those whose drinking is slowly increasing
  - Individuals with health conditions who should slow down
  - Recreational illicit drug users

- Detecting severe users who NEED treatment

SUDs and Chronic Health Problems

- SUDs related to increased risk:
  - Hypertension, heart failure, etc.
  - Renal and GI (liver failure, cirrhosis, Hep B and C, kidney failure)
  - Neurological (stroke, ischemic events, TBI)
  - Pulmonary (pneumonia, edema, TB)
  - Perinatal, postnatal complications
  - Endocarditis
  - HIV transmission
  - Mental health problems (depression, bi-polar disorder)

What is SBIRT?

- **S**creen Everyone for Risk in Primary Care
- **B**rief **I**ntervention (for those at Risk)
  - Give Feedback
  - Be Empathic
  - Give Advice / Offer a Menu of Change
- **R**eferral To **T**reatment (for Severe Risk)
  - Brief Treatment
  - Specialty Care / Detox / Rehab

Real-time Screening and Intervention

- Broad to focused screening / assessment
  - Brief screener (AUDIT-C / DAST-1 / Single ?)
  - Full screener (AUDIT / DAST / ASSIST)
- Who does the screening? And how?
  - Pencil and paper?
  - Medical Assistant / Provider Interview?
  - Automated electronic input – linked to EHR?
- Timing of Screening
  - Annual visits, new patient visits
  - Every visit

Brief Intervention: FRAMES

- **F**eedback (normative perspective)
- **R**esponsibility (patient's choice)
- **A**dvice (cut back or quit)
- **M**enu of Options (different quit strategies)
- **E**mpathy (take patient perspective)
- **S**elf-Efficacy (support patient ability)

Basic SBIRT Model

- Assess **2-3 min**
- Advise (Feedback) **1-2 min**
- Agree (Responsibility, Empathy) **3-5 min**
- Advise 2.0 (Advice, Menu of Options) **1-2 min**
- Assist (Support Self-Efficacy) **2-3 min**
- Arrange
- **Total** **9-15 min**

- *But – a busy provider can shorten it if equipped with good referrals and a practiced strategy!*

Brief Intervention: Feedback

Brief Intervention: Education

- What is a Drink?
- NIAAA Drinking Limits
  - Men – On average, no more than 2 drinks per day, no more than 14 per week, and no more than 4 on an occasion.
  - Women – On average, no more than 1 drink per day, no more than 7 per week, and no more than 3 on an occasion.

Treatment Referral

- Most difficult aspect of SBIRT intervention
- Providers unaware of solid treatment options
- Difficulty getting patients to follow-up
- Leaves the perception of failure with the most difficult patients

Evidence: SBIRT for Alcohol Use

- Three decades of research supporting the efficacy of brief intervention for alcohol
  - Strong evidence for BI in primary care and office based settings
  - Mixed / weak evidence for BI in hospitals and Eds
    - (i.e, earlier studies were strong but flawed)
- BI is effective for “at risk” and “risky” drinkers
  - Brief multiple contacts appear to exert the best effect (3-4)
  - Few drinks, drinking days, and safer drinkers
  - Fewer hospital days
- BI does not seem to be effective for “severe” drinkers

Evidence: SBIRT for Drug Use

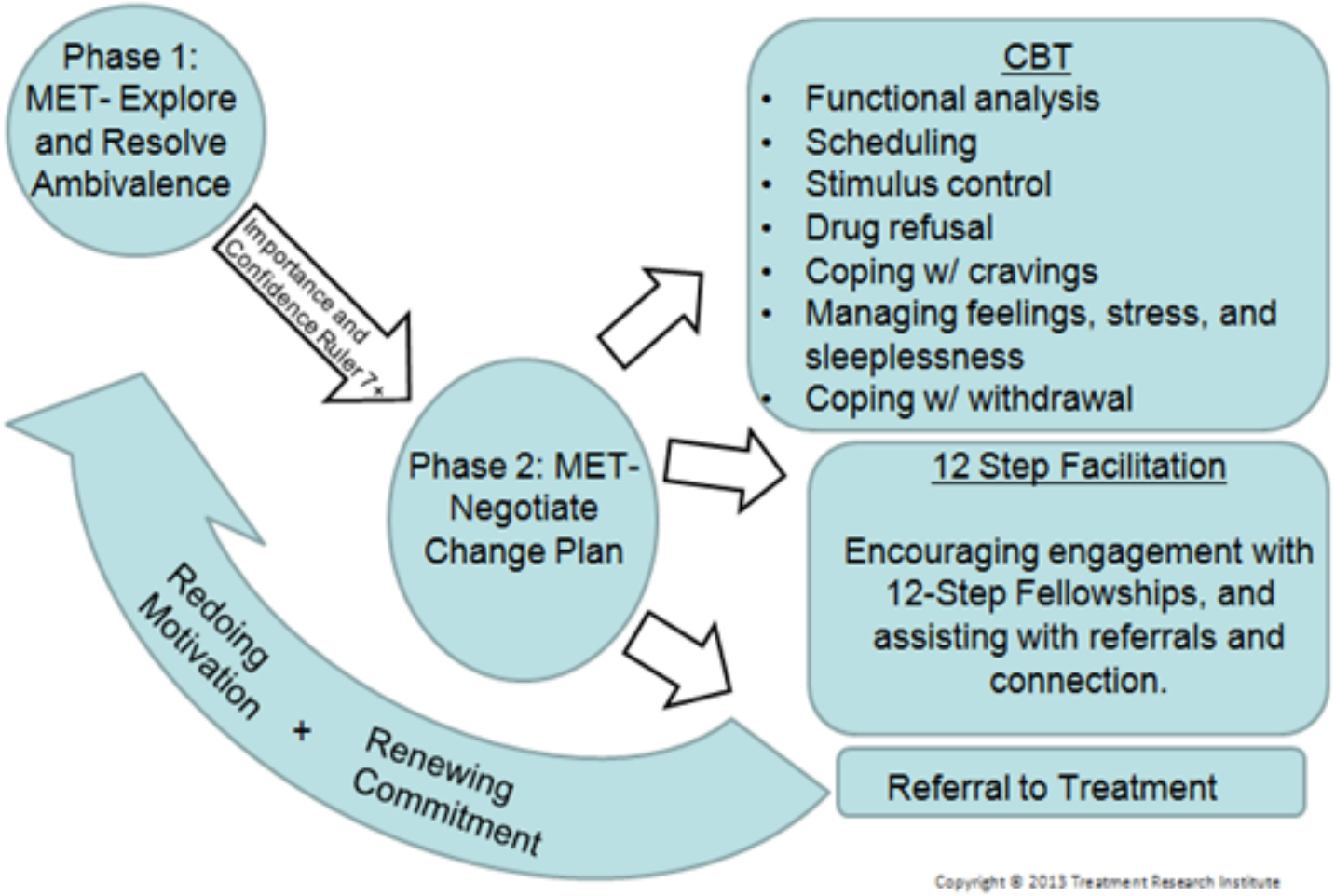
- Weak evidence for 1-session BI for drug use
  - Controlled studies show limited efficacy:
    - Screen only vs. Screen + BI
    - Screen + printed info vs. Screen + BI
  - Most recent rigorous designs = no effect
- Some indication that participation in more intensive interventions (more than one consult) yields better results

What is SBIRT+?

- Increasing patient access to on-site change strategies
  - Patients may need a little more help executing change
  - Barriers to accessing referrals

- Features of SBIRT +
  - 2-6 on-site consults, based on patient need
  - Phase 1: Motivational Enhancement Therapy
  - Phase 2: Brief quit / reduction strategies
    - Cognitive Behavioral / Relapse Prevention
    - 12-Step Facilitation
    - Referral to Specialty Care for Sever Users with Case Management Follow-up

Ongoing Coaching / Support



Questions and Discussion (1)

Section 2

Opportunities to Effectively Implement SBIRT

Why Limited Uptake of SBIRT?

