Results from a Five-Year Pilot Community Health Specialist-Enhanced SBIRT Workflow

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WHO WE SERVE

35
Health Centers
Across Cook and DuPage Counties

Nearly
165,000
Patients Served Each Year

We serve **16 of the 20** underserved communities in Chicago

OUR PATIENTS

58%
Hispanic

26%
African American

86% Live at or below the 200% of the Federal Poverty Level

56,000
Pediatric patients under the age of 18

4,500+
Prenatal patients cared for each year

6 out of **10**
are on Medicaid

SBIRT Model

"SBIRT is a comprehensive, integrated, public health approach to the delivery of **early intervention and treatment** services for persons with substance use disorders, as well as those who are at risk of developing these disorders…

- **Screening** quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- **Brief intervention** focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- **Referral to treatment** provides those identified as needing more extensive treatment with access to specialty care."

(SAMHSA, 2022)

History of SBIRT at ACCESS

- ACCESS has sustained a universal SBIRT workflow across all 35 health centers since 2015.
  - Workflow:
    - Annual screening for potentially risky alcohol and drug use conducted for all patients 12+
    - Pre-screening questions completed by M.A. during rooming process
    - Full screening and intervention completed as needed by medical provider
  - Limitations:
    - M.A. and medical provider workload
    - Time limitations for well-conducted brief intervention
    - Case management and follow-up
    - High completion rate and low positivity rate raised concerns about screening quality

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CHS-Enhanced SBIRT pilot

- Five-year SAMHSA SBIRT grant: September 30, 2018 – September 29, 2023
  - Funding for the enhanced SBIRT pilot program was made possible by Award Number 6H79TI081134-01M003 from SAMHSA. 100% of program costs ($3,501,145) are financed with Federal funds.
  - Pilot locations on west and south sides of Chicago:
    - ACCESS: six original pilot sites, three additional expansion sites added in year four
    - Partner organization Christian Community Health Center: three sites*
- Dedicated SBIRT Community Health Specialist (CHS) embedded in the health center at each pilot site.

*Today's presentation highlights only ACCESS workflows and evaluation findings.

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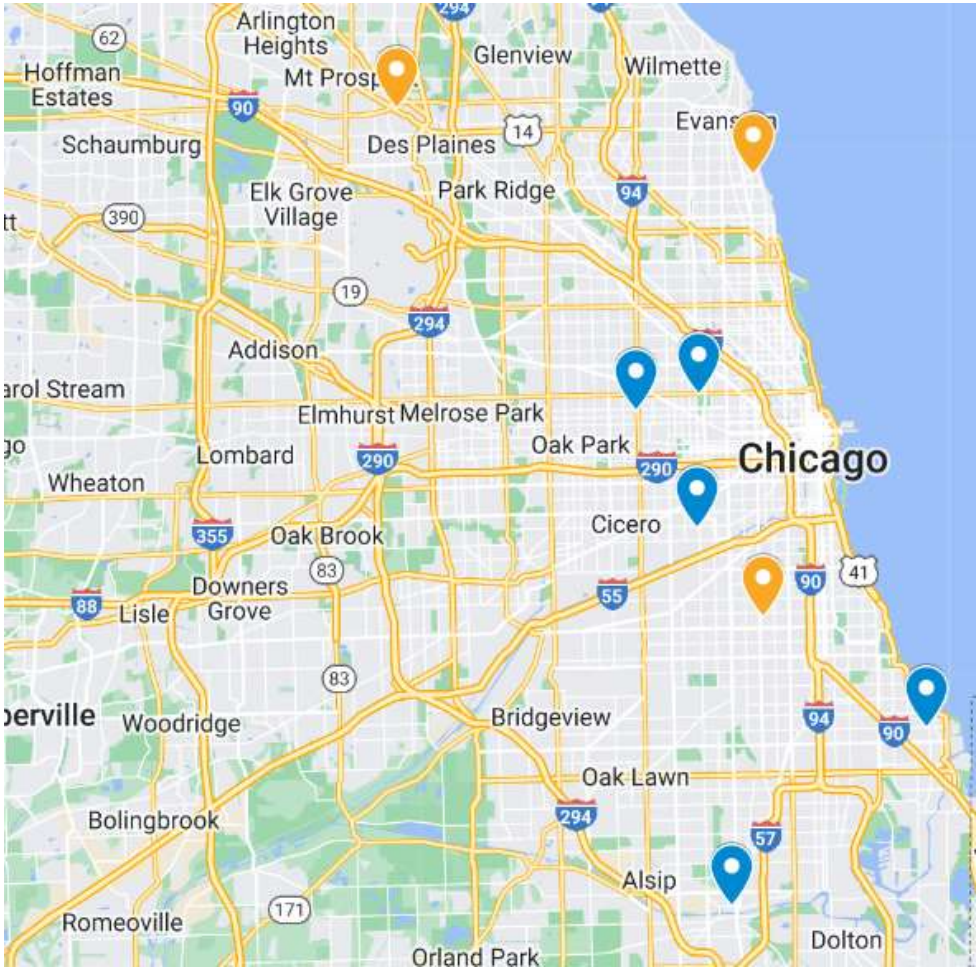
ACCESS SBIRT Locations

