

Vermont Health Care Innovation Project Final Report



Screening, Brief Intervention, and Referral to Treatment in the Medical Homes  
at University of Vermont Health Network, Central Vermont Medical Center.

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“Substance abuse management can be incredibly time consuming and labor-intensive. It has been wonderful having a readily available expert to hand off my patients to, when they are ready and willing to make changes. I am quite confident that, if patients had to go to a different facility, at a different time, most would not follow through. Having your counselors available has made it substantially easier, and therefore more likely to be successful, in my patients' treatment of their substance abuse. The counselors have similarly provided me with professional support and guidance. Thank you and your team for your good work.”

- Dr. Robinson, UVMHN CVMC Adult Medicine, Barre

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### Acknowledgements

Our SBIRT team would like to thank the UVMHN CVMC medical group practices that participated in the integration of the SBIRT model. Adult Medicine, Barre and Integrative Family Medicine, Montpelier were our first two sites and set standards in motion for our additional four practices: Family Medicine, Berlin; Family Medicine, Waterbury; Family Medicine, Mad River; and Granite City Primary Care participation.

We would like to thank the leadership at UVMHN CVMC for absorbing the medical group practice's SBIRT clinicians into the Community Health Team. The SBIRT model promotes our UVMHN CVMC mission to work collaboratively to meet the needs and improve the health of the residents of central Vermont. Moreover the integration of SBIRT clinicians into our Community Health Team affirms our vision that working together, we improve people's lives.

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### *Executive Summary*

The SIM grant awarded to University of Vermont Health Network Central Vermont Medical Center (UVMHN CVMC) supported the implementation of the Screening Brief Intervention and Referral to Treatment (SBIRT) model into medical homes throughout the UVMHN CVMC service area. UVMHN CVMC service area corresponds to both Washington County and the State's Barre Health Service Area (HSA). SBIRT services are directed at preventing the unhealthy consequences of alcohol and drug use of those that have not reached the diagnostic level of a substance use disorder, and to help those with the disease of addiction engage in treatment. This public health approach to reducing harm associated with substance misuse strategically meets the health care Triple Aim. Research has demonstrated that the SBIRT model is effective at improving population health and reducing health care costs (See Appendix A) and with the integration of the SBIRT model into our primary care settings we sought to improve quality of care we provide at UVMHN CVMC.

In addition to the traditional SBIRT intervention focused on reducing harm associated with alcohol and drug use, this project included tobacco cessation interventions. The inclusion of tobacco interventions in our model was crucial given smoking related health care costs and lost productivity in Vermont total more than \$430 million per year (CDC, 2007) with nearly \$348 million of those costs resulting from direct medical expenses (CDC, 2014). The availability of onsite tobacco interventions was met with excitement by all medical providers and had the highest referral and utilization rates. Our team collaborated with the Vermont Tobacco Control Program to allow for our SBIRT clinicians to distribute free Nicotine Replacement Therapy (NRT) for uninsured/underinsured patients engaged in counseling with our trained Tobacco Treatment Specialist (TTS).

Screening in the Medical Home (SiMH) aimed to prevent and reduce substance misuse, reduce healthcare costs, increase care coordination, and implement a novel strategy to enhance patient participation. Our novel strategy to enhance patient participation was the development and implementation of a Short Message Service (SMS) protocol to monitor substance use and engage and extend patient activation. Unfortunately, this service was underutilized by our patient population and discontinued due to ongoing technical issues.

The SIM grant award to UVMHN CVMC's medical group practices (MGPs) allowed a unique opportunity to build upon SBIRT work that was being done in the CVMC Emergency Department through a five year SAMHSA federal grant. Over the course of the SIM grant we were able to work with the federal grant to spread an SBIRT service net throughout our medical homes, Women's Health Clinic, Emergency Department and Inpatient Hospitalist Unit. Our team worked diligently to coordinate patient care between the six SBIRT clinicians working throughout UVMHN CVMC. The data results in this report are based on the work done in the MGPs supported by the SIM grant at UVMHN CVMC.

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Over the course of the two year SIM grant our main goal was to integrate the SBIRT model into seven medical homes throughout our services area. By the completion of the grant we have effectively integrated the SBIRT model into six medical practices with clinicians available on a part-time basis for each practice. Due to the time it takes to hire clinicians and create system change, demonstration of reducing health care costs is unrealistic within a two year timeframe. However, we did begin to track sustained reduction of use subsequent to engagement in brief interventions or brief treatment through asking patients' permission to participate in a follow up call at six months post intervention. This allowed us to assess sustained changes, encourage re-engagement, and provide additional resources as necessary.

The integration of the SBIRT model in our MGPs unearthed systematic, cultural, and reimbursement factors that impact the quality of care people misusing substances receive. The incorporation of tobacco alcohol and drug interventions in our MGPs reduced the burden medical providers' face when caring for this population of our community. The integration of tobacco treatment counseling into our SBIRT model provided a new treatment option for smokers generally not available due to lack of reimbursement.

The formation of the Washington County Substance Abuse Regional Partnership (WCSARP) organized local substance abuse resources. As a community we are taking steps to increase services, coordination of care, and communication among the varied treatment providers. Internal efforts are being made to utilize Care Navigator software and enhance our clinicians' intervention efficacy through the use of Feedback Informed Treatment (FIT).

There is significant work to be done to increase the number of patients being screened, administered secondary screens, provided with interventions and referred to intensive care as needed. The SIM grant has afforded UVMHN CVMC the opportunity to take initial step to integrate the SBIRT screening model in our medical homes. UVMHN CVMC understands the value of the SBIRT model and is committed to supporting these interventions in our medical homes through Community Health Team resources.

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### ***Project Description***

In 2014, as part of the Vermont Health Care Innovation Project (VHCIP), University of Vermont Health Network, Central Vermont Medical Center (UVMHN CVMC) was awarded a State Innovation Model (SIM) federal grant. The grant supported the implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services into seven medical group practices owned by CVMC.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidenced-based practice to identify, reduce, and prevent substance misuse and co-occurring disorders. Central Vermont Medical Center had recently implemented SBIRT in the Emergency Department (ED) and was uniquely positioned to implement SBIRT into its medical group practices (MGPs).

The overall goal was for seven patient centered medical homes to implement SBIRT to demonstrate a regional model of care that can be promoted statewide. Screening in the Medical Home (SiMH) aimed to prevent and reduce substance misuse, reduce healthcare costs, increase care coordination, and Implement a novel strategy to enhance patient participation. Studies on brief interventions in acute and primary care settings document positive outcomes, successful referral to and participation in addiction treatment programs, and reduction in injuries and hospitalizations.

Special attention focused on the coordination of patient care between the CVMC Emergency Department and the medical group practices. Shared access and structured fields to record SBIRT scores and interventions were incorporated into our electronic medical record (EMR).

In addition to the standard SBIRT model focused on misuse of alcohol and drugs, UVMHN CVMC included tobacco cessation treatment and the development of a Develop a Short Message Service (SMS) protocol to monitor substance use, engagement and extension of patient activation.

Collaboration with State and private insurers to explore the sustainability associated with a billing reimbursement model for SBIRT integration continues to be in progress. Creation of the Washington County Substance Abuse Regional Partnership (WCSARP) with representation from multiple treatment facilities and care providers now meets monthly to increase patient care coordination and treatment transitions. Presentations to UVMHN, State and private insurers as well as stakeholders will continue as we gain insight into our ability to improve population health, quality of care and reduce health care costs through the utilization of the SBIRT model.

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### ***Discussion***

Each participating MGP assembled a Champion Team consisting of a medical secretary, nurse, medical provider and the office supervisor. The purpose of the Champion Team was to work together to find the least disruptive way to integrate the SBIRT model into their practice flow. Moreover, the Champion Team representatives sought to identify issues, find solutions and support adherence to the SBIRT model.

The general flow of our SBIRT model was for medical secretaries to give patients our initial alcohol (AUDIT C) and drug (NIDA screen) questionnaire as patients checking into their medical appointment (See Appendix B). Once a patient was roomed with the nurse, the nurse would score and enter the initial screen into our EMR. If the patient's score was positive the nurse would give the patient a secondary screen (See Appendix C ) to complete and review with their medical provider. The medical provider would either engage the patient in a brief intervention, in a warm handoff to their SBIRT clinician, or with the patients' permission send a referral to the SBIRT clinician to follow up with the patient.

The integration of SBIRT services into six of our MGPs at UVMHN CVMC has been an incredible learning experience. Beyond the multiple components inherent in integrating the SBIRT model, setting into motion a cultural shift in our medical practices was by far the greatest challenge. Normalizing the screening and treatment of substance use as an integral part of medical care was met with resistance and often associated with a belief that asking these questions are inappropriate and intrusive. The additional work placed on medical staff in regards to administering, scoring, and entering the results into our Electronic Medical Record (EMR) generated constant complaints from an already burdened nursing staff.

Compromises to which patient visits the screen would be administered were made from universal screening to universal screening for patients scheduled for physicals. Our rate of secondary screen administration for alcohol use was low, only 21% of patients that scored positive on an initial screen received the secondary screen. Reasons such as medical staff (nurses, providers) not thinking that a secondary screen was appropriate due to time constraints, discomfort with the screening process or because the belief that the positive score cut off was too low.

We experienced similar challenges with the administration of the secondary drug screen which has an administration rate of 15%. In general, patients that endorsed smoking marijuana or reported recreational (or less than monthly) use of other drugs were not given the secondary screen or a brief intervention. Similar reasons as noted above with the alcohol screener appeared to be the root cause of low secondary screen rates.

The medical model has traditionally operated in a mode of responding to illness and the preventative nature of the SBIRT model challenges the standard system of care. We can all agree that more

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prevention based interventions are needed however; these interventions require asking questions that are traditionally addressed when there is a diagnosed problem. Consequently this cultural shift in care will take time and require consistent support by our larger institutions and support at the state and federal level.

### ***Project Evaluation***

Our final report seeks to review our experience implementing the goals of this project and to explore the complications inherent in creating change in a complex system. Although each medical practice developed their unique SBIRT model flow guided by their SBIRT Champion Team, for the most part there are consistent patterns. Our findings are divided into four categories: implementation, the challenges that emerged, accomplishments and our recommendations moving forward.

### ***Screening 6,162 pts were screened for alcohol, drug and tobacco use***

#### **AUDIT C/ AUDIT 10; NIDA Drug Questions/ DAST 10**

**Implementation:** Our goal was to incorporate yearly universal alcohol and drug screenings for all patients receiving care through our medical homes. Practice sites were able to administer the SBIRT screening questions at annual/physical visits. Each site successfully established an SBIRT Champion Team consisting of a medical secretary, a nurse, a medical provider and the office supervisor. All pertinent staff was trained on the screening tool, scoring and how to enter the information into our EMR. The screening measures were built into our EMR through structured templates allowing access to data retrieval.

**Challenges:** Implementation Challenges were present at multiple levels of the integration process

- Screening during physicals – the population of adults that come for an annual physical is on the decline and generally consists of older adults. Consequently, younger at risk populations were less likely to be screened.
- Time –Practice sites consistently complained that the staff (nurses) did not have time to administer, score and enter screens due to already being overburdened with tasks linked to payment that must be complete during a patient visit.
- Meetings –Integration into practice meetings and initiation of meetings to implement and improve quality of the SBIRT model was a consistent struggle. Champions ability to ignite practice participation varied.
- EMR – Structure templates capture screening results well, however, the integration of the results into the EMR is unpleasant (See Figure 1) and ultimately provides information that is cumbersome and difficult to decipher.

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**Figure 1 Display of SBIRT initial (alcohol and drug) and secondary screening answers once entered into EMR.**

**HPI:** ▾  
**SBIRT**

**Audit C** In the last year, how often in the last year did you have a drink containing alcohol? 2-4 times a month=2, How many drinks do you have on the occasion that you do have alcohol? 3 or 4=1, How often did you have five or more drinks on one occasion in the past year? Monthly =2, SCORE: 5 , INTERPRETATION OF SCORE: >=4 for women or >=5 for men- Go to Secondary ETOH or Secondary ETOH 65 if >=65. **Initial Drug Screening** How often in the past year have you used marijuana? 2-3 times per week=1, How often in the last year have you used non legal drugs? Never=0, How often in the past year have you used prescription drugs for non-medical reasons or ones that were not prescribed to you? Less than monthly=1, SCORE: 2 , INTERPRETATION: >=1 Go to Secondary Drug Screening, In the past year, have you requested an early refill on your medications? No. **Secondary ETOH** Audit C Total: 5, How often during the last year have you found that you were not able to stop drinking once you had started? Less than monthly=1, How often during the last year have you failed to do what was normally expected of you because of drinking? Monthly=2, How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? Never=0, How often during the last year have you had a feeling of guilt or remorse after drinking? Monthly=2, How often during the last year have you been unable to remember what happened the night before because of your drinking? Never=0, Have you or someone else been injured because of drinking? Yes, but not in the last year=2, Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested that you cut down? No=0, SCORE: 12 , INTERPRETATION OF SCORE: 8-15= At risk/conduct brief intervention. **Secondary Drug Screening** Have you used drugs other than those required for medical reasons? Yes=1, Do you abuse more than one drug at a time? No=0, Are you always able to stop using drugs when you want to? No=1, Have you had "blackouts" or "flashbacks" as a result of drug use? Yes=1, Do you ever feel bad or guilty about your drug use? No=0, Does your spouse (or parent) ever complain about your involvement with drugs? Yes=1, Have you neglected your family because of your use of drugs? No=0, Have you engaged in illegal activities in order to obtain drugs? No=0, Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? No=0, Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? No=0, SCORE: 4 , INTERPRETATION: 3-5=Moderate Risk (Brief Treatment). **Cannabis Screen** SCORE: .

