# *Implementing SBIRT through Integration with Primary & Specialty Medical Care:*

**July 2016**

## Disclosure of Relevant Financial Relationships

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**Date of Activity: July 13, 2016**

| Name | No Relevant Financial Relationships with Any Commercial Interests |
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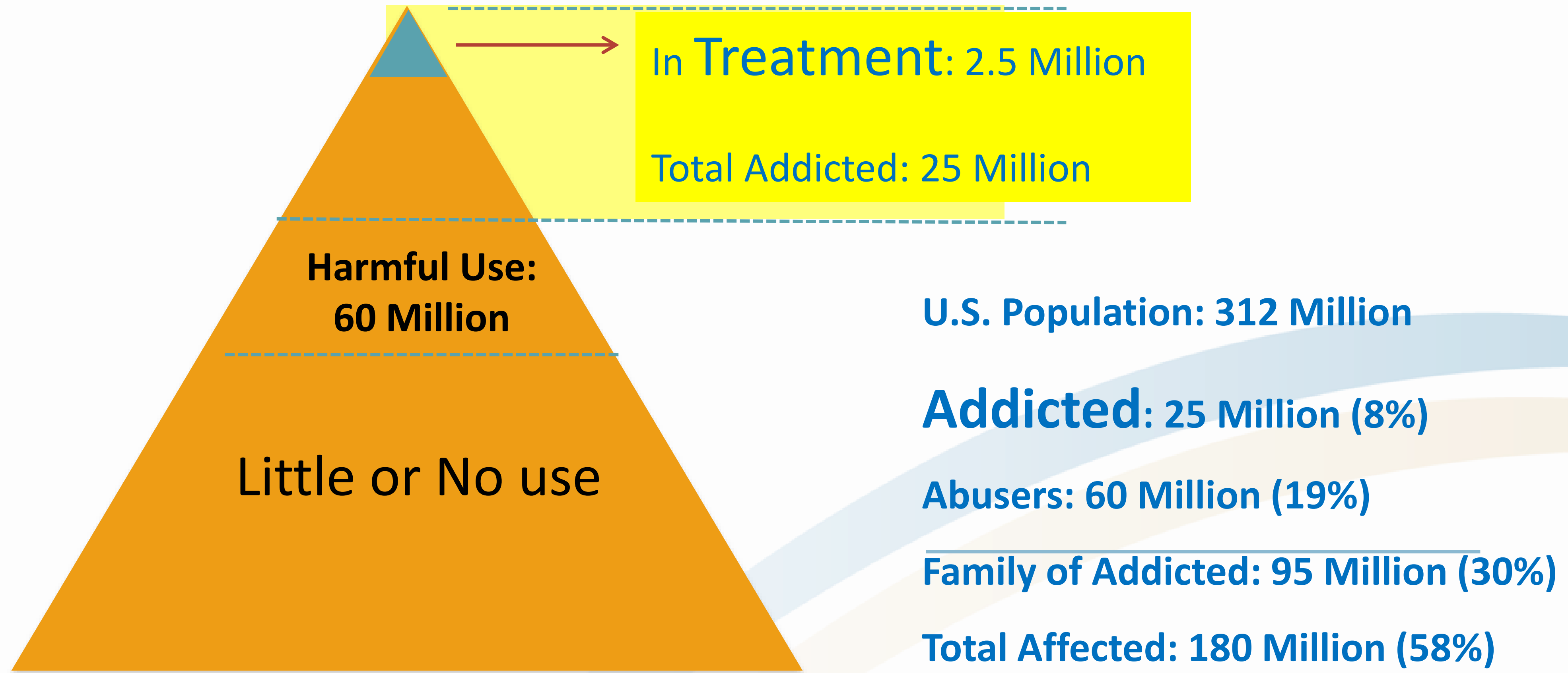
# What we Hope to Learn Today

- Why is Integration Important?
- Models or Phases of Integration
- Components of SBIRT model
- Barriers and Challenges

