Integrating Behavioral Health into Primary Care: SBIRT at CHCB

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CHCB

- Federally Qualified Health Center
- 18,000 patients – 15,000 medical and 3,000 dental
- Sites:
- Riverside Health Center – Main site
- Keeler Bay Health Center – S. Hero
- Safe Harbor Health Center - Health Care for the Homeless
- Pearl Street Clinic – Adolescents ages 13 - 26

Current Behavioral Health Staff

Behavioral Health Clinicians/Therapists:

- 8 at our main site
- 2 at SHHC, 1 at Pearl Street clinic
- 1 at Keeler Bay

Clinical Care Coordinators:

- Project Launch – children ages 0 – 8
- MAT Team – suboxone treatment, 1 Spoke RN and 1 BH Clinical Care Coordinator

Case Managers:

In the Process of hiring 2 social work case managers

Psychiatry: 1 Psychiatrist, 2 psychiatric nurse practitioners

Integration of Behavioral Health into Primary Care at CHCB

- 2000: Started hiring additional social workers for clinical work.
- 2001: Building renovation. Moved downstairs and created POD model. Clinical Social Workers integrated into the POD structure.
- 2002: Received our first Mental Health/Substance Abuse expansion grant to integrate mental health and substance abuse into primary care. Able to hire more clinical staff – Behavioral Health Consultation Model.
- 2002 - 2005: Participated in the National Depression Collaborative
- 2008: Received our second MH/SA Expansion grant.
  * Hired an additional clinical social worker at Safe Harbor site to staff our Housing First Program
  * Added psychiatry
- 2014: Received our third MH/SA Expansion grant.
  - * Adding child therapy, case managers, .5 psychiatric nurse practitioner

BH Services for CHCB Patients

- Behavioral Health Consultation in medical clinic
- Co-occurring counseling/therapy for mental health and addiction
- Case management
- Care coordination and panel management
- Psychiatry
- Refugee mental health

Co-located Counseling Services

- Clinicians: Dual Licensure (LICSW + LADC)
- Individual Therapy: depression, anxiety, trauma, addiction, adjustment, stress reduction
- Groups:
  - Managing Chronic Pain
  - Insomnia
  - Clinical Stress Reduction
  - Co-Occurring Recovery Group
  - Stress reduction for Refugee patients

Approaches

- Cognitive Behavioral Therapy
- Dialectical Behavior Therapy, DBT skills
- Seeking Safety
- Mindfulness training
- Relaxation training
- Eye Movement Desensitization Reprocessing, EMDR
- affect regulation

Embedded BH into primary care team: BH Consultation Model

- CHCB Delivery System Design in medical clinic: pods
- Medical Team: Medical Providers, Nurses or MAs, and LICSW/LADCs
- *Allows for:*
  - Routine BH screening and brief intervention and referral as part of visit
  - Curbside Consultation by BH
  - BH integration at point of primary care visit
  - Real Time BH consultation

Advantage of on-site Behavioral Health
Number of Visits by Primary Diagnosis – *UDS Report (2013)

Depression and other mood disorders: 7,606

Alcohol Related Disorders: 1,492

Other Substance Related Dx: 2,472

Anxiety Disorders, including PTSD: 6,385

Other Mental Disorders: 2,108

*Uniform Data System

Total BH visits last year

- 2,118 different individuals who received therapy services

- 8,273 BH visits last past year with Behavioral Health Clinicians

- Approx 4,172 were for 45 – 60 minute therapy sessions

- 1048 visits with psychiatry or psychiatric nurse practitioner

Primary Care BH: 20 – 30 mins BH Intervention

- LICSW/LADCs
- Screening
- Assessment/Diagnosis
- Provide brief intervention, coping skills training/ CBT skills, or self management goal setting
- Referral/linkage to other resources
- Consultant to Patient and Medical Provider – provide “curbside consultation” in real time.

Brief Interventions for:

- Depression
- Anxiety
- Addiction
- Smoking cessation
- Insomnia
- Stress Reduction
- Other medical conditions that would benefit from BH/Behavioral medicine interventions
- Motivational Enhancement

SBIRT Grant

CHCB Invited to join the VT Department of Health in applying to SAMSHA for a grant to implement SBIRT

- VT SBIRT includes:
  - CHCB
  - CVMC Emergency Department
  - Health Center in Plainfield
  - Three free clinics (Peoples, Rutland, Bennington)

- Year Two - new sites joining
  - UVM Student Health and Wellness
  - Rutland Regional Medical Center Emergency Department

Why is SBIRT Important?

