SBIRT

Implementation

Implementation Site Visit Report

Cohort IV State Grantee: Washington SBIRT

Cohort IV Implementation Site Visit

State of Washington

Prepared by JBS International, Inc., and Alliances for Quality Education, Inc.
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Implementation Site Visit: Washington

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Grant TI Number	TI023477
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The Cohort IV SBIRT State Demonstration Cooperative Agreement for the State of Washington is in the implementation phase. Past experience has shown that most deviations from the expectations of the Request for Application (RFA) occur in the first year of implementation. To prevent similar missteps, implementation site visits are being completed within 7 to 10 months of the first year of operation. The site visit teams consist of previously successful SBIRT implementers ("grantee mentors") and staff from the technical assistance contract (JBS International, Inc., and Alliances for Quality Education). The teams are tasked with observing and reporting on grantee implementation progress as well as providing technical assistance, when appropriate, as a means to enhance program success through the life of the grant.

Grantee Summary Introduction

On June 20 and 21, 2012, the SBIRT site visit team met with State of Washington SBIRT Primary Care Integration (WASBIRT-PCI) implementation team. The purpose of the site visit was to engage the State grantee in a discussion to identify the current status of their SBIRT program implementation, its strengths, and possible challenges. An additional purpose was to engage the grantee in identifying any potential enhancements that might be supported by technical assistance, as approved by SAMHSA. The site visit process included several components:

- Meeting onsite with the principal investigator/project director, core senior faculty, key partners, project evaluator, project coordinator, and State agency senior leadership
- Reviewing curriculum components and materials
- Visiting SBIRT implementation sites and site interviewing staff
- Meeting with key implementation partners
- Meeting with the Policy Steering Committee

Day 1: On June 20, 2012, the site visit team met first with the Washington implementation team. The implementation team provided a project overview, discussed project implementation to date, and described their service delivery model. In the afternoon, the team traveled to Sea Mar Community Health in Seattle (Figure 1), one of the initial implementation sites. The team toured the facilities and discussed SBIRT implementation, including successes and challenges, with health center staff.

Figure 1: Sea Mar Community Health Center—Seattle Clinic

Figure 2: Public Health Seattle & King County, Downtown Public Health Center

Day 2: On June 21, 2012, the team met with the WASBIRT-PCI Policy Steering Committee (PSC). Topics discussed included an update from participating community health centers, PSC subcommittee status reports, and WASBIRT-PCI SAMHSA technical assistance. Following this discussion, the team traveled to Public Health-Seattle & King County (Figure 2) to tour the facility, meet with staff, and discuss program implementation, including successes and challenges. The afternoon concluded with the site visit team and implementation team debrief, addressing key program areas including: the PSC, evaluation opportunities, brief treatment implementation, training and workforce development, sustainability, and marketing.

On June 25, 2012, the SBIRT site visit team and WASBIRT-PCI team debriefed the SAMHSA/CSAT project officer via teleconference.

Grantee Organization and Staffing

Grantee and Key Partners

The Washington SBIRT Primary Care Integration (WASBIRT-PCI) project team consists of the following members:

WASBIRT-PCI Administrative Team—Leads WASBIRT-PCI program and provides key project coordination:

- Dennis Malmer—SBIRT Program Director, formulates and disseminates project-related policies and procedures, serves as a liaison between the Washington State Department of Social and Health Services (DSHS) and other State and Federal agencies and participates on the PSC
- Alice Huber, Ph.D.—Principle Investigator, Division of Behavioral Health and Recovery, oversees project management
- John Taylor, Chief, Office of Behavioral Health and Prevention, oversees project management
- Elizabeth Speaker, M.S.—research manager

WASBIRT-PCI Evaluation Team—Provides ongoing performance monitoring and outcome evaluations of the project:

- Sharon Estee, Ph.D.—WASBIRT-PCI Project Evaluator, Chief of Program Research and Evaluation Section
- Melissa Ford Shah, M.P.P., Senior Research Manager
- Jim Mayfield, M.A., Senior Research Manager

King County Administrative Team—Coordinates SBIRT implementation and staff development throughout the Sea Mar and Seattle/King County Public Health networks:

- Jim Vollendroff, M.P.A., NCACII, CDP—Assistance Division Director, Substance Abuse Prevention and Treatment Coordinator
- Keri Acker-Peltier, M.S.W., LICSW, WASBIRT-PCI Program Coordinator, coordinates and supports implementation activities and collaborating partner organizations
- Jessica Knaster Wasse, M.P.H., Program Manager, Community and School-Based Partnerships

Grantee Organization and Leadership

Strengths

- WASBIRT-PCI staff members are highly experienced grant administrators who build effectively on extensive knowledge gained and infrastructure developed during the previous SBIRT cohort.
- Senior leadership is highly committed to adopting SBIRT within primary care and other systems and shows innovation utilizing available resources.
- WASBIRT-PCI team knows and understands roles and has well-defined responsibilities.

Challenges

- None noted at this time

Grantee Goals and Objectives

The WASBIRT-PCI project aims to implement SBIRT services for adults receiving primary care in community health clinics in King County.

WASBIRT-PCI has five ultimate goals for implementation, based on findings from the previous WASBIRT grant:

1) Reduced alcohol and drug use
2) Increased entrance to chemical dependency treatment
3) Reduced medical costs
4) Reduced criminal justice involvement
5) Reduced mortality

With these ultimate goals in mind, specific WASBIRT-PCI project goals, objectives, anticipated results and measures follow in Figure 3: WASBIRT Goals and Objectives.

Objective	Anticipated Results	Measure
Goal 1: Expand continuum of care to include SBIRT services in a community health care setting		
1.1 Increase use of SBIRT services in community health clinic setting	Increased identification of and treatment for substance abuse problems among community health clinic patients	Number of patients receiving screening, brief intervention, brief treatment, and referral to treatment
1.2 Train clinic staff to use evidence-based practices to identify substance abuse problems and encourage positive behavior change	Increased number of patients with substance abuse problems identified and given BI, BT, or RT	Percent of those screening positive for at least a BI who have cut back on substance use at 6-month GPRA followup
Goal 2: Promote behavioral health and primary care integration in patient-centered health care homes		
2.1 Build on existing Mental Health Integration Program (MHIP) in community health clinics to also address substance abuse problems	Expanded capacity of community health clinic staff to identify and intervene with both substance abuse and mental health problems	Number of staff at each clinic who are certified as both mental health and chemical dependency professionals
Goal 3: Achieve meaningful use of Health Information Technology (HIT)		
3.1 Develop interface between data collected through SBIRT project and other electronic health records and Web-based patient registry	Better management of patient care through secure use and sharing of health information	Reductions in inappropriate emergency department use, medical costs, inpatient hospital admissions, and mortality
Goal 4: Increase referrals to and coordination with chemical dependency treatment providers		
4.1 Promote recovery-oriented systems of care by minimizing barriers to treatment and recovery	MHIP Care Coordinators/SBIRT specialists will provide integrated mental health treatment and connections to social services, as needed, through existing resources	Reduced homelessness and criminal involvement and increased labor market participation and housing stability
4.2 Improved coordination between clinics and chemical dependency and mental health treatment providers	Fewer patients "falling through the cracks"	Percent of patients in need of specialized treatment who receive it
Goal 5: Implement fee-for-service reimbursement for SBI		
5.1 Integrate/sustain SBIRT services in community health clinics through fee-for-service reimbursement	Pilot clinics/providers will adopt and utilize the SBIRT reimbursement codes created by the CMS	Number of claims for reimbursement made by pilot clinics to Medicaid for SBIRT services