# Population Prevalence




**U.S. Population: 312 Million**

**Addicted: 25 Million (8%)**

**Abusers: 60 Million (19%)**

**Family of Addicted: 95 Million (30%)**

**Total Affected: 180 Million (58%)**

# We’ve Come a Long Way from This…

## The Moral Model of Addiction

# …to This

## Addiction is a Brain Disease

# But Not From This…

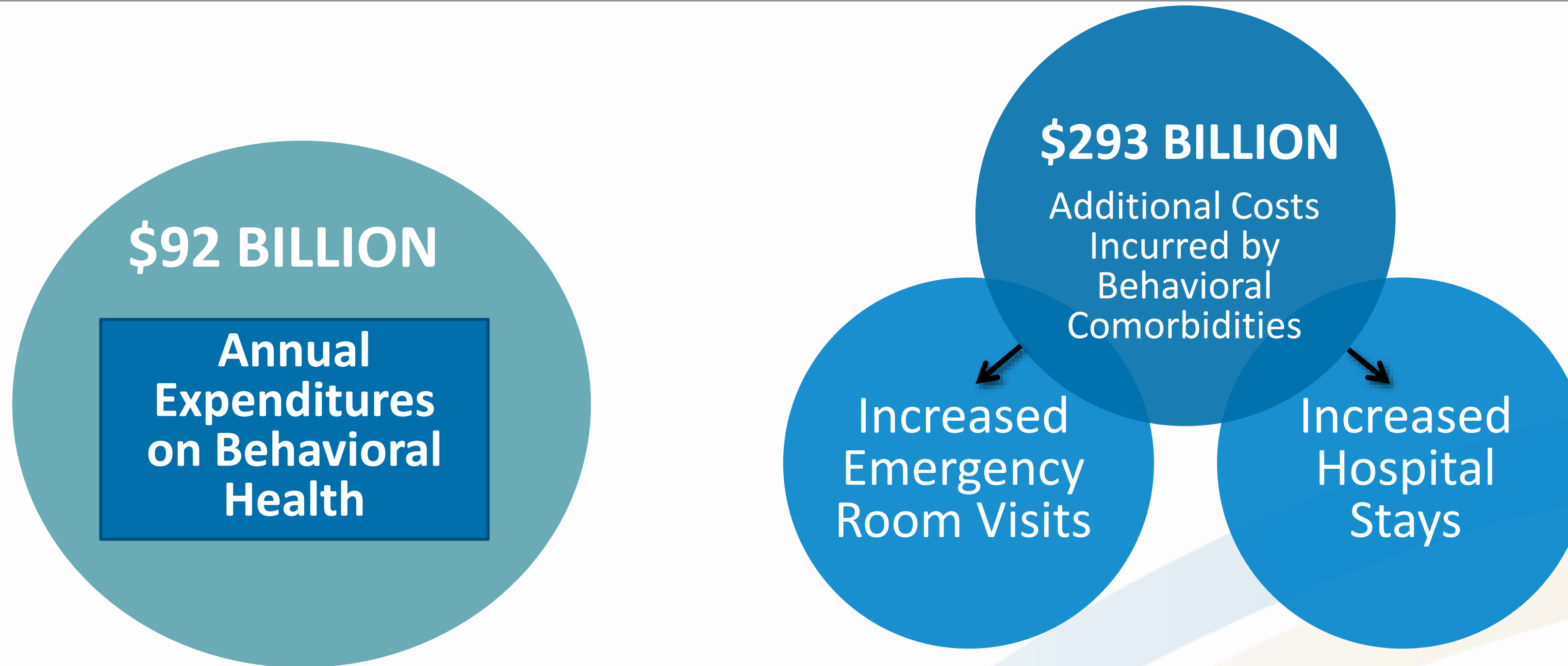
**The Acute Care Treatment Model for a Chronic Disease**

# MH/SUD Patients are High Cost

Patients with MH/SUD cost 2-3 times more ($1,000 PMPM compared to $400 PMPM)