- Unhealthy and unsafe alcohol and drug use are major preventable public health problems resulting in more than 100,000 deaths a year.
- The costs to society are more than $600 billion annually
- Effects of unhealthy use have far reaching implications for the individual, family, workplace, community, and the healthcare system.

Effective in Primary Care

- Patients are open to discussing their substance use with their physicians and PC team to help their health
- Research shows that SBIRT is effective
- Saves money in the health care system:
  - A randomized trail in family physician health clinics compared problem drinkers who received Brief Intervention vs. usual care
  - The total average cost per patient of brief intervention (inclusive of patient costs + clinic costs) was $205.00
  - The total average benefit per patient (based on savings in ER and hospital use, and in costs due to crime and auto accidents, for intervention vs. control patients) was $1,151. (Sources: Fleming et al., 2000, 2002).

Good Match

- We felt that we could do universal screening on a broader scale
- We had some history with this approach
- Integrated BH for a while
- We are trying to implement this modality on a larger scale through universal screening. Hope to screen 8,000 patients in our first year.

Population Focused Approaches

- SBIRT shares components of some other population focused approaches, including the chronic care model for the treatment of depression in primary care or tobacco cessation.

Depression

- MacArthur Initiative and IMPACT models include:
  - Universal screening using evidence based screening tools.
  - Score on PHQ-9 suggests intervention
  - Includes brief counseling component- Problem Solving Therapy, PST
  - Self management goal setting.
  - Community supports (Groups, MH Recovery supports, Healthy Living Workshops, NAMI, etc.).
  - Use of Technology – tracking, reporting, panel management using the electronic health record.

MacArthur Initiative - Depression

DIAGNOSTIC CATEGORIES FOR DEPRESSION

PHQ-9 Symptoms & Impairment	*PHQ-9 Severity*	*Provisional Diagnosis*	*Treatment Recommendations***
1 to 4 symptoms, functional impairment	< 10	Mild or Minimal Depressive Symptoms	- Reassurance and/or supportive counseling - Education to call if deteriorates
2 to 4 symptoms, question a or b +, functional impairment	10-14	Moderate Depressive Symptoms (Minor Depression)*	- Watchful waiting - Supportive counseling - If no improvement after one or more months, consider use of antidepressant or brief psychological counseling
☐ 5 symptoms, question a or b +, functional impairment	15-19	Moderately Severe Major Depression	-Patient preference for antidepressant and/or psychological counseling
☐ 5 symptoms, question a or b +, functional impairment	≥ 20	Severe Major Depression	- Antidepressants alone or in combination with psychological counseling

*If symptoms present for > 2 years, Chronic Depression, or functional impairment is severe, remission with watchful waiting is unlikely, immediate active treatment indicated for moderate depressive symptoms (minor depression).

Tobacco Cessation – 5 As

- ***Ask*** – Do you use tobacco?
- ***Advise*** – About the health risks of smoking
- ***Assess*** – Readiness to Change (pros and cons of use) and assess level of nicotine dependence with Fagerstrom Tolerance Questionnaire (evidence based screening tool).
- ***Assist*** – Assist with NRT if indicated
- ***Arrange*** – for support, including Cessation Support Group, Quit Line.

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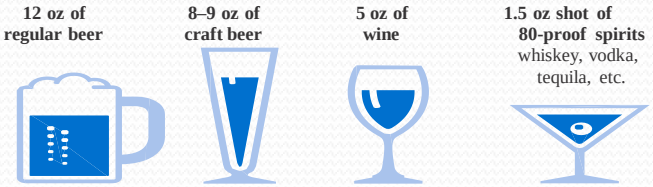
Screening, Brief Intervention & Referral to Treatment

