The Screening, Brief Intervention, Brief Treatment and Navigation to Services (SBINS) Model
Frequently Asked Questions – January 30, 2019

I work in a primary care practice (or emergency department) that is interested in participating in SBINS. How do I find out more information about the expectations and process for participating in SBINS?
If you are interested in learning more about SBINS for your practice or ED, please contact your local Blueprint for Health Program Manager first! We want to ensure that our community efforts are well-coordinated; communicating with our local Program Managers is absolutely essential to ensuring a coordinated approach. That said, our information can be found on the same page, and we are happy to support you.

Is participation in SBINS mandatory?
No! Blueprint-participating primary care practices and Emergency Departments choose to participate in SBINS, as is true for all Blueprint for Health programs. Hence, an attestation document, representative of volitional participation, was included as part of the readiness package submission required under SBINS. Blueprint for Health Program Managers, located in our 13 health service areas, are available to support interested primary care practices and EDs in understanding the Blueprint for Health program, the specifics of the SBINS model, readiness package requirements (attestation form and elements of an implementation checklist), and overall process.

When can we begin hiring for the SBINS positions?
The SBINS model is currently in the planning phase. If funded, the SBINS model was designed to support the equivalent of 19 full-time equivalents (FTEs) of staff in the 14 hospital Emergency Departments (EDs) throughout Vermont, 16 FTEs in FQHC primary care settings, and 55 FTEs in hospital-owned and independent primary care practices, all working together to integrate mental health into primary care and emergency department settings, meet patients where they are, and support improved health and well-being for Vermonters.

In addition, the SBINS model was designed to support up to 3 FTE Quality Improvement/Implementation Support Staff (please reference page 3 of the SBINS planning guidance document for more information). It is important to note that SBINS remains a proposed initiative currently; while some one-time Tobacco Settlement Funding has been allocated to continue SBIRT services in the 4 original Emergency Department SBIRT sites (St. Albans, Central Vermont, Rutland, and Bennington) that are transitioning their services from SBIRT to SBINS, and many communities to plan for SBINS implementation, the model has not yet been funded.

For Blueprint-participating primary care practices interested in participating in SBINS, the planning guidance document states the funding to support SBINS would be based on the number of attributed Medicaid members for the practice. What age groups were included in the attribution methodology?
Ages 1+ were included in the proposed attribution methodology for initial calculations of a full-population approach, intended to estimate the number of Medicaid members by primary care setting type. The attribution methodology for SBINS is currently in the process of being finalized, following feedback received from key stakeholders, after release of the initial estimates.

Are there any licensing requirements for staff?
There is not a requirement for staffing by a specific type of professional. Instead, Blueprint-participating primary care practices and EDs are asked to work with their local Blueprint for Health Program Manager to assess their

current staffing, and determine what additional type of staffing is required in order to meet all 5 of the core components of the SBINS model. Following the precedent established by the Community Health Team program, the Blueprint has allowed the greatest amount of flexibility possible to support each Health Service Area in considering existing staff within the Community Health Team and practices, and in determining the type of professionals needed to support development of a multidisciplinary, integrated care team that can supplement the services available in primary care practices for well-coordinated care that is focused on prevention and wellness, and that can meet the community's health needs.

We believe that the SBINS model requires highly-skilled, licensed professionals working at the top of their licenses to best deliver all of the services required under the SBINS model. However, we also recognize that workforce shortages require innovative approaches for supporting increases in the licensed mental health clinician workforce, and that some services included under the SBINS model, such navigation for health-related social needs, do not require licensed clinical staff for effective delivery.

What skill development/training is required for staff that would be funded through SBINS?

In addition to the standard training and orientation that Community Health Team members are given, some of the additional considerations for skill development and orientation of individuals fulfilling functions related to SBINS:

- Overall process, rationale for SBINS;
- Screening tool(s) – Primary and Secondary;
- Assessment;
- Motivational Interviewing;
- Trauma-informed Care;
- Care Coordination Principles and Tools (e.g. Care Navigator);
- Topic Specific – Mental Health, Substance Use, Suicide, Housing, Food and Nutrition, Interpersonal Violence.

Some of these trainings will be offered by the State of Vermont.

- Integrated care trainings offered by the State began in January of 2019. These trainings offer current Community Health Team members an opportunity to learn about tools and strategies for integration, effective use of Motivational Interviewing, screening techniques, assessment, and a more general introduction to the opportunities for working with a broad range of patient goals. Any Community Health Team staff (Patient-Centered Medical Home, Medication Assisted Treatment and/or Women's Health Initiative) staff can attend.

The State is currently in discussions about how to best coordinate and offer trainings for suicide prevention and evidence-based interventions for suicidality, Motivational Interviewing, and for effectively building referral relationships at the community-level.