- Past implementation efforts in the context of research and provider grants
  - Grant dries up, SBIRT dries up
  - Must generate revenue OR reduce, not add to, provider hassle
- Opportunities in multiple areas to improve uptake of SBIRT
  - Financial
  - Workflow
  - Perception

Financing Barriers

- Payers may or may not reimburse for SBIRT
- Clinicians may perceive that reimbursement rates for SBIRT are not worth the hassle
- Cost effectiveness of SBIRT is not felt at the primary care level

SBIRT Codes & Fee Ranges

Medicaid Code	Purpose	Fee Range (USD$)	# States with Open Codes
99408	Alcohol and/or substance abuse structured screening and brief intervention services: 15-30 minutes	14.00-60.22	18
99409	Alcohol and/or substance abuse structured screening and brief intervention services: >30 minutes	27.60-117.57	17
H0049	Alcohol and/or drug screening	14.35-35.35	11
H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	16.15-65.55	12

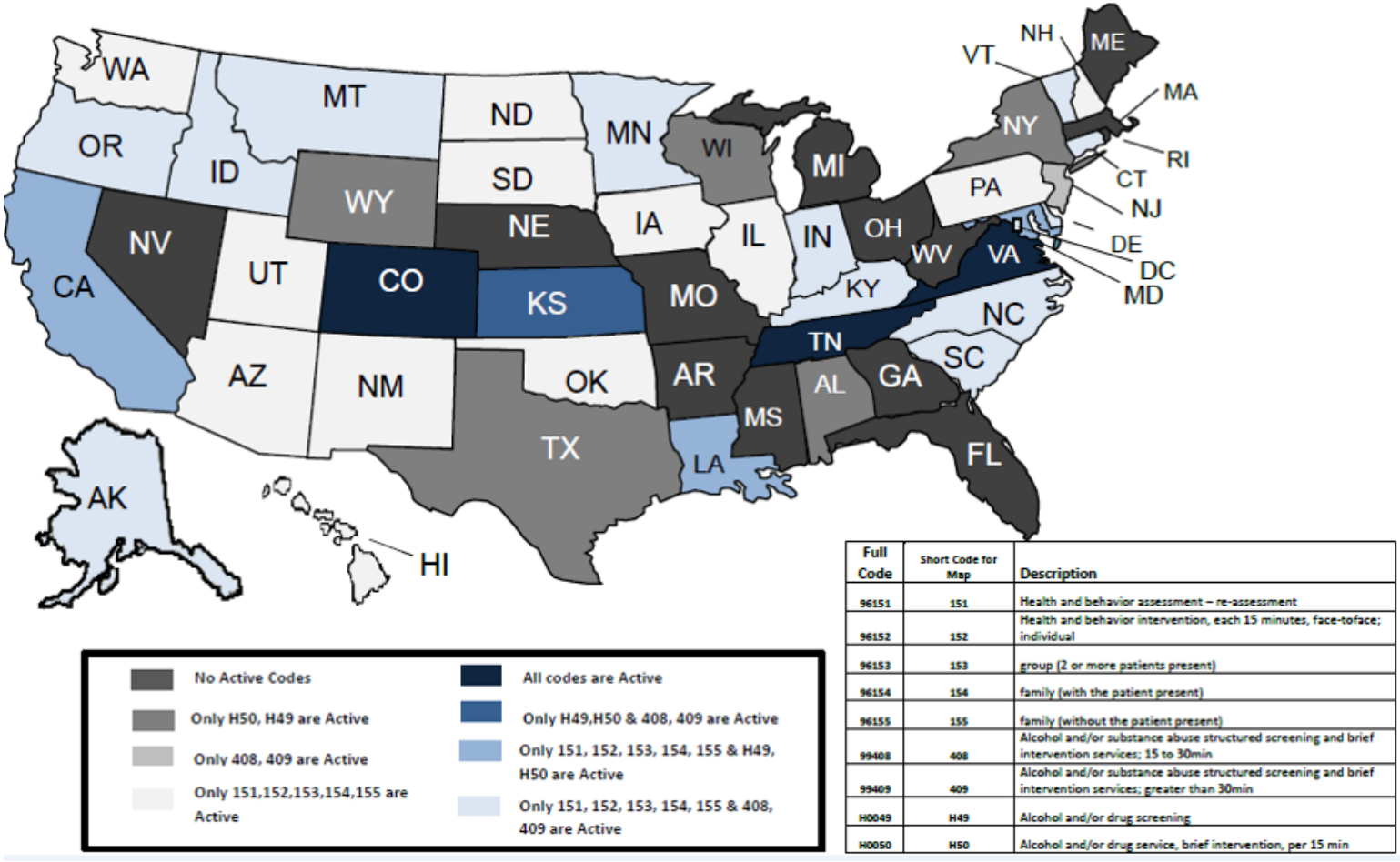
Source: Institute for Research, Education & Training in Addictions, SBIRT Reimbursement

Health and Behavior Assessment Codes & Fee Ranges

Medicaid Code	Purpose	Fee Range (USD$)	# States with Open Codes
96151	Health and behavior assessment/re-assessment	7.16-30.95	30
96152	Health and behavior intervention, individual, face-to-face, per 15 minutes	5.30-26.25	27
96153	Group intervention (≥ 2 patients present)	2.76-18.96	28
96154	Intervention with family and patient	10.90-28.83	27
96155	Intervention with family, patient not present	13.62-30.15	16

Source: Institute for Research, Education & Training in Addictions, SBIRT Reimbursement

States that Reimburse SBIRT Codes



Full Code	Short Code for Map	Description
96151	151	Health and behavior assessment – re-assessment
96152	152	Health and behavior intervention, each 15 minutes, face-toface; individual
96153	153	group (2 or more patients present)
96154	154	family (with the patient present)
96155	155	family (without the patient present)
99408	408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min
99409	409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min
H0049	H49	Alcohol and/or drug screening
H0050	H50	Alcohol and/or drug service, brief intervention, per 15 min

Source: Institute for Research, Education & Training in Addictions, SBIRT Reimbursement

Addressing Financial Barriers

- Turn on SBIRT codes
- Examining payment rates relative to other prevention efforts (e.g., tobacco use screen, depression screen)
- Evaluation of providers permitted to provide SBIRT
- Encourage uptake in settings such as FQHCs where increasing the opportunity for behavioral health interventions makes strong fiscal sense to provider
- Incentive payments
  - Recognize that SBIRT reimbursement may not entice
  - Tying incentives to “quality care” - such as universal screening

Workflow Barriers

- SBIRT implementation takes time
- PCP's under mandate to screen for multiple conditions
- Limited referral options for BI (brief intervention) or RT (referral to treatment)
- Self-administered / self- scoring screening instruments are more attractive

Addressing Workflow Barriers

- Develop partnerships
  - Agency partnerships (SSAs, Academic)
    - See the Massachusetts ED SBIRT Initiative webpage -- Massachusetts' Boston College Effort
  - Primary care referral pathways
    - See Colorado's PC Referral Network
- Incorporate SBIRT screening, intervention pathways, and referral pathways into EHRs and population-based registries
  - Put the single question screeners right in the EHR
  - Attach educational PDFs to intervention tabs

Addressing Workflow Barriers, cont'd

- Encourage the use of paraprofessionals for SBIRT
  - Effects are stronger when nurses and behavioral health specialists provide BI (will spend more time, can follow-up)
  - Frees physician time
  - Requires initial training and ongoing support to build paraprofessional skills and integration of SBIRT into clinical flow
- Example – The Christiana "Concierge" Model
  - Embedded Peer Specialists in hospital and ED
  - Intervene with patients to encourage SUD treatment
  - Address other medical provider concerns
    - Reduction of "slip and fall" in ED

Perception Barriers

- Primary care clinicians are often unaware of SBIRT
- Clinicians do not believe their patient caseload has problems with substances
  - They “detect” only the highly problemed patients
- Clinicians are not confident regarding their ability to provide brief intervention (BI)
- Clinicians erroneously believe that SUD treatment doesn’t work

Addressing Perception Barriers

- Clinician and practice education
  - Sponsor training and dissemination of SBIRT
    - Link SUD to medical problems
    - Increase comfort with SBIRT
  - Encourage communication with main SUD providers and persons in recovery
- Perception Management – Colorado Example
  - Engaged numerous partners
    - Providers
    - The SSA, Office of the Governor, and Behavioral Health Associations
    - Peer Networks
    - Academic Institutions

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New York

Implementing SBIRT at the State-Level

Peggy Bonneau, Director, Health Initiatives,

NYS Office of Alcoholism & Substance Abuse Services

Provider Types Who Are Eligible to Bill for SBIRT Services (1 of 4)

- Provider Type: Required OASAS Approved Training/Certification
- Physicians:
  - Services may be performed by another provider type while under the supervision of the physician
  - 4 hours
    - Unless certified by the American Society of Addiction Medicine, the American Board of Ambulatory Medicine, the American Academy of Addiction Psychiatry, or the American Academy Osteopathic Association