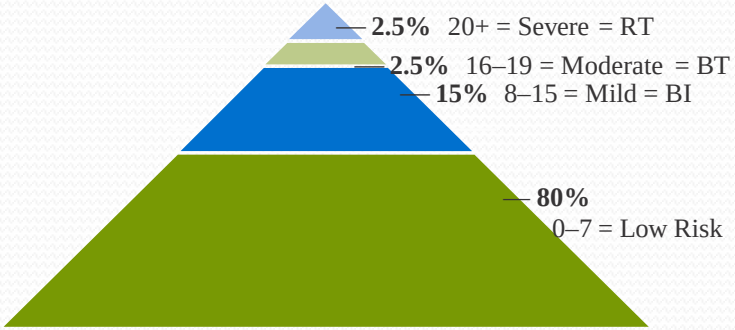
Low-Risk Drinking Limits

	Drinks/ day	Drinks/ week
Men	4	14
Women & 65+	3	7
Pregnant Women	0	0



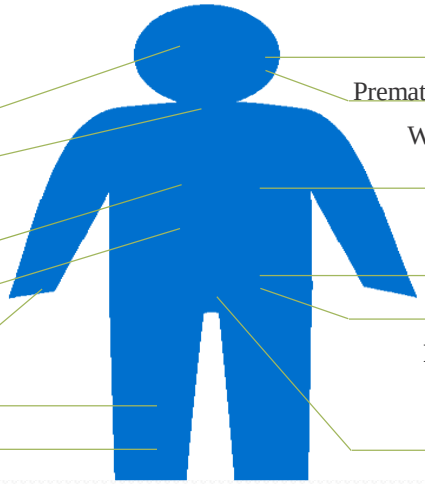
Percent of alcohol may vary.

AUDIT-10 Scores & Risk Level



Percentages may change depending on population sample. Initial screening shows 80% screen in the low risk category and don't require further screening.

Effects of High-Risk Drinking



Aggressive, irrational behavior. Arguments. Violence. Depression. Nervousness.

Cancer of throat & mouth.

Frequent colds. Reduced resistance to infection. Increased risk of pneumonia.

Liver damage. Ulcer.

Trembling hands. Tingling fingers. Numbness. Painful nerves.

Impaired sensation leading to falls.

Numb, tingling toes. Painful nerves.

Sleep disturbance. Alcohol dependence. Memory loss.

Premature aging. Persistent facial reddening.

Weakness of heart muscle. Heart failure. Anemia. Impaired blood clotting.

Breast cancer.

Vitamin deficiency. Bleeding. Severe inflammation of the stomach.

Vomiting. Diarrhea. Malnutrition. Inflammation of the pancreas.

In men: Impaired sexual performance. **In pregnant women:** Consuming even one drink daily can lead to serious birth defects, including facial deformities and neurological deficits.

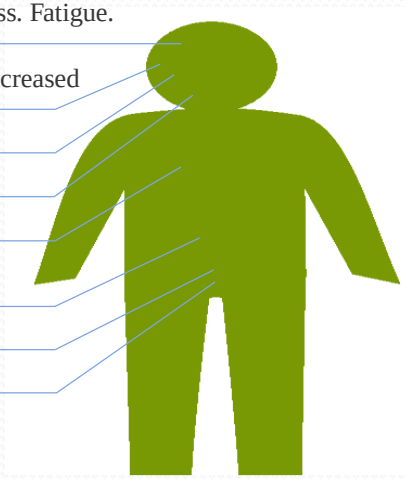
High-risk drinking may lead to social, legal, medical, domestic, employment and financial problems. It may also reduce your life span and lead to accidents and death from drunken driving.

Readiness Ruler

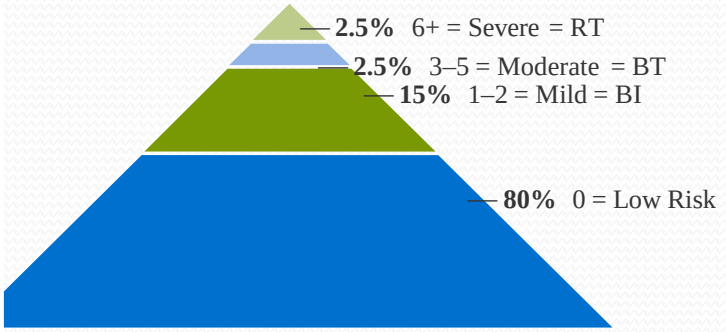
1 = Not ready at all
10 = Ready right now

Effects of Opiates

Drowsiness. Confusion. Memory loss. Fatigue.
Hallucinations. Convulsions.
Dilation of blood vessels causing increased pressure in brain.
Pupil constriction.
Slurred speech.
Respiratory depression.
Nausea. Vomiting.
Weight loss.
Sexual dysfunction.
Constipation.