Figure 3: WASBIRT-PCI Goals and Objectives

WASBIRT-PCI aims to achieve their goals and objectives by utilizing the resources and program components outlined in Figure 4: WASBIRT-PCI logic model:

Resources (Inputs)	Program Components (Activities)	Outputs (Objectives)	Outcomes (Goals)
People • Primary care providers and medical assistants • MHIP Care Coordinators • Behavioral Health Intervention Specialists • Treatment providers **Funds** • Prioritizing the use of CD treatment resources for SBIRT-referred patients through MHCADSD contracts with providers **Partner agencies** • Neighborcare Health clinics • Sea Mar clinics • Public Health – Seattle and King County • University of Washington Department of Psychiatry • Northwest Frontier Addiction Technology Transfer Center • Department of Social and Health Services (DSHS) • King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) **Other resources** • Facilities • Equipment	**Special training** • Motivational interviewing • Screening, Brief Intervention, and Referral to Treatment (SBIRT) **Screening/assessment** • Universal pre-screening • Substance abuse screening (AUDIT, DAST) • Mental health screening to identify co-occurring disorders (PHQ-9, GAD-7, PSRS) • Client Interview/GPRA **Enhanced health information technology** • Interface between WASBIRT-PCI project data and other electronic health records • Expand capacity of MHITS data registry to include WASBIRT-PCI-related information **Evaluation** • Process evaluation • Outcome evaluation	**Number of hours per month** • Staff hired • Staff time • Partners/type **SBIRT implementation** • Community Primary care clinics that adopt SBIRT **Number of patients** • Pre-screened • Screened • Brief Intervention • Brief Treatment • Referral to Treatment **Ancillary services** • Integrated mental health treatment through MHIP • Referrals to needed social services	**Increase identification of and treatment for substance abuse** • Increase screening • Increase interventions and referrals to treatment **Reduce risky drinking and drug use** • Patients will have cut back or abstained between baseline and six month follow-up **Minimize barriers to treatment and recovery** • Reduce homelessness and criminal involvement • Increase labor market participation and housing stability **Increase staff capacity to address behavioral health needs** • Increase number of clinic staff with both mental health and chemical dependency certification **Improved care management** • Reductions in health care costs, avoidable emergency department visits, inpatient hospital admissions, and mortality risk **Implement fee-for-service reimbursement for SBI** • Increase number of claims made by pilot clinics to Medicaid for SBI services (with each site adopting billing codes after one year)

Figure 4: WASBIRT-PCI Logic Model

Target Population(s)

The WASBIRT-PCI program focuses on adult, low-income patients in Seattle and King County primary care community health centers. King County is the most populous county in the State of Washington, comprising 30 percent of the State's residents. As of 2009, the demographic makeup of King County was 67 percent non-Hispanic white, 14 percent Asian/Pacific Islander, 8 percent Hispanic, 6 percent black, and 4 percent multi-racial; 19 percent of the county's population were foreign-born, and 24 percent of residents 5 years and older spoke languages other than English in the home.

WASBIRT-PCI plans to serve approximately 20,000 people annually and 96,720 individuals over the life of the project. WASBIRT-PCI program recipients are primarily urban, low-income, and uninsured.

SBIRT Implementation

WASBIRT-PCI is currently implemented in two Sea Mar community health centers (Seattle and Burien) and two Public Health-Seattle & King County clinics (Downtown and North Seattle). In addition, WASBIRT-PCI is in discussion with Swedish Medical Center and Harborview Medical Center about implementing SBIRT in their clinic networks.

Pre-Screening: WASBIRT-PCI clinics pre-screen all patients using the two alcohol pre-screen questions from NIAAA and a one-question drug pre-screen question from NIDA (Figure 5: WASBIRT-PCI Pre-Screen):

ALCOHOL 2-QUESTION PRE-SCREEN	**Negative**	**Positive**			
A.1. Do you sometimes drink beer, wine, or other alcoholic beverages?	No or refused to answer	IF YES, ASK NEXT QUESTION			
A.2. How many times in the past year have you had… 4 or more drinks in a day? (for women) 5 or more drinks in a day? (for men)	0 times	1–9 times (less than monthly)	10–25 times (monthly)	26–50 times (weekly)	Over 50 times (daily)
ACTION	**RECORD ANSWERS**	**RECORD ANSWERS AND CONDUCT FULL ALCOHOL SCREEN-AUDIT**			
ALCOHOL 2-QUESTION PRE-SCREEN	**Negative**	**Positive**			
D.1. How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?	0 times	1–9 times (less than monthly)	10–25 times (monthly)	26–50 times (weekly)	Over 50 times (daily)
ACTION	**RECORD ANSWERS**	**RECORD ANSWERS AND CONDUCT FULL ALCOHOL SCREEN DAST-10**			

Figure 5: WASBIRT-PCI Pre-Screen

If the patient does not meet the threshold of a full screen, he or she is provided with GPRA section A.

Screening: If a patient does score positive on the alcohol pre-screen question, the AUDIT is administered. If a patient scored positive on the drug pre-screen question, a DAST-10 is administered. Based on AUDIT and DAST-10 scores, the patient is either administered the appropriate GPRA sections and/or a mental health screen (the PHQ-9 and GAD-7) and provided with score feedback, brief intervention, referral to brief treatment, or referral to chemical dependency treatment as needed. Please see Figure 7, WASBIRT PCI Screening and Data Collection Flowchart, for additional information on the pre-screening and screening process.

Brief Intervention (BI): A 10–15 minute intervention is provided (usually by the BHI) when a full screen indicates moderate risk. BI involves using motivational interviewing (MI) to educate people at low-moderate risk about moderate drinking and health risks if limits are exceeded and to facilitate their setting specific behavior-change goals.

Brief Treatment (BT): After a screening result of moderate risk, BT involving MI and other techniques is provided to help patients recognize the need to brief treatment (either within the community health network or outside the network, depending on the implementation site).

Referral to Treatment (RT): Following a screening result of high risk, RT, a discussion using MI and other techniques, is administered with the goal of helping the patient recognize the need for a specialized treatment program.