Provider Types Who Are Eligible to Bill for SBIRT Services (2 of 4)

- Nurse Practitioners:
  - 4 hours
    - Unless qualified as a Certified Addictions Registered Nurse (CARN)
- Psychologists:
  - 4 hours

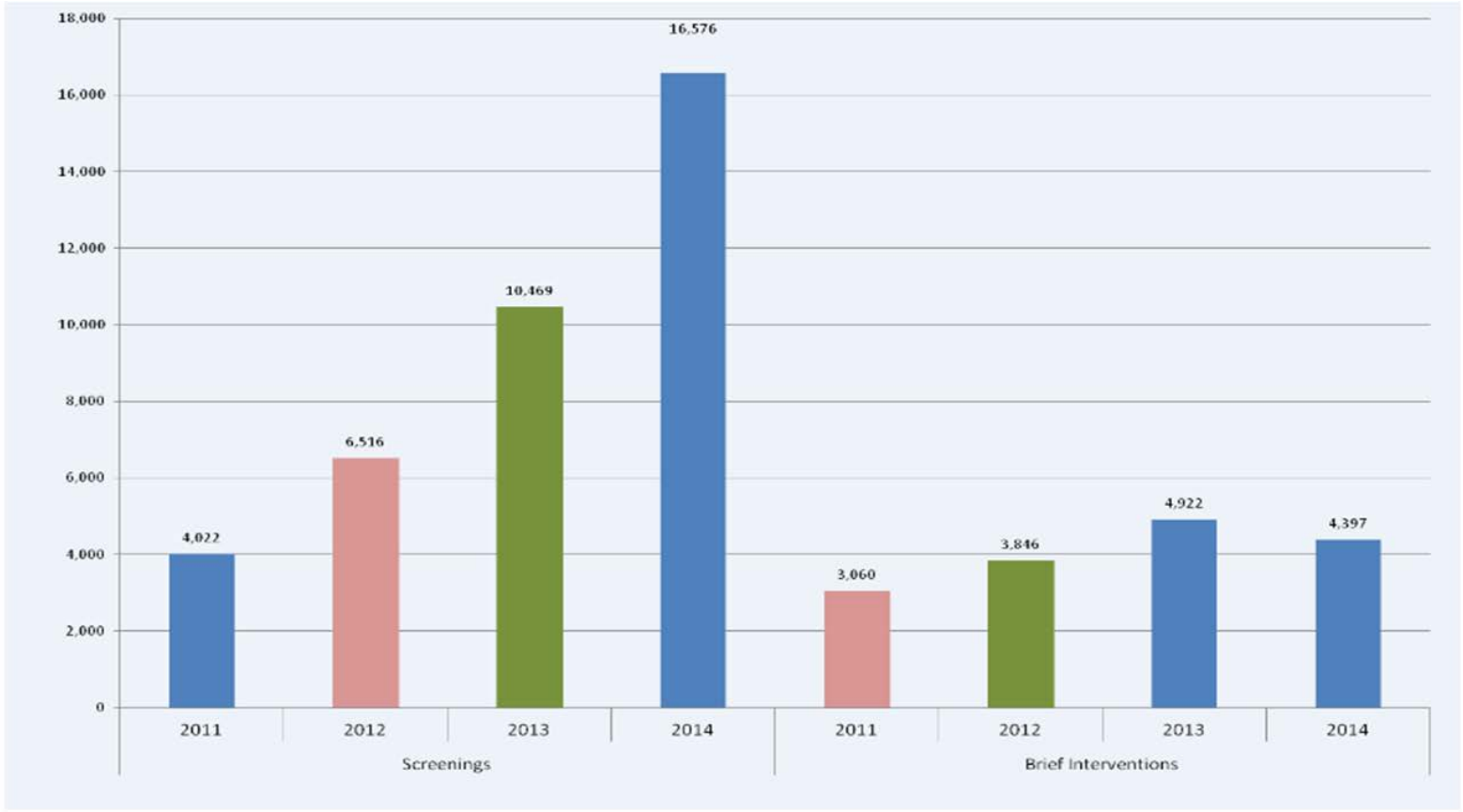
Provider Types Who Are Eligible to Bill for SBIRT Services (3 of 4)

- Provider types requiring 4 hours:
  - Physician Assistants
  - Registered Nurses (unless CARN qualified)
  - Licensed Practical Nurses
  - Licensed Master Social Worker/Licensed Clinical Social Worker
  - Licensed Mental Health Counselors
  - Licensed Marriage and Family Therapist
  - Certified School Counselor
  - OASAS-credited professionals including Credentialed Alcoholism and Substance Abuse Counselors (CASACs), Credentialed Prevention Professionals (CPPs), Credentialed Problem Gambling Counselors

Provider Types Who Are Eligible to Bill for SBIRT Services (4 of 4)

- Provider types requiring 12 hours:
  - Health Educators
  - Unlicensed individuals
- These individuals may only provide SBIRT services under the supervision of a licensed health care professional, following consistent protocols

Number of SBIRT Screenings and Brief Interventions Per Calendar Year



Source: Salient Interactive Data Miner - - June 01, 2015

Promoting SBIRT in New York

- Raising awareness with managed care organizations
- Integration
- Raising awareness
- Working with Performing Provider Systems (PPS) and Delivery System Reform Incentive Payment (DSRIP) program
- Training

Questions and Discussion (2)

Oregon: Part 1

Part 1. Implementing SBIRT at the State-Level

Michael Oyster, LPC, CADC III, SBIRT Specialist, Oregon Health Authority

Overview

- How SBIRT fits into the CCO structure
- The ramp up of SBIRT
- Where are we now
- What it will take to fully implement SBIRT