- **Billing** – Our team has been working with Win Turner of the federal SBIRT grant, and Josh Plavin of BCBS to develop a coding/ reimbursement guide for the integration of SBIRT and behavioral health services. Billing for health risk screening/ SBIRT interventions is complex and appears to require a team of experts in coding knowledge. BCBS and state coders continue to work on this reimbursement guide.
- **Measures (length)** – The AUDIT C and NIDA Drug questions create an initial screen that is 6 questions long, and for those patients that score positive on the initial screen a secondary screen (AUDIT 10/DAST 10/SMAS-T-G) is required which may be up to an additional 17 questions. There is an understanding in the field that the DAST 10 does not adequately address the symptoms associated with marijuana use. Therefore patients scoring positive for marijuana use would ideally receive a different secondary screen adding a potential for 15 additional questions (See Appendix D). Consequently if a patient screens positive for alcohol, drug and marijuana use a total of 38 questions would be asked prior to an intervention being done.
- **Measures (appropriate fit)** –Although the AUDIT 10 is widely used in SBIRT models, the screen indicates the level of alcohol dependence and appears less effective at identifying risky alcohol use in adults. For older adults the AUDIT 10 does not adequately capture the unique patterns of alcohol use in older adults and we utilized the SMAS-T-G when screening patients over 65 (See



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Appendix E). The NIDA questions regarding misuse of prescription medication received little endorsement by our patient population. As mentioned above the DAST-10 appears to be a poor measure of cannabis use symptoms.

- Secondary Screens –Nurse participation in administering secondary screens is low. Only about 21% of the patients that scored positive on the initial AUDIT C screen were given the AUDIT 10. 15% were only administered the secondary drug screen.
- Culture –Conducting screening for at risk alcohol and drug use is a shift in the typical medical model of care. This shift has been met with complications associated with medical staff (mainly nurses) opinion on the appropriateness of asking these questions, discomfort with asking the screening questions, and judgments associated with the acceptability of alcohol consumption. Moreover, the integration of substance abuse intervention in the medical model requires a review of complications associated with records release and federal regulations in 42 CFR part 2.

**Accomplishments:** We were successful at implementing the SBIRT screening model into six of our medical group practices and are continually working to improve the screening process. We are beginning to transform the UVMHN CVMC medical model of care to incorporate substance misuse interventions. We have been able to identify and are working to address the challenges to implementing substance misuse services. Our organization plans to continue to build upon the work made possible by the SIM grant and understands that substance misuse has a significant impact on the health of our community.

**Recommendations:** Universal screening annually for all patients receiving care through our medical homes with utilization of a briefer screen to be completed by the patient prior to visit and entered in to EMR by nurse or designated staff member. Routine quality improvement projects to increase screening model effectiveness.

- Utilization of a briefer one question annual (See Appendix F) combined with appropriate secondary screen (See Appendix G)
- The combined screen to be given to patient by medical secretary upon arrival for appointment and entered into EMR by either nurse or designated staff member. Ideally this combined screen will minimize the burden on nurses and increase the secondary screen administration.
- Limit information entered into EMR to intervention level indicated and final AUDIT/DAST score (See Figure 2), initiate Cannabis Integration Screener during brief intervention or brief treatment.

**Figure 2 Display of limited information, indicating level of intervention and AUDIT/DAST Score.**

**HPI:**   
Annual SBIRT

Brief intervention indicated, Pt scored at risk for alcohol and drug use.

**ETOH Screen (f)** INTERPRETATION: 8-15= At risk/conduct brief intervention , SCORE: 12 . **Drug Screen**

INTERPRETATION: 3+ =moderate to severe risk/referral to SBIRT Clinician, SCORE: 3. **SBIRT Intervention** Brief Intervention .

- Continuation of monitoring screening, interventions and referral rates with regular feedback to MGPs.
- Incentivized alcohol and drug screening linked to payer, ACO, and/or state mandate.
- Assess the usefulness of technology to streamline the screening portion of the visit (e.g. use of ipads, check in kiosk)
- Consider a novel strategy to engage patients in yearly health screening. Designate a month to campaign patients' participation in getting their yearly health screen done electronically through the patient portal, at a kiosk at their doctor's office, or at a local library.
- Mandatory training requirements for nursing staff (RN, LPN, LNA, CNAs )in screening and engagement with patients struggling with alcohol and drug use disorders as part of maintaining certification or license.
- State initiated guidance on 42 CFR Part 2 and the appropriate disclosure of health information associated with alcohol or drug treatment offered in medical setting.

***Brief Intervention 219 patients received a brief intervention by our clinicians***

**Implementation:** Three master's level SBIRT clinicians covered six medical homes throughout UVMHN CVMC's service area to provide onsite brief intervention and brief treatment sessions with patients scoring positive for tobacco, alcohol, and or drug use. A majority of medical providers at each site were trained to deliver the brief intervention. We utilized our internal messaging system to communicate regarding the need for an "in the moment" brief intervention.

**Challenges:** The part-time availability of an SBIRT clinician spread across multiple sites complicated by scheduled brief treatment appointments were significant barriers to consistently being available for in the moment interventions.

- Training -Although medical providers engaged in brief intervention trainings, providers were explicit that they did not have time to engage in brief interventions with patients. Moreover, the time that would need to be invested in order for medical providers to become efficacious in delivering brief interventions would require larger organizational support/mandate.
- Culture –The SBIRT model requires a shift from identifying and treating patients that are dependent users to identifying and intervening with patients that are at risk. The preventative approach of SBIRT requires a cultural shift for the medical model. There have been numerous

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missed opportunities for interventions simply because the nurse or provider did not feel the patient needed an intervention. This occurs most often with patients positive for regular marijuana use.

- Screening -The decision to screen on only patients scheduled for a physical reduced the number of patients potentially eligible for brief interventions or brief treatment which impacted the ability to justify having a clinician fulltime at a practice.
- Availability -With the workforce divided among multiple practices, when a clinician was onsite, much of her time was scheduled with brief treatment sessions, impacting availability for brief interventions.
- Quality Improvement –Practices are reluctant to devote time to universal SBIRT screening for all patients and to engage in quality improvement efforts. This is due to the lack of screening mandate or screens being linked to payment, access to a full time clinician to support any increases in patient care needs, and the increased burden expansion of screening will place on nurses' time.
- Accessing Additional Resources -Space limitations, separate medical record systems, and the need to bill for services impeded the ability to contract from our designated agency for additional clinicians.
- Access to detox/residential treatment –When a referral to intensive treatment is recommended, multiple barriers are encountered from access to care - to the patients' ability follow through on recommendations. Please see Referral to Treatment section for specific details.

**Accomplishments:** Over the past two years we have been able to set into motion an integrated care model aimed at reducing harm associated with tobacco, alcohol and substance misuse. Our medical providers perceive the clinicians as a valuable resource and express the desire for increased access to brief intervention services. All screening and interventions are recording in our EMR, enhancing our ability to provide quality coordination of care throughout the UVMHN CVMC system of providers.

### Recommendations:

- Restructure model to include increased support and collaboration with the Community Health Team Health (CHT) Coordinators/Panel Coordinators. An ideal model would be for each practice to have access to a full time SBIRT clinician and the assistance of a CHT member trained to score and entering screens and be able to effectively deliver brief interventions when the SBIRT clinician is unavailable.
- For each medical practice to be mandated to complete quality improvement projects to improve screening and brief intervention efficacy yearly.
- Increased integration of SBIRT clinician into each medical practice teams (nurses/ medical providers) and medical practice staff meetings.
- Morph SBIRT clinician position into a generalist counseling position, available to provide brief interventions for mental health and/or substance misuse issues. The separation of substance

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misuse and mental health interventions limits the impact our competent counselors could have on medical home patient panel.

### ***Brief Treatment 614 patients engaged in brief treatment services***

**Implementation:** We were able to secure office or exam room space for clinicians to offer brief treatment sessions in each participating MGP. Patients were linked to brief treatment sessions either through a brief intervention or through a referral generated by the medical provider. Upon receiving a referral the clinician would attempt to contact the patient twice over two weeks and if she was unable to reach patient a letter detailing available resources would be sent. Through the assistance of this grant and support through the Tobacco Control Team our SBIRT clinicians have been able to provide free NRT (patches, gum, lozenge etc) to uninsured/underinsured for patients enrolled in our brief treatment sessions for tobacco cessation counseling.

**Challenges:** There were no significant challenges associated with the brief treatment integration. In fact all MGP sites welcomed and promoted patient access to onsite brief treatment options. However, there are challenges associated with aspects of providing brief treatment.

- Access to NRT Inhaler -Generally the first line recommendation NRT for patients who are quitting smoking is the NRT patch and gum/lozenge. If a patient is unsuccessful with these products, obtaining alternative NRT products such as the Nicotrol inhaler is difficult for patients to get due to high cost and lack of insurance coverage. Patients who don't have the means to afford Rx NRT such as the inhaler are often at a disadvantage when it comes to tobacco cessation.
- Underestimation of complexities inherent in tobacco referrals -Many patients who are referred for tobacco counseling often present to counseling with untreated co-occurring issues such as depression, anxiety, bi-polar, trauma, grief, PTSD, OCD, schizoaffective disorder, and personality disorder(s) comorbid with chronic health conditions.
- Accessing Care Patients struggling with alcohol misuse and addiction regularly opted to engage in brief treatment over engagement in intensive treatment options. Often this was due to lack of transportation, insurance/financial issues, desire for individualized treatment, and resistance to abstinence only approaches.
- Detox Services -When a person is ready for intensive treatment options, access to detox or inpatient services are limited, void of local options and often cumbersome to navigate.
- Release of Information – We currently have one release of information (ROI) that is used for both personal and professional requested for shared information.

**Accomplishments:** We enjoyed a welcomed integration of behavioral interventions into each medical practice. Documentation in a shared EMR made coordination of care and care planning with primary medical providers simple. The ease of patients having access to a therapist at their medical office appeared to reduce stress and stigma associated with seeking treatment. The ability to offer free brief

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therapy for patients seeking to change tobacco alcohol or drug use was met with optimism from both referring medical providers and patients.

Our SBIRT clinicians received weekly supervision and incorporated Feedback Informed Treatment (see Appendix H) to promote patient engagement and development of therapeutic alliance. Clinicians tracked patient engagement and were able to follow up with patients 6 month post intervention to assess progress and offer additional services as needed. The clinicians' outreach to patients post intervention has been welcomed by patients and many that were initially unsuccessful in reaching or maintaining use goals re-engaged in our services.

The ability to synergize the SIM grant SBIRT clinicians with the clinicians embedded into the Emergency Department, Women's Health Clinic and Inpatient Hospitalist Unit (funded through the larger Federal SBIRT grant) created a strong web of prevention and intervention services throughout UVMHN CVMC.

### **Recommendations:**

- Provide continued free access to on site brief treatment for tobacco, alcohol and substance use.
- Increase clinicians time at in each MGP to provide brief treatment services including brief mental health interventions.
- Additional attention needs to be given to release of information documents and sensitivity to alcohol/drug use treatment documentation into medical record. Two different ROIs are needed in our system, one for coordination of care with other professional and one for a patient to complete about a release of records to self/others (non professionals).
- Comprehensive review of releases used when patients access substance abuse treatment to ensure compliance with federal standard of care (42 CFR part 2).
- Professional development for clinicians to include use of FIT tools and consistent clinical supervision
- Advocacy to state leadership and key stakeholders to promote changes in the substance abuse system of care.

***Referral to Treatment 900 patients were referred to SBIRT brief treatment services; 243 score indicated intensive treatment service level***

**Implementation:** Internal referrals from medical providers to SBIRT clinician was a simple process of generating a referral in our EMR. Patients were generally contacted with 24 to set up an appointment. If the clinician was unable to reach the patient after attempting for two weeks, the patient would receive a letter encouraging participation in our free brief treatment services at the medical home or available community resources.