- Original ACCESS SBIRT Site
- Expansion ACCESS SBIRT Site



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CHS-Enhanced SBIRT Workflow

Screening

- Pre-screening completed by M.A.; full screening (and pre-screening workflow) supported by CHS
  - Adults 19+: AUDIT (alcohol) and DAST-10 (illicit drugs)
  - Adolescents 12-18: **CRAFFT-N2.1** (launched 2021)

BI

- **CHS completes brief intervention (BI)**: Motivational interview (MI), patient education
  - >50 hours of MI, trauma-informed care, and microaggression/bias training
  - Assisted by Readiness Ruler, Decisional Balance tool; discretely documented in Epic

BT/RT

- CHS refers patient to integrated and external services as appropriate
  - **Brief Treatment**: Individual behavioral health session
  - **Referral to Treatment:** M.A.R. program or external treatment services

Follow-up

- All qualifying patients: CHS attempts discharge interview within 5-6 months
- BT/RT services: CHS attempts monthly check-in throughout program

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Pilot Evaluation

- Grants Reporting and Accountability Act (GPRA) Survey
  - Required for all individuals receiving SAMHSA-funded services
  - Collected at initial screening, and approximately six months later+
  - Includes: Planned/received services, demographic, substance use+, and social determinants of health+ data
  - Collected and managed using REDCap electronic data capture tools hosted at ACCESS, then submitted to SAMHSA's SPARS data management system