Figure 6: WASBIRT-PCI Implementation Predicted Outcome outlines the anticipated numbers associated with each step of the SBIRT process.

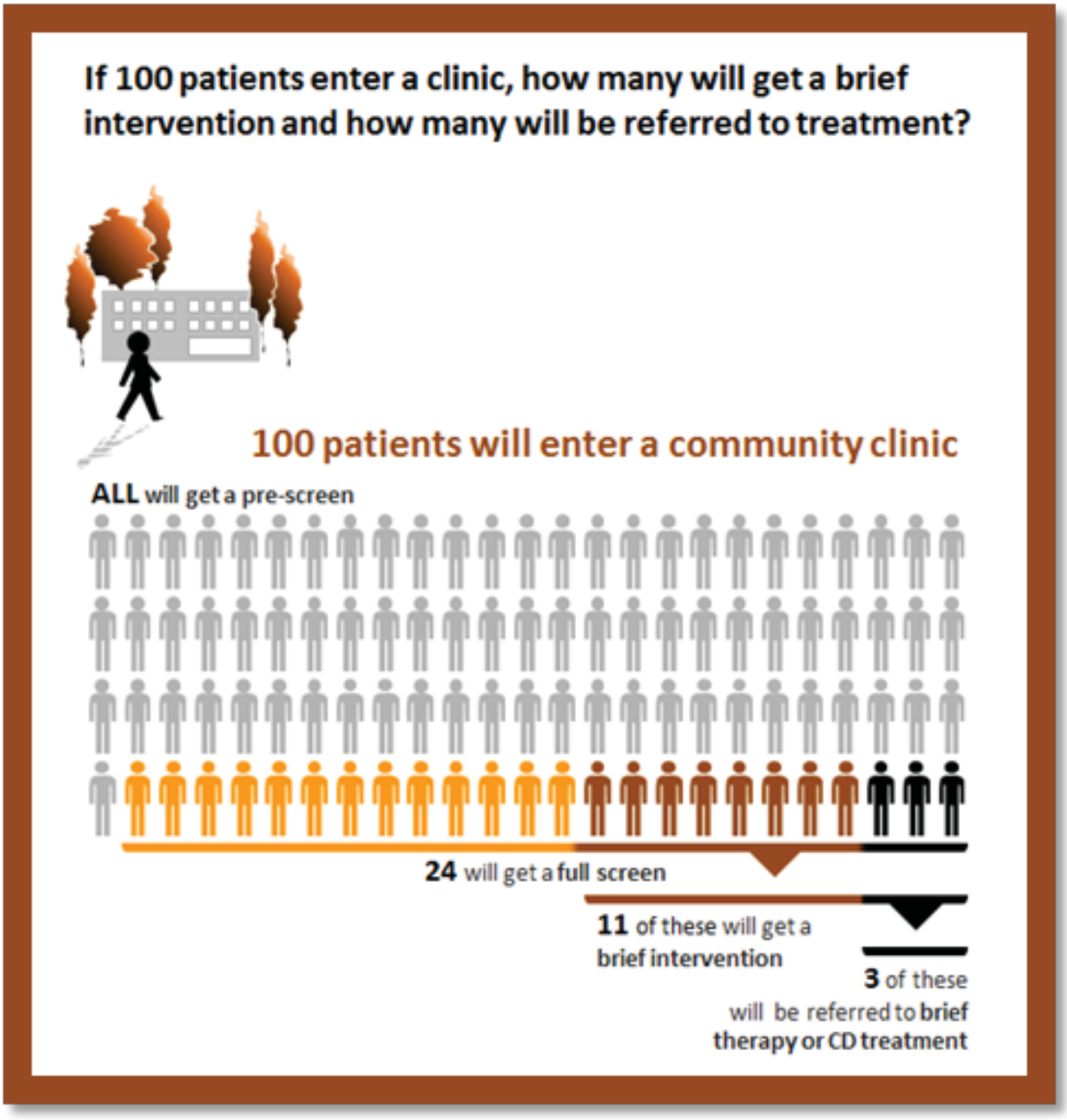


Figure 6: WASBIRT-PCI Implementation Predicted Outcome

WASBIRT•PCI Screening and Data Collection Flowchart

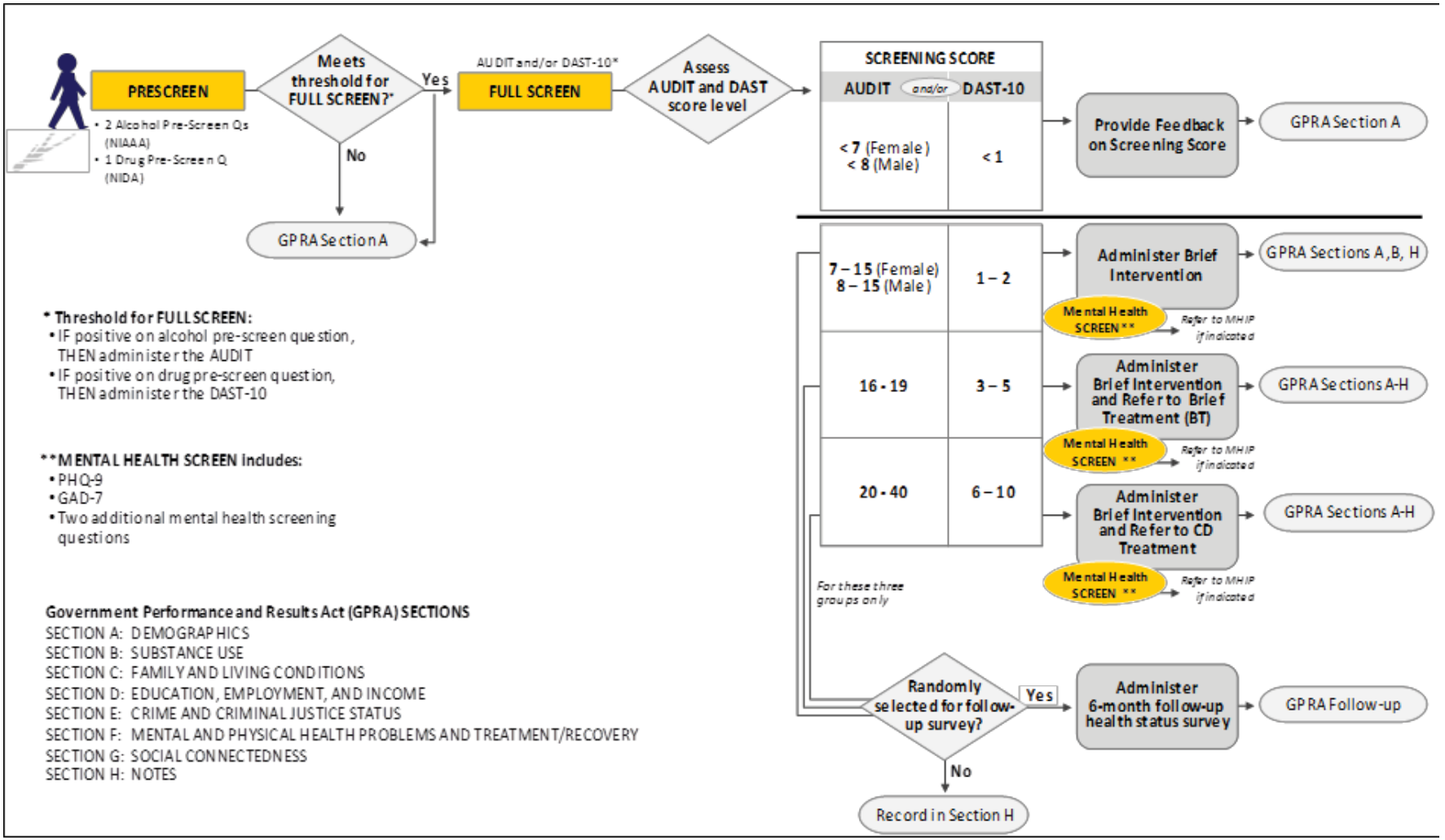


Figure 7: WASBIRT-PCI Screening and Data Collection Flowchart

WASBIRT•PCI Behavioral Health Intervention Specialist Clinic Flow Chart

FULL SCREEN NEGATIVE:	BRIEF INTERVENTION:	BRIEF INTERVENTION AND REFERRAL TO BRIEF TREATMENT:	BRIEF INTERVENTION AND REFERRAL TO TREATMENT:
• AUDIT - less than 7 for women and less than 8 for men • DAST-10 score of less than 1	• AUDIT score of 7 - 15 for women and 8 - 15 for men • DAST-10 score of 1 - 2	• AUDIT score of 16 - 19 • DAST-10 score of 3 - 5	• AUDIT score of 20 - 40 • DAST-10 score of 6 - 10
1. SBIRT BHI shares alcohol/drug guidelines with patient and supports patient in maintaining adherence to safe levels of consumption. 2. Enter AUDIT and/or DAST -10 in MHITS.	1. Verify whether Pt is currently enrolled in MHITS. If not, add Pt. 2. Review self-administered documents. • AUDIT • DAST-10 • PHQ-9 • GAD-7 (If mental health screen is positive, follow clinic protocols for referral and follow up) 3. SBIRT BHI completes GPRA section B 4. SBIRT BHI engages patient in brief intervention. 5. SBIRT BHI completes Section H. 6. Add self-administered screens in MHITS after Pt leaves but before the end of the day. • AUDIT • DAST-10 • PHQ -9 • GAD – 7 7. Provide feedback to PCP and write chart note.	1. Verify whether Pt is currently enrolled in MHITS. If not, add Pt. 2. Review self-administered documents. • AUDIT • DAST-10 • PHQ-9 • GAD-7 (If mental health screen is positive, follow clinic protocols for referral and follow up) 3. SBIRT BHI completes GPRA section B and C-G 4. SBIRT BHI engages patient in brief intervention. 5. SBIRT BHI completes Section H. 6. Add self-administered screens in MHITS after Pt leaves but before the end of the day. • AUDIT • DAST-10 • PHQ -9 • GAD – 7 7. Provide feedback to PCP and write chart note.	1. Verify whether Pt is currently enrolled in MHITS. If not, add Pt. 2. Review self-administered documents. • AUDIT • DAST-10 • PHQ-9 • GAD-7 (If mental health screen is positive, follow clinic protocols for referral and follow up) 3. SBIRT BHI completes GPRA section B and C-G 4. SBIRT BHI engages patient in brief intervention. 5. SBIRT BHI completes Section H. 6. Add self-administered screens in MHITS after Pt leaves but before the end of the day. • AUDIT • DAST-10 • PHQ -9 • GAD – 7 7. Provide feedback to PCP and write chart note.

Figure 8: WASBIRT-PCI Behavioral Health Intervention Specialist Clinic Flow Chart

SBIRT Implementation

Strengths

- The Sea Mar Community Health Center clinics and Public Health-Seattle & King County have successfully initiated SBIRT.