Smooth transition of referrals to external intensive treatment services is uncommon. Our team continues to make efforts to increase communication and ease of patient flow with external referral

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treatment sources. We established the Washington County Substance Abuse Regional Partnership (WCSARP) consisting of substance abuse treatment stakeholders to discuss patient care issues, identify treatment gaps in services, reduce complexity of clinical pathway to accessing treatment, increase ease of coordination of care, and knowledge of community resources.

**Challenges:** The main referral to treatment challenges we encounter are with the external referrals to intensive treatment and ability to efficiently coordinate patient care. Included in our appendices is a case example of a patient's struggle to navigate the treatment system (See Appendix I).

- Initiating contact –Attempts to initiate contact with intensive treatment agencies can be deterring. Limited hours of operation, staff availability to engage patients for an intake, and ability to provide a rapid response to patients about intensive treatment admission significantly slows the treatment engagement process.
- Culture (patient) –Many patients that are ready to engage in intensive substance abuse treatment have limited resources (often due to consequence of disease). Barriers such as inactive cell phones, transportation, houselessness, lack of family support (child/pet care), ability to miss work, financial issues (underinsured/uninsured), and fleeting desire to engage in detox/treatment process have a significant impact on an individual ability to follow through with treatment intentions.
- Culture (system) –We have a system that treats people with a chronic health disease through disjointed brief treatment programs. Residential treatment programs offer services from 1 week to 4 weeks, barely enough time to detox and begin reflecting on impact of substance use on life functioning. Patients that are “successful” at completing their inpatient stay are then transitioned to either intensive outpatient services, outpatient services, or returned to medical provider for an appointment. Patients that leave treatment against medical advice (AMA) have little to no coordinated care as they return to the community.  
Patient access to receiving an intake upon placing a call is uncommon. Patients generally have to leave a message for a returned call, schedule an intake for another time, or if they do get connected with a screener it may be incomplete due to missing information (insurance, notes from provider, lab work etc.). Regardless, the patient must be able to receive a returned call to learn whether he/she is accepted into at facility and the potential wait associated with admission. The assumption that the patient has their basic needs met enough to make or receive a follow up call to complete the intake or follow up when a bed may be available underestimates the progression, severity, and dysfunction associated with many patients' disease.
- Culture (workforce) –Our state's designated agencies that provide inpatient, intensive outpatient and outpatient substance abuse services struggle to maintain staff and consequently consistent services including coordination of care. The combination of high turnover, low wages, ineffective reimbursement of essential services, and vacant positions create an unrealistic expectation of a workforce (See Appendix J). Moreover, there is a lack of professionals trained in

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the substance abuse counseling field making recruitment and retainment of competent counselors difficult.

There appears to be a chronic game of hot potato with patients engaged in treatment where patients are transferred from one provider to another with little coordination of care or follow up on engagement with subsequent care. Even with an SBIRT clinician in the medical home/emergency department/inpatient hospital working diligently to coordinate care with treatment agencies a smooth transition or two-way communication on treatment progress was irregular.

- Releases – Concurrent with the above challenges sharing information associated with drug and alcohol treatment is complicated by one way releases unique to each treatment setting. The WCSARP did create a unified release and memorandum of understanding to use the agree upon release however use has been inconsistent due to delays in agencies' implementation of agreed upon release.
- Rapid Access -Currently we do not have a rapid access to treatment center or central intake/triage for patients seeking help.

**Accomplishments:** Through the strategic placement of SBIRT clinicians at UVMHN CVMC we have been able to identify and support hundreds of patients struggling to navigate our current substance abuse system of care. People that are able to create change in the brief outpatient treatment model provided in the medical homes have enjoyed ease of establishing appointments, consistent care coordination with their medical provider, post treatment follow up check ins, and when needed, diligent efforts to ensure a warm handoff to higher levels of care.

Medical providers in our medical homes have expressed gratitude for their access to an onsite substance abuse specialist. High utilization of clinicians for tobacco cessation counseling has signified a concrete need for onsite tobacco interventions and services. Clinicians being available to help complex patients navigate and access intensive treatment services allow for a reduction of patient care burden traditionally placed on our medical providers.

The high utilization of SBIRT clinicians in our medical practices combined with the growing need to incorporate these types of intervention services for best patient care has fueled the continuation of our SBIRT program post SIM grant. Outreach to regional and state substance abuse treatment providers through the WCSARP meetings is encouraging a coordinated effort to increase care for our community. The WCSARP is identifying treatment gaps and coordination of care issues, advocating to state leadership to create change in a struggling system of care.

The SIM grant allowed us to establish a program that provides meaningful interventions for our patients and the appropriate program evaluation and clinical supervision to ensure success. Engagement in regular clinical supervision, data review, team meetings and coordination with SBIRT services active throughout UVMHN CMVC has set a standard for quality care.

## Central Vermont Medical Center

### Recommendations:

- The continuation and expansion of SBIRT clinician integration into medical home care.
- Continued development of the WCSARP to encourage increased participation of additional community resources, coordination of care efforts and identification and advocacy regarding gaps treatment.
- A rapid access center or centralized point of entry for residential and intensive treatment care.
- A shift from disjointed brief treatment to a system of care that provides coordinated care pathways conducive to chronic disease management.
- Adequate reimbursement to designated agencies in order to provide case management of patients care coordination planning.
- Utilization of Care Navigator software to increase ability to coordinate care as patients move through the substance abuse system of care.
- Development of a plan to incentivize recruitment and retainment of substance abuse clinicians

### *Data Evaluation and Interpretation*

All data was collected through patient self report and entered into our EMR. Potential errors could be associated with false reporting and inaccurate data entry by staff. Once data is in our EMR, the screening, brief intervention, brief treatment and referral to treatment frequencies were collected through our SQL software. Six month follow up data was collected by SBIRT clinicians and entered in an excel file as well as logged into our EMR.

Our data analyst provided our Project Manager with a large Excel file with the ability to filter specific information. Identification of integration challenges were gathered through direct experience of the SBIRT team and self report of staff members at the participating medical practices.

The data presented in this final report represents a lower number of screened patients than what was presented in the last quarterly report. The reason for the decrease is that this data reflects the subset of patients that received the alcohol, drug and tobacco screen during a visit. Unlike data reported in the last quarterly report, this data does not include any of the Women's Health Clinic screening rates, and it does not include patients that may have received an alcohol screen and not a drug or tobacco screen. This subset is being presented in the final report to simplify data charts and to gain insight into the cohort that completed all three screens this grant was intended to capture.

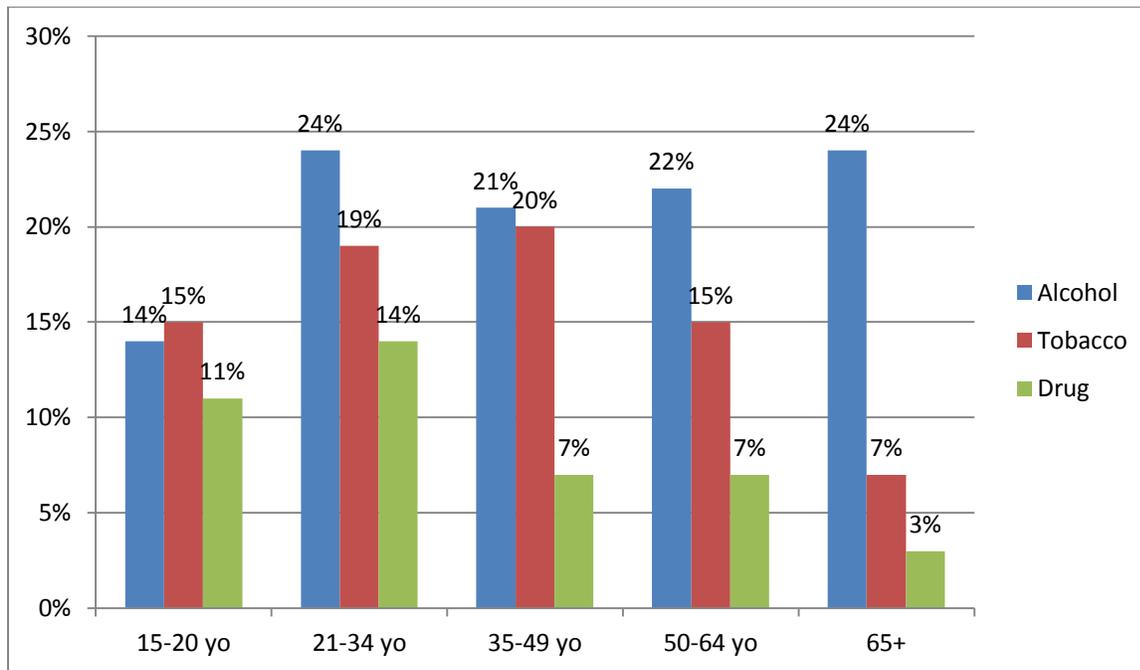
Throughout our six participating medical practices 6,162 patients with an age range from 15-96 and the average of 54 years old were screened. These patients consisted of 2,807 males and 3,355 females. Patients were screened for alcohol, drug and tobacco use at a medical visit. Please note that referrals and consequent brief treatment sessions were not contingent on a positive drug or alcohol screen.

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Regardless if a screen was done medical providers could send a referral to an SBIRT clinician for engagement in brief treatment for a tobacco, alcohol or substance use concern.

Of the 6162 patients 860 (14%) screened positive for tobacco use, 1211 (19.7%) positive on the AUDIT C, and 418 (6.8%) scored positive on the NIDA drug screen questions. The average age of the participants screened was 54 years old, so we looked deeper to see how different age groups scored (See Figure 3).

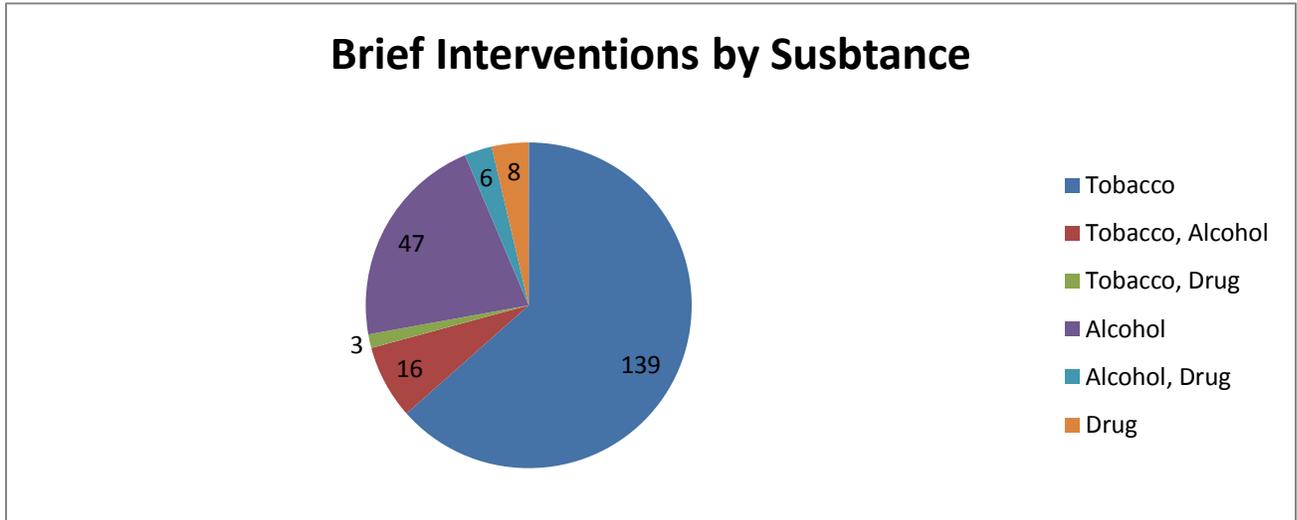
**Figure 3 Screening Rate Based on Age Group**



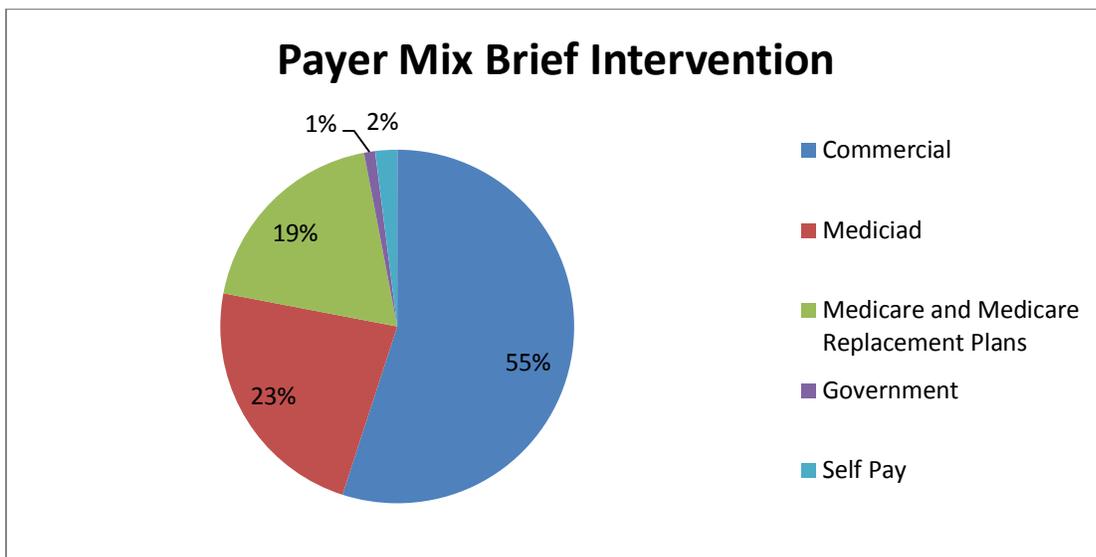
As mentioned earlier we struggled with consistent administration the secondary alcohol and drug screens. Consequently the rate of secondary screen completion was low, 21% of patients that scored positive on the AUDIT C received the AUDIT 10 and 15% of patients that scored positive on the NIDA drug questions received the DAST 10. We hope that by changing our initial screen to include the secondary screen combined with having patients complete the form prior to their appointment will help increase our overall screening rates.

