

ADDICTIONS AND MENTAL HEALTH DIVISION (AMH)

**SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT (SBIRT)
WORKGROUP WEBINAR**

February 27, 2015

Minutes - DRAFT

AMH Participants: Michael Oyster, Patricia Alderson

Webinar & Phone Participants: Emma Abiles, Will Brake, Emileigh Canales, Lesa Dixon-Gray, Sarah Dryfoos, Jenna Harms, Sara Kleinschmit, Tammie Metzler, Jetta Moriniti, Emily Plotkin, Ginger Scott, Debbie Standridge, Dan Thoma

Presenters: Michael Oyster

Absent: Sarah Bartelmann

| TOPIC | KEY DISCUSSION | ACTION/TASK/DECISION | RESPONSIBLE | DUE DATE |
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| INTRODUCTION (MICHAEL OYSTER) | <ul style="list-style-type: none"> • Brief review of webinar functions and features and conference line muting and unmuting. • Reminders: <ol style="list-style-type: none"> 1. Only unmute when needing to speak. 2. Do not place call on hold or the group cannot hear the speaker over the hold music. 3. State your name before speaking to avoid confusion. | | Michael and audience | |
| UPDATES/FOLLOW UP TOPICS (MICHAEL OYSTER) DISCUSSION TOPICS: | Metrics Updates for Hospitals: Michael posed that there has been some competition between primary care clinics and hospital emergency departments over patient screenings. There has been the perspective that if a patient has been screened in one setting, then they have already been serviced and could not be served in the other setting. Essentially leading to the view that whoever gets to the patient | | | |

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| | <p>first will be able to have their metric counted.</p> <p>(Sara Kleinschmit: Because of audio problems, we relied on texting within the Webinar). The baseline report on the hospital incentive measures is scheduled to come out on April 20th. The hospital association is working on an SBIRT training for hospitals, to occur in April.</p> <p>Sara clarified that the intent is that patients would be screened in both primary care as well as hospital settings. A screening in primary care does not count for the ED measure, and a screening in the ED does not count for the primary care/CCO measure. There really shouldn't be competition for this, as they are meant to be screened in both places. Each setting should use the information from the other setting and conduct a more in-depth screening / review / assessment of substance use, the plan developed to reduce or stop substance use, and to problem solve challenges the patient is experiencing.</p> <p>Question: If a patient has been screened by primary and end up in E.R. due to an accident, doesn't this warrant another screening? Yes, this would warrant another screening. The hospital must screen the patient in the ED in order to get credit for the SBIRT ED measure.</p> <p>If anyone hears of these conflicts talk to Michael or Sara K. on this to trouble shoot the issue.</p> <p>Where are you documenting the screening information notes?:</p> | <p>Screeners discuss with Michael or Sara K. with issues</p> <p>Michael would like it to go in the main medical record where other health/medical staff would be looking for it.</p> | | |

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| | <p>Confidential section or main record? One screener does screening for pregnant women and</p> <p>What percentage of patients are screening in to needing a full screen? People with higher income tend to screen into needing a full screen more than what is expected, and often more than the Medicaid population, at least in some systems. That said, these higher income patients who receive a full screen are also scoring much more into the low risk category and are quite receptive to receiving education and changing their substance use patterns.</p> | | | |
| ANNOUNCEMENTS | None to report | | | |
| OTHER DISCUSSION TOPICS | <p>Michael would like to get SBIRT trainer information so he can create a list for a workgroup to develop training policies.</p> <p>Developing essential trainer expectations and policy for originating all trainings;</p> <p>Required topics to be covered:</p> <ul style="list-style-type: none"> ❖ SBIRT definition and research for effectiveness ❖ Skills in facilitating screenings, brief intervention, and referral to treatment ❖ Encounters (billing and counting the work toward CCO and ED metrics) ❖ Connecting community treatment resources with clinics and hospitals <p>Referral to Treatment: Successes & Challenges:</p> | <p>Email Michael with your input for SBIRT trainings</p> | | |

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| | <ul style="list-style-type: none"> ❖ Adolescents get referred to treatment and then there is lack of follow through for both outpatient and residential venues. ❖ Probably not unique to adolescents, could also be an issue with adults ❖ Michael has experience with MH and A&D providers so he would be a good resource for developing close relationships between clinics / hospitals and community providers to develop effective referrals to treatment ❖ Needs to be a collaboration between mental health and alcohol and drug providers ❖ Seems like a lot of clinics are not yet experiencing smooth referrals and have been reluctant to make referrals ❖ Most residential programs are aware that clients may have psychiatric issues and are able to treat co-occurring patients | | | |
| <p>FUTURE TOPICS FOR WORKGROUP?</p> | <ul style="list-style-type: none"> • Email your future topic ideas to Michael • Please email to Michael any SBIRT trainer your system is using, especially internal trainers or training coordinators, so that he can build the SBIRT Trainer Workgroup • Next agenda will include a presentation on opioid dependency by John McIlveen, Opioid Specialist for AMH to discuss opiate misuse and abuse, whether heroin or medication, how treatment works, and it's collaboration with SBIRT services. We will also talk about how the PDMP (the prescription database) will be used to help identify patients who may be misusing medication | <p>Email Michael with your agenda ideas</p> | <p>all</p> | |
| <p>NEXT MEETING</p> | <p><input type="checkbox"/> Meetings are the last Friday of the month starting Jan. 2015</p> | | | |

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| | <input type="checkbox"/> Next meeting: March 27, 2015, 9-10:30 a.m. (webinar format) | | | |