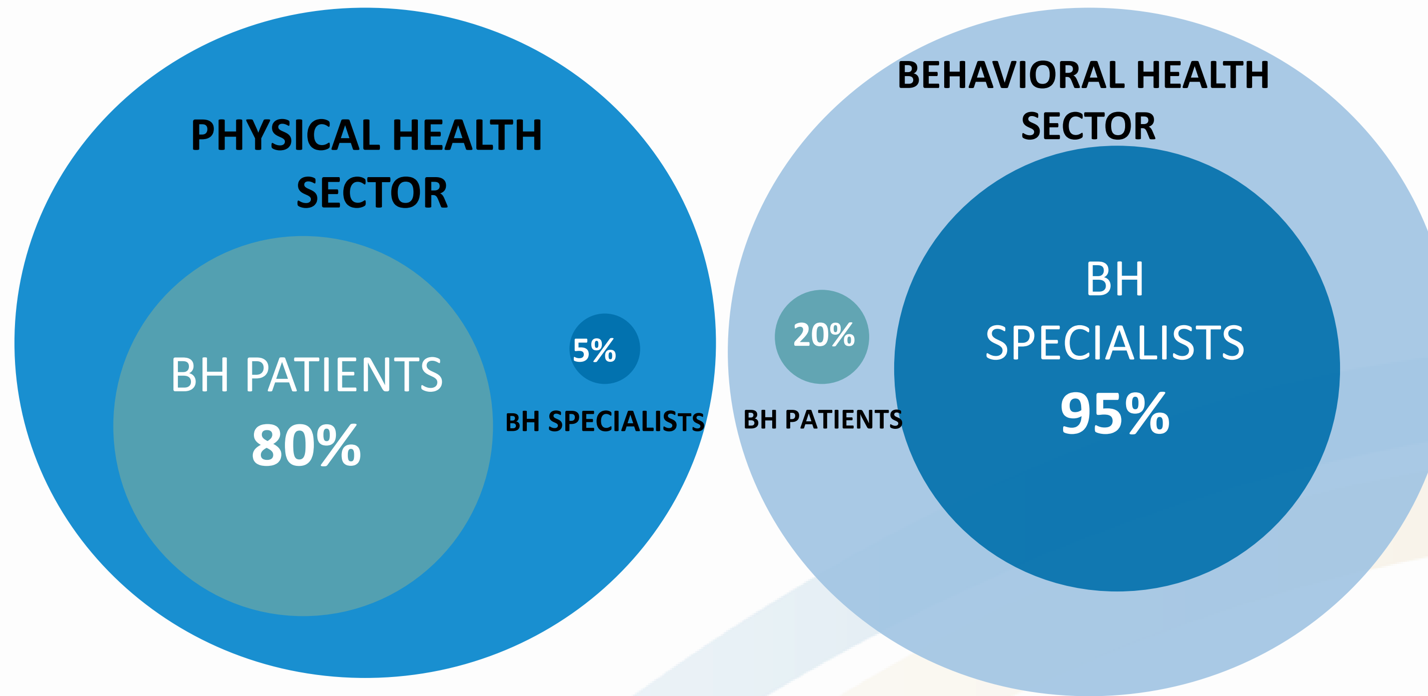
Most of added cost is facility based (ER & Inpatient) for medical care

# What This Means and Why it Matters




Milliman Report 2014

# BH Specialist-Patient Mismatch



# Hospital "Medical" Admissions* with BH Comorbidity

| *Care Delivery Systems* | Number of Hospitals | Total Adm/Yr | % BH | Longer BH vs. non-BH ALOS | Higher BH vs. non-BH Readmits | Sitter Use |
|---|---|---|---|---|---|---|
| System 1 | >10 | 135,000+ | 26% | 1.1 | 35% | $6.0M |
| System 2 | 1 | 19,000+ | 36% | 1.2 | 40% | $3.1M |
| System 3 | 4 | 34,500+ | 29% | 1.3 | 70% | $.42M |
| System 4 | 5 | 40,000+ | 26% | 1.8 | 30% | $2+M |
| System 5 | 1 | 19,000+ | 23% | 0.6 | 45% | |