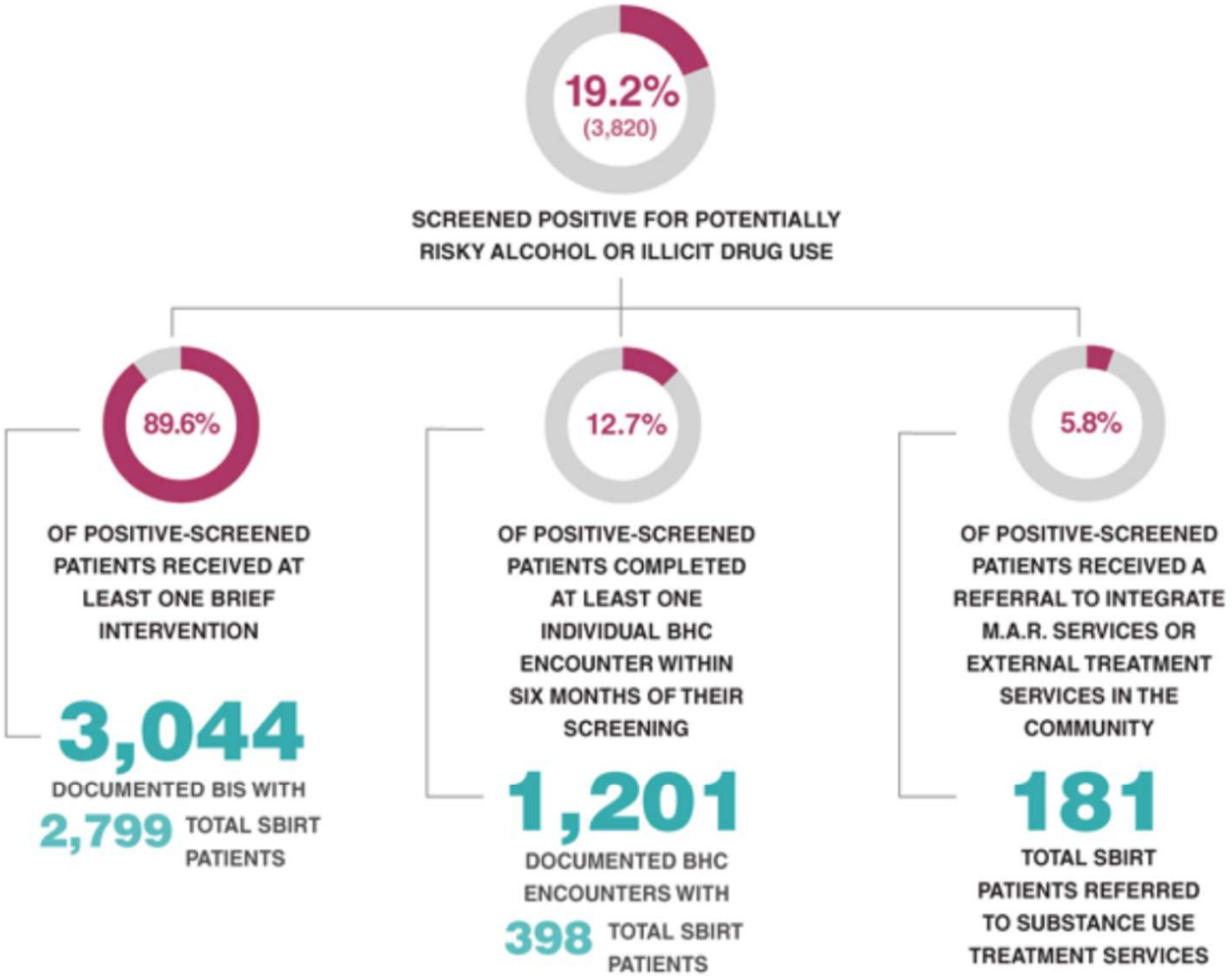
  +Only applies to positive patients assigned to BI/BT/RT services
- Electronic health record (Epic) data
  - Structured SBIRT note created to document all SBIRT CHS encounters
  - Continuous documentation of all completed screenings (all care team roles, including non-CHS and non-pilot sites)
- Original topic-specific qualitative and quantitative data collection
- Unless otherwise noted, all results highlighted in this presentation are based on GPRA data

OVERALL SCREENING RATES WERE MORE RESILIENT THROUGH THE COVID-19 PANDEMIC AT PILOT SITES COMPARED TO NON-PILOT SITES.

17,212
TOTAL PATIENTS SERVED

BY THE FINAL YEAR OF THE PILOT PROGRAM, PILOT SITES WERE DETECTING A HIGHER RATE OF POSITIVE ADULT SCREENINGS ON THE AUDIT AND DAST.

