MIDD Briefing Paper

ES 1c Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance abuse, depression and/or anxiety in emergency departments, primary care settings and community behavioral health centers (formerly Emergency Room Early Intervention)

Existing MIDD Program/Strategy Review ☒ MIDD I Strategy Number ___1c_____ (Attach MIDD I pages)
New Concept ☐ (Attach New Concept Form)
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: This concept expands an existing MIDD I strategy to see develop an expanding network of SBIRT (Screening, Brief Intervention, and Referral to Treatment) providers, using proven community organizing strategies, that will successfully implement evidence-based strategies across the continuum of care for prevention (universal, selective and indicated), including focused environmental strategies. All SBIRT prevention efforts will be evidence-based and proven to be effective in alcohol and other drug (AOD) and depression screening. This strategy would see the creation of, or continued partnerships with, community stakeholders, hospitals, primary care clinics and behavioral health providers to develop and implement SBIRT prevention strategies within their King County communities. The implementation of SBIRT practices will identify, reduce, and prevent problematic use, abuse, and dependence and identify and prevent depression. The SBIRT model was cited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.[1] In addition, this expansion provides for an infrastructure for regional SBIRT prevention services.

Collaborators:

Name		**Department**
Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.		
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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This concept expands an existing MIDD I strategy to see develop an expanding network of SBIRT (Screening, Brief Intervention, and Referral to Treatment) providers, using proven community organizing

[1] http://www.integration.samhsa.gov/clinical-practice/SBIRT

strategies, that will successfully implement evidence-based strategies across the continuum of care for prevention (universal, selective and indicated), including focused environmental strategies. All SBIRT prevention efforts will be evidence-based and proven to be effective in alcohol and other drug (AOD) and depression screening. This strategy would see the creation of, or continued partnerships with, community stakeholders, hospitals, primary care clinics and behavioral health providers to develop and implement SBIRT prevention strategies within their King County communities. The implementation of SBIRT practices will identify, reduce, and prevent problematic use, abuse, and dependence and identify and prevent depression. The SBIRT model was cited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.[2] In addition, this expansion provides for an infrastructure for regional SBIRT prevention services.

The King County SBIRT initiative will include infrastructure and service development in four areas within King County:

1. Hospitals (Emergency Departments and other clinics within hospitals);
2. Primary Care Clinics;
3. Behavioral Health organizations; and
4. Dental and Pharmacy Providers.

The King County SBIRT will include three stages, the following stages are underway or being planned as part of SBIRT initiative expansion:

Stage 1: Technical assistance would begin at the County level working with potential SBIRT partners to assess readiness on the integration of SBIRT into their agency or practice. The following questions would be posed:
1. Do you believe that SBIRT can help your patients and society as a whole?
2. Can SBIRT generate revenue or at least be cost neutral?
3. Is your agency equipped to handle integrating SBIRT?
Technical assistance will be provided depending on readiness and information provided about how SBIRT can help improve patient/individual outcomes, generate revenue, and help create a truly integrated system of care.[3] King County staff are trained in the SBIRT model and available to provide technical assistance on the implementation and delivery of SBIRT.

Stage 2: In partnership with the University of Washington, School of Social Work, as part of the Substance Abuse Mental Health Services Administration (SAMHSA) funded Screening, Brief Intervention and Referral to Treatment (SBIRT) Health Professions Student Training grant, Northwest Leaders SBIRT project; King County will develop and provide regional symposiums in order to increase knowledge, skills and awareness of SBIRT. The NL-SBIRT project will provide professional skill development in SBIRT for teachers, students, faculty, field supervisors, and delivering a regional training for practitioners in the health service systems in the Pacific Northwest.

An SBIRT symposium of leaders in Health and Behavioral Healthcare in King County would be organized to present data on the County's findings, the rationale, and next steps in the implementation of SBIRT in a variety of settings including emergency departments, primary care clinics, community behavioral health clinics, dental offices and pharmacies.

[2] http://www.integration.samhsa.gov/clinical-practice/SBIRT
[3] https://www.centeronaddiction.org/sites/default/files/files/An-SBIRT-implementation-and-process-change-manual-for-practitioners.pdf

The goal of the symposium would be: 1) identify sources of data that can be improved and analyzed to assess, as fully as possible, the local technical assistance/training need to more fully implement SBIRT throughout King County; 2) On-going strategies to better address the sustainment of SBIRT in the changing word of health care. This symposium could be part of the annual regional SBIRT training that is part of the current NL-SBIRT grant and will complement the SBIRT initiative.

Stage 3: The first cohort of contracted provider agencies will receive intensive training and technical assistance to sustain implementation the SBIRT initiative, which includes expanding implementation of SBIRT at other clinic and hospital locations. A learning collaborative will be created in order for providers implementing SBIRT to connect and enhance cross-agency learning for staff. Each participating agency will assess readiness for SBIRT sustainability over two years. There will be a graduation and incentives for agencies that are successful in adopting and maintaining SBIRT Upon graduating from county funding, the learning collaboration will continue.