SBIRT clinicians performed 219 brief interventions with patients in the MGPs. Brief interventions ranged from single substance to combination of substances. See Figure 4 for specific details and Figure 5 for payer mix of patients that received a brief intervention.

**Figure 4 Brief Interventions by Substance**



**Figure 5 Payer Mix of Brief Intervention Patients**

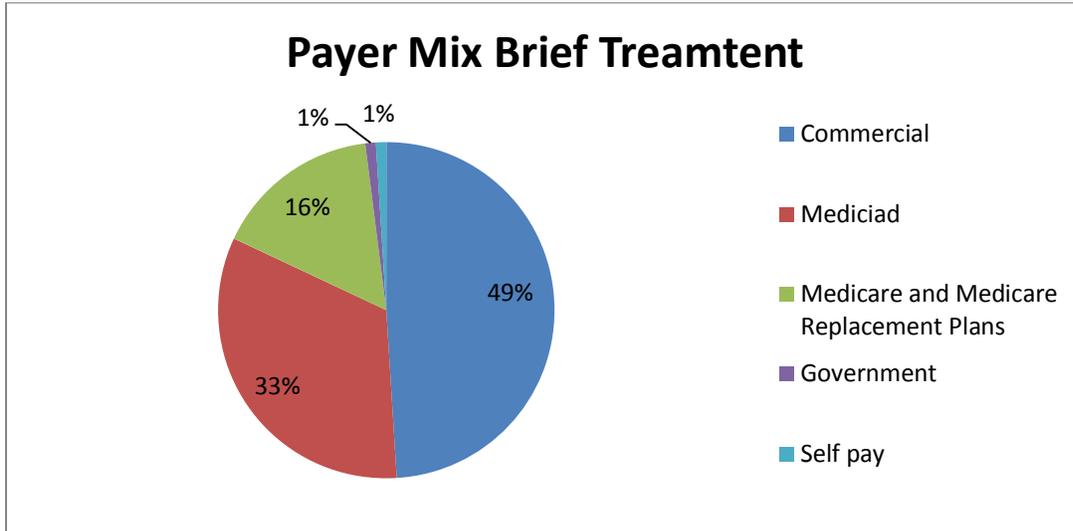


614 patients received brief treatment sessions from our SBIRT clinicians. Unfortunately we do not have a division of sessions by substance. In our EMR SBIRT visits are label SBIRT and do not specify information associated with what substance initiated the patient’s engagement in SBIRT counseling. This was done to minimize the disclosure of patient substance use issues visible in our EMR resource schedule. The

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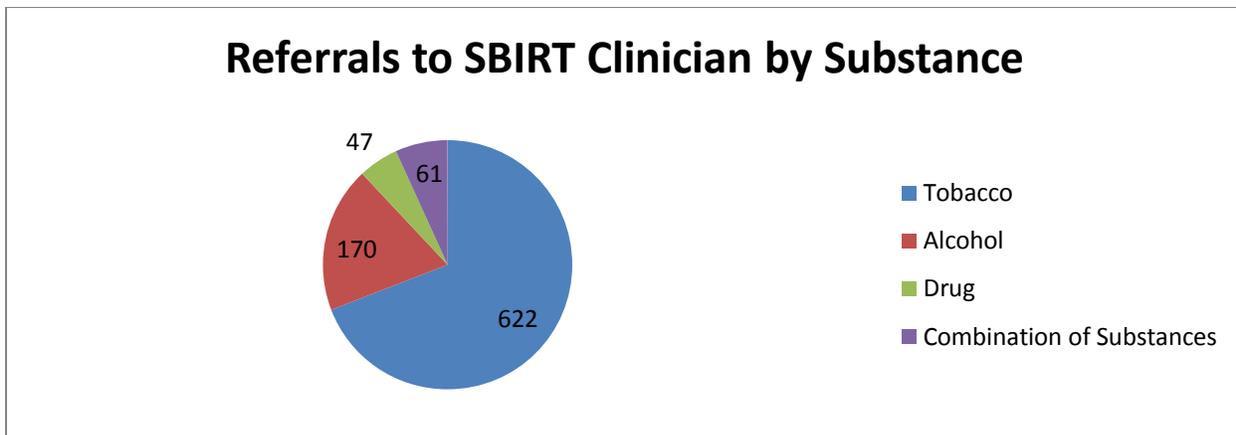
payer mix for patients engaged in brief treatment is similar to that of brief interventions, with a higher engagement of commercial payers than any other payer, see Figure 6.

**Figure 6 Payer Mix of Brief Treatment Patients**



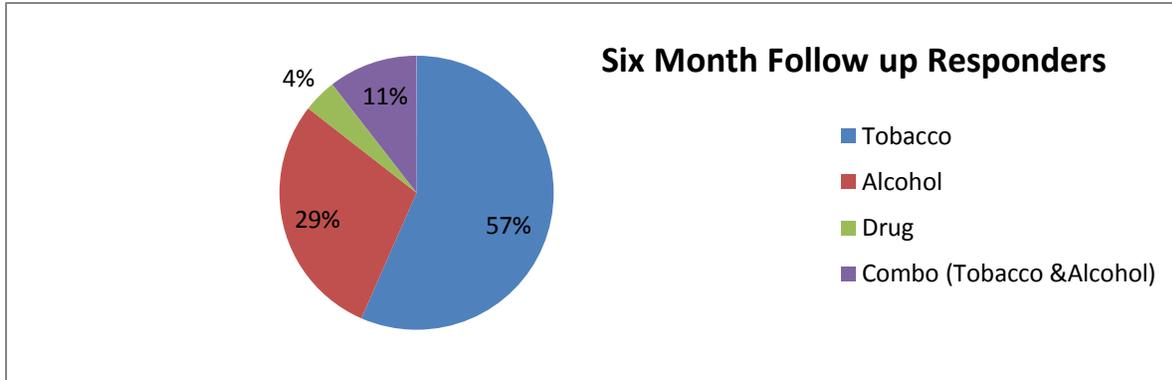
Our MGP SBIRT clinicians received 900 referrals from medical providers for patients interested in brief treatment. Of those referrals 614 patients engaged in at least one treatment session. A majority 69% of patients were referred for tobacco cessation counseling, see Figure 8.

**Figure 8 Referrals to SBIRT Clinicians by Substance**



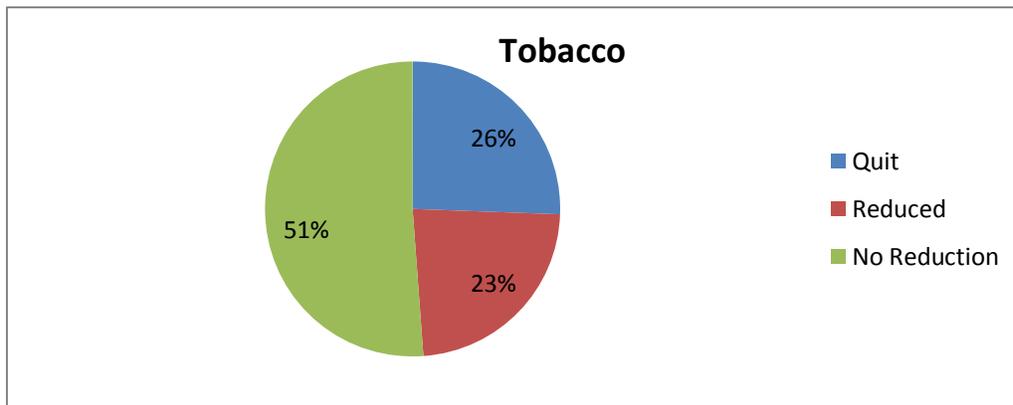
Approximately 46% (77) of the eligible patients entered into our clinician follow up spreadsheet responded to our six month follow up calls, see Figure 7.

**Figure 7 Six Month Follow Up**



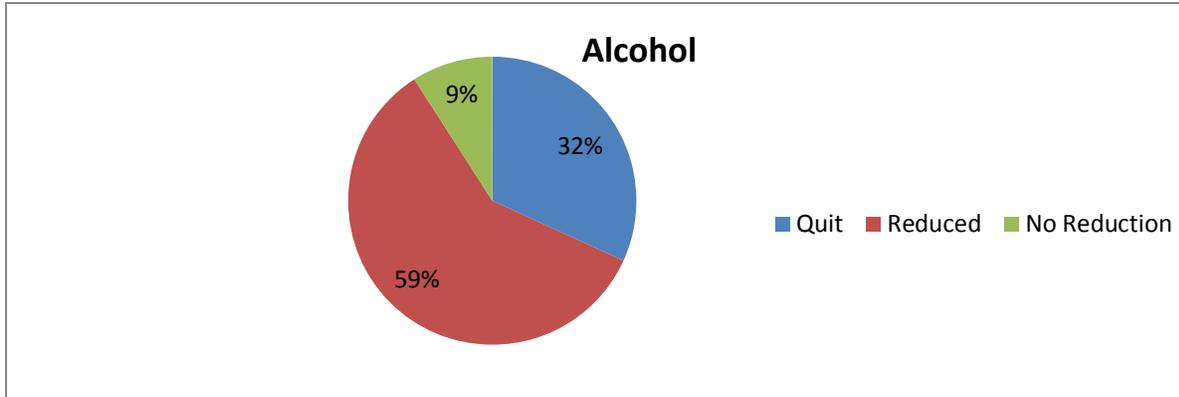
**Tobacco:** 57% (43) of the responders had engaged in services for tobacco treatment and 26% (11) reported staying quit, 23% (10) maintained a reduction, and 51% (22) continued to smoke. Ten of the twenty two people that continued to smoke requested to re-engage in services, see Figure 8.

**Figure 8 Tobacco Responders**



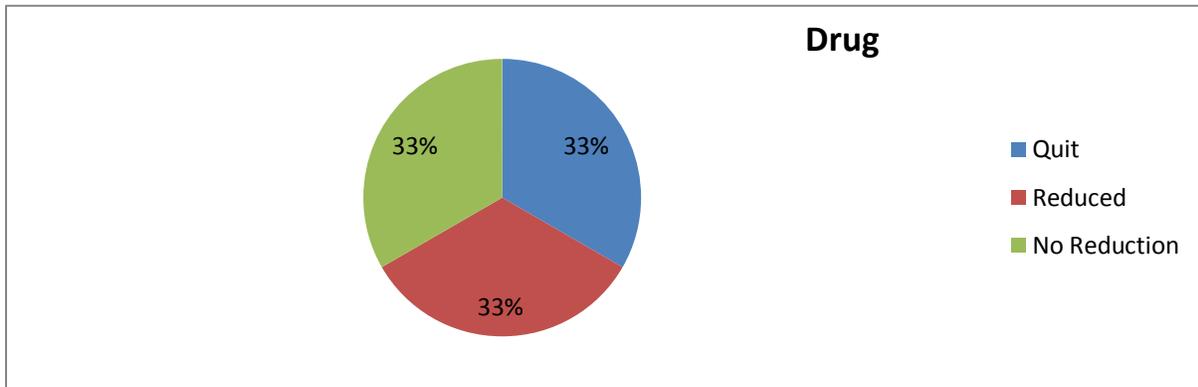
**Alcohol:** 29% (22) of the responders had engaged in services for alcohol treatment and 32% (11) reported staying quit, 59% (13) maintained a reduction to healthy limits, and 9% (2) reported no reduction. One of the two people that reported no reduction requested to re-engage in services, see Figure 9.

**Figure 9 Alcohol Responders**



**Drug:** 4% (3) of the responders had engaged in services for drug treatment and 33% (1) reported staying quit, 33% (1) maintained a reduction in use, and 33% (1) reported no reduction. Two of the three responders had sought treatment for marijuana use, one reduced use and the other did not reduction use. The third responder sought treatment for cocaine use and reports maintaining abstinence. The marijuana users did not express interest in re-engagement, see Figure 10.