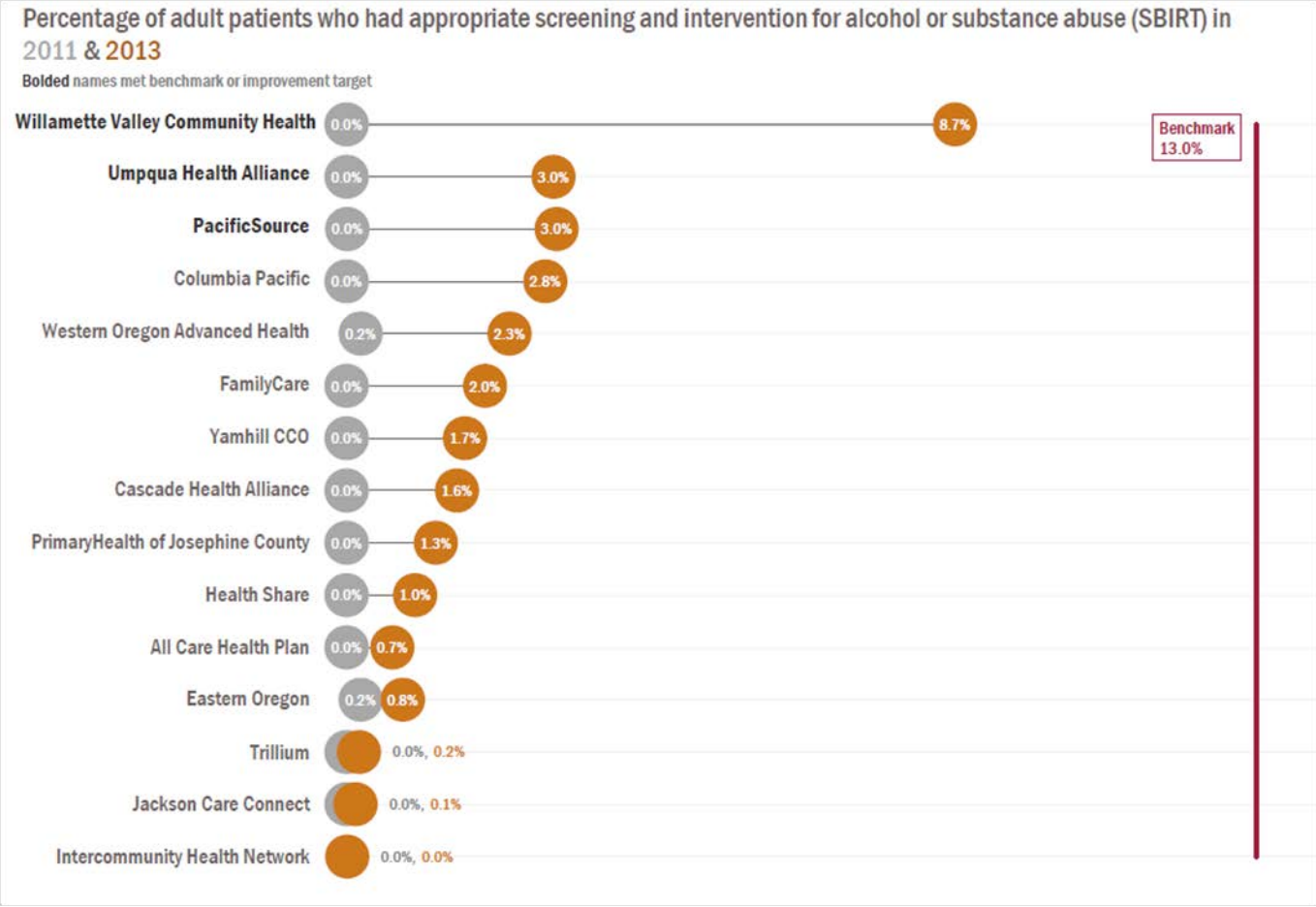
SBIRT in the CCO Structure

- SBIRT is 1 of 17 measures that CCOs are accountable to the Oregon Health Authority
- If the 3 percentage point improvement target toward the benchmark is met for SBIRT, then the CCO can receive an incentive payment for that measurement year
- Benchmarks
  - 2013-2014: 13%
  - 2015: 12%

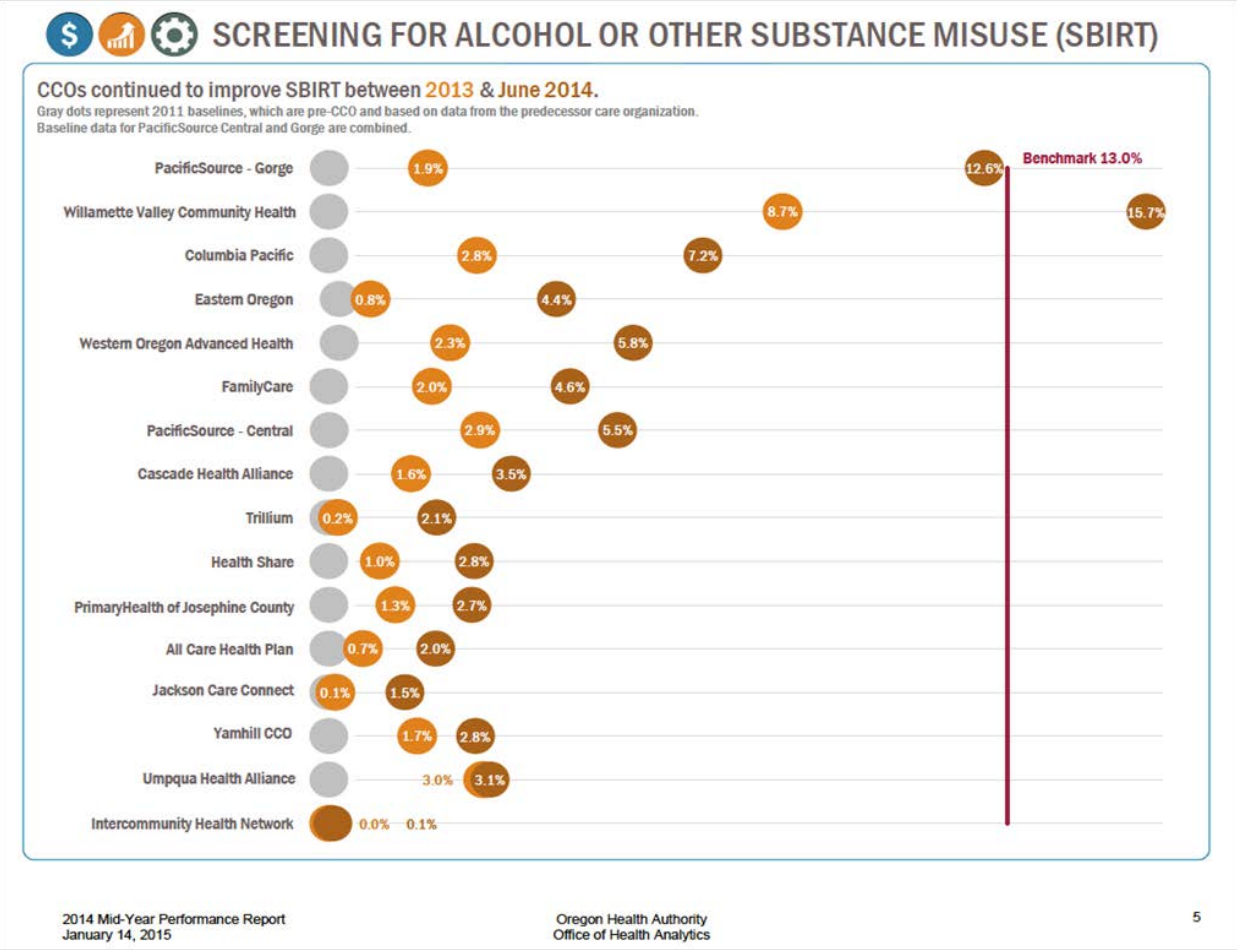
Where Does the Incentive Payment go?

- Some CCOs pass this incentive straight through to participating clinics
- Other CCOs hold a percentage for infrastructure development
  - EHR forms for SBIRT
  - Motivational Interviewing training
  - Referral system coordination