Technical assistance would continue at the County level working with current King County SBIRT providers (CHI Franciscan, UW Medicine, Harborview Emergency Department (ED), Swedish Medical Group, Swedish Health Services) in order to ensure continuity of care and SBIRT sustainability with the existing network.

Stage 4: A second cohort of contracted provider agencies will join the learning collaborative, repeat the training and technical assistance steps outlined above; Phase 2 will begin, repeating the stages in the following Phase 2 and 3 sites: hospital and healthcare systems participating in SBIRT.

What is SBIRT

SBIRT stands for Screening, Brief Intervention, and Referral to Treatment. SBIRT is a universal public health approach to integrate behavioral and primary health care. It is a way to increase awareness that substance abuse is preventable, help for depression is available and that treatment works. SBIRT can be provided in a wide variety of medical and community healthcare settings.

SBIRT is specifically designed to find and help individuals who are not seeking help for addiction and therefore is termed an "opportunistic intervention". SBIRT is both a public health approach as well as a preventative service. It is a public health approach in that it provides services to people who may never become addicted to substances but whose risky substance use, as defined above, puts their health and well-being at risk. On the other hand, SBIRT is a preventative service in that, by intervening early, it may reduce the likelihood that a risky substance user will go on to become addicted. While this makes SBIRT a very powerful tool to help those who may not have otherwise gotten services or may have only gotten services once they become addicted, it is also a kind of intervention very different from traditional addictions treatment. Analogous to routine blood work as a preventative screening measure, SBIRT is performed to identify risky substance use among your patients/clients and provide them with appropriate interventions.[4]

SBIRT CONSISTS OF THREE MAJOR COMPONENTS:

[4] https://www.centeronaddiction.org/sites/default/files/files/An-SBIRT-implementation-and-process-change-manual-for-practitioners.pdf

Screening — a healthcare professional assesses a patient for risky substance use behaviors and depression/anxiety using standardized screening tools. Screening can occur in any healthcare setting (e.g., hospital, primary care, dental office, behavioral health clinic)
Brief Intervention — a healthcare professional engages a patient showing risky substance use behaviors and/or depression/anxiety in a short conversation, providing feedback and advice.
Referral to Treatment — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.[5]

SBIRT is a tool to universally screen and identify people with mild to severe substance use disorders (SUD) and/or who have depression or anxiety. Persons identified by SBIRT screening are given a brief intervention (BI) by a medical professional or counselor. The BI addresses the individual's substance use, depression and/or anxiety and assists with establishing a plan to reduce use in the future. When indicated, patients are referred to specialty care for their substance use disorder, depression or anxiety.

In addition to identifying and intervening with people who have mild SUDs, SBIRT also identifies individuals with moderate to severe SUDs and works to connect them (Referral to Treatment) to substance use treatment or options. In cases where there is not a SUD but there is an indication of depression or anxiety, patients are referred to a behavioral health specialist. In cases where SUD and depression and/or anxiety are present, depression/anxiety are handled first because often times the SUD is the self-medication for the depression/anxiety symptoms. SBIRT services connect behavioral and primary health care to effectively meet the needs of individuals.

Current SBIRT Services

Current SBIRT (MIDD strategy 1c - Emergency Room Substance Abuse and Early Intervention Program) services have focused on emergency departments (ED) by providing staff support (full time equivalent or FTE) to assist with SBIRT for SUD. Harborview ED (4 FTEs), St Francis ED (1 FTE) and Highline ED (1 FTE) have staff that assist in SBIRT. Universal screening has not been possible with limited staff resources for an ED with 24 hour seven days per week operation and the current Medicaid/Medicare reimbursement is not adequate in Washington State to support SBIRT[6] (Note: providers are not reimbursed in Washington state for SBIRT screening; they can only bill for brief interventions, which is 22 percent of everyone screened[7]). Some work in preparation for initiating the King County SBIRT component in primary care settings has been funded by a Substance Abuse and Mental Health Services grant (WASBIRT).

Under the current strategy practice, SBIRT is provided to individuals age 18+ when a patient shows an indication of use of alcohol or drugs; the SBIRT clinician is alerted and will complete a brief screen for alcohol and or drugs. The tools chosen are the Alcohol Use Disorders Identification Test (AUDIT)[8] and Drug Abuse Screening Test (DAST)[9]. Based on screen results a brief intervention using Motivational Interviewing techniques may be completed. The patient is offered assistance in connecting to further

[5] http://www.integration.samhsa.gov/clinical-practice/SBIRT
[6] Reimbursement rate: Non-Facility Setting: $20.65 for 15-30 minutes, $39.90 for 30+ minutes; Facility Setting: $19.25 for 15-30 minutes, $38.90 for 30+ minutes
[7] Washington State, Division of Behavioral Health and Recovery
[8] Babor TF, Higgins-Biddle JC , Saunders JB, Monteiro MG. *AUDIT: The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd Edition.* World Health Organization. 2001
[9] Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982, 7(4): 363-371.
Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007, 32:189-198.

assistance with the behavioral health clinician either for a follow-up brief therapy visit or for a referral for an assessment. "Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence".[10]

The current strategy (MIDD 1c SBIRT) has served more than 16,192 people since beginning in 2009.