- Swedish Medical Center and Harborview, influential statewide entities, are engaged to become SBIRT implementation sites.
- The SBIRT program builds upon a foundation of prior successful grants and collaboration among the participating organizations as well as in-depth content knowledge among the WASBIRT-PCI partners.
- WASBIRT-PCI lost one targeted implementation site but has subsequently gained interest from eight additional clinics.

Challenges

- The grantee describes a need to further develop the BT component for implementation sites.
- Some implementation sites are experiencing challenges with workflow and establishing site protocol.
- Statewide billing codes are not activated at this time, and behavioral health specialists, medical assistants, and other non-licensed professionals cannot bill for reimbursement of SBIRT services.

Staffing Model

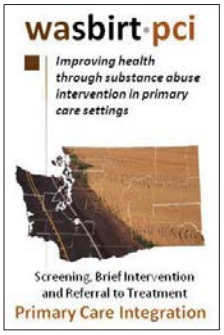
SBIRT implementation processes are specific to each site. The program's staffing model integrates support from front desk staff, medical assistants (MAs), nurses, and behavioral health intervention specialists (BHIs), with a protocol to suit the setting and its respective patient flow. In general, BHIs play a primary role in delivering SBIRT (see Figures 7, 8 and 9).

At Sea Mar Community Health Center (two clinics implementing SBIRT) and Public Health-Seattle & King County (also two clinics implementing SBIRT), some physicians are involved with providing BI while others are not. For these initial clinics, only BHIs were trained to implement SBIRT.

For the Swedish Medical Center implementation sites, the WASBIRT-PCI administrative team is placing greater emphasis on training the entire clinic team to facilitate greater buy-in. This allows all staff members to understand the process and the value of SBIRT. Physicians at Swedish Medical Center want to know what methods are being used and to be involved in the conversation. Under this model, MAs will pre-screen using the NIAAA two-question pre-screen and the NIDA single question pre-screen. If the patient screens positive, the AUDIT or the DAST-10 are administered by the MA. The provider looks at the screen and conducts an initial BI. The patient is then transferred to a BHI to conduct another BI and administer the GPRA. Under this model, there are essentially two BIs taking place, providing a unique opportunity for evaluation of the efficacy of two BIs compared with one.

The Swedish Medical Center medical residency director is an SBIRT champion and has been training residents prior to the grant award. One challenge that the WASBIRT-PCI team anticipates in implementing SBIRT in these clinics is that providers are not accustomed to GPRA requirements as part of the SBIRT process. In addition, providers do not have the time or the expertise to refer patients to treatment. Using the team approach, BHIs are trained to refer patients to BT in the primary care office or to a treatment facility.