Where We Started

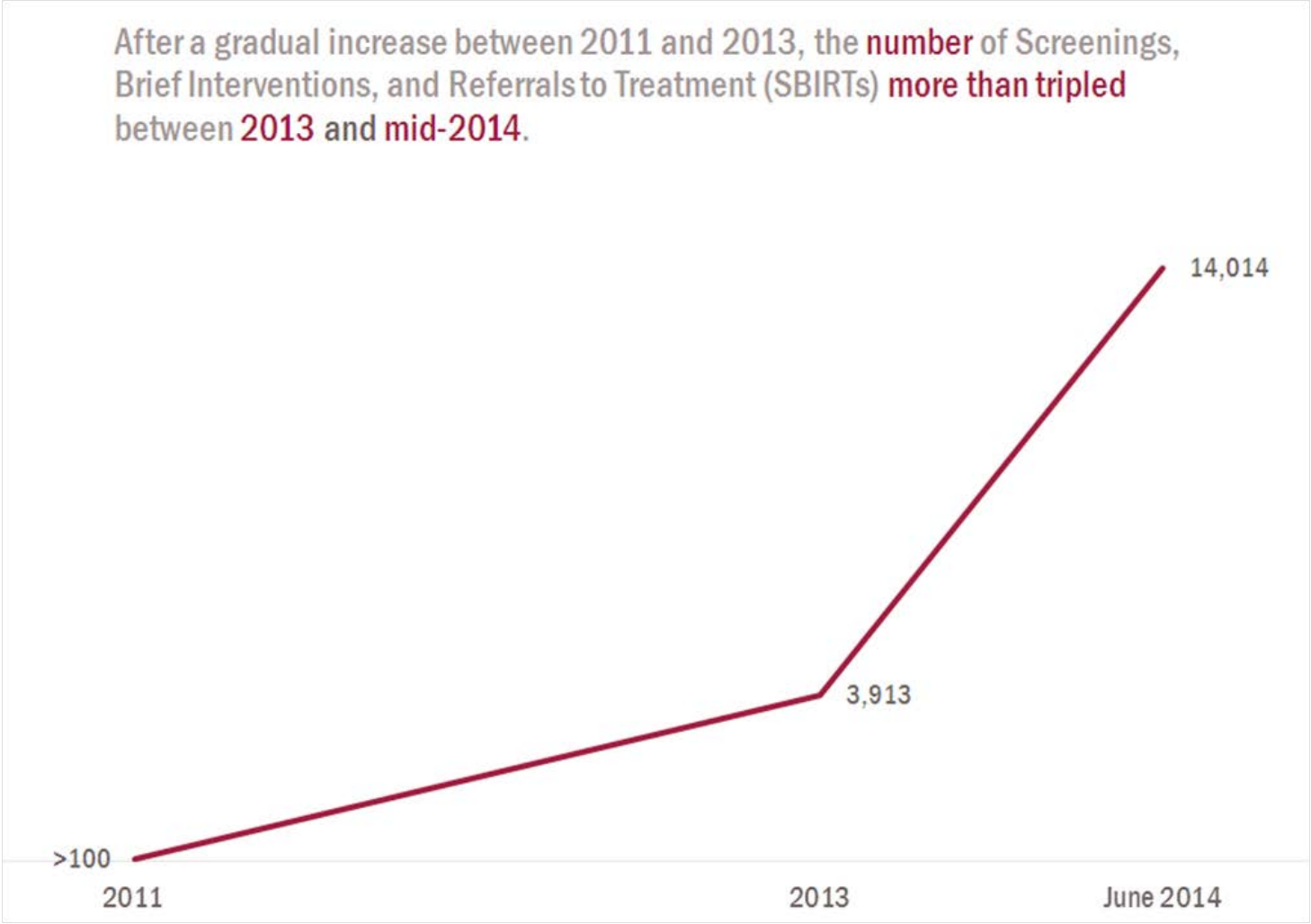


Where We Are Going



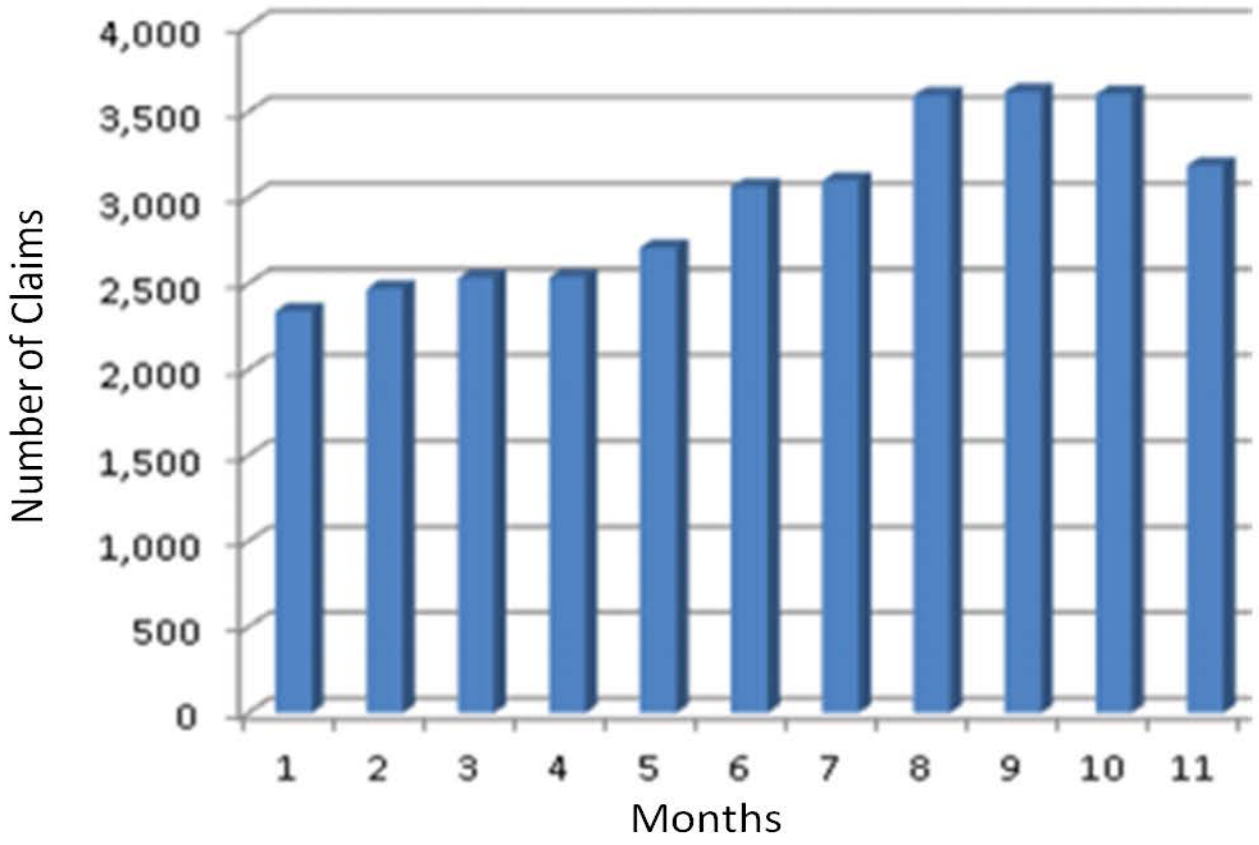
The Number of Services

After a gradual increase between 2011 and 2013, the **number** of Screenings, Brief Interventions, and Referrals to Treatment (SBIRTs) **more than tripled** between **2013** and **mid-2014**.



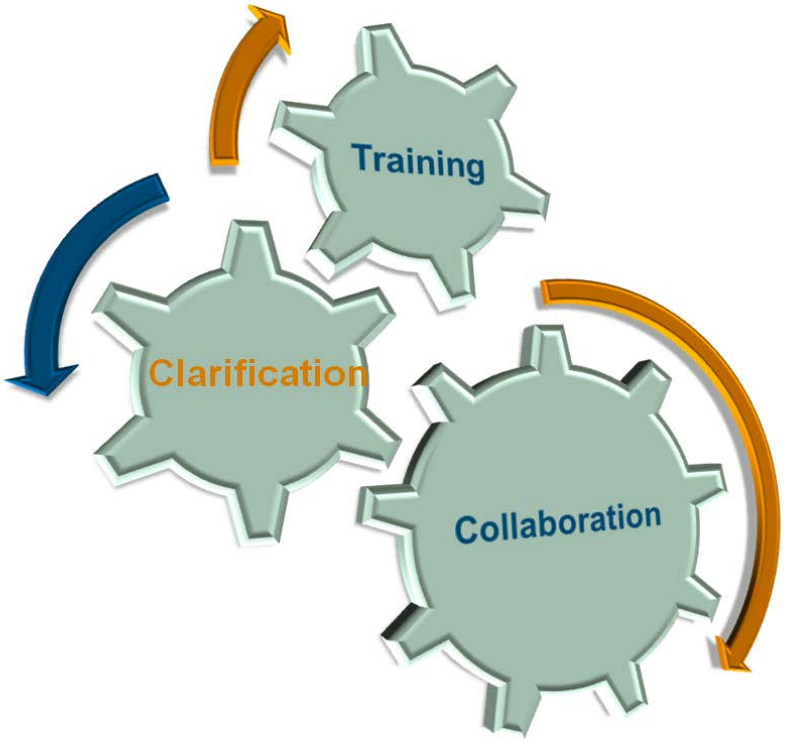
Where We Are Now – SBIRT Claims

Number of SBIRT Claims per Month over the Last Rolling Year (raw data)