DAST-10 Scores & Risk Level



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Effects of Marijuana

Short-term

- Anxiety and panic
- Problem-solving difficulty Impaired
- attention and memory Impaired
- coordination and judgment,
- especially when driving within 24 hours

Cardiac problems for people with heart disease or high blood pressure, because marijuana increases the heart rate

Long-term

- Weight gain due to overeating
- Erectile dysfunction & fertility difficulties due to low sperm production
- Lack of motivation Chronic
- bronchitis Lung cancer

Effects of Cocaine

Short-term

- Intense high followed by depression
- Poor appetite & sleep hygiene
- Increased heart rate & blood pressure
- Paranoia & anxiety
- Increased aggression

Long-term

- Sleep deprivation
- Malnutrition
- Tooth decay
- Impaired sexual function
- Heart attacks and strokes

Implementing SBIRT

- Initial Screening - Nurses ask PHQ-2 and AUDIT-C and DAST – 3
- If positive, nurse or medical provider provides "warm handoff" to BH clinicians
- Medical provider links risky use of drugs or alcohol to medical consequences
- Secondary Screening in EMR by BH
- Brief Intervention and Referral to Brief Tx or Tx as indicated by AUDIT or DAST-10 score by BH Clinicians
- BT or RT can be done by another agency or in-house

Brief Intervention by BH

- In patient room:
- Brief Negotiated Interview, BNI:
  - Review screening scores
  - MI to enhance discrepancy – list pros and cons of use
  - Assess readiness to change
  - Self Management Goal setting
  - Referral to Brief Treatment or Specialty Treatment

Brief Negotiated Interview (BNI) Algorithm

1. Raise the subject	*Is it OK if we discuss the health & wellness questionnaire you completed?*
2. Pros & Cons	
Elicit	*Help me understand the good things about using [X]. What are some of the negatives?*
Summarize	*So, on the one hand [PROS], and on the other hand [CONS].*
3. Information & feedback	*I have some information on low-risk guidelines for drinking and drug use, would you mind if I shared them with you?*
Provide	*We know that …* • *drinking 4 or more (Women) / 5 or more (Men) drinks in a few hours,* • *drinking more than 7 (Women) / 14 (Men) drinks in a week, and/or* • *using illicit drugs of any kind* *… can put you at risk for social or legal problems, as well as illness and injury. It can also cause health problems like [insert medical information].*
Elicit	*What do you think about that?*
4. Readiness ruler	*On a scale from 1–10, with 1 being not ready at all and 10 being completely ready, how ready are you to change your [X] use?*
Reinforce positives	*You marked ___. That means you're ____% ready to make a change!*
Ask about lower number	*Why did you choose that number and not a lower one like a 1 or 2?*
5. Negotiate a plan	*What are some steps you can take to reduce your risk?* *What will help you to reduce the things you don't like about using [X]?*
Identify strengths & supports Have patient write down steps	*What supports do you have for making this change?* *How can you use those supports/resources to help you now?* *Why don't we write down your Prescription for Change? This is what I heard you say …*
Offer appropriate resources	*I have some additional resources that people sometimes find helpful. Would you like to hear about them?* • *Primary care, outpatient counseling, mental health treatment*

Readiness Ruler

1 = Not ready at all
10 = Ready right now

Brief Treatment

- Integrated Change Therapy (ICT)/ from SAMSHA

- Brief Treatment for Adults with Substance Use and Co-Occurring Mental Health Disorders
- 6 – 8 sessions (can add more sessions- 14 weeks of curriculum)
- Incorporates CBT, mindfulness, functional analysis of triggers, relapse prevention planning

Specialty Treatment

- Outpatient individual or group Counseling
- Intensive Outpatient Program – IOP
- Residential Program

Lessons Learned

- Competing Demands
- Medical Home – already working on other chronic conditions: diabetes, hypertension, depression.
- Other Projects -
  - MAT Teams
  - Project Launch

Air Traffic Control Needed!

- Too many competing demands can lead to collision on the runway!
- No longer the small morning “huddle.”
- We needed to rework our workflow.

Revised Workflow

- Initial Screening starts with a Health Survey handed out at the front desk (similar to survey at Medicare PE)
- Nurse brings the survey to the Unit Secretary
- Unit Secretary enters responses into the EMR. Initial screening tools score electronically and suggests if further screening needed.
- Unit Secretary pages the SW/BHCs, who connect with team and then go into the patient room for secondary screening, BNI, referral to BT or RT
- LEP patients screened at check-in by SW using a phone interpreter

More Lessons Learned

- Be flexible on how to implement
- Motivate staff with incentives!

- PDSA
- Develop SBIRT Champions:
  - physicians, nurses, BH clinicians, administrative staff, front desk staff, IT staff
  - SBIRT team meets regularly

Future of SBIRT

- HRSA – SBIRT criteria in HRSA expansion grants
- Medical Home BH Goal?

- Can be flexible with implementation:

  - Screen at every Physical Exam
  - Once a year in a health survey
  - When rooming the patient

References for Primary Care BH

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