Recruiting and building champions within primary care will support further adoption of SBIRT. The grantee may wish to (1) look within the health centers to identify and groom potential champions, and (2) confer with other States regarding strategies for developing physician champions.



WASBIRT•PCI Behavioral Health Intervention Specialist Checklist

Washington State

Screening, Brief Intervention and Referral to Treatment

Primary Care Integration

Getting Started in the Washington State Screening, Brief Intervention and Referral to Treatment – Primary Care Integration Program

(WASBIRT•PCI)

Behavioral Health Intervention Specialist Checklist

- ❑ Review role and responsibility requirements of BHI Specialist with WASBIRT supervisor
- ❑ Work with WASBIRT supervisor (clinic behavioral health program manager or clinic administrator) to introduce BHI Specialist role to all members of the care team
- ❑ Familiarize yourself with SBIRT program research and screening protocol
- ❑ Familiarize yourself with:
  - ❑ Clinic practices including patient flow
  - ❑ Scheduling responsibilities
  - ❑ Documentation
  - ❑ Accessing patient charts
  - ❑ Utilization of interpreters
- ❑ Review clinic specific protocols regarding:
  - ❑ Referring for positive mental health screening
  - ❑ Disclosure of sexual abuse or rape
  - ❑ Suicide assessment
  - ❑ HIV testing or positive status
- ❑ Review or develop system for regular communication about patient screening and interventions with PCPs to ensure continuity of care.
- ❑ Orient yourself to community resources and referral processes with specific attention to chemical dependency treatment and housing.

Figure 9: Behavioral Intervention Specialist Checklist

SBIRT Implementation in Practice Settings

Sea Mar Community Health Centers

Sea Mar is the largest network of federally qualified health centers (FQHCs) in Washington State and includes a total of 52 sites, 36 of which are medical. Sea Mar's network includes medical, dental, housing, nutrition, childcare, outpatient behavioral health, and chemical inpatient services. Sea Mar originated out of a need to serve Latino patients but has since shifted to a diverse population base. Twenty-three languages are spoken throughout Sea Mar clinics.

SBIRT implementation began at two Sea Mar locations (Seattle and Burien) in April 2012. Initially, SBIRT was piloted in smaller areas of the clinics, called "pods" and gradually rolled out to other pods over time. Universal screening was in place by May 18, 2012. Sea Mar administrators stated that SBIRT was a natural fit with the community health centers because SBIRT fits with a previously identified need for behavioral health services. Sea Mar was already screening patients for depression and anxiety and found that adding SBIRT screening to existing behavioral health screening minimized provider and staff resistance. Sea Mar's goal is to pre-screen 3,500 patients per year per clinic. They are on target to meet their goal for 2012.

MAs administer the pre-screen, which is built into the social history section of the electronic health record. For patients who score positive, the MA will administer a paper screen (integration into the electronic health record is planned). The BHI specialists, a care coordinator, or the primary care provider then reviews negative scores with the patient, and the BHI enters data into an electronic system. For patients who screen positive, BHI specialists conduct the brief intervention, enter data into an electronic mental health system and the patient medical record, and refer the patient to treatment, as needed. Behavioral health intervention specialists complete brief treatment or refer patients to chemical dependency programs.

The implementation site stated that brief therapy is a challenge because patients referred to external brief treatment resources were not willing to go. Patients would, however, see SBIRT BHIs and attend follow-up at medical appointments.

Sea Mar utilizes care coordinators that assist with directing patients to services. Care coordinators receive MI training and subsequent refresher trainings. In addition, this implementation site may benefit from MI training for front desk staff to involve staff at all levels in the SBIRT process.

Sea Mar staff members report that more patients with less severe substance abuse issues after SBIRT intervention are being referred to treatment than previous to SBIRT interventions. However, ensuring that patients have access to treatment as soon as a referral occurs remains a challenge for Sea Mar patients. Patients identified through SBIRT intervention are considered a priority population, so staff members are able to troubleshoot and get patients directly into chemical dependency treatment. Placing patients in inpatient mental health treatment continues to be a challenge, however, due to limited availability of publicly funded programs statewide. Outpatient mental health services are not a problem for Sea Mar patients, because the Sea Mar network includes outpatient mental health programs.

Public Health-Seattle & King County

Public Health-Seattle & King County began piloting SBIRT at their downtown Seattle clinic in January 2012, and their north Seattle clinic in February 2012. Each clinic has gone through several patient flow pilots. MAs or front desk staff generally administer pre-screens and screens. SBIRT counselors typically follow up with patients and conduct BIs, although some medical providers and residents also address BI during patient visits. Seattle and King County administrators have made attempts to systematize patient flow in clinics but discrepancies among practice styles within clinics make systemization a challenge. Multiple patient flow charts may be required for each MA and provider team, particularly for the north clinic location. In addition, role specification may reduce resistance and conflict.

The clinics are facing massive system-wide changes to improve coordination of care. These changes include transitioning from a paper-based record system to a new electronic record system, integrating a different phone system, a new patient registration/billing system, etc. The change to a new electronic record system is anticipated to again shift the patient flow. Currently, clinics are using paper screening tools and entering data into three separate systems, causing additional challenges to patient flow efficiencies. The program has developed a simple, low-tech approach to manage the SBIRT screening process, using color-coded forms and stickers to track which patients need to be screened.

At the Public Health-Seattle & King County implementation site, buy-in from MAs and physicians has been a challenge. Monitoring with incentives including both rewards and reprimands is advised. Developing a logic model and patient flow chart for this implementation site, including identifying factors that are barriers to implementation, conducting focus groups, and then addressing these barriers, may assist with clinic implementation concerns.

Both Sea Mar and Public Health-Seattle & King County implementation sites would benefit from strengthening the BT component of SBIRT implementation. The grantee may wish to examine potential payment options outside of specialty systems and determine criteria for putting patients in brief treatment.

Practice Site Implementation

Strengths

- Implementation sites (Sea Mar and Public Health-Seattle & King County) have self-motivated staff at all levels that strive to make improvements and systems changes.
- Sea Mar Community Health Center had a strong integrative care and team approach established prior to implementation, which aided a smooth transition to SBIRT integration.

Challenges

- Implementation sites mentioned concerns with MA buy-in and need for additional staff training, particularly around MI.
- The grantee mentioned that they needed to change tactics during implementation concerning whom to work with at implementation sites. They found that working with the medical director, and then moving down the line of the organizational chart at a site, yielded better results than targeting behavioral health administrators and then having to go back to connect with higher leadership.