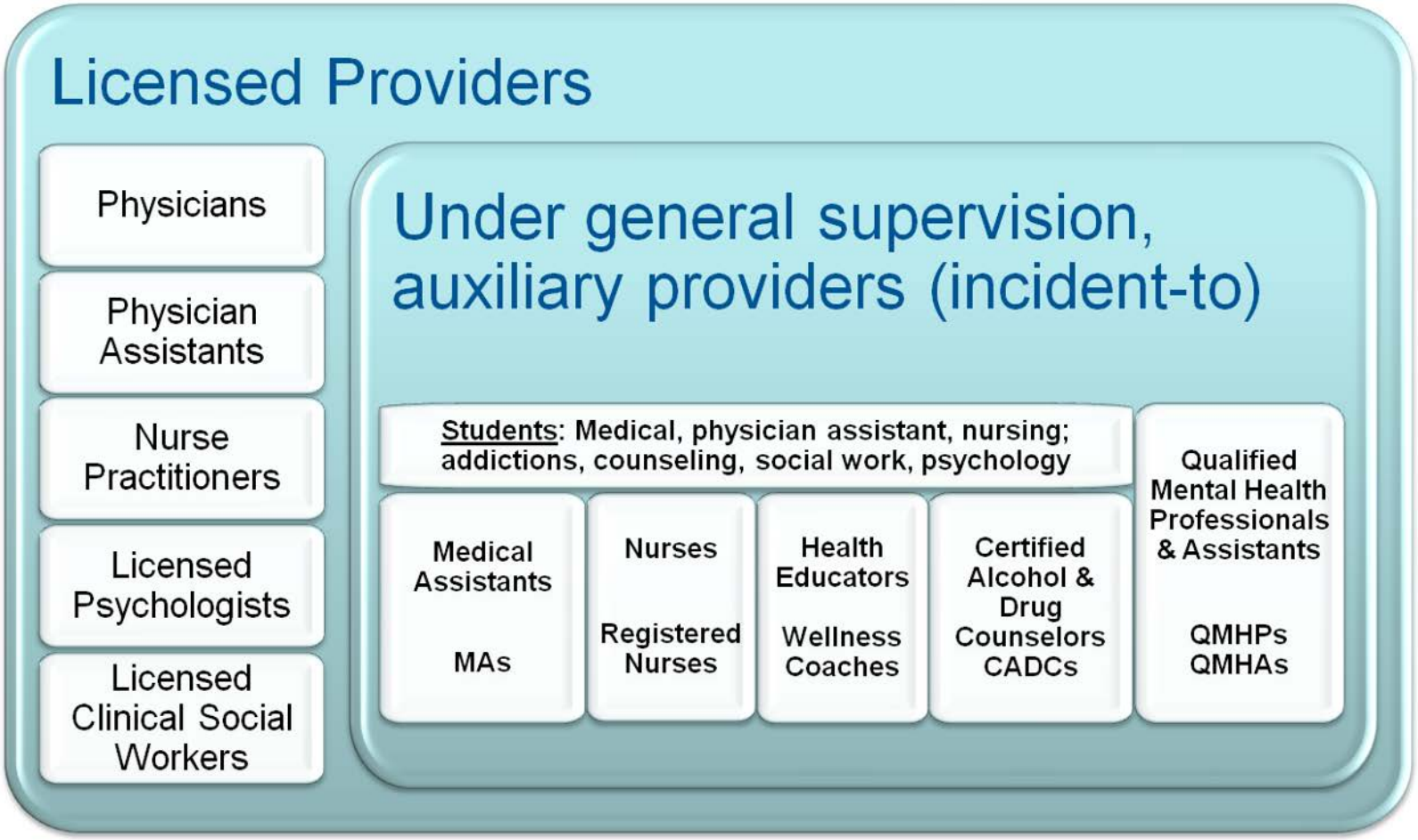


Estimated total of SBIRT Claims: 33,462 (31,056 people)