I'm completing some of the implementation checklist materials and I am wondering if the Blueprint has an expectation for how many patients I should begin screening as I look to incorporate SBINS into my existing workflow?

In the planning guidance document, we tried to emphasize the expectation of universal screening (the gold standard to ensure we don't miss identifying patients who have depression, suicidality, substance use disorder, or

a social need). We state that the PCMH or Emergency Department should "develop and implement policies, procedures, and clinical workflows for the evidence-based practice of systematically **screening all patients** for …" (see page 7). That said, we also ask the teams to define their patient population under the implementation checklist (page 9), recognizing that some practices will want to begin with a smaller population – e.g. tying screening to annual preventative visits as the practice first begins implementation. We leave it open for teams to propose how they would do this during the implementation period, and we set the expectation of all patients as the eventual goal.

I know that Vermont Medicaid has proposed investments into the Blueprint for Health's Community Health Team program to support SBINS moving from planning to implementation, though no financial commitment has yet been made (Nissa made that really clear at a SBINS change leadership session, thank you!). Would this mean that we are only expected to screen Medicaid patients?
The Blueprint for Health believes all patients, regardless of their insurer, should be screened because early identification of, and the provision of effective interventions for, factors that negatively impact health is absolutely essential for improving population health and for improving health and well-being for individual Vermonters.

What conditions (or domains) should my practice be screening for under SBINS and which tools should we using?
We have outlined that SBINS is designed to ensure all patients are screened for depression, suicidality, substance use disorder, social determinants of health, and patient perception of health, but we do recognize that this may take time to achieve. We leave it open for teams to propose if they will implement screening, brief intervention and treatment, and navigation to services for all domains at once or sequentially over time (e.g. start with depression, suicidality, and substance use, then add food insecurity after 2 months, housing instability after another 2 months, etc.). The Blueprint provided a recommendation for a brief, initial screening tool and will review requests to modify or substitute tools/questions, providing that the plan demonstrates a research-based rationale. Additional domains may also be added to the initial brief screen, be conducted as a secondary screen, or as part of the assessment process, if the practice wishes (e.g. pregnancy intention).

Do we need to screen for everything (depression, suicidality, substance use disorder, interpersonal violence, housing instability, and food insecurity) at the start of our implementation?
A Blueprint-participating primary care practice or ED may choose to implement one domain (e.g. depression) first – ensuring adequate workflow, staff skills, referral agreements, etc. are in place before proceeding on to the next domain. As part of the readiness package submission, the practice or ED should provide a clear plan and timeline to the State that describes how implementation will occur for all domains.

Can we add questions to the initial, brief screen?
As part of your readiness package submission, you are welcome to provide a description of the rationale and evidence base for any additional or alternative questions proposed for screening. The State will review all readiness package submissions and contact you with any follow-up questions before approval for participation in SBINS is issued.

During the SBINS Change Leadership sessions, it was shared by an ED that implemented under VT SBIRT that asking a patient about what services they currently receive or might be eligible for has been added with great

success (in this example, the clinician asked about military service – and began making referrals to Veteran's Affairs on an almost daily basis).

What is the difference between Brief Intervention and Brief Treatment?
Brief intervention is the ability to respond in real time to the screening results of the patient and address any pertinent needs while establishing a therapeutic relationship. Brief treatment is limited to approximately 3 sessions, intended to engage patients in short term change strategies that will provide immediate/bridge treatment and care management services. The intent is to assist the patient in transitioning to a longer-term relationship to address their needs and goals.

What is meant by navigation to services? How is it different than referrals?
Navigation to Services assures that support is readily available to assist individuals in accessing the services they need for improved health and well-being – it is an active process! Thus, building relationships with community partners will be essential; eco-mapping is a tool that has demonstrated effectiveness for starting this process. Organizations will need to work through MOUs or another type of interorganizational agreement in order to establish a shared understanding of expectations for responsiveness, information sharing, etc. (see template on pg. 21 of the planning guidance).

What is required for reporting and evaluation?
SBINS participation requires that there is a systematic plan for capturing key process and outcome information relevant to implementation. From a process perspective, this information may include #/% screens completed, #/% brief interventions indicated and provided, #/% brief treatments indicated and provided, #/type of connections for supports and services made and completed. From an outcome perspective, this information may include scores resulting from screening and assessment tools initially and re-administered (e.g. to demonstrate improvement in symptom burden), and patient experience of care results. At the end of the day, we want to be able to show that we have been effective – and that Vermonters are better off because of our combined efforts through SBINS!

What if my EMR cannot be modified to capture standardized SBINS information?
Some concerns were raised that existing EMRs do not have the capacity to be modified for collection of this information. How the EMR will be used to collect this information should be described in the submitted readiness package. For example, if the EMR cannot collect/report the necessary information, a description of the work-around plan should be provided.