Proposal for Expanded SBIRT Services

King County will expand SBIRT Services, which will continue to include hospital emergency departments, and will expand to include other parts of the hospital, primary care settings, and community behavioral health centers and will add youth (ages 12-17). The SBIRT screening will also expanded from alcohol and drugs to also include screening for depression and anxiety.

Working with the medical community and behavioral health providers to integrate SBIRT into EDs, hospitals, primary care clinics or community behavioral health center operations is the first priority. This builds on current relationships with the health care systems. Current work with WASBIRT has allowed the County to work closely with CHI Franciscan, Swedish Health Services and Swedish Medical Group. Currently, SBIRT is being implemented at three of the Swedish primary care clinics. In addition, King County is working with Swedish Medical Group on implementing screening for depression at 15 primary care clinics (and King County is working to expand to full SBIRT implementation, which will include alcohol and drug screening). King County through funding from the WASBIRT grant also worked with Sound Mental Health to implement SBIRT with all new behavioral health clients at intake and all clients annually. Current work with this MIDD strategy has partnered King County SBIRT with UW Medicine at the UW Medicine Adult Clinic on the Harborview Campus.

The US Preventive Services Task Force In 2012, (USPSTF) found adequate evidence that brief counseling interventions in adults with screening-detected risky or hazardous drinking positively affect several unhealthy drinking behaviors, including heavy episodic (binge) drinking, high average weekly intake of alcohol, and consumption above recommended intake limits.[11] In 2016, the USPSTF reinforced a similar finding for screening and brief intervention for depression stating "The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.".[12]

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☐ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☐ **Recovery and Re-entry** ☐ **System Improvements**

   Please describe the basis for the determination(s).

[10] Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, *23*, 325-334.

[11] U.S. Preventive Services Task Force. (2013, May 14). *Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: U.S. preventive services task force recommendation statement*. Retrieved from http://www.uspreventiveservicestaskforce.org/uspstf12/alcmisuse/alcmisusefinalrs.htm

[12] U.S. Preventive Services Task Force. (January 2016) Depression Screening in Adults. Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1

SBIRT is an evidence-based prevention and early intervention practice acknowledged by the Substance Abuse and Mental Health Services Administration (SAMHSA).

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

Individuals who have abused alcohol and/or other drugs have an increased risk of being involved in vehicle and other crashes, as well as a heightened risk for other health problems, which may lead to emergency room admissions. 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.

Describing the Unmet Need

National studies show the need for a tool such as SBIRT: Results of the most recent National Survey on Drug Use and Health (NSDUH) show that an estimated 22.1 million people aged 12 or older have a diagnosable alcohol or illicit drug use disorder. In 2010, according to NSDUH, 8.1 percent of the population aged 12 or older – about 20.5 million people – needed but did not receive substance use treatment at a specialty SUD facility in the past year. In 2006, excessive drinking cost the United States $223 billion. Factoring in public health, public safety, and lost productivity, illicit drug use cost the Nation an estimated $193 billion in 2007. [13]

The Center for Disease Control has stated "At some point each year, about 25 percent of adults in the United States drink too much, and excessive alcohol use causes an even higher percentage of the injuries seen. Over 40 percent of motor vehicle deaths and injuries result from excessive alcohol use, but the same is true of so-called pedestrian accidents. Moreover, a high percentage of falls, injuries from violence, spousal and child abuse, and many other factors result from someone drinking too much. The second reason for implementing SBIRT is to help prevent future alcohol-related injuries."[14]
The picture in King County for both youth and adults confirms an ongoing need for reduction in health risk behaviors including the use of alcohol and drugs. The Public Health Community Health Indicators Project[15] is a set of indicators measuring the health of King County residents. It was developed to provide a broad array of comprehensive, population-based data to hospitals, community-based

[13] Substance Abuse and Mental Health Services Administration, 2011. Results from the 2010 National Survey on Drug Use and Health: Volume 1. Summary of National Findings. DHHS Publication No. SMA 10-4856.
3 Substance Abuse and Mental Health Services Administration, 2011. Results from the 2010 National Survey on Drug Use and Health: Volume 1. Summary of National Findings. DHHS Publication No. SMA 10-4856.
4 Bouchery, E., Harwood, H., Sacks, J., Simon, C., Brewer, R. (2011). Economic Costs of Excessive Alcohol Consumption in the U.S., 2006. *American Journal of Preventive Medicine, 41*(5), 516-524.
[14] Higgins-Biddle J, Hungerford D, Cates-Wessel K. Screening and Brief Interventions (SBI) for Unhealthy Alcohol Use: A Step-By-Step Implementation Guide for Trauma Centers. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2009.
[15] http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

organizations, community health centers, public agencies, policymakers and the general public. Table 1 provides a picture of the need found within King County communities.