Cultural Competency

At the Sea Mar Seattle and Burien clinic implementation sites, 70 percent of patients are Latino. As a result, nearly all of the staff employed at these locations are bilingual in Spanish and English, and all SBIRT materials are translated into Spanish. In addition, Sea Mar utilizes translation services on a regular basis for other languages and has SBIRT material translated into Vietnamese, Cambodian, and Russian.

Screening populations more than 60 years old has been a challenge at Sea Mar clinics. MAs were not administering pre-screens to older adults because of respect for elders in Latino populations. MAs are also hesitant to screen pregnant women because they make an assumption that pregnant women are not drinking. Training with all staff, including those who administer the pre-screen, may be beneficial to aid in achieving the goal of universal screening.

Cultural Competency

Strengths

- The grantee shows high level of cultural competence and consideration of the diverse populations served by implementation sites. For example, Sea Mar, one of the implementation sites, has made a point of employing staff that are culturally matched to their patient population and has translated SBIRT resources into five different languages and are in the process of adding more.

Challenges

- While staff members are culturally matched to their patient populations, there is a potential to assume a level of cultural competence that may not be present. For example, one implementation site noted cultural barriers screening older adults and pregnant women that resulted in lower screening levels for these populations.

Training and Workforce Development

WASBIRT-PCI training consists of the following components:

- Motivational Interview Trainings—SBIRT staff members participate in 2-day basic and 2-day advanced workshops to facilitate MI skill building.
- SBIRT Skills Training—SBIRT staff participate in a 1-day training.
- New Behavioral Health Intervention Specialist Training—BHIs participate in a 1-day intensive training after initial hire, followed by intensive mentoring and supervision.
- Fidelity will be monitored in a variety of ways including web-based training, taping, coding, coaching, and feedback.
- Technical Assistance—the project manager provides assistance to clinics interested in adopting the SBIRT model.
- Learning Collaborative Model—each BHI specialist participates in a monthly learning collaborative with SBIRT clinical staff for additional training and skill development in MI, SBIRT, and educational topics identified by BHIs.
- Improving the WASBIRT-PCI Training Model—this model is designed to adapt existing online SBIRT training to be deployed in Year 2 of the grant.

SBIRT counselors at the Public Health-Seattle and King County implementation site requested additional MI training.

Training/Workforce Development

Strengths

- WASBIRT-PCI adapted SBIRT training for future implementation clinics to include the entire medical team including MAs, BHIs, and MDs to aid with buy-in and to ensure that the entire team understands the SBIRT process.

Challenges

- BHI staff at Public Health-Seattle & King County mentioned that they would benefit from additional training, particularly in MI.

Electronic Medical Records (EMRs)

WASBIRT-PCI is beginning work with Oregon Health Science University (OHSU)'s SBIRT medical residency program to integrate SBIRT screening and billing codes into the EMR system EPIC. WASBIRT-PCI's efforts to integrate SBIRT screening questions in EPIC and other EMRs are part of their push to disseminate SBIRT throughout the State.

GPRA is currently integrated into a web-based mental health system statewide (Mental Health Integrated Tracking System [MHITS]). Unfortunately, clinicians do not have access to data that they have entered, and it is challenging to integrate recent changes to GPRA questions into the system. WASBIRT-PCI is seeking sample codes from other States so data can be accessed efficiently.

The Health Information Technology, Health Integration and Implementation subcommittee of the PSC identified the following activities to improve SBIRT EMR capabilities:

- Identify and address workflow issues that adversely influence SBIRT implementation and the collection and integration of SBIRT-related data
- Identify opportunities and barriers to automating and integrating health information across different systems
- Identify common standards and procedures for compiling and sharing health information across different systems
- Examine opportunities to leverage existing health information exchange initiatives (such as One Health Port)
- Enlist a privacy officer to provide guidance on data security and privacy

Billing

Currently, SBIRT billing codes are not turned on in the State of Washington. WASBIRT-PCI estimates that the codes will be activated by July 1, 2013. WASBIRT-PCI is exploring the option of integrating billing code into the EMRs, such as EPIC so that billing is generated behind the scenes, based on the patient intervention provided. THE OHSU SBIRT medical residency program has integrated behind-the-scenes billing into their EPIC system and has been offering support for WASBIRT-PCI's efforts to adapt EPIC.

Dissemination Strategies

The Communications, Social Marketing, Training, Cultural Relevancy and Dissemination Workgroup of the PSC identified the following activities for dissemination:

- Have current sites share lessons learned with prospective clinics
- Develop strategies to improve coordination between clinics and chemical dependency and mental health treatment providers
- Develop glossary of standard acronyms used
- Create standardized messaging for WASBIRT-PCI for PSC and clinic staff
- Produce a WASBIRT Tool Kit for PSC and clinic staff
- Review current health education materials to determine recommendations for clinic use
- Work with CSAT to sponsor SBIRT training for the community in King County
- Provide input and feedback on educational and marketing tools
- Provide training throughout the county to increase knowledge and awareness of SBIRT
- Bring in guest speakers from under-represented communities to the PSC to provide education and address cultural relevancy needs
- Review list of current PSC members and increase membership to include additional members from under-represented communities
- Highlight the benefits of implementing WASBIRT as preparation for health care reform
- Develop Frequently Asked Questions materials as part of the WASBIRT-PCI tool kit
- Build collaboration and relationship among stakeholders, who often have varying philosophical beliefs regarding alcohol use
- Promote Recovery-Oriented System of Care by minimizing barriers to treatment and recovery
- Create messaging themes that focus on stigma reduction and an approach from the health and wellness perspective
- Utilize social media to increase knowledge of SBIRT and normalize routine screening for drugs and alcohol
- Train future professionals in SBIRT
- Ensure sustainability for SBIRT screening by providing education and training that foster clinician change to seeing SBIRT as routine screening
- Ensure the utilization of trainers who have experience in cultural relevancy
- Assure cultural relevancy in all manners related to communications, social media, training, and dissemination
- Promote routine SBIRT and alcohol/drug screening to reduce stigma and judgment
- Participate in association meetings and conferences in order to increase awareness of SBIRT and begin replication in other clinics and counties

The project team is in the process of broadening implementation beyond Sea Mar and Public Health-Seattle & King County to Swedish Medical Center and Harborview clinics. Swedish and Harborview are highly regarded institutions statewide, and their adoption of SBIRT carries significant weight with other medical institutions. Additionally, Swedish Medical Center recently merged with Providence Health, a prominent healthcare entity in the region, providing further opportunity for expansion.

Sustainability

Strengths

- With sustainability in mind, WASBIRT-PCI leadership is pursuing integrating multiple data collection systems and using EPIC to collect AUDIT and DAST records into patient health records.
- The grantee plans to train licensed social workers (embedded in the Swedish Medical system) in SBIRT. This measure both makes use of non-grant dependent positions and allows for service reimbursement when billing codes are turned on.
- WASBIRT-PCI leadership is motivated to pursue innovative billing opportunities beyond turning State SBIRT codes on.