*medical and surgical admissions to 5 general hospital systems in the US, excluding neonate and primary psychiatric admissions

Cartesian Solutions, Inc., 2012-2013

# 30 Day Readmission Rates by Diagnosis (18-64 y.o. Medicaid)

| Diagnosis | % of Total Adm. | Cost in MM | Readm Rate/100 Admits |
|---|---|---|---|
| **Mood Disorders** | **6.2** | **$286** | **19.8** |
| **Psychotic Disorders** | **5.3** | **$302** | **24.9** |
| **Alcohol/Drug** | **5.2** | **$244** | **45.1** |
| Diabetes | 3.5 | $251 | 26.6 |
| Pregnancy Comp | 3.2 | $122 | 8.4 |
| CHF | 2.8 | $273 | 30.4 |
| COPD | 2.4 | $178 | 25.2 |

Agency for Healthcare Research & Quality April 2014

# Impact of BH Comorbidity in Patients with Chronic Medical Conditions

| Patient Groups | Annual Cost of Care | Illness Prev. | % with Comorbid BH Condition* | Annual Cost with BH Condition | % Increase with BH Condition |
|---|---|---|---|---|---|
| Arthritis | $5,220 | 6.6% | 36% | $10,710 | 94% |
| Asthma | $3,730 | 5.9% | 35% | $10,030 | 169% |
| Cancer | $11,650 | 4.3% | 37% | $18,870 | 62% |
| Diabetes | $5,480 | 8.9% | 30% | $12,280 | 124% |
| CHF | $9,770 | 1.3% | 40% | $17,200 | 76% |
| Migraine | $4,340 | 8.2% | 43% | $10,810 | 149% |
| COPD | $3,840 | 8.2% | 38% | $10,980 | 186% |

*Approximately 10% receive evidence-based mental condition treatment

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# We Can Do Better

# IOM Quality Chasm 2003 Report

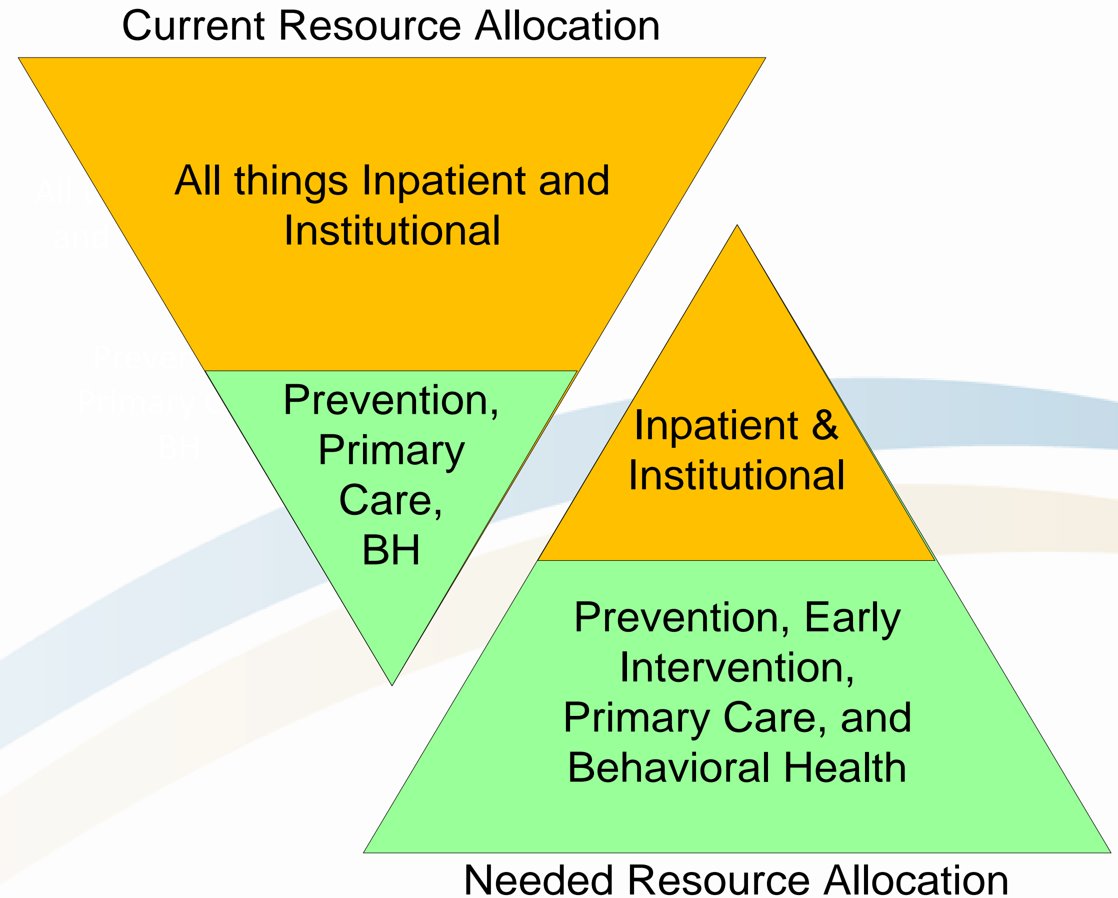
"Current care system can't do job"