19,913
TOTAL CHS-SUPPORTED SCREENINGS



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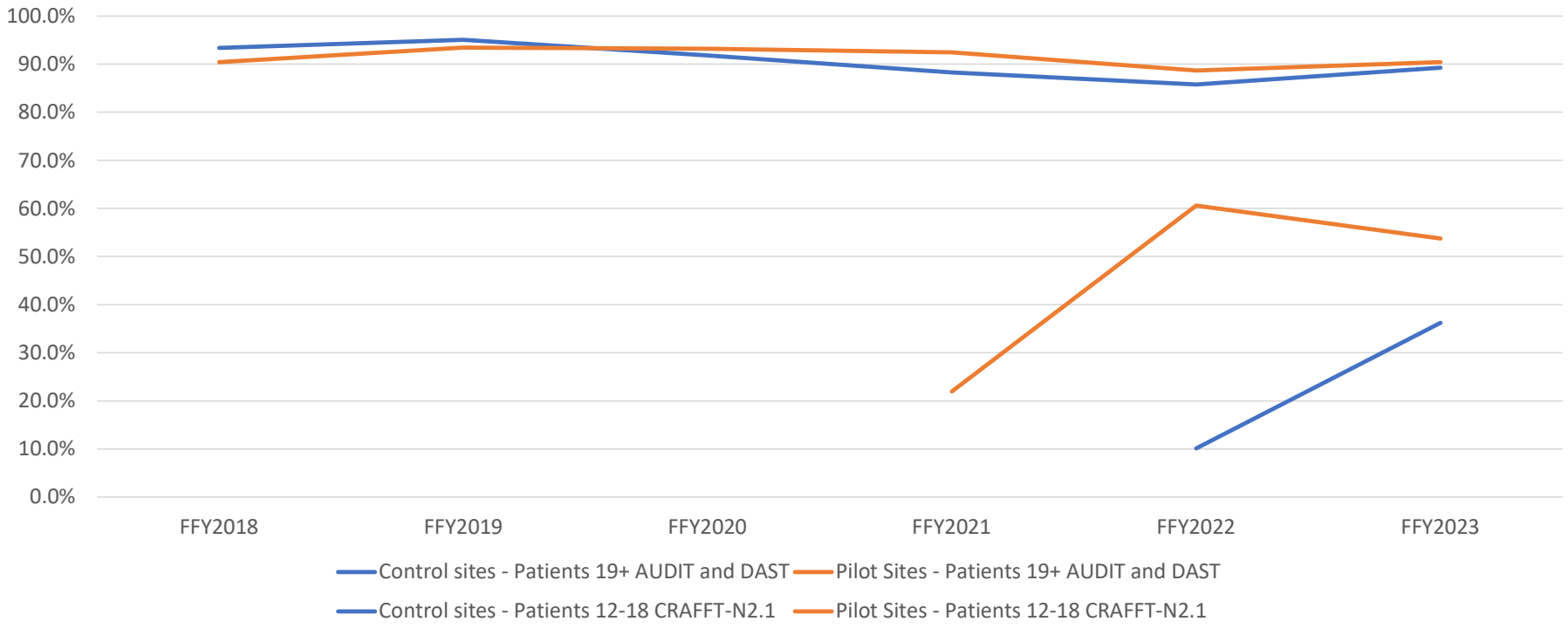
Epic-Documented Screening Rates at ACCESS Pilot Sites Were More Resilient During the Pandemic



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Staff Report CHS Services Make Screenings Meaningful

- Care team members are more committed to the screening workflow because there are effective follow-up steps when patients screen positive.

"…at some point we were kind of lost as to who we need to reach out to when people screen positive for alcohol abuse. So, once she did come here, we're like, OK, this is our resource." - Health Center Manager

"Definitely it was a good thing for the providers, for her to be here. I really think so, because then we don't just put it on the backburner. We know that [the CHS] is here to give that support to the patient, to give those resources, and if she was here, she could do it the same day. If it couldn't happen that same day, we knew that she was going to follow up - that she was going do her part in it." – Health Center Manager