Challenges

- Behavioral health specialists are an integral component of the flow for current implementation sites posing possible challenges for funding these positions beyond the grant funding period.
- The grantee is interested in making a business case for covering SBIRT primary care services under a payer system after their success under the previous grant demonstrating cost effectiveness of SBIRT in emergency departments.

Policy Steering Committee (PSC)

The WASBIRT-PCI PSC meets monthly during Year one of the grant and will continue to meet quarterly in subsequent years. Most of the PSC's work occurs in sub-committees that meet monthly. PSC consists of the following four sub-committees:

- Policy System Change Finance and Sustainability
- Progress Performance and Review, Data and Evaluation
- Health Information Technology, Health Integration and Implementation
- Communications, Social Marketing, Training, Cultural Relevancy and Dissemination

PSC members are engaged through sub-committee participation and completion of committee mission statements and specific tasks. Figure 10, below, provides specific details on the WASBIRT-PCI subcommittees.

The PSC may benefit from adding primary care physicians, particularly for the subcommittee pertaining to sustainability. In addition, having representatives from the target SBIRT population may also add a different perspective to the PSC.

In addition to the PSC, several other WASBIRT-PCI groups meet on a regular basis. The clinical implementation team meets twice a month on conference calls to discuss specific clinic issues and problem solve. The Learning Collaborative for Brief Intervention meets monthly to discuss areas of development, identify strengths, and skills-building opportunities. Finally, the core administrative WASBIRT-PCI team meets weekly to discuss programmatic issues and review a weekly performance report.

Policy, System Change, Finance and Sustainability Workgroup		
Purpose of Workgroup:	**Short-Term Tasks:**	**Long-Term Tasks:**
• Increase use of SBIRT services in community health clinic settings • Collaborate using data to (1) continuously improve the quality of the intervention and ensure fidelity to the SBIRT model, (2) build long-term support for sustaining SBIRT in the clinics once Federal funding ends, and (3) make the business case for turning on Medicaid SBIRT billing codes statewide at the end of the 5-year project period • Integrate/sustain SBIRT services in community health clinics through fee-for-service reimbursement utilizing SBIRT reimbursement codes created by CMS • Ensure financing options for SBIRT are coordinated with health care reform requirements • Ensure WASBIRT PSC's voice on health care reform, financing options, and integration of SBIRT statewide	• Conduct search across SBIRT cohorts to assess sustainability efforts nationwide • Begin work on cost benefit analysis for SBIRT, including potential for fee-for-service models, managed care, and other third-party reimbursements • Review SBIRT projects that established medical cost off sets in primary care settings • Assess and review SBIRT providers authorized to bill for patient SBI services, fidelity measures, NPI, and core provider agreements. • Assess and review billing and financing issues at FQHCs for non-covered and uninsured patients • Assess policies, rules, or other issues in health care settings that create barriers for integrating SBIRT	• Secure billing codes for Washington State. • Develop billing instructions for State-financed SBIRT • Open State billing codes for SBIRT • Secure agreements from other payers to open billing codes for SBI • Secure reimbursement for brief therapy in primary care settings • Develop SBIRT curriculum and information for use in public presentations to ensure consistent messaging • Support integrating SBIRT in non-grantee sites, such as community health settings and hospital emergency departments • RT opportunities at non-grantee sites (BH/CD, and primary care)

Policy, System Change, Finance and Sustainability Workgroup		
Purpose of Workgroup:	**Short-Term Tasks:**	**Long-Term Tasks:**
Using data to (1) continuously improve the quality of the intervention and ensure fidelity to the SBIRT model, (2) build long-term support for sustaining SBIRT in the clinics once Federal funding ends, and (3) make the business case for turning on Medicaid SBIRT billing codes statewide at the end of the 5-year project period	• Provide input and feedback on design and content of weekly reports that RDA will use to securely provide feedback to clinics regarding problems with specific patient records • Provide input and feedback on the design and content of the monthly monitoring reports RDA will share with participating clinics, partners, and the PSC	• Provide input and feedback on quarterly and annual reports to SAMHSA, which will report on progress, barriers encountered, and attempts to overcome barriers • Provide feedback on design of the process evaluation, which will help identify opportunities for program improvement and any necessary adjustments; provide feedback on the design of the outcome evaluation; develop strategies for ensuring 80 percent response rate is met and maintained for 6-month followup GPRA survey

Health Information Technology, Health Integration and Implementation Workgroup		
Purpose of Workgroup:	**Short-Term Tasks:**	**Long-Term Tasks:**
Encourage the meaningful use of Health Information Technology (HIT) to improve integration and implementation of SBIRT in community health primary care settings—to do so, the Health Information Technology Workgroup will investigate and recommend technological solutions for the following purposes: • Orient HIT toward the long-term goal of providing sufficiently integrated health information • Improve the interface between data collected through SBIRT and EMRs • Use information to improve workflow and training • More efficiently manage patient care through sharing of health information • Measure and track clinical improvement • Protect the privacy of patients • Support Medicaid SBIRT billing codes	None identified for this report	• Identify and address workflow issues that adversely influence SBIRT implementation and the collection and integration of SBIRT-related data • Identify opportunities and barriers to automating and integrating health information across different systems • Identify common standards and procedures for compiling and sharing health information across different systems • Examine opportunities to leverage existing health information exchange initiatives (such as One Health Port) • Enlist a privacy officer to provide guidance on data security and privacy

Communications, Social Marketing, Training, Cultural Relevancy and Dissemination Workgroup		
Purpose of Workgroup:	**Short-Term Tasks:**	**Long-Term Tasks:**
• Develop and implement strategies that result in universal, routine SBIRT screening in primary care throughout King County and Washington State • Create infrastructure and mechanisms to support communication, social marketing, and training, while ensuring that cultural relevance is a key element that is woven throughout the entire project • Ensure that individuals involved with the project have the appropriate tools to effectively represent WASBIRT-PCI	• Have current sites share lessons learned with prospective clinics • Develop strategies to improve coordination between clinics and chemical dependency and mental health treatment providers • Develop glossary of standard acronyms • Create standardized messaging for WASBIRT-PCI for PSC and clinic staff • Produce a WASBIRT Tool Kit for PSC and clinic staff • Review current health education materials to determine recommendations for clinic use • Work with CSAT to sponsor SBIRT training for the community in King County • Provide input and feedback on educational and marketing tools • Provide SBIRT training throughout the county to increase knowledge and awareness of SBIRT • Bring in guest speakers from under-represented communities to the PSC to provide education and address cultural relevancy needs • Review list of current PSC members and increase membership to include additional members from under-represented communities • Highlight benefits of implementing WASBIRT as preparation for health care reform. • Develop FAQ materials as part of the WASBIRT-PCI Tool Kit	• Build collaboration and relationship between stakeholders who often have varying philosophical beliefs regarding alcohol use • Promote Recovery-Oriented System of Care by minimizing barriers to treatment and recovery • Create messaging themes that focus on stigma reduction and an approach from the health and wellness perspective • Utilize social media to increase knowledge of SBIRT and normalize routine screening for drugs and alcohol • Train future professionals in SBIRT • Ensure sustainability for SBIRT screening by providing education/ training that fosters clinician change to seeing SBIRT as routine screening • Ensure the utilization of trainers who have experience in cultural relevancy • Assure cultural relevancy in all manners related to communications, social media, training, and dissemination • Promote routine SBIRT and alcohol/drug screening to reduce stigma and judgment • Participate in association meetings and conferences in order to increase awareness of SBIRT and begin replication in other clinics and counties