"Trying harder (doing the same thing) will not work"

"Changing care systems will/might"

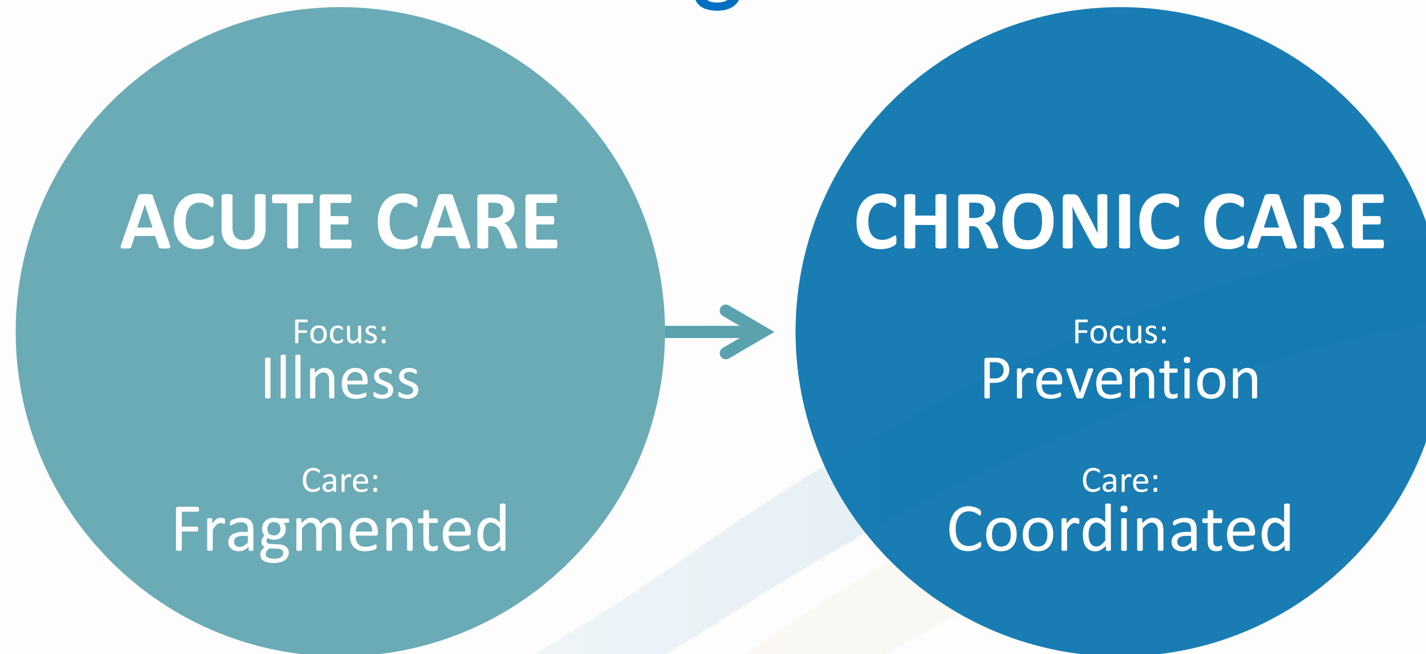
# Inverting the Triangle

Moving from focus on acute inpatient to early intervention, primary care and extended engagement



# Transition in Health Care

## Paradigm Shift



# Factors Compelling Integration

- Service system can't accommodate demand or need
- More seek help for MH problems in primary care
- As many people need SU treatment as diabetes, but 18.3 percent vs. 84 percent receive care
- Failure of Referral Conversions
- Stigma Endures
- Behavioral Factors in Chronic Disease Management

# Levels of "Integration"

- Level 1: Minimal Collaboration--Separate Systems, little communication
- Level 2: Distance-Collaboration--Separate Systems, periodic communication
- Level 3: Onsite Collaboration--Co-location, still separate; infrequent communication
- Level 4: Partial Integration--Same site, common scheduling/charting, but BH and medical still seen as separate entities
- **Level 5: Full Integration--Same site, same vision, same team, a fully unified practice**

| Integrated Model | Traditional Model |
|---|---|
| Population Management | Specialty Care |
| 15-20 min. visits | 45-60 min. visits |
| 1-3 visits and done | 5 or more visits |
| No limit # patients/day | 5-7 patients/day |
| Open Access-Same Day Visit | Waiting Lists |
| Interruptible | Do Not Disturb |
| Instruct, Guide, Enhance | Diagnose and Treat |

| Integrated Model | Traditional Model |