Substance Abuse and Chemical Dependency	Alcohol impaired driving fatalities	1.0 per 100,000 population
	Alcohol, marijuana, painkiller or any illicit drug use in the past 30 days (school-age)	29% of King County youth attending public schools in the 8th, 10th and 12th grades
	Alcohol-induced deaths	9.8 per 100,000 population
	Binge drinking (adults)	20% of King County adults 18+
	Binge drinking (school-age)	14% of King County youth attending public schools in the 8th, 10th and 12th grades
	Drug-induced deaths	12.5 per 100,000 population
	Marijuana use (adults)	11% of King County adults 18+
	Marijuana use (school-age)	18% of King County youth attending public schools in the 8th, 10th and 12th grades

Table 1 Substance Abuse and Chemical Dependency indicators

More than one out of 20 Americans 12 years of age and older reported current depression in 2005–2006. Table 2 provides a demographic picture of the general population and the percentage of the population affected by depression.

Age		Gender		Race and Hispanic Origin	
12-17	4.3%	Female	6.7%	Mexican American	6.3%
18-39	4.7%	Male	4.0%	Non-Hispanic black	6.0%
40-59	7.3%			Non-Hispanic white	4.8%
60 and older	4.0%				

Table 2 Percentage of persons 12 years of age and older with depression by demographic characteristics: United States, 2005-2006

The Public Health Community Health Indicators Project[16] includes health measurement on mental health needs. Depression is relatively common in primary care patients but is not always identified by primary care providers. Individuals with depression often experience not only sadness, but a lack of interest or enjoyment in activities, decreased energy, insomnia, weight changes, feelings of loss and worthlessness, and recurrent thoughts of death or suicide.[17] Table 3 provides mental health measures for King County.

Mental Health	Frequent mental distress (adults)	11% or about 167,000 King County adults age 18+
	Serious psychological distress (adults)	4% or about 59,300 King County adults age 18+
	Has depressive feelings (school-age)	27% of King County youth attending public schools in the 8th, 10th and 12th grades

[16] http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

[17] O'Connor E, Rossom RC, Henninger M, Groom HC, Burda BU, Henderson JT, Bigler KD, Whitlock EP. Screening for Depression in Adults: An Updated Systematic Evidence Review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 128. AHRQ Publication No. 14-05208-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; 2016.

Table 3 Mental Health Indictors [18]

The current MIDD 1c SBIRT strategy has been focused on adults (and SUD); there is currently enough evidence that depression screening with follow-up for adults and youth in primary care setting is a valuable, needed and effective tool, as it is for adults. The USPSTF recommends screening for major depressive disorder (MDD) in adolescents ages 12 to 18 years when adequate systems are in place for diagnosis, treatment, and monitoring. There is a growing body of evidence the SBIRT intervention for alcohol and drugs can be an effective tool with youth as well. Currently NIAAA and SAMHSA have both endorsed the use of SBIRT with youth.[19]

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

The effectiveness of the use of SBIRT in addressing substance use, depression and anxiety identified in EDs, hospitals, primary care settings and in community behavioral health settings has been well researched and documented. The USPSTF is the authority on the use prevention interventions in medical settings. In addition, the use of SBIRT has been endorsed by the following because of the effectiveness in addressing substance use, depression and anxiety:

The White House Office of National Drug Control Policy, 2012 National Drug Control Strategy[20]

"Screening, Brief Intervention, and Referral to Treatment services continue to reach more Americans in the health care system, and more patients in health centers across the Nation were provided access to substance disorder treatment services."

Affordable Care Act[21]

After September 10, 2010, new health insurance plans were required to cover alcohol misuse screening and counseling for adults. SBIRT is a Medicaid billable service in Washington State as of January 1, 2014.

Centers for Medicare and Medicaid Services (CMS)[22]

From the Decision Memo for Screening and Behavioral Counseling Interventions in Primary Care: CMS has determined there is adequate evidence to conclude that adult screening and behavioral counseling to reduce alcohol misuse in primary care settings is reasonable and necessary for the prevention or early detection of illness or disability. CMS will cover annual alcohol screening and, for those that screen positive, up to four brief, face-to-face interventions per year for Medicare beneficiaries.

Joint Commission (JCAHO)[23]

The Joint Commission adopted SBIRT screening to help integrate substance use screening, brief intervention and treatment in hospitals across the country. (The Joint Commission accredits and certifies nearly 21,000 health care organizations and programs in the United States.)