**Figure 10 Drug Responders**



Through the support of this SIM grant we have started the process of integrating the SBIRT model into our MGPS. We have significant work ahead us to increase the universality of patients being screened, and finding a path to increase access of clinicians for in the moment brief interventions. The data suggests that a significant number of patients responded to the opportunity to received free tobacco cessation counseling and some of those patients were successful in quitting their tobacco use. Our six month post intervention responders indicate that we had moderate success in helping people that were misusing alcohol abstain from use or reduce their use to low risk drinking levels at six months post intervention. The effectiveness of our interventions on people struggling with drug use is unclear as our number of patients that received interventions or brief treatment is low.

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### ***Project Sustainability***

Sustainability of the SBIRT model will likely need to come from resources alternative to a fee for services model. Low reimbursement rates combine with complex coding and unclear documentation requires makes billing for these services deterring. Regardless we will continue to work with BCBS and State coders to complete the behavioral health reimbursement guide to help organizations navigate the billing potential of the SBIRT model.

UVMHN CVMC is fortunate to have leadership that values the benefits the SBIRT model has brought to our patients and medical providers. At this point it appears that the SBIRT program will continue to operate in our MGPs and merge with the Community Health Team. This seems appropriate in light of a majority of our referred patients are for tobacco counseling with extremely limited reimbursement ability combine with the broad range of insurance carriers reached by these interventions.

We anticipate a continuation of data collection and quality improvement efforts to increase our screening and interventions rates. We plan to start examining our SBIRT data file to create patient panels for each MGP consisting of patients that scored positive on their alcohol and drug screen, seeking to engage these patients in targeted brief interventions and treatment.

UVMHN CVMC will continue to host WCSARP meetings and work with community resources to increase clinical coordination of patient care, access to treatment resources, and review gaps in our services area. Clinicians are participating in trainings regarding Care Navigator software and we look forward to the possibilities this platform will bring to providing enhanced patient care. Our team will continue to explore the use of Feedback Informed Treatment aimed at increasing patient engagement and therapeutic alliance both crucial to behavioral change.

### ***Conclusion***

The SIM grant awarded to University of Vermont Health Network Central Vermont Medical Center (UVMHN CVMC) supported the implementation of the Screening Brief Intervention and Referral to Treatment (SBIRT) model into medical homes throughout the UVMHN CVMC service area. This public health approach to reducing harm associated with substance misuse strategically meets the health care Triple Aim. Research has demonstrated that the SBIRT model is effective at improving population health and reducing health care costs and with the integration of the SBIRT model into our primary care settings we have been able to the improve quality of care we provide at UVMHN CVMC.

We have learned significant lessons about the complexities associated with integrating the SBIRT model into participating MGPs. Efforts are being made to continue the services initiated by our SIM grant and to improve on the quality of screening and interventions we offer our patient population. A behavioral

## Central Vermont Medical Center

health reimbursement guide is being developed by coding experts; however there doesn't appear to be clear pathway to funding an interventionist position through billing reimbursement alone.

Future work aimed at integrating "in the moment" substance abuse and mental health interventions, with an option to engage in counseling services onsite would be ideal. Our SBIRT clinicians each have a master degree in mental health counseling and specialized training in addiction treatment. Although this grant was aimed at offering substance misuse treatment, our clinicians would be better utilized by being available for both mental health and substance misuse interventions. The inclusion of tobacco cessation counseling provides a gateway to offer services to a population of our community significantly in need of counseling services that otherwise may not seek counseling services.

Our system of substance abuse prevention and intervention struggles to meet the demand of Vermonters. We are in desperate need of a comprehensive evaluation and plan to revitalize our State wide treatment structure. An innovative approach to recruitment and retainment of substance abuse counselor working in our designated agencies is vital. Attention to increasing interventions that utilize Feedback Informed Treatment a tool that supports the engagement of patients and enriches the therapeutic alliance will be helpful to restore trust and encourage patient investment in their outcomes.

The development of a strategic plan to address the growing demand for patients to be screened annually for numerous health risk concerns is necessary. Use of technology will likely play a role in streamlining health screenings and finding a way to engage patients in this process without adding burden to our health care teams. The potential of designating a month to focus a mass campaign for people to complete their annual health screens, much like a get out to vote effort, may be a pathway to consider.

Throughout the past two years we have experienced success treating patients with alcohol, tobacco and substance use concerns. In our report we chose to share a case study that illustrates the progress UVMHN CVMC has made in our ability to identify and intervene, highlighting the challenges presented for patient struggling to navigate a complex system of care. We think that this case example demonstrates the value of our WCSARP meetings. There we are able to build bridges with outside agencies, identifying gaps in care and ideally increase accountability and find solutions. We are in the process of a cultural shift to how we deliver medical treatment. One that emphasizes an integrated team approach to medical care, an increased understanding of the impact addiction has on our community's health, and advocacy to improve care coordination with community partners.

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Additional medical provider response to the SBIRT project...

“Having SBIRT services available on site has been an invaluable resource to patients who are ready to make positive changes, but who may just need a bit more support than we have time and ability to give at our regular office visits. Kara's expertise has helped many of my patients quit smoking and quit, or cut down on alcohol.” -Eliza Anti, NP-C

“I think the availability of having onsite SBIRT counselling has been a very valuable asset to our patients, esp for tobacco, but also for alcohol and substance abuse, I hope the services continue, and I thank you and Kara very much for your services and communication.” – Mark Yorra, MD

“It is invaluable to have someone in the office to support our patients particularly around tobacco and alcohol use. It is hard to quantify as the impact is long term, but we all know well that getting our patients to reduce or quit their use of these substances is one of the best things they can do for their long term health. Kara is a great provider and has been excellent at really connecting with patients.” -Elizabeth Suiter, MD

“This service has been invaluable. I wish I had it available years ago. Many of my smokers have stopped smoking due to this service. Patients who are identified as abusing drugs have been able to get off the drugs, b/c of this program.” – Anthony Williams, MD

“I've found it extremely helpful to have Kara in the practice a few days a week. It's definitely more appealing to patients to come here.”  
–Courtney Rauer, FNP-BC

“It's been great to have Tia available to speak with our patients about addiction right when they are asking for help. Definitely an important improvement in the patient-centered services we offer.”  
–Alison Hobart, NP

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## **SBIRT: Screening, Brief Intervention, and Referral to Treatment** *Opportunities for Implementation and Points for Consideration*

### **SBIRT: Basics**

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidenced-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs<sup>1, 2</sup>. Typically, this practice is conducted in medical settings, including community health centers, and has proved successful in hospitals, specialty medical practices such as HIV/STD clinics, emergency departments, and workplace wellness programs such as Employee Assistance Programs. SBIRT can be easily used in primary care settings and enables healthcare professionals to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues. SBIRT aims to prevent the unhealthy consequences of alcohol and drug use among those whose use may not have reached the diagnostic level of a substance use disorder, and to help those with the disease of addiction enter and stay with treatment.

Charged with developing a strategy to substantially improve healthcare quality over 10 years, the Institute of Medicine's Committee on the Quality of Health Care in America in 2001 called for community-based screening for health risk behaviors — including substance use — with appropriate assessment and referral activities<sup>3</sup> in its report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. In that landmark report, the Institute of Medicine specifically cited the SBIRT model as a promising practice.

### **SBIRT: Benefits**

Substance misuse and abuse often result in poor health outcomes and substantial healthcare costs related to illness, hospitalizations, motor vehicle injuries, and premature deaths. An Office of National Drug Control Policy study estimated that in 2011 substance use accrued a societal cost of \$193 billion<sup>4</sup>. Research has demonstrated SBIRT's numerous benefits. Specifically, SBIRT successfully reduces:

- Healthcare costs<sup>5</sup>;
- Severity of drug and alcohol use; and
- Risk of trauma (distressing events that may have long lasting, harmful effect on a person's physical and emotional health and wellbeing) and the percentage of at-risk patients who go without specialized substance use treatment<sup>6</sup>.

#### **SBIRT reduces healthcare costs**

- Multiple studies have shown that investing in SBIRT can result in healthcare cost savings that range from \$3.81 to \$5.60 for each \$1.00 spent<sup>8</sup>.

A 2010 study examined SBIRT's cost - benefit from an employer's perspective. The study considered the costs of absenteeism and impaired presenteeism due to problem drinking. The results indicated that when absenteeism and impaired presenteeism costs, the net value of SBIRT adoption was \$771 per employee<sup>7</sup>.

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- People who received screening and brief intervention in an emergency department, hospital or primary care office experienced 20% fewer emergency department visits, 33% fewer nonfatal injuries, 37% fewer hospitalizations, 46% fewer arrests and 50% fewer motor vehicle crashes<sup>9</sup>.

**SBIRT decreases severity of drug and alcohol use**

- In 2002, researchers analyzed more than 360 controlled trials on alcohol use treatments and found that screening and brief intervention was *the single most effective treatment method* of the more than 40 treatment approaches studied, particularly among groups of people not actively seeking treatment. Additional studies and reports have produced similar results showing that substance use screening and intervention help people recognize and change unhealthy patterns of use<sup>10</sup>.
- Studies have found that patients identified through screening as having unhealthy patterns of drug or alcohol use are more likely to respond to brief intervention than those who drink heavily<sup>11</sup>. The latter group is more likely to meet diagnostic criteria for a substance use disorders that needs more intensive treatment.

**SBIRT reduces risk of physical trauma and the percentage of patients who go without specialized substance use treatment**

- Studies on brief intervention in trauma centers and emergency departments have documented positive effects such as reductions in alcohol consumption,<sup>12</sup> successful referral to and participation in alcohol treatment programs,<sup>13</sup> and reduction in repeat injuries and injury hospitalizations<sup>14, 15</sup>.

Given SBIRT's demonstrated cost and health savings, federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), Veterans Administration, Department of Defense and the White House Office of National Drug Control Policy, as well as managed care providers and major medical associations, have recommended SBIRT's routine use. Not only does SAMHSA recommend SBIRT, but the agency also continues to [support SBIRT's expanded use](#) by [funding grants](#) across the country to further implement the practice in healthcare settings.



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phone 202.684.7457

Full Brief available at [http://www.integration.samhsa.gov/sbirt\\_issue\\_brief.pdf](http://www.integration.samhsa.gov/sbirt_issue_brief.pdf)

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Alcohol screening questionnaire  
 (AUDIT-C)/ NIDA Questions**

Substance use can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:	 12 oz. Beer or 8-9oz Craft Beer	 5 oz. wine	 1.5 oz. liquor (one shot)		
1. In the last year, how often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Clinical Use Only AUDIT C Total: _____	0	1	2	3	4
4. How often in the past year have you used marijuana?	Never	Less than monthly	2-4 times per month	2-3 times per week	4 or more times per week
5. How often in the past year have you used non legal drugs?	Never	Less than monthly	2-4 times per month	2-3 times per week	4 or more times per week
6. How often in the last year have you used prescription drugs for non-medical reasons or ones that were not prescribed to you?	Never	Less than monthly	2-4 times per month	2-3 times per week	4 or more times per week
Clinical Use Only NIDA Questions Total: _____	0	0, 1, 1	0, 1, 1	1, 1, 1	1, 1, 1

Men AUDIT C: 5 or more  
 Women AUDIT C: 4 or more  
 Go to AUDIT 10 / 65 + Geriatric Screen  
 NIDA: 1 or more  
 Go to DAST 10



**Alcohol screening questionnaire (AUDIT 10)**

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:	 12 oz. Beer or 8-9oz Craft Beer	 5 oz. wine	 1.5 oz. liquor (one shot)		
AUDIT C Score: _____					
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Total Score (AUDIT C + AUDIT 10) = \_\_\_\_\_

	I	II	III	IV
M:	0-7	8-15	16-19	20+
W:	0-7	8-15	16-19	20+

Patient name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_





**NIDA Score \_\_\_\_\_**

Substance use can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions

**Secondary Screen (DAST 10)**

- |   |     |     |
|---|-----|-----|
| 1. Have you used drugs other than those required for medical reasons?   | Yes | No  |
| 2. Do you abuse more than one drug at a time?   | Yes | No  |
| 3. Are you always able to stop using drugs when you want to?  | No  | Yes |
| 4. Have you had "blackouts" or "flashbacks" as a result of drug use?  | Yes | No  |
| 5. Do you ever feel bad or guilty about your drug use?  | Yes | No  |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs?   | Yes | No  |
| 7. Have you neglected your family because of your use of drugs?   | Yes | No  |
| 8. Have you engaged in illegal activities in order to obtain drugs?   | Yes | No  |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?                                 | Yes | No  |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? | Yes | No  |
|   | (1) | (0) |

I	II	III	IV
0	1-2	3-5	6+

Patient name: _____
Date of birth: _____



**Appendix D Cannabis  
Integration Screener**

**Central Vermont Medical Center**

**Page 1 Instructions:** Because we care about your health, we are interested in learning about your marijuana use. Please answer the following questions as openly as possible. Your answers are strictly confidential within your health team.