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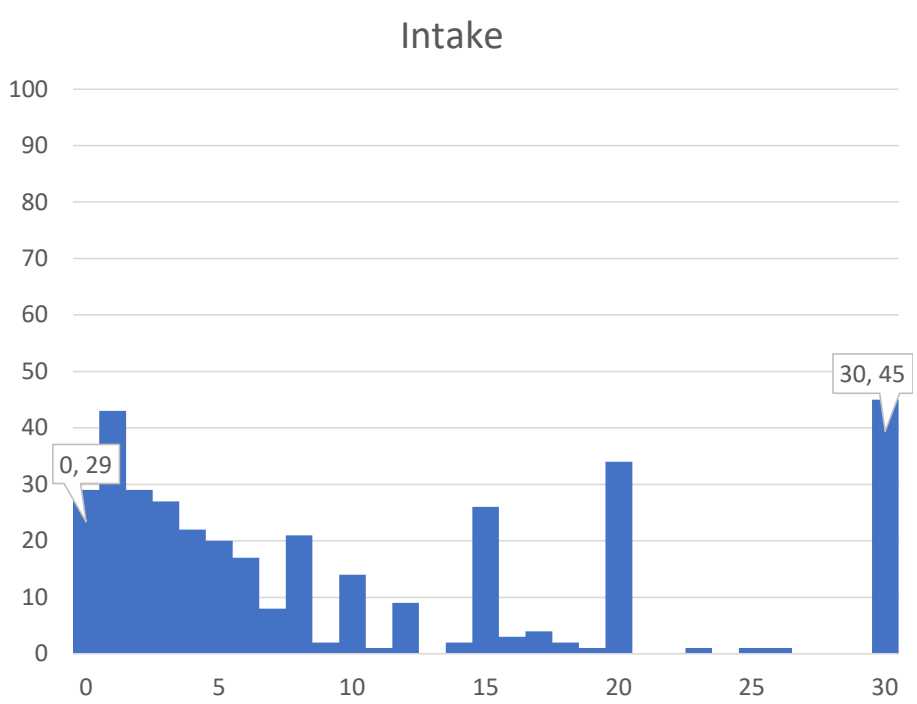
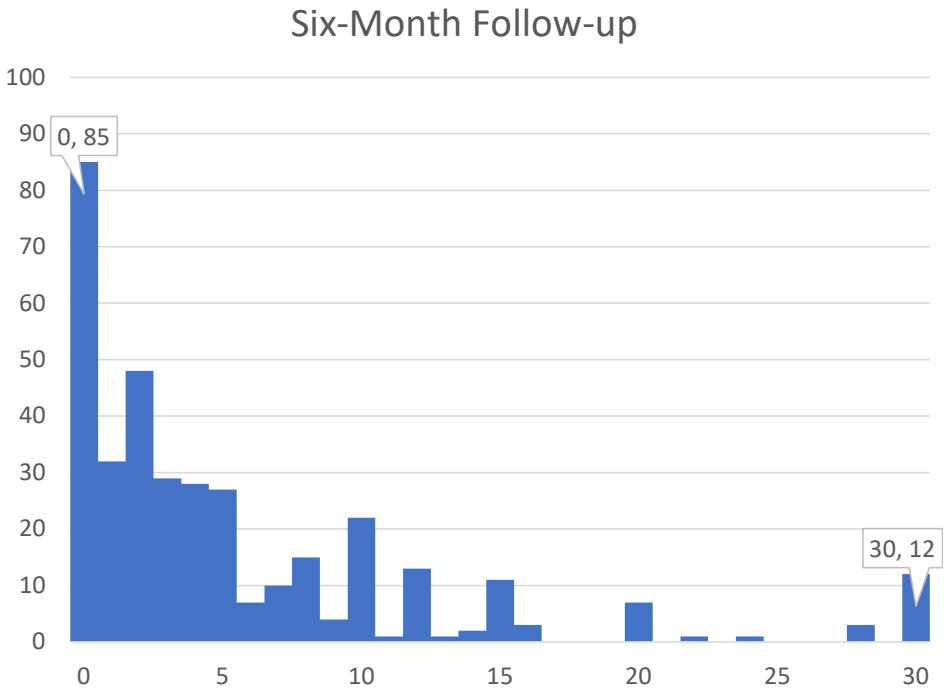
Patient-Reported Past 30-day Alcohol Use (GPRA)