Other Organizations that Support SBIRT

- World Health Organization
- Centers for Disease Control and Prevention
- Emergency Nurses Association
- American Medical Association
- American College of Surgeons
- American Trauma Society

[18] http://www.kingcounty.gov/healthservices/health/data/indicators.aspx
[19] http://www.samhsa.gov/sbirt
[20] https://www.whitehouse.gov/ondcp/
[21] https://www.healthcare.gov/
[22] https://www.cms.gov/
[23] http://www.jointcommission.org/

In addition the following Research and Publications speak well to the SBIRT intervention addressing the unmet need:

- WASBIRT: Final Program Performance Report: October 1, 2003 through September 20, 2009 (July 2010)[24]
- WASBIRT: Impact of SBIRT on Entrance to Chemical Dependency Treatment (February 2010)
- All WASBIRT Hospitals: Six Month Follow Up Survey of WASBIRT Patients: April 12, 2004-March 31, 2008 (September 2009)
- SBIRT White Paper Report (April 2011)
- Office of National Drug Control Policy & SAMHSA: SBIRT Factsheet (July 2012)
- Health Care Reform, Medicaid Expansion and Access to Alcohol/Drug Treatment: Opportunities for Disability Prevention (October 2010)
- Evaluation of the Washington State Screening, Brief Intervention, and Referral to Treatment Project: Cost Outcomes for Medicaid Patients Screened in Hospital Emergency Departments (Abstract: January 2010)

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

See 2. Above

The following is from the most current annual MIDD report.
The MIDD supports SBIRT for patients admitted to three selected emergency departments (ED). The SBIRT approach involves establishing rapport and asking to discuss a patient's alcohol/drug use, providing feedback, enhancing motivation, and making treatment referrals if needed.

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original or Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Screenings	6,400 with 8 FTE	Target	3,333	4,800	6,000	5,600	5,600	4,000	4,560
		Actual	2,558	3,344	4,649	3,695	4,422	2,584	2,177
		Percent	77%	70%	77%	66%	79%	65%	48%
Brief Interventions	4,340 with 8 FTE	Target	2,260	3,255	4,069	3,798	3,798	2,688	3,092
		Actual	2,250	4,050	5,475	4,763	3,488	2,869	2,585
		Percent	100%	124%	135%	125%	92%	107%	84%

[24] Washington State, Division of Behavioral Health and Recovery

Table 4 Emergency Room Substance Abuse and Early Intervention Program Outputs

Target Adjustments and Notes: Year 1 (5 - 9 months); Years 1 & 2 (6 FTE); Year 3 (7.5 FTE); Years 4 & 5 (7 FTE); Year 6 (5 FTE); Year 7 (5.7 FTE) Screening numbers fell short of expectations due in part to provider prioritization of quality (time spent) over quantity.

Not counting Harborview emergency admissions associated with SBIRT encounters marking the start of MIDD services, reductions in total ED visits there approached 40 percent by the fifth post period. By contrast, ED visits rose in the first year following SBIRT services by more than 45 percent at Harborview and by 29 percent at other Emergency Departments in King County.

Jail bookings and days rose by as much as 18 percent in the first two years following the first recorded SBIRT service. By the third year, jail use began to decline, with the greatest reductions noted in the fourth post period (-40 percent for bookings and -35 percent for days). Of the 2,082 clients first served before July 2011 and who had any jail use, 61 percent lowered both jail bookings and days over time (64 percent of Harborview SBIRT clients and 53 percent of those initially served elsewhere).

One of every five clients who received their first SBIRT service at Harborview Medical Center was linked to publicly-funded SUD treatment within a year of that encounter. For those seen at one of two participating hospitals in the south region of King County, the linkage to SUD treatment rate was 12 percent. Note that SBIRT clients served at Harborview were slightly more likely to be seen more than once, as brief ongoing therapy is offered only at that location.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

The US Preventive Services Task Force In 2012, (USPSTF) found adequate evidence that brief counseling interventions in adults with screening-detected risky or hazardous drinking positively affect several unhealthy drinking behaviors, including heavy episodic (binge) drinking, high average weekly intake of alcohol, and consumption above recommended intake limits.[25] In 2016, the USPSTF reinforced a similar finding for screening and brief intervention for depression stating "The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.".[26]

The WASBIRT Program was conducted in nine hospitals within six counties in the state. Over 104,000 screenings were completed in the hospital emergency departments. This report provides detailed information about the results of the WASBIRT evaluation project, which found reductions in substance use, reductions in medical costs, improvements in social and mental health outcomes, and reduced risk of death.[27]

[25] U.S. Preventive Services Task Force. (2013, May 14). *Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: U.S. preventive services task force recommendation statement*. Retrieved from http://www.uspreventiveservicestaskforce.org/uspstf12/alcmisuse/alcmisusefinalrs.htm