	Never	Monthly or Less	Several Days per Month	Weekly	Several Days per Week (2-4 days)	Daily or Almost Daily (5-7 days)
How often have you used marijuana <b>in the past year?</b> (including smoking, vaping, dabbing, or edibles)	<input type="checkbox"/>	<input type="checkbox"/>				



↳ If you chose "Never" please **STOP HERE**. Otherwise, go to the next question.

	One	Two	Three	Four or More
When you use marijuana, how many <b>times per day</b> do you typically use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Smoke (joints, bong, pipe, etc.)	Vape (Inhaling plant/herb or liquid vapor via electronic device)	Dab (Inhaling intensely heated hash oil/resin)	Edibles (brownies, candy, etc.)
How do you use marijuana? (check all that apply)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Have you used marijuana for medical or physical health reasons such as pain, cancer, or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used marijuana for mental health reasons such as trouble focusing, worries or anxiety, stress, or negative or sad emotions?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a state-approved medical marijuana card or <a href="#">cannabidiol</a> registration card?	<input type="checkbox"/>	<input type="checkbox"/>

Different things happen to people when they are using marijuana, or as a result of their marijuana use. Read each statement below carefully and check 'Yes' if it happened to you in the past year. Check 'No' if it never happened to you in the past year.		
In relation to your marijuana use <b>in the past year...</b>	Yes	No
Have you tried to <b>control</b> your marijuana use by smoking only at certain times of the day or certain places?	<input type="checkbox"/>	<input type="checkbox"/>
Have you worried about the amount of <b>money</b> you've been spending on marijuana?	<input type="checkbox"/>	<input type="checkbox"/>
Have you gone to <b>work</b> or <b>school</b> high or stoned?	<input type="checkbox"/>	<input type="checkbox"/>
Has your family, friends, or a health provider expressed <b>concern</b> about your marijuana use?	<input type="checkbox"/>	<input type="checkbox"/>
Have you <b>driven</b> a car or other vehicle, including a bicycle, after using marijuana, on more than a few occasions (at least three)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed the <b>amount</b> or <b>frequency</b> of your marijuana use has increased over time?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed that your <b>memory</b> is not as good as it used to be?	<input type="checkbox"/>	<input type="checkbox"/>
Have you <b>continued</b> to smoke marijuana when you promised yourself you would not? [ <input type="checkbox"/> <i>Not applicable: I've not promised myself that I would not use marijuana</i> ]	<input type="checkbox"/>	<input type="checkbox"/>
When you have <b>stopped using</b> marijuana for a period of time (even several days), have you experienced any of the following: irritability, restlessness, anxiety, depression, loss of appetite, sleep problems, pain, or headaches? [ <input type="checkbox"/> <i>Not applicable: I've not tried to stop using marijuana</i> ]	<input type="checkbox"/>	<input type="checkbox"/>
In relation to your <b>lifetime</b> marijuana use...	Yes	No
Have you ever seen a counselor or other professional as a result of your own concerns, or concerns that someone else had, about your marijuana use?	<input type="checkbox"/>	<input type="checkbox"/>

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The Short MAST-GERIATRIC VERSION (SMAST-G)	
Please answer Yes or No to the following questions:	
1. When talking with others, do you ever underestimate how much you drink?	Yes No
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?	Yes No
3. Does having a few drinks help decrease your shakiness or tremors?	Yes No
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?	Yes No
5. Do you usually take a drink to calm your nerves?	Yes No
6. Do you drink to take your mind off your problems?	Yes No
7. Have you ever increased your drinking after experiencing a loss in your life?	Yes No
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?	Yes No
9. Have you ever made rules to manage your drinking?	Yes No
10. When you feel lonely, does having a drink help?	Yes No
Score AUDIT C + SMAST-G= _____	1 0

I	II	III	IV
0-1	2-3	4-6	7+

Patient name: _____
Date of birth: _____



**Annual questionnaire**

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

<b>Alcohol:</b>	One drink =		12 oz. beer		5 oz. wine		1.5 oz. liquor (one shot)	
							None	1 or more
<b>MEN:</b> How many times in the past year have you had 5 or more drinks in a day?							<input type="radio"/>	<input type="radio"/>
<b>WOMEN:</b> How many times in the past year have you had 4 or more drinks in a day?							<input type="radio"/>	<input type="radio"/>
 <b>Drugs:</b> Recreational drugs include methamphetamines (speed, crystal), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).								
							None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?							<input type="radio"/>	<input type="radio"/>
<b>Marijuana:</b>							No	Yes
In the past year have you used cannabis (weed, pot, marijuana) multiple times a week?							<input type="radio"/>	<input type="radio"/>

Central Vermont Medical Center

*(For the medical professional)*

**Interpreting the Annual questionnaire:**

**Alcohol:** Patients who answer "1 or more" should receive a full alcohol screen (AUDIT).\*

**Drugs:** Patients who answer "1 or more" should receive a full drug screen (DAST).\*

**Marijuana:** Patients who answer "Yes" should receive a full cannabis screen.

More resources: [www.sbirtoregon.org](http://www.sbirtoregon.org)

\* Smith P, Schmidt S, Allensworth-Davies D, Saitz R. "Primary Care Validation of a Single-Question Alcohol Screening Test." *J Gen Intern Med* 24(7):783-8. 2009

\* Smith P, Schmidt S, Allensworth-Davies D, Saitz R. "A Single-Question Screening Test for Drug Use in Primary Care." *Arch Intern Med* 170(13): 1155-1160. 2010

**Patient Health Questionnaire**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Annual questionnaire**

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

**AUDIT 10: (Please circle response, you do not have to score)**

**Alcohol: One drink =**

	12 oz. beer		5 oz. wine		1.5 oz. liquor (one shot)
---	----------------	---	---------------	---	---------------------------------

In the last year...		0	1	2	3	4
Office Use Only:		no	Yes			
Men	How many times in the past year have you had 5 or more drinks in one day?	Never	Monthly or less	2-4x month	2-3x week	4+ times per week
Women	How many times in the past year have you had 4 or more drinks in one day?					

**If You Answered Never, Please Skip Questions Below and Turn Page Over – To D1.**

2. In the last year, how often do you have a drink containing alcohol?	Never	Monthly or less	2-4x month	2-3x week	4+ times per week
3. In the last year, when you drink alcohol, how many drinks do you typically have on any given day?	0-2	3 or 4	5 or 6	7-9	10 or more
4. How often have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	2-4x month	2-3x week	4+ times per week
5. How often have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	2-4x month	2-3x week	4+ times per week
6. How often have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	2-4x month	2-3x week	4+ times per week
7. How often have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?	Never	Monthly or less	2-4x month	2-3x week	4+ times per week
8. How often have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	2-4x month	2-3x week	4+ times per week
9. Have you or someone else EVER been injured as a result of your drinking? In the past year?	No		Yes, not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?	No		Yes, not in the last year		Yes, during the last year

Office Use Only:

AUDIT 10 Score (1-10):

**D1**

(Please circle response, you do not have to score)

		0		1	
--	--	---	--	---	--

**D1.** How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?

**Drugs:** Recreational drugs include methamphetamines (speed, crystal), inhalants (paint thinner, aerosol, glue), tranquilizers (valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or opiates/narcotics, heroin.

	No/never		1 or more	
--	----------	--	-----------	--

**D2.** In the past year have you used cannabis (pot, marijuana) 2-3 times or more times a week?

	No/never Or medical card Holder		2-3 times or more per week	
--	---------------------------------------	--	----------------------------------	--

**IF No/NEVER to ALL of the above questions SKIP below:**



DAST: In the past 12 months....	1	0
Have you used drugs other than those required for medical use?	Yes	No
Do you abuse more than one drug at a time?	Yes	No
Are you always able to stop using drugs when you want?	No	Yes
Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
Do you ever feel bad or guilty about your drug use?	Yes	No
Does your spouse/partner/parents ever complain about your involvement with drugs?	Yes	No
Have you neglected your family because of your drug use?	Yes	No
Have you engaged in illegal activities in order to buy/obtain drugs?	Yes	No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
Have you had medical problems as a result of your drug use (e.g. memory loss, seizures, bleeding, hepatitis, coughing, chest irritation, & bronchitis)?	Yes	No
<b>DAST Score:</b>		

Alcohol:			
I	II (BI)	III (BT)	IV (RT)
0-7	8-15	15-19	20+

DAST:			
I	II (BI)	III (BT)	IV (RT)
0	1-2	3-5	6+

**Interpretation:** I= no risk; II= PCP or SBIRT conduct Brief Intervention (BI); III or IV= referral to SBIRT



**Patient Health Questionnaire(65+)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_



**Annual questionnaire**

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

**AUDIT 10: (Please circle response, you do not have to score)**

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

**In the last year...**

1. How many times in the past year have you had 4 or more drinks in one day?	Never	1 or more times
--	-------	-----------------

**If You Answered Never, Please Skip Questions Below and Turn Page Over – To D1.**

65 + Screen:	1	0
1. When talking with others, do you ever underestimate how much you drink?	Yes	No
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?	Yes	No
3. Does having a few drinks help decrease your shakiness or tremors?	Yes	No
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?	Yes	No
5. Do you usually take a drink to calm your nerves?	Yes	No
6. Do you drink to take your mind off your problems?	Yes	No
7. Have you ever increased your drinking after experiencing a loss in your life?	Yes	No
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?	Yes	No
9. Have you ever made rules to manage your drinking?	Yes	No
10. When you feel lonely, does having a drink help?	Yes	No
<b>Screen Score</b>		

ETOH: I	II (BI)	III (BT)	IV (RT)
0-1	2-3	4-6	7+

**Interpretation: I= no risk; II= PCP or SBIRT conduct Brief**

**Intervention (BI); III or IV= referral to SBIRT**



**Appendix H Feedback Informed Treatment (FIT)**

**Central Vermont Medical Center**

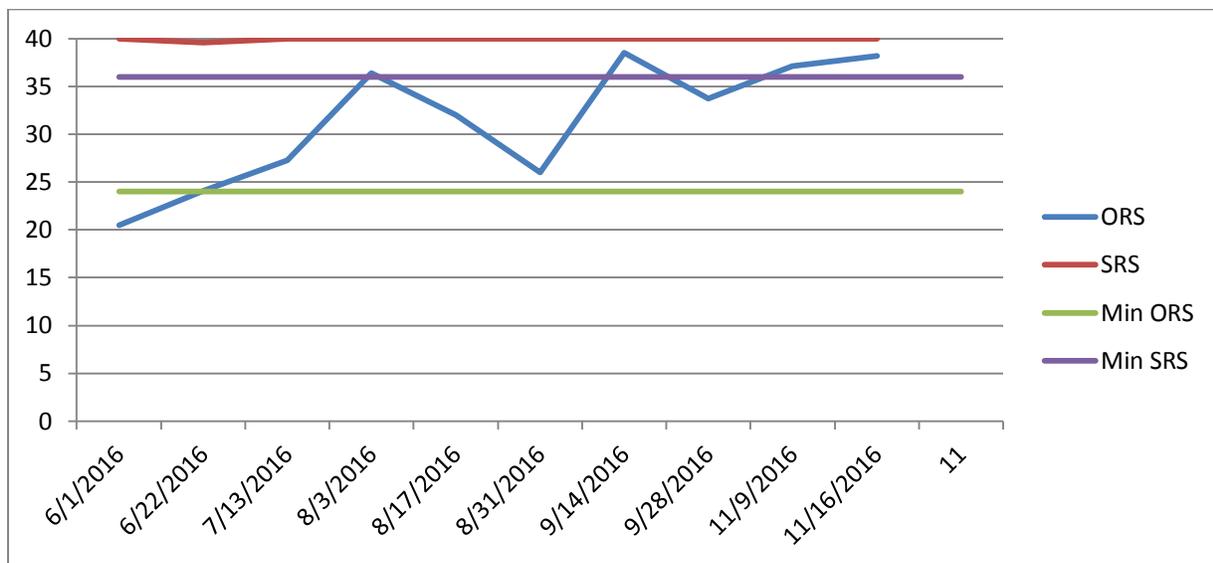
Description of Feedback Informed Treatment.

“Feedback Informed Treatment (“FIT”) is a new public health initiative aimed at fostering a shift in thinking among providers toward incorporating patient feedback, useable outcome measures and meaningful practice metrics to improve clinical performance. FIT is an evidence-based outcome measurement tool that provides immediate feedback to clinicians regarding the efficacy of care being provided to clients. The clinician uses feedback from the client to adjust the treatment approach to maximize effectiveness. Clinicians ask clients at the beginning of the session to rate their own progress by completing an Outcome Rating Scale (ORS). At the end of the session, clinicians ask clients to provide feedback about the session and the therapeutic alliance using the Session Rating Scale (SRS). The data provides a statistical method for identifying areas of concern and tracking patient progress.