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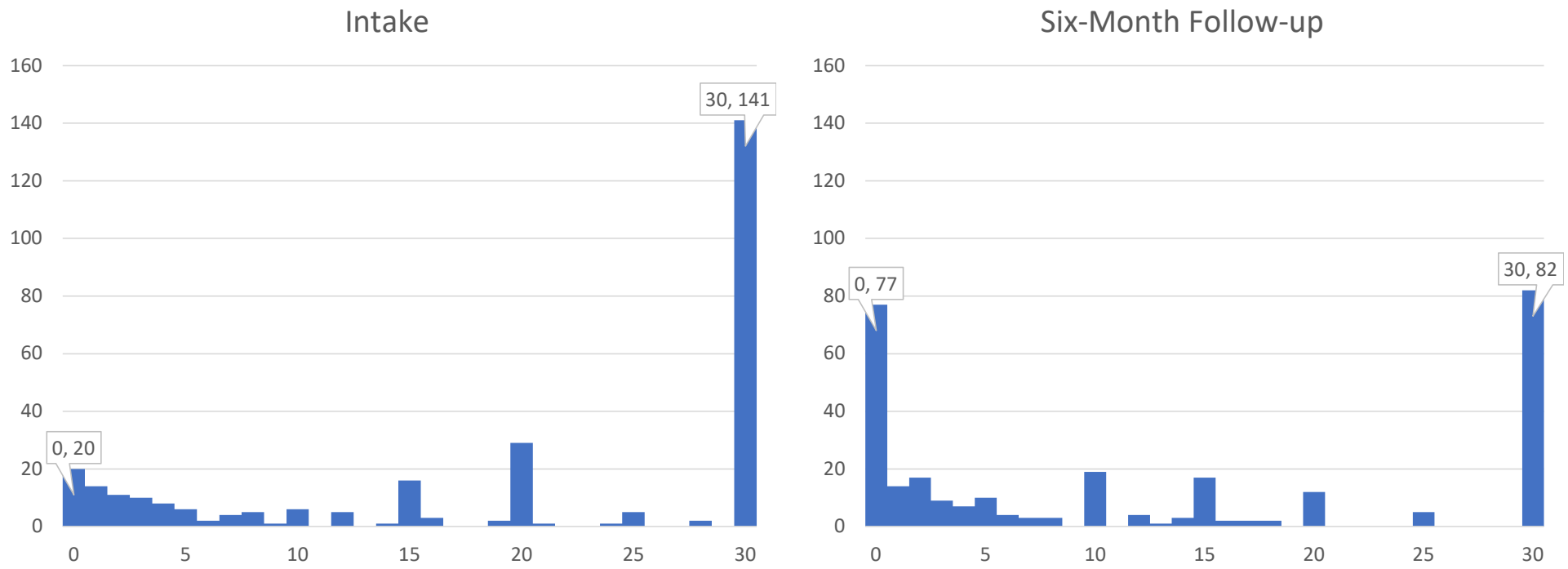
Patients reporting alcohol use at either timepoint showed a statistically significant mean reduction in their past 30-day alcohol use of 4.60 days (SD = 9.84), $t(361) = 8.90$, $p<.001$, $d=0.47$

Patient-Reported Past 30-day Marijuana Use (GPRA)



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Patients reporting marijuana use at either timepoint showed a statistically significant mean reduction in their past 30-day marijuana use of 6.88 days (SD = 13.48), $t(292) = 8.74$, $p<.001$, $d=0.51$.

DL0

Sustainability and Expansion

- SBIRT CHS and existing Medication Assisted Recovery (M.A.R.) CHS roles expanded to the Substance Use Disorder (SUD) CHS role covering full continuum of substance use care
- Telehealth and Epic-documented referrals leveraged to serve patients across multiple health centers
- CHS rotates through multiple health centers throughout the week for in-person encounters, while also conducting telehealth visits

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Slide 14

DL0 There are a lot of acronyms in here. At some point earlier, should be spelled out.
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Implementation Insights

Challenges

- Robust documentation needs:
  - Clinical encounter, screening, and intervention documentation
  - SAMHSA-required GPRA interview
  - M.A.R. assessments, waivers, etc.