Is there any funding to support EMR modifications?
At this time, there is no additional funding for EMR modifications. The State is exploring federal funding opportunities to support inclusion of health information technology into the implementation of SBINS.

How will evaluation occur if tools are not standardized?
The ideal implementation would have consistent tools used systematically across the state, but we recognize the importance of working with what practices already have in place and the need to be responsive to the various patient populations served. Our recommendation is to choose the tools that make most sense within the parameters laid out within the Planning Guidance Document. We will be reviewing each plan submitted as part of a readiness package against what is outlined in the SBINS implementation guidelines. We anticipate that

there will be more in common across participating practices and EDs than not. Just as SBIRT to SBINS is an evolution, the SBINS implementation process will need to be adaptable in order to balance setting circumstances and needs with the need for programmatic evaluation. We are exploring an opportunity to see if IT solutions – tablets, kiosks or smart phones – may be able to assist with both consistency of statewide implementation and standardization.

Is billing fee-for-service (FFS) allowable under SBINS participation?
As always, any staff funded through our Community Health Team (CHT) program, including our Spoke and Women's Health Initiative staff, should never bill fee-for-service for services provided during their time funded under an alternative payment arrangement (e.g. the CHT program, including Spoke and WHI-funded staff).

Non-CHT staff could potentially bill fee-for-service for services where codes are available (e.g. screening and brief intervention services), as long as the services provided are eligible per the requirements for billing, and were not double-billed (again, you cannot bill FFS for services provided by staff funded through CHT, including Spoke and WHI-funded staff). Very specific requirements apply for some billing codes, and there is variability by payer.

Do we need different workflows for different patient populations?
We would expect different workflows based on population (e.g. pediatric vs. adult), and variation by settings. If your site participates in the OneCare Vermont network, you will likely need to reflect workflows that would incorporate documentation in a shared care plan. Workflows should also reflect emergent, urgent, and non-urgent responses.

How do we screen our pediatric population?
There are recommendations that exist for screening tools specific to various ages within the pediatric population; the recommendations do change depending on the age of the child. Bright Futures, of the American Academy of Pediatrics, is a great resource for those looking to identify appropriate pediatric screening and assessment tools. For younger children, many of the recommended screening tools are designed for parents to provide answers to the questions; for youth aged 12 and older, the recommendations include screening tools that practices may already be familiar with, such as the CRAFFT for substance use. Consistent with our recommendation, Bright Futures does recommend universal screening (their recommendation is specific to issues such as child development, maternal or adolescent depression, substance use and oral health at selected pediatric visits). Please see https://brightfutures.aap.org for more information.

What is YSBIRT?
YSBIRT is a federal grant that was received by the Center for Behavioral Health Integration that focuses on SBIRT implementation specific to adolescent populations (defined under this grant as 12 to 25 years old). There are currently 7 sites signed up for the first cohort. Grant funding is for a term of 18 months. The Center for Behavioral Health Integration has been working closely with the Blueprint to ensure alignment between YSBIRT and SBINS as much as possible.

Is there any funding for telemedicine?
Telemedicine funding opportunities exist through HRSA Office of Advancement of Telehealth (OAT) https://www.hrsa.gov/rural-health/telehealth/index.html. In addition, the Department of Vermont Health Access (VT Medicaid) released information to providers through the November 2018 Advisory in order to provide answers to frequently asked questions about telemedicine. The Advisory may be accessed here: http://www.vtmedicaid.com/assets/advisories/November2018Advisory.pdf

We would like to expand the tobacco screening question to include nicotine-containing products. Do you know if the new work of YSBIRT and its screening recommendation reflects the changing community conditions?
When the Blueprint for Health first began working with VT SBIRT, we tried to ensure our recommendations were aligned for the initial, brief screening tool. To that end, we do know that YSBIRT has updated both the tobacco and prescription medication questions that were previously used during the work completed through VT SBIRT for YSBIRT. The updated questions are as follows:
1) In the past year, how many times have you used tobacco or any nicotine products? (Examples: including cigarettes, e-cigarettes, juuling, chewing tobacco, etc.)
2) In the past year, have you used prescription opioids just for the feeling, more than prescribed, or that were not prescribed for you? (Examples: Fentanyl, Oxycodone, Percocet, Oxycontin, etc.)
3) In the past year, have you used non-opioid prescription medications just for the feeling, more than prescribed, or that were not prescribed for you? (Examples: Ritalin, Adderall, Klonopin, Ambien, etc.)

For all 3 updated questions, YSBIRT uses the five response options of: Never, Once or twice, Monthly, Weekly or more, Daily

INTERESTED IN LEARNING MORE ABOUT THE SBINS MODEL?

General Inquiries – Contact the Blueprint's Central Office Staff based at the Waterbury State Office

Inquiries from EDs or Practices interested in participating in SBINS – Contact your local Blueprint for Health Program Manager