The FIT Project is designed to provide training and support to behavioral health providers to systemically collect patient outcome measures that will be used to foster professional development and treatment efficacy. The goal of the FIT program is to demonstrate improved outcomes and patient satisfaction and also lower total cost of care by increasing efficiency and effectiveness of behavioral health care.”

Summary provided by BCBS FIT initiative.

Example of an SBIRT patient’s FIT data chart



Patient’s initial ORS score was 20.5 indicating (poor functioning) and has increase to 38.2 indicating (healthier functioning) over the course of ten treatment sessions. Consistent positive ratings of therapeutic alliance as shown by the SRS score. Data is regularly reviewed with patient and feedback is encouraged on the counseling process.

### Outcome Rating Scale (ORS)

Name \_\_\_\_\_ Age (Yrs): \_\_\_\_\_ Gender \_\_\_\_\_  
Session # \_\_\_\_\_ Date: \_\_\_\_\_  
Who is filling out this form? Please check one: Self \_\_\_\_\_ Other \_\_\_\_\_  
If other, what is your relationship to this person? \_\_\_\_\_



Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

**Individually**  
(Personal well-being)

I-----I

**Interpersonally**  
(Family, close relationships)

I-----I

**Socially**  
(Work, school, friendships)

I-----I

**Overall**  
(General sense of well-being)

I-----I

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### Session Rating Scale (SRS V.3.0)

Name _____	Age (Yrs): _____
ID# _____	Gender: _____
Session # _____	Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

#### Relationship

I did not feel heard, understood, and respected.

I-----I

I felt heard, understood, and respected.

#### Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about.

I-----I

We worked on and talked about what I wanted to work on and talk about.

#### Approach or Method

The therapist's approach is not a good fit for me.

I-----I

The therapist's approach is a good fit for me.

#### Overall

There was something missing in the session today.

I-----I

Overall, today's session was right for me.

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## Appendix I Case Example

### Central Vermont Medical Center

#### Case Example

Patient: 36 y/o Female

Chief Complaint: Maintain abstinence (alcohol)

Engaged with SBIRT program: 5/21/16 – 7/6/16

SBIRT Clinician: Kara Dudman, MS, NCC, AAP

This patient initially engaged with an SBIRT counselor when admitted to the inpatient floor at Central Vermont Medical Center in May, 2016. The patient was initially admitted to the hospital for complications related to alcoholic pancreatitis. The patient was screened by an SBIRT clinician; patient scored “13” on the AUDIT-10 and “0” on the DAST. While the patient was initially recommended for Brief Treatment (BT) counseling per the AUDIT score, after further assessment of the patient’s needs, a higher level of care was indicated and it was recommended that the patient engage residential level of care. However, due to employment, financial and additional home-life barriers, the patient was not able to commit to long-term inpatient care. The patient was open and receptive to a referral for intensive outpatient (IOP) level of care at a local substance abuse agency. The referral for IOP was made with the understanding that the patient could be referred to a higher level of care (i.e. residential program) if the patient was unable to maintain sobriety and if that program determined a referral was necessary; the patient acknowledged this.

The SBIRT clinician who screened this patient in the hospital also worked within the patient’s medical home. Since the patient was not able to engage IOP immediately following hospital discharge, the patient agreed to meet with the SBIRT counselor in the medical home for support until the patient could engage IOP treatment.

When the patient eventually engaged IOP, the patient reported an unwelcoming experience while in the IOP and was asked to leave due concerns of the patient’s medical health and ability to engage IOP treatment. The patient was left with little support and no plan for care following the IOP discharge. The agency providing IOP care did not contact the patient’s medical home or SBIRT counselor regarding the patient’s discharge from IOP. The patient later contacted her medical home and reconnected with the SBIRT counselor. Together, the patient and client worked collaboratively to make an action plan for treatment and recovery. During the treatment planning and referral process, the patient relapsed on alcohol and returned to a harmful level of alcohol consumption; nearly 20 oz of distilled spirits daily. When meeting with the SBIRT counselor, the patient reported some withdrawal symptoms and it was recommended that the patient go to the emergency department for medical examination and supervised detox. At this point in time, the patient specifically requested assistance getting into a residential program for alcohol dependence.

This case was brought to the attention of the Washington County Substance Abuse Regional Partnership (WCSARP), as several system-issues compromised the treatment process. Primarily, it was identified that lack of communication and coordination of care on behalf of the agency receiving the IOP referral stalled the treatment process; leaving the patient isolated and disconnected to appropriate care. Together members of the WCSARP team strategized how to support this patient with alternative services and community resources until the patient could begin residential care.

While the patient was readmitted to the hospital for detox, the SBIRT counselor made referrals to several inpatient programs across the state. Following discharge from the hospital, the patient was able

**Appendix I Case Example**

**Central Vermont Medical Center**

to engage a 4 week residential program and attain sobriety. The SBIRT counselor coordinated care with the residential program to ensure SBIRT was a part of the patient's discharge plan. Although the patient was scheduled to meet with the SBIRT clinician at her medical home, the patient did not show for the appointment and the patient was unreachable by phone or mail.

Since the patient did not re-engage with the SBIRT counselor upon discharge from residential care in July 2016, it is uncertain how the patient's AUDIT and DAST scores might have changed. However, the patient's SBIRT clinician was recently notified that the patient wants to re-engage brief treatment at the medical home and the clinician is actively reaching out to reconnect with the patient.



**Vermont's Designated and Specialized Service  
Agency System – A Workforce at Risk**

**February 2016**

**By Vermont Care Partners Human Resources Directors Group**

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Vermont Care Partners: Vermont Care Network and the Vermont Council of Developmental and Mental Health Services



## Executive Summary

*Due to chronic underfunding of Vermont's Designated/Specialized Service Agency system's ability to recruit and retain workforce to support Vermonters with developmental, mental health and substance abuse issues has reached its breaking point.*

- ❖ The Designated/Specialized Service Agency (DA/SSA) system in Vermont serves individuals with mental illness, substance abuse issues, and/or developmental disabilities, most of whom are lower income Vermonters covered by Medicaid. The system has proven to be highly efficient, with administrative costs less than half those of Vermont's Hospital system.
- ❖ Chronic underfunding frustrates provider agency efforts to recruit and retain a stable direct service workforce to deliver essential services to Vermonters.
  - Turnover rates for agency staff are high, with low wages cited as the prime reason
  - High DA/SSA job vacancy rates statewide reflect difficulty in recruitment
  - DA/SSA system agencies have not received regular COLAs from the State
  - The gap between DA/SSA funding and Consumer Price Index has widened
- ❖ This situation should not come as a surprise. In 2004, the Pacific Health Policy Group, retained by the State of Vermont Agency of Human Services to evaluate the system, reported that DA/SSA agencies faced serious challenges with respect to recruitment and retention of direct services staff, largely due to low wages and the inability to offer raises.
- ❖ Underfunding of the system of care has already led to extensive wait lists for Vermonters seeking various services including: outpatient therapy; family, school and community based services; and medication assisted treatment.
- ❖ If the chronic underfunding of the DA/SSA system is left unaddressed, we should expect an ongoing erosion of the provider workforce. Over time, the consequence will be devastating, and felt by individuals, schools, businesses and communities throughout Vermont:
  - more Vermonters with untreated or under-treated mental health conditions
  - an increase in the rates of substance abuse and addiction
  - increased homelessness
  - increased incarceration rates and an added strain on the judicial system
  - a rise in referrals to psychiatric hospitalization and
  - increased use of emergency rooms in response to mental health crises
- ❖ Beyond underfunding, new and unanticipated expenses have directly impacted the ability of DA/SSA agencies to continue to be creative with resources and retaining a viable workforce. These include:
  - Costly implementation of Electronic Health Records
  - Increased costs of providing health insurance benefits that meet ACA mandates
  - Updated FLSA Law which will require more staff overtime wages
  - Decreasing reimbursement rates for certain services
- ❖ The All Payer Model will require a significant investment of resources in both the ACO(s) and in the community infrastructure to start shifting the balance from high cost hospital care to more cost effective community care. We should not proceed with the expectation of savings, unless we fully enable community providers to function with a well-paid, credentialed, skilled and experienced workforce.

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## Vermont's Designated and Specialized Service Agency System – A Workforce at Risk

*"Decisions need to be made with respect to the State's commitment to the community based system of care for people with mental health and development needs. Policy makers and stakeholders need to work collaboratively to develop a 5-year funding plan that is consistent with both fiscal realities and the state's commitment to its citizens. The financial plan should address both the inflationary effects in the system (cost of living increases for personnel, rising energy and insurance costs, facility maintenance etc.), and funding for caseload growth... The people whose lives are deeply affected by these decisions are counting on responsible and compassionate stewardship."*  
(2004 Pacific Health Policy Group Report to the State of Vermont)

### OVERVIEW

The Designated / Specialized Service Agency (DA/SSA) system in Vermont serves individuals with mental illnesses, substance abuse issues, and/or developmental disabilities, most of whom are low income Vermonters enrolled by Medicaid. These Vermonters are not able to receive the level of comprehensive care that they need from any other system in Vermont. Roughly 85% of the funding for the DA/SSA system comes from Medicaid reimbursement and grants. Vermont state government controls Medicaid payment rates and our ability to provide Cost of Living Increases (COLAs) to our staff. Average DA/SSA administrative costs are 8.9% of the overall budget. Staff salary and benefits account for 85% of agency budgets.

Over the last 5 years, the gap between increases in DA/SSA funding, and increases in the Consumer Price Index has widened to 15%, bringing already inadequate compensation levels even lower. These disparities are negatively impacting the stability of the workforce within the DA/SSA system, which has a direct and significant adverse effect on the quality of life and treatment outcomes for the people we serve.

For the Vermont's DA/SSA system to be sustainable, the lack of regular COLAs for our workforce must be addressed because it is degrading access to critical services to vulnerable Vermonters. Chronic underfunding of Vermont's Designated/Specialized Service Agency system has brought our workforce to a breaking point.

### PAST RECOMMENDATIONS

In 2004, the Pacific Health Policy Group was retained by the State of Vermont Agency of Human Services to do an evaluation of the DA/SSA system. As part of their findings, they reported that the Designated and Specialized Services Agencies were facing serious challenges with respect to recruitment and retention of direct services staff, in large part due to low wages and the inability to guarantee raises. In their report they recommended that the State, "Tie administrative allocations for wage increases to the increases (cost-of-living and step increases) provided for state employees on an annual basis. Under this option AHS would provide an adjustment to Designated Agency budgets for wage increases in an amount that could, over time, permit the equalization of wages within the DA system to those of other public employees. At a minimum, such an adjustment should allow the agencies to move their wage levels to something that more closely mirrors the public sector wage levels in Vermont. With the Designated Agencies functioning as a type of quasi-governmental system,

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*wage equity is an important issue for maintaining a stable and experienced workforce within these programs.”*

These problems still exist and current employment, economic and demographic trends will clearly exacerbate these problems in the years ahead. This has the makings of a perfect storm. As we move to more home and community-based services across all of health and human services, utilizing more direct service staff, these issues take on even greater strategic importance.

#### **PROGRAMMATIC AND CLINICAL IMPACTS**

Across our system of care there are numerous examples of vulnerable Vermonters who are unable to access critical services because inadequate reimbursement rates prevent DA/SSAs from offering competitive compensation packages to recruit and retain staff. Underfunding of the system of care has led to wait lists for various services including hundreds of people waiting for outpatient therapy; nearly 500 children and youth waiting for family, school and community based services; and hundreds of people are waiting for substance use disorder and outpatient mental health treatment. Recent changes in structure and reductions in Medicaid reimbursement rates for group therapy and applied behavioral analysis (ABA) services, in particular, will exacerbate the problems of access to needed services and the challenge of recruiting and retaining skilled and experience staff. Recently, a designated agency returned funds allocated for a pilot program designed to reduce inpatient hospital care, because they simply were unable to recruit staff at the compensation rates they could offer at the proposed funding level.

If the chronic underfunding of the DA/SSA system is left unaddressed, ongoing erosion of our workforce will be unavoidable. This has a direct effect on the quality of care we are able to offer, and reduces our ability to offer services that meet the best practice standards for our various populations. We are faced with using less educated and credentialed staff, who will work for lower wages, to provide services which Master level / licensed staff should be performing. Clients have to wait longer to get an appointment or cannot be offered the type of service indicated by the clinical assessment. In many regions of the State group therapy and Applied Behavioral Analysis service are being reduced or eliminated, as the reduced reimbursement rates no longer support the service. In some cases, large caseloads require clinicians to increase the interval between appointments in order to see everyone on their caseload. Clients with complex needs who require a 2:1 staffing ratio are only able to have a 1:1 staffing ratio, which is a safety concern for both the client and the employee.