Keys to Success

- Custom Epic tools
- Custom GPRA forms in REDCap
- Integrating Evaluation and IS staff into the program team
- Training all tasks (SBIRT/M.A.R.; Epic/ REDCap) as one continuous workflow

Implementation Insights

Challenges

- Consistent delivery of high-quality brief interventions

Keys to Success

- Robust and continuous training
  - Motivational Interview Network of Trainers (MINT)
  - Group training, print materials, role play, and individual coaching
  - Ongoing refresher activities in team meetings
- Retaining experienced CHS

Implementation Insights

Challenges

- Financial sustainability

Keys to Success

- Leveraging telehealth and referral workflows to maximize CHS presence
- SBIRT billing codes (not implemented by our pilot program)
  - Billed to Medicaid/Medicare (zero cost to patient)
  - CHS-provided services must be supervised and approved by provider

Summary of CHS-Enhanced SBIRT Advantages

- More resilient screening workflows at pilot sites
  - Screening completion rates remained higher and recovered faster at pilot sites during COVID-19 pandemic
- Follow-up services
  - Approximately **90%** of positive patients screened by CHS received brief intervention
  - Higher than expected referrals to BHC
- Decreased substance use
  - Positive-screened patients engaging in intake and follow-up encounters showed a statistically significant decrease in alcohol and marijuana use

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Appendix

CHS and Integrated Behavioral Health (GPRA)

- **44%** of patients who received BHC services were not originally identified for BT services based on their substance use
- Patients that had at least one BHC encounter had, on average, more CHS-led BI sessions than patients with no BHC encounters, t(246.79) = -5.16, p<.001, equal variances not assumed, F(1,1224) = 10.40, p=.001

Identified for BT services at intake	(n)	Completed at least one BHC encounter (n)	%
Yes	1002	222	18.1%
No	1723	176	9.3%
Total	2725	398	12.74%

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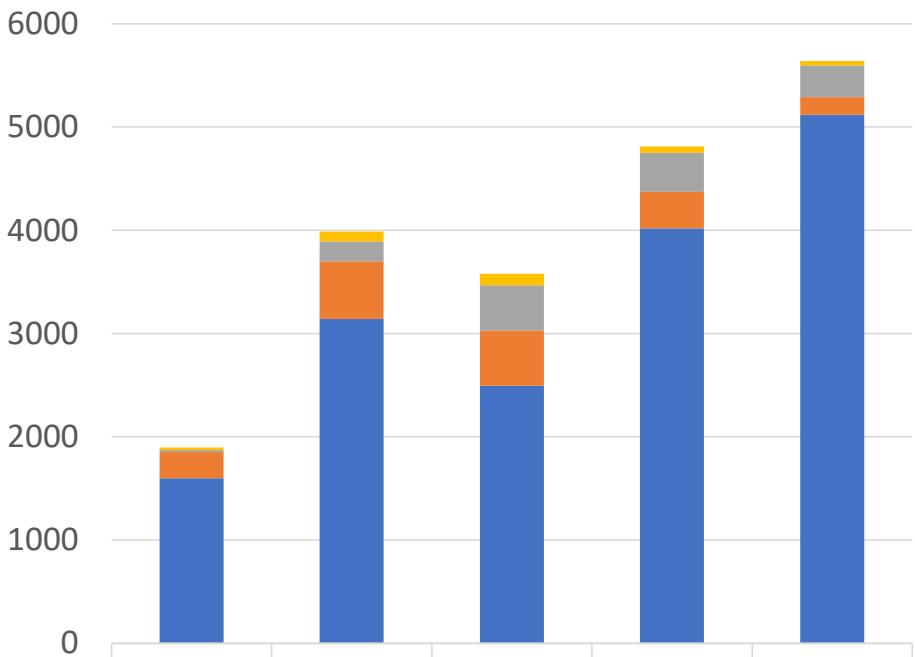
GPRA Intakes by Highest Planned Service Level by Federal Fiscal Year (FFY)