Strategies for Implementation

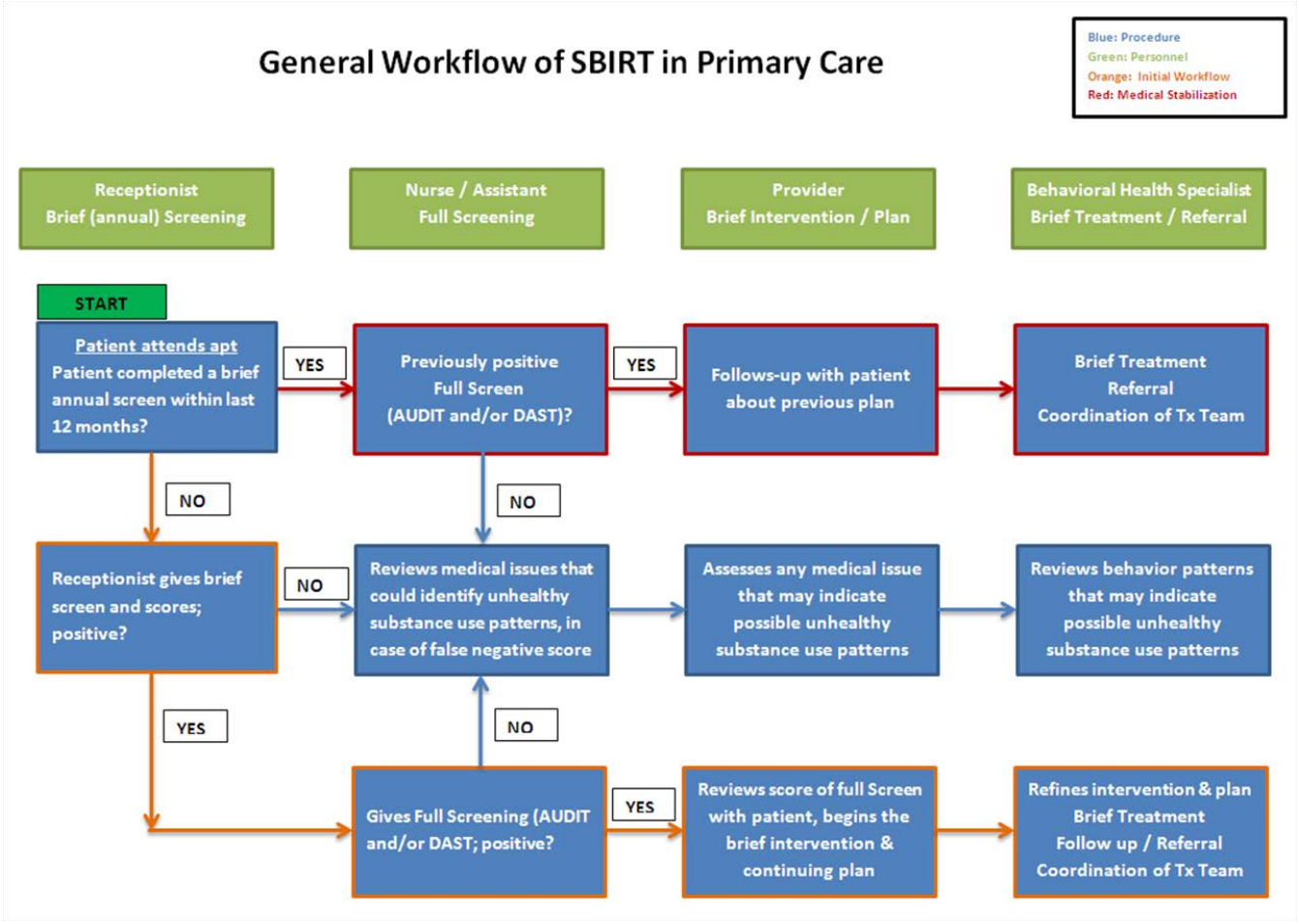


Example Guidance Forms: Qualifications for Providers

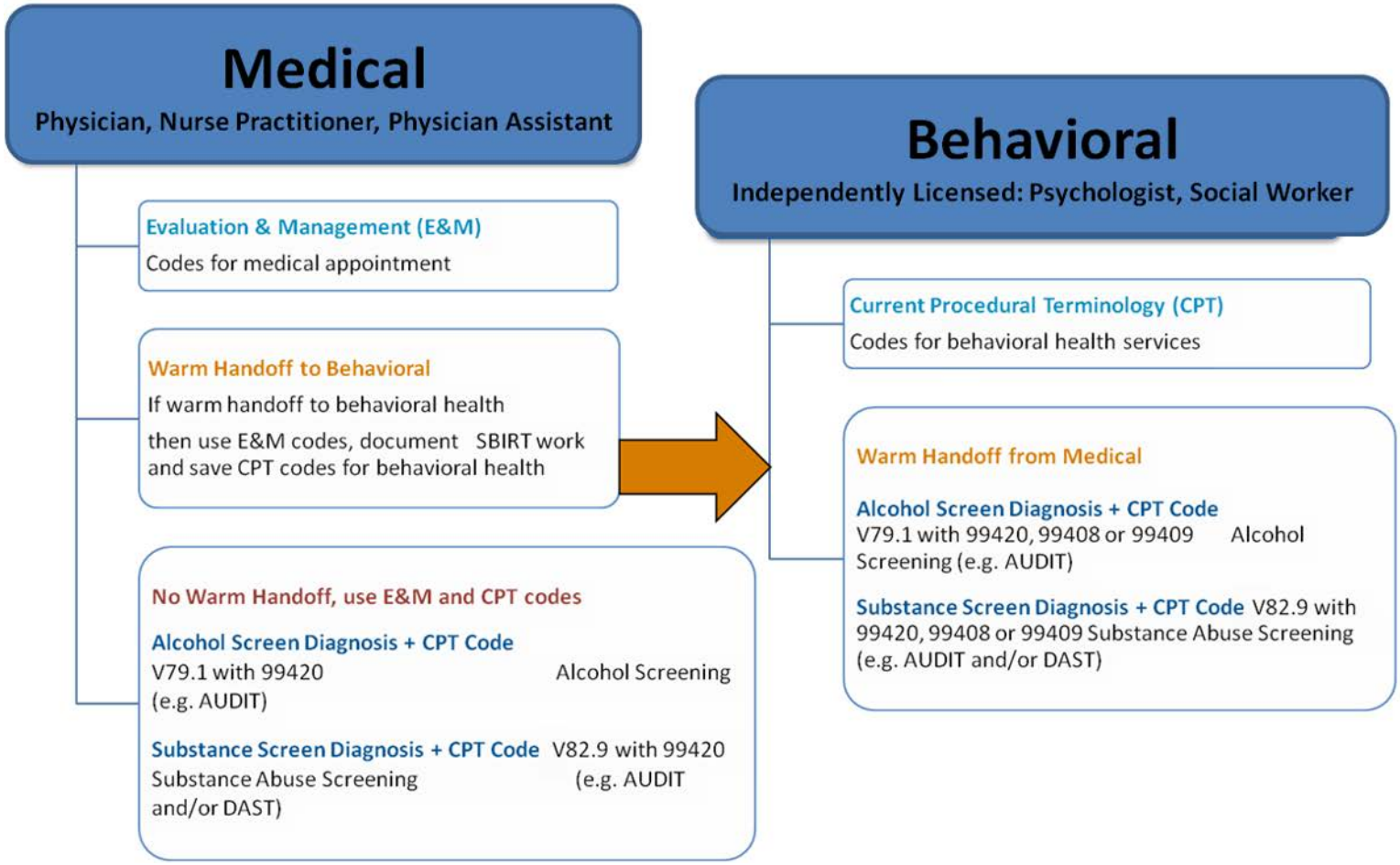


Source: SBIRT Guidance Document

General Workflow of SBIRT in Primary Care

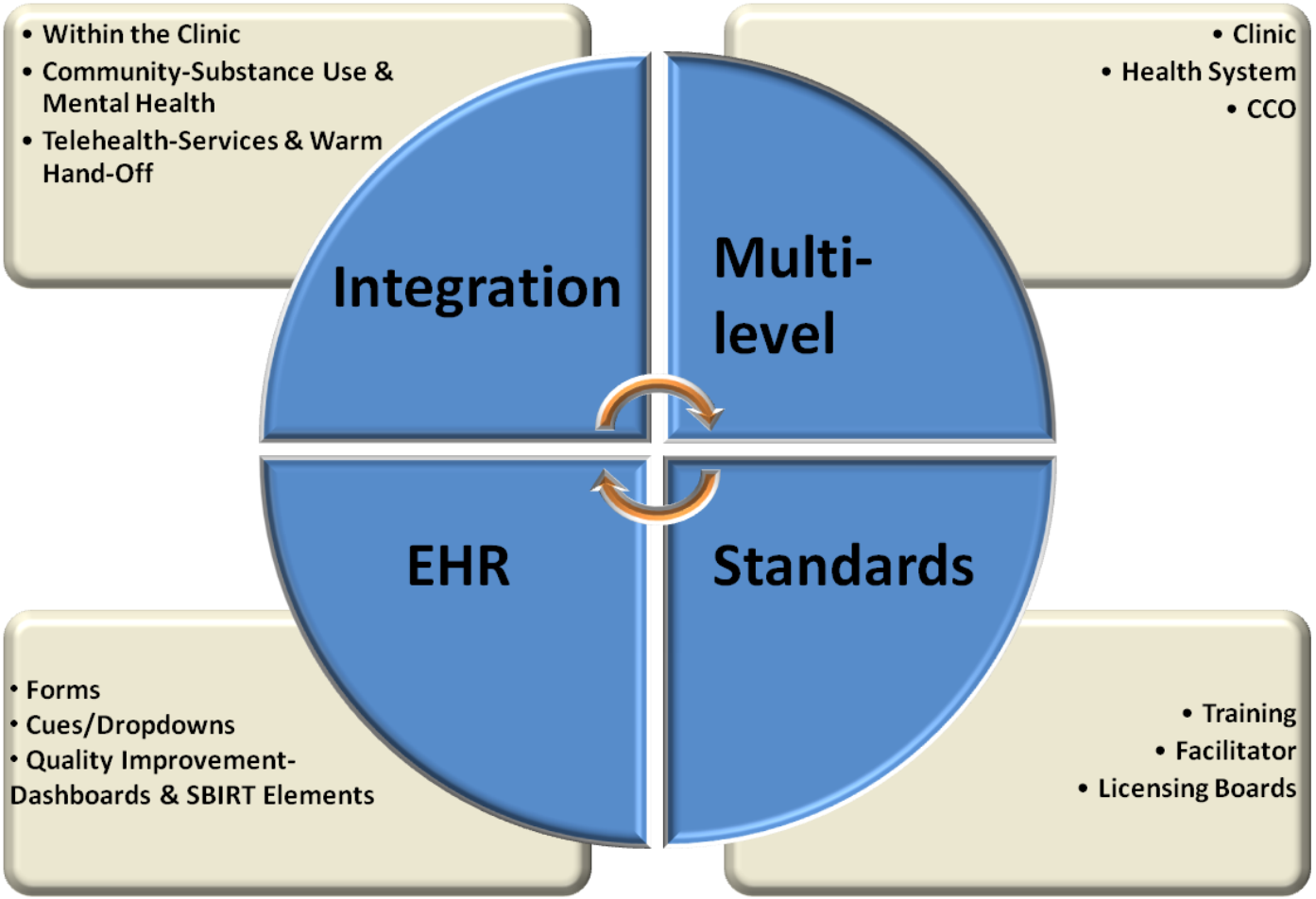


SBIRT Encounters in Medical Settings



Sources: SBIRT Guidance Document and Addictions and Mental Health Services - SBIRT

What will it take for full implementation?



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Oregon: Part 2

Part 2. SBIRT from the Trenches: A Primary Care Perspective

John Muench, MD, MPH,
Oregon Health & Science University

OREGON HEALTH & SCIENCE UNIVERSITY
OHSU

IAP Medicaid Innovation Accelerator Program

The Problem

- Unhealthy use of alcohol and drugs is a major factor preventing achievement of the triple aim in the United States

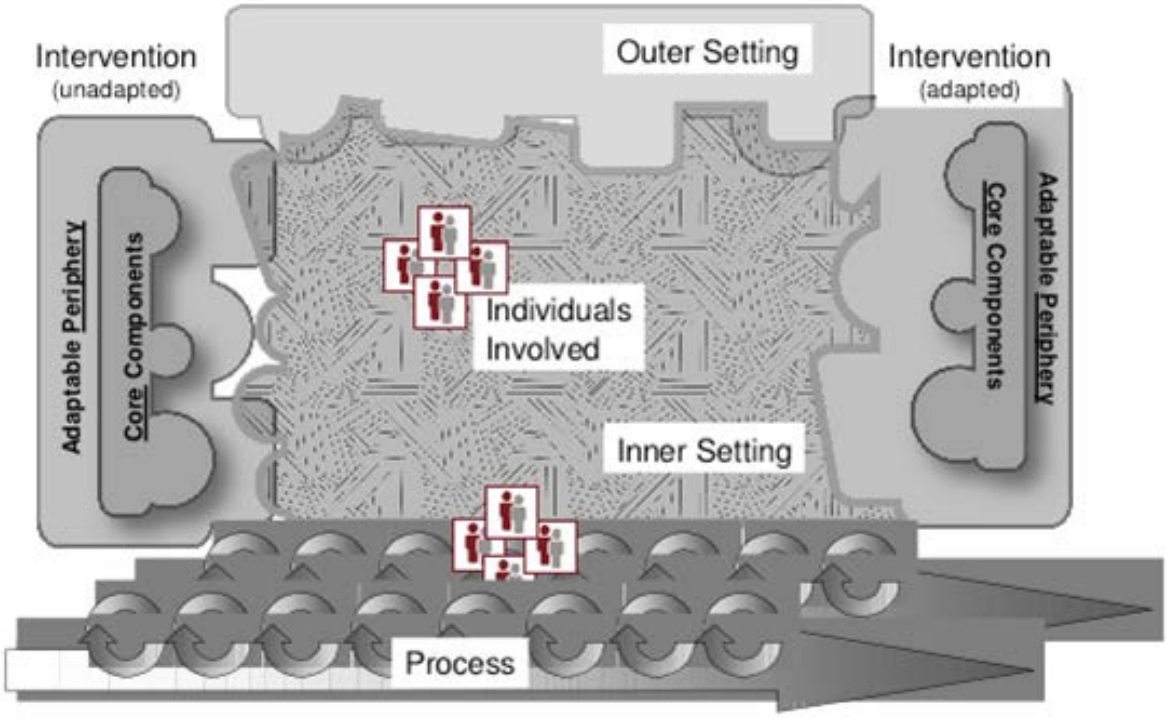
Care	Health	Costs
Improving the experience of care	Improving the health of populations	Reducing per capita costs of health care

Missed Opportunities / Possible Solutions

Business As Usual		SBIRT
Inconsistent and selective assessment		Routine and universal screening
Non-systematized, narrative questions		Validated screening tools
Usually seen as dichotomous	VS.	Substance use seen as a continuum
Directive style of communication		Patient-centered change talk
Discoordinate/unclear referrals and follow up		Transition between primary care and AOD treatment

Implementation Science – CFIR Elements

- 5 Domains
  - Intervention Characteristics
  - Outer Setting
  - Inner Setting
  - Characteristics of Individuals
  - Process of Implementation
- 39 Constructs



Source: Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implement Sci.* 2009;4:50.