| --- | --- |
| Therapeutic Relationship not Focus | Therapist-Patient Relationship Critical |
| Visit Primarily Medical | Visit specific to BH Issue |
| Stigma Minimal | Stigma Usually Very High |
| Interventions Support Med Providers | Interventions Rarely involve Med Providers |
| Referrals from Med Providers | Referrals from Community, Family, Self |
| Patient “Ownership” is Shared | Clinician “Owns” the Patient |
| Provider Moves Rapidly between activity | Clinician Can Focus on 1-1 Interaction |

| Integrated Model | Traditional Model |
| --- | --- |
| MI, CBT & Solution Focused Approaches | Varies Based on Clinician Preference |
| Documentation in Unified Record | BH documentation stands alone |
| PCP Always Involved | PCP Hardly Ever Involved |

**Best of All**

## NO CANCELLATIONS VS. 20-30% CANCELLATION RATE

# Gosnold's Primary Care Integration

- Clinicians received PG cerytification in "Primary Care Integration" through UMass Medical School
- Provide integrated behavioral services at:
  - 2 Federally Qualified Health Centers
  - Ob-Gyn Office
  - Pediatric Practice
  - Family Medicine Practices (2)

# What is SBIRT?

- **Screening** to identify risk
- **Brief Intervention** to raise risk awareness & motivates to action
- **Referral** to help patients access specialized care

- Enables early identification→*preventive care*
- Offers systematic approach to address issues→avoids “judgment call”
- Repeat use can reflect improvement or worsening of symptoms