- 2019 (9/29/18-9/30/19):
  - Initial development and launch
- 2020 (9/29/19-9/30/20) – 2021 (9/29/20-9/30/21):
  - COVID-19 pandemic and recovery
  - Development of telehealth services
- 2022 (9/29/21-9/30/22):
  - Expansion sites
  - Adolescent/CRAFFT workflow expansion
- 2023 (9/29/22-9/30/23): :
  - Final push to meet grant deliverables
  - Expansion sites and cross-training



	2019	2020	2021	2022	2023
Referral to Treatment	23	95	112	63	43
Brief Treatment	18	194	440	378	307
Brief Intervention	255	558	533	355	173
Screening Only	1599	3140	2493	4017	5117

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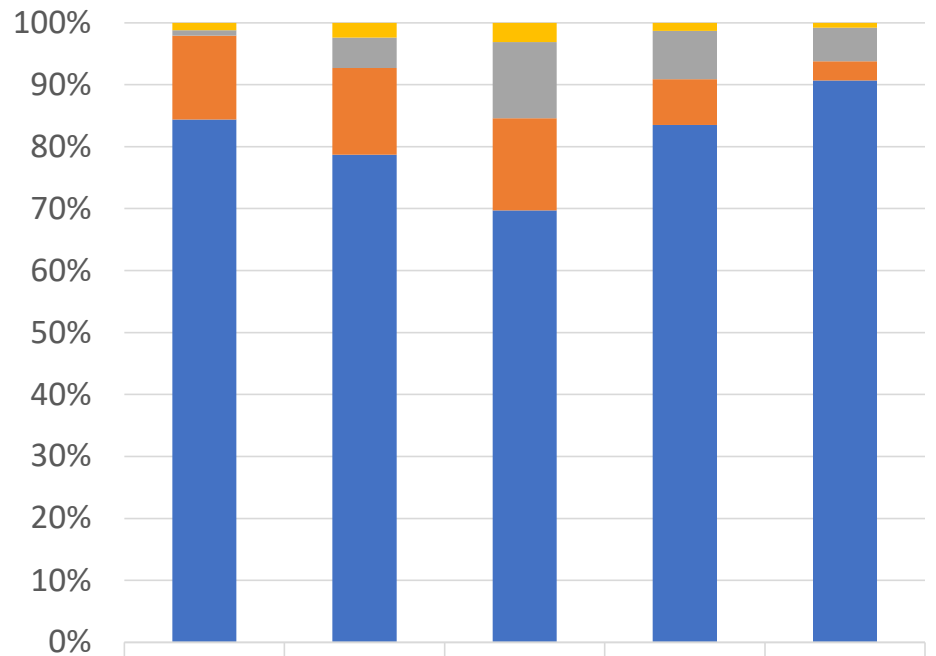
Intakes by Planned Service Level by FFY

- 2020-2021
  - More targeted outreach and screening-follow-up during pandemic
  - Many BI patients escalated to BT for general behavioral health needs
- 2023
  - New GPRA may underrepresent planned services
    - declined services not consistently captured as planned services
  - Preventive follow-up screenings with established SBIRT patients
  - Focus on expansion



	2019	2020	2021	2022	2023
Referral to Treatment	1.2%	2.4%	3.1%	1.3%	0.8%
Brief Treatment	0.9%	4.9%	12.3%	7.8%	5.4%
Brief Intervention	13.5%	14.0%	14.9%	7.4%	3.1%
Screening Only	84.4%	78.8%	69.7%	83.5%	90.7%

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Slide 24

DL0 You need to label the graphs. It is confusing since it is the same time preiod and showing the same information - but one is actual number and the other is percent of total. I would choose one or figure out how to combine. I usually prefer percentages given the large number of patients. The story isn't very different. Unless I am missing something.

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