SBIRT Clinic Workflow

SBIRT Innovation	Clinic Workflow
Routine and universal screening	Annual tickler for all patients who come for care, leading to:
Validated screening tools	Collection of patient screening data leading to:
Substance use seen as a continuum	A risk stratification process that will automatically lead to:
Patient-centered change talk	An effective brief intervention that combines risk level with patient readiness to change that might lead to:
Transition between primary care and AOD treatment	A more intensive intervention from clinic behavioral health personnel OR referral into AOD treatment system.

Primary Care Prevention: USPSTF on Alcohol SBI

- For both alcohol screening and brief intervention for all adults
- Insufficient evidence for adolescents
- Insufficient evidence for drugs
- Insufficient evidence for "RT" (no clear effectiveness for higher severity EtOH problems)

The Oregon Experience

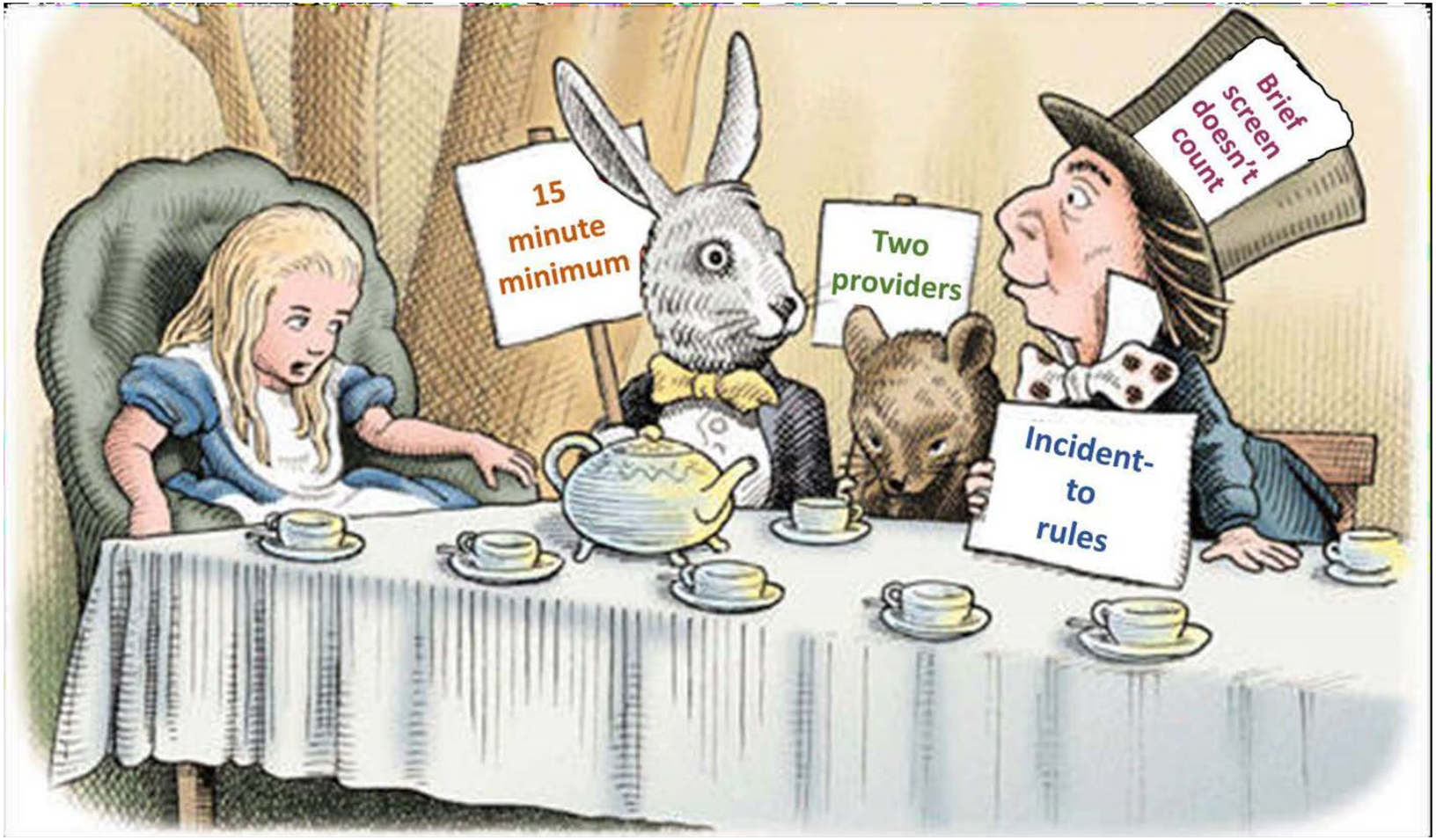
- SAMHSA Curriculum Project 2008-2013
  - 400 primary care residents (and their faculty) trained
  - 40,000 patients screened and tracked using EHR systems
- 2013: New Oregon ACO incentive metrics based on CPT/ICD9 codes

Sources: SBIRT Oregon and Muench J, Jarvis K, Gray M, et al., Implementing a team-based SBIRT model in primary care clinics. *Journal of Substance Use*, 2013.

Billing Codes to Track Incentive Metrics

- Provision of AUDIT or DAST = 99420
  - Must be associated with V78.1 (EtOH) or V82.9 (drugs), as well as text that results have been given to patient
- OR: Provision of Brief Intervention = 99408 (15-30 minutes) or 99409 (>30 minutes) along with V78.1 or V82.9
- As laid out in the 24 page Oregon Health Plan SBIRT Guidance Document

When Figuring Out the Billing Takes Longer Than the Clinical Intervention…



How to Maintain Fidelity to the Original Innovation?

SBIRT Innovation	Clinic Workflow	EMR Overlay
Routine and universal screening	Annual tickler for all patients who come for care, leading to:	Clear, automatic tickler in health maintenance module
Validated screening tools	Collection of patient screening data leading to:	Patient screening data input optimally directly (tablet, kiosk, or portal)
Substance use seen as a continuum	A risk stratification process that will automatically lead to:	Automatic summation of risk level communicated to clinician

How to Maintain Fidelity to the Original Innovation? (continued)

SBIRT Innovation	Clinic Workflow	EMR Overlay
Patient-centered change talk	An effective brief intervention that combines risk level with patient readiness to change that might lead to:	Required action (hard stop?) driven by Smart Text decision support reminding clinician of appropriate change talk for patient at given risk level
Transition between primary care and AOD treatment	A more intensive intervention from clinic behavioral health personnel OR referral into AOD treatment system.	Immediate availability of accurate info about referral resources. Automated reminders for follow-up phone call to patient
		Automated input of appropriate CPT/ICD9 codes screening results and clinician progress notes

Results After the First Year

- The North Star goal
  - Less heavy use of EtOH and drugs
  - Less morbidity/mortality
  - Less cost
- Currently
  - Increased provision of validated alcohol and drug screenings statewide
  - Unclear fidelity to brief intervention model
    - Much time being spent determining how to meet incentive measure criteria
  - From a clinical perspective, there has been some shift in culture
    - Addressing unhealthy alcohol and drug use in medical clinics is becoming normalized (anecdotal)

Questions and Discussion (3)

Resources (1 of 3)

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services, Centers for Medicare & Medicaid Services, Department of Health and Human Services Fact Sheet

- SBIRT: Screening, Brief Intervention, and Referral to Treatment, SAMHSA-HRSA Center for Integrated Health Solutions

Resources (2 of 3)

- SBIRT Colorado
- Massachusetts ED SBIRT Initiative
- SBIRT Oregon, Oregon Health & Sciences University

Resources (3 of 3)

- Screening, Brief Intervention and Referral to Treatment (SBIRT), Addictions and Mental Health Services, Oregon Health Authority

- Technical Specification and Guidance Documents for CCO Incentive Measures, Office of Health Analytics, Oregon Health Authority

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