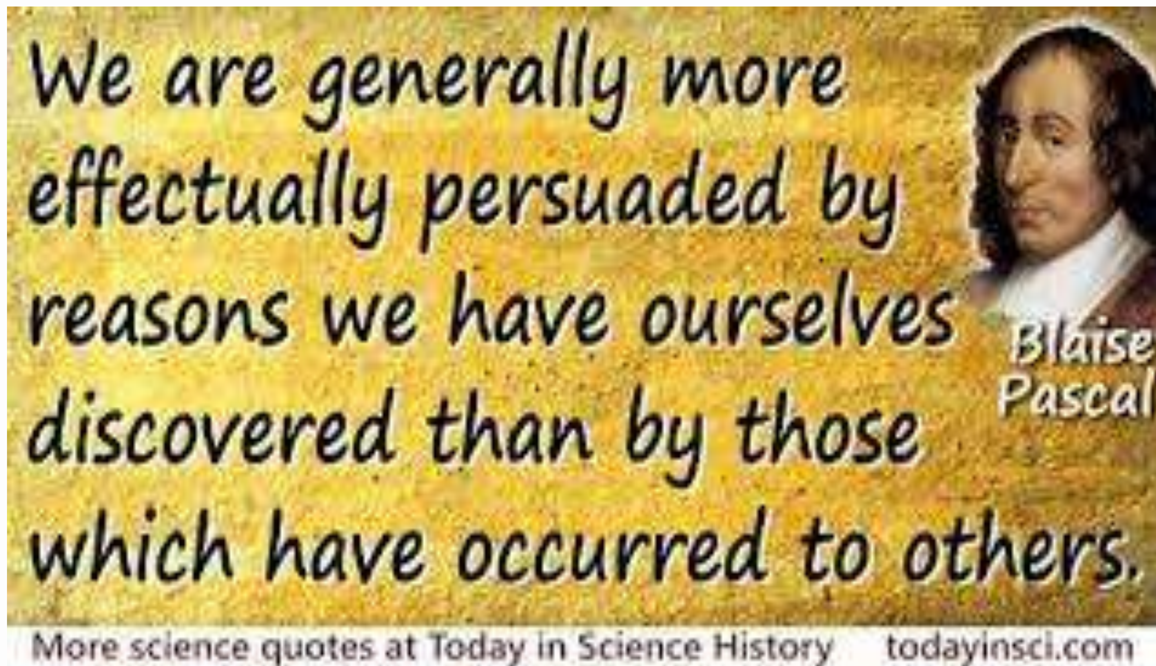
# Common Screening Tools

- Patient Health Questionnaire (PHQ-9),
- The Generalized Anxiety Disorder (GAD-7) ,
- Screen for Child Anxiety Related Disorders (SCARED)
- Primary Care Posttraumatic Stress Disorder Screen (PC-PTSD),
- Alcohol Use Disorders Identification Test (AUDIT) or CRAFFT ,
- Edinburgh Postnatal Depression Scale (EPDS), Pediatric Symptom Checklist

**Patient Stress Questionnaire** combines PHQ9, GAD7, PC-PTSD, and AUDIT

# Brief Interventions

Motivate patient to action (enter treatment, modify behavior, think differently




- **DBT Skill Acquisitions:**
  - Emotion Regulation
  - Distress Tolerance
  - Interpersonal Effectiveness
  - Core Mindfulness