High turnover rates cause clients to lose valuable ground in their recovery process and force them to retell their story to new staff over and over again. We cannot measure the impact of rebuilding trust, especially for those recovering from trauma, but the overall impact is an ever lengthening duration of healing and recovery which in turn drives an increase in the cost of service delivery. Clients who have a major mental illness or a developmental disability need the continuity and stability of staff that they come to trust and recognize.

High turnover rates also contribute to the de-stabilization of a treatment team. At times, a treatment team and/or clinical supervisors are unable take on the cases left behind. When this occurs short term needs may fall to the emergency services system to respond. Using emergency staff in this manner delays their ability to respond adequately to crisis situations in the community. This can result in clients in crisis accessing more expensive services such as hospital emergency rooms, calls to 911 or

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trips to crisis bed programs. This added burden on emergency staff has a domino effect of causing staff turnover within the emergency team, which only compounds the issue.

The long term consequences of chronic underfunding will be:

- more Vermonters with untreated or under-treated mental health conditions impacting schools, employers and communities at large;
- an increase in the rates of substance abuse and addiction;
- increased homelessness;
- increased incarceration rates and an added strain on the judicial system;
- a rise in referrals to psychiatric hospitalization; and
- increased use of emergency rooms in response to mental health crises

The increasing need for opiate treatment by a growing number of Vermonters will require counselors to be available to work with that population. We are currently experiencing an extreme delay in our ability to recruit for these positions, which has resulted in burgeoning caseloads and delays in accessing needed services. Additionally, due to the aging population, the need for services continues to grow, thus the competition for staff continues to escalate. For example, the need for Personal Care Aides and Home Health Aides is expected to grow by 71% and 69% respectively from 2010 – 2020. (PHI Publications, November 2013 Facts #3 Update)

#### RECRUITMENT AND RETENTION

Staff are the backbone of the DA/SSA system, yet our average turnover rate for the past 3 years has been 27.5% annually. In stark contrast, even during a period that includes the closing of the Vermont State Hospital in 2011, staff turnover for the State of Vermont Departments which contract for the services (DAIL, DCF and DMH) in the most recent 5 year period was 14.36%. (US Department of Labor, May 2014 Occupational Employment and Wage Estimates)

The increasing loss of our workforce is expensive, disruptive and detrimental to the system's capacity to deliver quality services to the people we are contracted by the State of Vermont to serve. Currently there are over 350 job vacancies being recruited for in the DA/SSA system, and we estimate that roughly 1200 positions turnover over each year. The time it takes to recruit staff to fill open positions has increased dramatically, causing gaps in programming and a significant increase in advertising costs.

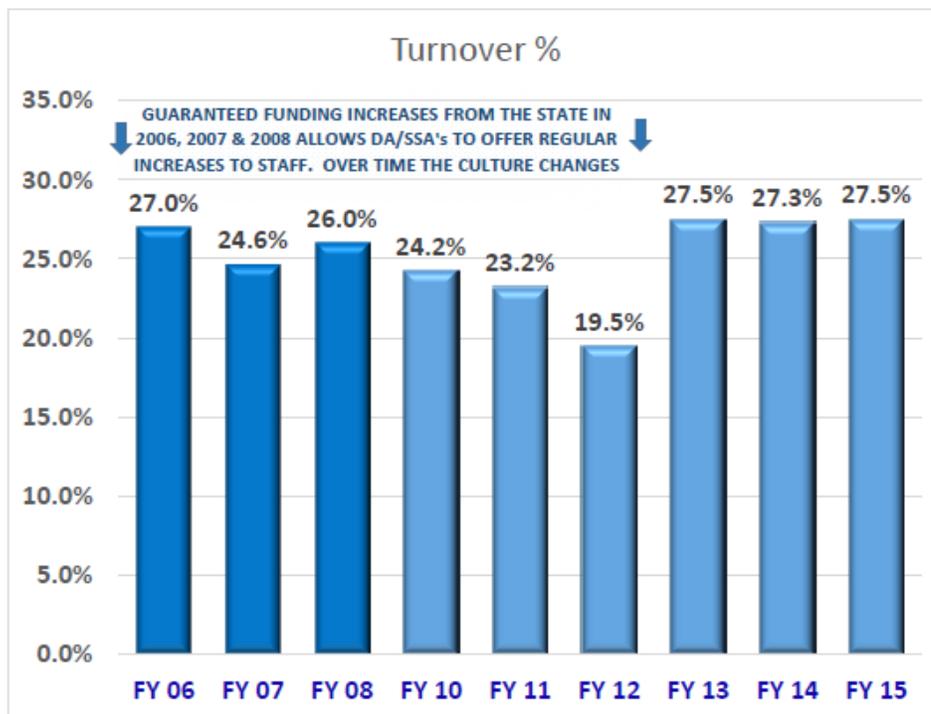
In a December 2015 survey of our DA/SSAs, 23% of our collective workforce had an hourly rate less than the 2014 Vermont Livable Wage amount of \$13.00 / hour. (2015 Basic Needs Budgets and the Livable Wage, prepared by the Vermont Legislative Joint Fiscal Office) We are losing our credentialed and trained staff to higher paying positions in hospitals, public schools and the State of Vermont where they work as social workers, psychiatric aides, and Blueprint counselors. In fact, we frequently serve as a training ground for entry level staff by providing supervision for licensure. Once the staff achieve licensure they often leave for higher paid jobs. Adding to the recruitment problem is the lack of availability of prospective employees. Vermont's unemployment rate was the fourth lowest in the country in 2004 at 3.4%. In August 2015, Vermont had the third lowest unemployment rate at 3.6%. (2004 PHPG Report, page 4-1; August 2015 Unemployment and Jobs Press Release, Commissioner Annie Noonan) The lack of candidates for our job openings forces us to compete to

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hire people who are already working elsewhere at higher compensation levels. This has made recruiting for positions extremely challenging.

As seen in the chart below, Vermont's Designated Agency system is in a pattern of three consecutive years of 27% staff turnover. This follows four consecutive years of a decreasing turnover, which came on the heels of a commitment by the Douglas Administration to provide COLAs to the DA/SSA system in 2006, 2007 & 2008. We have not had a commitment of COLA increases since then.

### Vermont Care Partners Network Average Statewide Turnover FY 06 - 15

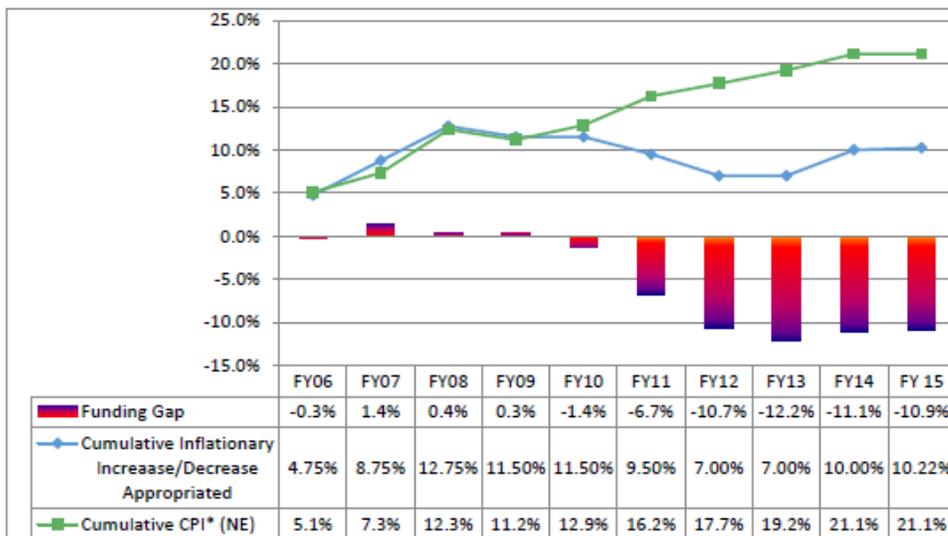


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**HISTORICAL INCREASES AND PROMISES MADE**

*"I'm proud to maintain the commitment to the state to the very kind of services that we still owe to the population that was once at Brandon, and is now in the community. We will continue to assure that individuals receive support & services; We will continue to assure that those services meet acceptable levels of quality; We will continue to assure that persons receiving the services are free from abuse and neglect or mistreatment; To assure that the folks taking care of the people needing these services have adequate training & support. So our commitment does not end with the closing of this institution. Our commitment continues." Governor Howard Dean, at the Ceremony to close the Brandon Training School in 1993 – Video in VIMEO, "The Very Most Glorious of Occasions"*

The chart below shows the gap between the Consumer Price Index and inflationary funding in the DA/SSA system since FY07. This gap in parity with other Vermont health care providers is preventing us from attracting and retaining an appropriately scaled workforce.



**INADEQUACY OF PAYMENTS**

Due to the caps on certain programs, DA/SSAs revenues are limited regardless of whether or not they provide more services to the increasing number of children, families and adults who request help. In FY16 we received a 0.22% Medicaid Rate increase. That, combined with the 1.5% allowed annual cap on gains, means that the ability of the DA/SSA system to address turnover, build in annual increases for staff and address staffing shortages falls somewhere in a range between extremely limited and non-existent. The recent spikes in health insurance premium costs has required a reduction in comprehensive health insurance coverage, and/or switching to high deductible health plans as the

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affordable option for health care. Despite annual increases in insurance and other costs, the DA/SSA system does not receive annual increases from the State.

The State of Vermont employees, most public school employees and hospital staff generally do receive annual increases in pay. For example, in a recent article by Erin Mansfield in VT Digger, the CEO of Rutland Regional Medical Center, Thomas Huebner, was cited as saying "Our whole staff tends to get raises every year. They're generally in the 2 to 3 percent range." Over time, this practice has caused an ever growing gap in base wages of similar positions in our DA/SSA system with those in the hospitals, public school system and at the State of Vermont.

At the ceremony of the closing of the Brandon Training School in 1993, Barbara Snelling, Lt. Governor, spoke to the crowd who had gathered for this celebratory event and she told the crowd, "*I know that the State of Vermont will remain committed to all of those individuals who have been here at the [Brandon] Training School and will see that in our communities they receive the funding and attention and the advocacy that is needed for their future enjoyment of their full life's potential*". Video in VIMEO, "*The Very Most Glorious of Occasions*" This commitment to the DA/SSA system is now at stake.

#### **UNANTICIPATED FINANCIAL IMPACTS SINCE JULY 2015**

In addition to the challenges of not receiving an annual COLA increase, the DA/SSA system has had many significant and unanticipated costs in the past 6 months. Some of these events are:

- New State mandate for supervised billing;
- 75% reduction in group therapy rates;
- Restructuring and reduction in the applied behavioral analysis rates;
- Change to the Federal Fair Labor Standards Act broadening the definition of Non-Exempt workers which will increase payment of overtime wages;
- Additional mandates by the Federal ACA which impact health insurance costs;
- Changes to the Federal Home Health Care Exemption;
- Customization of electronic health records to account for a change in ICD-10 billing codes and the addition of an electronic patient portal;
- Monthly checks of the OIG website for all employees; and
- Insurers recouping revenue from paid bills for errors associated with VT Health Connect

Each of these impacts funnel resources away from staff and towards administrative costs in some fashion.

#### **HEALTH REFORM**

Vermont employs many dedicated workers in its DA/SSA system, but increasingly we are seeing our staff leave this system for higher paying jobs with better benefits within the public education system, the hospital system and for positions working for the State of Vermont. State dollars spent on the designated agency and specialized services system will make the most impact on the Triple Aim of improving health care quality, improving health outcomes and reducing cost, but only if we have enough resources to fully and effectively address the social determinants of health with sufficiently-paid, experienced and qualified staffing.

We would be wise to remember that it is community services that emptied out state hospital beds and maintains that system on a thread; and it is the community that closed Brandon Training School, developing one of the most advanced systems for people with developmental challenges in the country; and it is the community that closed nursing home beds throughout the state, in favor of more home based care.

If the State wants to succeed in health reform it will be essential that the investment in community based services be made up front, just like we did in the other efforts to deinstitutionalize populations. The All Payer Model will require a significant investment of resources in both the ACO(s) and in the community infrastructure to achieve the shift in balance from high cost hospital care to more cost effective community care. We should not proceed with the expectation of savings, unless we fully enable community providers to carry out their mandate with a well-paid, skilled and experienced workforce.

#### SUMMARY

Unless proactive steps are taken immediately, the future of the Vermont DA/SSA system is in jeopardy. As the state strives to contain and control health care expenses in general, community developmental, mental health and substance use disorder services are by far the most cost effective and successful model for independent living and recovery. Vermont Care Partners and our member agencies are experiencing the negative effects of the long standing practice of the State to not include in its budgets any provision that allows us to provide regular COLA increases to our staff. Our current ability to recruit and retain a workforce that is adequately credentialed, trained and skilled to treat and support needs of vulnerable Vermonters with developmental, mental health and substance abuse issues is at a breaking point.