Figure 10: WASBIRT-PCI Sub-committees

Policy Steering Committee

Strengths

- WASBIRT-PCI has a strong, organized and diverse Policy Steering Committee. WASBIRT-PCI has clearly delineated the Policy Steering Committee roles and responsibilities. Policy Steering Committee subcommittees are effectively utilized to accomplish tasks.
- PSC includes over 30 members representing diverse perspectives including WASBIRT-PCI staff, each participating clinic site, payer organizations, public entities, Washington State Health Care authorities and non-profits.
- PSC is composed of subcommittees that meet regularly in small groups to complete specific tasks and then report back to the full PSC.

Challenges

- PSC sub-committees do not have representatives from some key stakeholders (for example primary care physicians, individuals in recovery, etc.).

Grantee Evaluation

GPRA Plan

WASBIRT-PCI is streamlining data collection and reporting by modifying MHITS, a Web-based registry used by all community health clinics in King County. Using MHITS, GPRA and alcohol/drug screening data are entered, scored, and tracked automatically. Baseline data are collected through face-to-face interviews and screening at intake. Universal pre-screening is conducted at intake using the NIAAA recommended prescreening questions for alcohol and the NIDA recommended prescreening question for drugs. An MA, nurse, or provider then reviews the pre-screen and refers the patient to the BHI if needed. The BHI screens using the AUDIT and the DAST and collects GPRA data (Section A for screen only, Sections A and B for SBI and Section A through G for SBI/RT).

Process

The goal of the WASBIRT-PCI process evaluation is fidelity monitoring to identify opportunities for program improvement and any necessary adjustments. Process evaluation for the WASBIRT-PCI program will attempt to answer the following questions:

- How well does the implementation process fit with the original design?
- Is the project meeting the intermediary objectives that lead to the desired program outcomes?
- What barriers and challenges are the clinics encountering?
- What can be done to overcome any barriers and improve the program?
- Specifically, the process evaluation tracks the following performance metrics:
- Number of patients receiving screening, brief intervention, brief treatment, and referral to treatment
- Number of staff at each clinic who are trained as both mental health and chemical dependency professionals

- Number of clinics/networks that have integrated SBIRT for substance abuse with MHIP
- Number of claims for reimbursement made to Medicaid for SBIRT services (after Year 1 at each clinic)

As part of the process evaluation, the WASBIRT-PCI evaluation team documents the implementation practices, including how the intervention is delivered, by whom, the degree to which the intervention is carried out with fidelity, and the roles of and relationships among key participants.

The evaluation team generates monthly, quarterly, and annual reports on participation and progress both across sites and by site. Reports show the number of patients screened, administered brief interventions, brief treatment, and referral to treatment. During the site visit, the WASBIRT-PCI evaluation team discussed adding graphics to display this information over time and adding annotations when relevant to explain events that impacted numbers (staff leave, change to screening administration method, etc.). These reports will be used by the administrative team to monitor progress, to motivate clinic staff, and to keep the PSC informed.

The evaluation team uses standardized templates to collect data across sites (such as number of staff trained, staff turnover rate, average time to complete screening, BI, etc.). In addition, GPRA baseline, discharge, and follow-up data are used for ongoing program monitoring and improvement.

Outcomes

The goal of the WASBIRT-PCI outcome evaluation is to evaluate the programs ability to achieve results. The evaluation team will attempt to answer the following question with their outcome evaluation:

- Is the program improving outcomes for clients and achieving measurable results?
- Can an empirical case be made for sustaining SBIRT services through fee-for-service reimbursement and expanding statewide once Federal funding ends?
- If sustained, where is the State likely to experience cost offsets in the future (e.g. Medicaid, medical costs, criminal justice system)?

The WASBIRT-PCI program will answer these outcome questions through (1) pre-post analysis of GPRA data, (2) statistically matched comparisons of WASBIRT-PCI participants and similar non-participant individuals.

WASBIRT-PCI is using GPRA data to assess the projects impact on substance abuse use, specifically:

Percentage of those screening positive for at least a BI who have reduced substance use at the 6-month follow-up

Additionally, for patients accessing BT or RT services, the grantee is using GPRA data to measure the impact from baseline to 6-month follow-up on measures of family and living conditions, education, employment and income, criminal involvement, mental health, social connectedness, access to treatment, and treatment retention.

The grantee is also linking WASBIRT-PCI participants to similar individuals and utilizes an integrated client database containing more than 14 years of longitudinal client level data across the Washington State public insurance program. Through this approach, the grantee will assess the project's impact on the following measures:

- Among WASBIRT-PCI participants with Medicaid coverage compared to a statistically matched cohort of peers:
    - Reductions in inappropriate emergency department use, medical costs, inpatient hospital admissions, and mortality risk
- Among WASBIRT-PCI participants with any DSHS service history from July 1997 forward, compared with a statistically matched cohort of peers:

    - Reduced homelessness and criminal involvement and increased labor market participation and housing stability

- Among WASBIRT-PCI participants with any DSHS service history from July 1997 forward, compared with a statistically matched cohort of peers, controlling for need for alcohol/drug treatment through the use of an indicator in the DSHS-integrated client database that has been validated against the AUDIT and DAST through the WASBIRT project:
    - Percent of patients in need of specialized chemical dependency treatment who receive it

GPRA Follow-up

Clinic staff (primarily BHIs) keep patient information up to date, including alternate phone numbers. If the BHI has trouble tracking down patients for the 6-month follow-up, the evaluation survey team takes over responsibility for tracking down the patient, conducting the interview, and transmitting follow-up data. The survey team has a track record of more than 80 percent follow-up with difficult-to-find populations.

Evaluation

Strengths

- The grantee has a clearly defined plan for evaluation including GPRA collection, GPRA Follow-up, and process evaluation.
- The grantee is self-motivated to expand on the innovative evaluation plan from the previous SBIRT grant.

Challenges

- The grantee described a need to relate results of the evaluation to staff in a manner that provides incentive and motivation.
- The grantee has interest in implementing a process evaluation that will allow them to track implementation more closely.