Expresss Empathy- non judgmental stance, active listending

Develop Discrepancy between use and goals/values/beliefs

Principles of MI

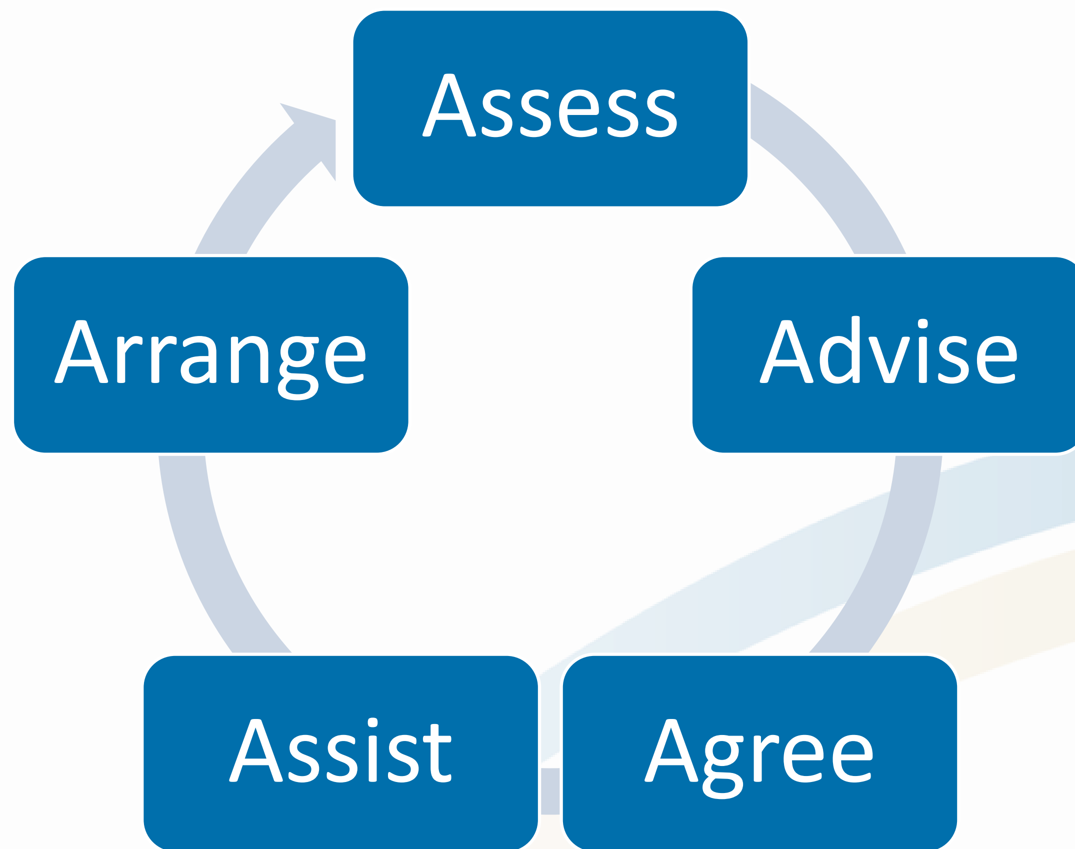
Roll with Resistance—avoid debate, affirm autonomy

Support Self Efficacy- express confidence and past successes

# The Toolkit of Interventions

1) Relaxation Training
2.) Goal Setting
3.) Cognitive Disputation
4.) Motivational Interviewing Strategies
5.) Problem Solving
6.) Self-Monitoring
7.) Behavioral Self-Analysis
8.) Stimulus Control
9.) Assertive Communication

# The 5 A's Model of Behavioral Change



# Referral to Treatment

- Patients prefer returning to the physician's office.
- Better screening, earlier intervention, less need for referral
- When we do refer out, compliance rates are higher
- Better coordination across disciplines, SOME OF THE TIME!
- Overcoming the PCP lack of confidence in BH providers.

# Barriers and Challenges

- Primary & BH systems/practitioners cultures
- Lack of clinician training in a different service setting
- Clinicians Unable to Adapt to PCP Setting
- Information sharing/Electronic Health Record
- Issues of Confidentiality and Space
- Financing and Reimbursement

# We Have What Health Care Systems Need

- Expertise in Specialty Areas of SUD & MH
- Understanding & we Know How to Talk to Patients
- Knowledge of Community Resources
- Improve Engagement/Compliance
- Reduce Use of High Cost Resources
- Help Medical Practitioners Understand BH Links to Disease
- HELP PATIENTS BEFORE THEY'RE IN CRISIS

# Self Management Tools

ACHESS—measures progress, educates, maintains engagement, networks patients.

My Strength

Steps Away

Sober Grid

# Tele-Mental Health

We'll never be able to have a therapeutic relationship with a video screen.  Patients want to have that face to face connection with their therapist.

# BH Screening in a Kiosk

Who's going to sit at a kiosk to get health services? That will never happen!

Attendant Call Light

Privacy Handset

Blood Pressure Cuff

Keyboard

Electronic Signature Pad

Handicapped Accessible Seat with Weight Scale

MAG Card Reader

Touch Screen

Thermometer

Breathalyzer

Thumbprint Verification Device

Emergency Call Light

# Contact Information

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