[26] U.S. Preventive Services Task Force. (January 2016) Depression Screening in Adults. Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1

[27] Washington State Screening, Brief Intervention, and Referral to Treatment Program Final Program Performance Report: October 1, 2003 through September 30, 2009

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

   Outcomes that would result from SBIRT screenings in a variety of settings include the following:
   - Increase in admissions into substance use disorder treatment;
   - Increases in admissions to co-occurring disorder treatment;
   - Reduction in the average days of alcohol use, binge drinking and use of other drugs;
   - Reduction in medical cost for medical patients by reducing ED visits, hospital days;
   - Improved social outcomes including reduction in arrests, reduced shelter use of homelessness, improved employment;
   - Improved mental health including reduction in symptoms of depression and anxiety; and
   - Reduced deaths of patients.

Current data sources are in place either with the present MIDD or with Public Health Seattle & King County to collect the data needed to monitor outcomes.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☒ **Black/African-American**
☐ **Children 6-12**	☒ **Hispanic/Latino**
☒ **Teens 13-18**	☒ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☒ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☒ **Families**	☒ **Homeless**
☐ **Anyone**	☒ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**
☐ **Other – Please Specify:**	

   Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

Individuals receiving medical or behavioral health services at EDs, hospitals, primary care clinics or community behavioral health clinics throughout the county are included in the population to be served, ages 12 and above. The SBIRT tools and implementation is not normed for youth under age 12.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Health care systems in King County, including current contracted mental health and SUD treatment providers. Health care systems, including current SBIRT partners (CHI Franciscan and Emergency Departments at St Francis and Highline hospitals, Swedish Medical Group, Swedish Health Services, UW Medicine and Harborview ED). Expanding those partnerships and supporting new partnerships with HealthPoint, Neighborcare, Overlake Medical Center, Multicare and Evergreen Health. Continuing BHRD's partnership with Public Health Seattle & King County will also benefit implementation.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

Some hospitals are required to do SBIRT
To retain accreditation, Level I and Level II trauma centers are now required to have a mechanism to identify patients whose alcohol drinking is unhealthy. In addition, Level I trauma centers must have the capacity to help these patients.

The US Department of Veteran Affairs mandates routine screening for risky alcohol use system-wide. The Joint Commission, the accrediting body for 95 percent of the hospital beds in America, has approved four measures of SBIRT in its core set of measures. Hospitals may select to report the SBIRT measures as part of their accreditation.

The Affordable Care Act creates carrots (and sticks) for the use of SBIRT
SBIRT helps meet 14 Center for Medicaid and Medicare Services (CMS) Accountable Care Organization quality measures. SBIRT helps fulfill dozens of patient-centered medical home recognition criteria.

SBIRT helps hospitals address ACA-required community health needs assessments, which often find high rates of community binge drinking and prescription drug misuse. The ACA's CMS Hospital Readmissions Reduction Program reduces payments to IPPS hospitals with excess readmissions; SBIRT can play a role in reducing readmissions. The ACA's move toward bundled payments creates a strong incentive to reduce costly episodes of care; SBIRT can play a role in reducing these costs. Under the ACA, hospitals must provide US Preventive Health Task Force recommended screens (including SBIRT) with no co-pays.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

The current rate for payment established for SBIRT by Washington State Health Care Authority does not reimburse at a rate sufficient to cover costs. The Health Care Authority could change their policy and

allow billing for screenings. This is permissible under Medicaid. Additional system implementation issues such as clinic flow and lack of provider (doctor) time also hinder SBIRT adoption/implementation.

Other factors, such as the lack of connected capacity for referring patients/clients remains a concern, as does the lack of capacity for essential services such as detoxification. This hinders referrals, and therefore implementation. Although SBIRT's primary goal is the reduction in the health harm done by use of alcohol or drugs or untreated depression or anxiety, the lack of capacity to provide screening and brief intervention forces an emphasis on those needing referral to treatment.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

The single largest potential unintended consequence with a universal SBIRT implementation is the identification of greater need than the treatment system will be able to initially address; however, given that SBIRT is a public health preventative approach, designed to help integrate behavioral health care into medical services, it is critical to look at the improved patient outcomes when weighing this unintended consequence.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

The need for prevention and intervention is well documented for youth and adults. If this need ,is not addressed, the result will include greater costs for criminal justice, emergency room care, hospital care, and behavioral health care costs rather than a documented reduction in these areas. This is in addition to the loss of life and the reduction in quality of life of those impacted by substance use, depression, and anxiety.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

There are no other alternatives to the SBIRT approach. Providing a prevention service before a problem, addiction, or depression crisis compared to crisis and treatment services following high end services, such as detox, involuntary treatment, or hospitalization is always more desirable and less costly. The King County behavioral health system currently offers all of these services in a comprehensive continuum using MIDD funding and time-limited grant funding.

It is unlikely that this new expanded concept can be merged with another concept, since this is an overarching initiative for SBIRT; however, there is a component for school-based SBIRT within the Collaborative School Based Behavioral Health briefing paper. If both concepts are funded, the initiatives should look for opportunities for collaborating, and at the least, communicating.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

The SBIRT Initiative is a multi-pronged approach: a primary prevention effort that will divert people from the behavioral health system entirely; an early intervention/ secondary prevention effort that will provide brief intervention during a problem, and also help people engage in services sooner and avoid more costly and intrusive interventions; and referral to treatment that will connect people to care sooner, before they have reached the need for higher end services.

This proposal will provide integrated behavioral health care, primary care, and SUD treatment. With outreach, early intervention and coordinated services, the program will fit King County's focus on providing a continuum of care. It moves the County closer to achieving state-mandated integration of behavioral and physical health care by 2020. The proposal's focus on early intervention and coordinated services aligns with the recovery ordinance recommendations to collaborate with other services and systems to improve results and reduce costs by coordinating and integrating services whenever appropriate in order to prevent downstream conditions such as homelessness, incarceration and substance abuse; and to facilitate collaboration between systems. This also fits with Best Start for Kids strategy to provide youth screening for depression and substance abuse.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

Providing a range of prevention, intervention, treatment and support services will help individuals manage their depression and substance use issues before they lead to devastating consequences and before these problems have grown too big to easily manage. The expectation is that early intervention will engage and motivate individuals who have experienced mental health issues or substance use to modify unhealthy behaviors or to pursue treatment (if indicated), while also focusing on what is important for the individual. Providing an early intervention does not disrupt the individual's life if their symptoms are identified and treated early. It will allow them and their families to gain a better understanding of what is happening and the services that are available.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

Mental health issues such as depression and anxiety or substance use can affect anyone, regardless of income level or ethnic background. But some who have experienced mental health issues or substance use may have less access to intervention or treatment services, particularly those who are low-income, who do not speak English well, or who come from cultures where mental illness is not addressed. King County is home to large populations of people of color, people living with low incomes, and people with poor health. Integrated, early intervention services will further King County's equity and social justice work by providing all adults and young people with the same opportunities to recover from mental illness and substance use disorders

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

The estimated resources needed are the following:

- 1FTE Project/Program Manager III
- Trainings

- Laptop, projector, speaker
- Start-up and implementation funding for five Emergency Departments, five primary care clinics and five behavioral health centers per year

Funding for start-up and implementation would assist in covering training costs for staff.

2. **Estimated ANNUAL COST. $1,500,001-$2.5 million Provide unit or other specific costs if known.**

Budget Item	**Estimated Cost**
Support for five Emergency Departments	$750,000
Support for five primary care clinics	$500,000
Support for five behavioral health centers	$500,000
Trainings	$5,000
Laptop, portable projector, speakers (for trainings outside of office)	$2,500
1 FTE Project/Program Manager III	$130,000
TOTAL Estimate	$1,887,500

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

SBIRT services are billable to Medicaid and Medicare and for some insurance plans. The rate, combined with HCA's billing restrictions, is insufficient to cover costs.

4. **TIME to implementation: Less than 6 months from award**
    a. **What are the factors in the time to implementation assessment?**

It is intended that the assistance will last for one calendar year of operation and could be used to support

- changes to the electronic health record system to accommodate SBIRT for clinical use and for billing;
- Staff training including physicians and other clinical staff;
- Staff support for the one year pilot; and
- Other costs directly related to the implementation of SBIRT.

    b. **What are the steps needed for implementation?**

Develop an RFP and identify the award recipients. Health systems that are currently working with King County in implementing SBIRT would be encouraged to apply to expand SBIRT to their other health care sites. Following that, the identified contractors will need to hire staff, train staff on EBP's and plan and implement the program.

    c. **Does this need an RFP?**

Yes. The initial services are in place with three EDs, four primary care clinics and with one community behavioral health center. A procurement process would call for the selection of additional Emergency Departments, clinics, and centers who are interested in receiving some assistance in the adoption of SBIRT. It is intended that the assistance will last for one calendar year of operation and could be used to support changes to the electronic health record system to accommodate SBIRT for clinical use and for billing.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

Existing MIDD Strategy 1c Final

Strategy Title: Increase Access to Community Mental Health and Substance Abuse Treatment

Strategy Title: 1c - Emergency Room Substance Abuse and Early Intervention Program

County Policy Goals Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

Individuals who have abused alcohol and/or other drugs have an increased risk of being involved in automobile and other accidents, as well as a heightened risk for other health problems, which may lead to emergency room admissions. Admissions to hospital emergency services may provide an opportunity to engage individuals who have abused substances into accepting the need for intervention and brief treatment, and prevent future alcohol and drug-related hospitalizations. This strategy provides delivery of early intervention and treatment services to hospital emergency room patients who have substance use disorders or are at risk of developing these disorders.

◊ *B. Reason for Inclusion of the Strategy*

The existing substance abuse intervention program at Harborview Medical Center already has a record of success and has demonstrated cost effectiveness with regard to reducing substance abuse and other health problems associated with drug use and reducing utilization of medical services. Patients who received services in this program at Harborview have altered their substance use patterns significantly. Among substance abuses who received at lease a brief intervention, use reported in the six month follow-up interview declined significantly compared to use reported at screening.[28] The current program is funded by a federal grant which began in 2003 and will end in September 2008. Implementation of this strategy will allow the

[28] Department of Social and Health Services - Research and Data Analysis Division, (May 2, 2007) *Harborview Medical Center Substance Use Outcomes,* http://www1.dshs.wa.gov/pdf/ms/rda/research/4/60/HMC.2007.1.pdf

continuation of the program at Harborview and expansion of the service to additional hospitals in south King County. The program will reduce the number of individuals with substance abuse and dependency issues in hospital emergency rooms and increase access and referral to treatment.

◊ *C. Service Components/Design*

The program is delivered by integrating chemical dependency professionals into the multidisciplinary team within emergency rooms. Service design includes the following:

- Maximize the number of emergency room patients who are identified through screening to have substance abuse problems.
- Deliver brief counseling, or "brief interventions," to patients who screen positive for substance use disorders.
- Increase referrals of chemically dependent people from the generalist medical setting to CD community treatment agencies.
- Reduce subsequent emergency room use rates, medical costs, criminal behavior, disability, and death for patients with alcohol and drug problems of all severity levels.
- Improve the links between the medical and chemical dependency treatment communities so that providing screenings and interventions for substance use disorders become routine.

◊ *D. Target Population*

The program provides early intervention for at-risk substance users before more severe consequences occur, as well as intervention and referral for high utilizers of hospital emergecy room services.

Expansion to south King County hospital emergency departments was made at the request of the Washington State Hospital Association and as a result of an increase in low income and indigent clients in south King County.

◊ *E. Program Goals*

Provide early intervention and referral to treatment for those with less severe addiction issues who are admitted to hospital emergency rooms in order to reduce the risk of more serious chemical dependency.

◊ *F. Outputs/Outcomes*

3,488 new clients would be served each year in addition to the current number of clients served for a total capacity of 7,680 served annually.

Expected outcomes include reductions in emergency room visits, other medical costs, accidents, criminal behavior, and death.

2. Funding Resources Needed and Spending Plan

The emergency room substance abuse and early intervention program will have an annual cost of $796,500.

Dates	Activity	Funding
Sept – Dec 2008	Continue Harborview contract	$120,000
	Total Funds 2008	**$120,000**
Jan – Dec 2009	Harborview	$442,500
Jan – Dec 2009	Expansion to south King County	$354,000
	Total Funds 2009	**$796,500**
2010 and onward	Ongoing program cost	$796,500
Ongoing Annual	**Total Funds**	**$796,500**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of Providers (and where possible FTE capacity added via this strategy)*

This strategy will provide support for nine FTE Chemical Dependency Professionals (CDPs); five at Harborview Medical Center (existing staff) and four new FTE CDPs in south King County.

Although there is a statewide shortage of substance abuse professionals and recruiting can be a challenge, selected provider will have access to *Chemical Dependency Professional Education and Training* under MIDD strategy 1e.

◊ *B. Staff Resource Develop Plan and Timeline (e.g. training needs, etc.)*

Dates:	Activity:
Oct 1 – Dec 31,2008	Funding to Harborview for existing program staff.
Oct 1– Dec 31, 2008	Recruitment for south King County positions
January 1, 2009	Services start in south King County
January 1, 2009	Fully operating programs at all facilities

◊ *C. Partnership/Linkages*

MHCADSD will partner with Harborview Medical Center and south King County hospitals on this project. South King County hospital locations will be identified in collaboration with the Washington State Association of Hospitals.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

The current contract with Harborview will be extended without interruption, pending final approval for spending authority by the King County Council prior to the end of federal funding on September 30, 2008.

Services in south King County will begin in January 2009.

◊ *B. Procurement of Providers*

There is a current contract with Harborview for services, so an RFP is not required to continue services. State law allows sales tax funds to be used to replace lost federal funding.

Procurement of providers for south King County will be determined in collaboration with the Washington State Association of Hospitals. Procurement will occur Oct-Dec 2008.

◊ *C. Contracting of Services*

Contract with Harborview will be amended effective October 1, 2008.

Contracts for south King County will be effective January 1, 2008.

◊ *D. Service Start Date(s)*

Services at Harborview will start October 1, 2008.

Services at south King County hospitals will start January 2, 2009.