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Facilitating Alcohol Screening and Treatment (FAST) Lessons Learned in Colorado

Presented by: Jennifer Halfacre; Andrew Bienstock, MHA; Stephanie Kirchner, MSPH, RD; Carolyn Swenson

TIFF WEEKLEY
Thank you. Thank you so much. Thank you all for coming today. I'm Tiff Weekley. I'm a senior research assistant at the Oregon Rural Practice Based Research Network housed here at Oregon Health and Science University or OHSU.

CHRYSTAL BARNES
And I'm Crystal Barnes and I'm a qualitative research data analyst. also at ORPRN and OHSU.

TIFF WEEKLEY
So, thanks for all for joining us today. We're going to be going over some of the preliminary qualitative outcomes of the ANTECEDENT study, which is around improving screening and treatment for unhealthy alcohol use. A quick note is that our team was one of six grantees under the Agency for Health care Research and Quality, managing unhealthy alcohol use initiative. So a quick shout out to AHRQ for funding this work and making it happen for us. So a little bit of background about unhealthy alcohol use or UAU, in the United States, in particular. UAU is a leading cause of preventable death here in Oregon and in the US as a whole. So it comes in landing at 3rd and 4th leading causes respectively. Additionally, the United States spends around $249 billion annually on excessive alcohol consumption. And also, UAU has risen during the COVID-19 pandemic and also barriers to treatment for UAU have also increased and we're continuing to see the effects of that today as we move forward. So obviously, this is an issue that we should prioritize and really work on and primary care clinical practice settings actually have a really unique opportunity to address UAU through effective screening, brief intervention and referral to treatment. Otherwise known as SBIRT, we will be mentioning SBIRT a lot throughout this presentation, and medication assisted treatment for unhealthy alcohol use, which is known as MAT, which is another acronym we'll be mentioning quite a bit. However, though this is evidence backed and is shown to be effective, this is not sufficiently implemented across primary care settings. So that really leads us into our project: ANTECEDENT. A little bit of a mouthful and alphabet soup here: partnerships to enhance alcohol screening treatment and intervention. ANTECEDENT is really an initiative designed to help primary care clinics implement and refine workload to support SBIRT and MAT routine care. So, as you can see here, we did enroll 75 clinics into the ANTECEDENT project. It might be a little bit hard to see, but most of those are going to be in the Oregon area. However, we did have a few stragglers over here in Idaho and up here in Washington as well. But again, our focus area

was primarily Oregon. So when these practices signed up or enrolled with us, they enrolled for a 15 month flexible implementation period to participate sometime between May of 2020 April of 2023. Here, a flexible implementation period means that when they enroll for that 15 month period, we would spend some time in the 1st 1 to 3 months doing some required foundational activities, primarily getting some of that initial data that we needed, figuring out their data reporting capabilities, really setting the foundation for the rest of our time together. And then after that, the rest of the time together falls into that supplemental support. And so that means that these practices got to set their own goals, we'd help them set their own goals, and then they would get to choose from a variety of options to support those goals. And that would be things like monthly practice facilitation, maybe HIT support, expert trainings, peer to peer learning via webinars. Really just a variety of options that they could choose from to help them reach their goals in the rest of their time together. Additionally, for ANTECEDENT, most of our practices also had the option to coimplement alongside another study we have going on called Pinpoint, which is around chronic pain and opioid management and primary care. So some of our practices took that on and others chose not to. And ultimately, too, we had, practice facilitation was a central strategy to enhance adoption implementation and sustainability of SBIRT and MAT throughout the project period. So each practice was assigned one practice facilitator at a time to really support them through the project and help them set their goals, help them select the options that they wanted to partake in and really just connect them to resources, help improve their team dynamics, improvement processes, really just stick with them through the whole project and really help them improve. So ultimately, ANTECEDENT just aims to improve standardized delivery of delivery of SBIRT and MAT in primary care, all while gaining insight into efforts made by the practice facilitators and the clinics, you know, how did practice facilitators support these clinics based on context and capacity considering it was such a flexible and less prescriptive approach? What---how did clinic set goals? What goals did they set? What was their experience like, what were their contacts like? Really just a lot of different factors that we'll get into very shortly. But first of all, we'll dive a little bit into the methods beforehand. So in terms of data collection for this project, basically qualitative data collection, we held monthly periodic reflections with practice facilitators, an hour each time. Bi-annual practice facilitator one on one interviews and clinic post implementation interviews as well. All of those sessions and interviews were recorded, transcribed, and validated, and then alongside field notes in REDCap, they were exported to Atlas.ti, where they were then double coded by two analysts using a codebook that was previously made based on an initial set of data and the research questions for the project. So once we had that data, the qualitative team met weekly to create analytical memos, you know, identify some of those emerging themes. After we had those themes, we built them into a matrix by clinic. And then we ran queries in Atlas based on those matrix domains, reviewed them again by the qualitative team, lots of reviewing, and finally identified, find some final themes which we're going to touch on in just a moment. But all in all, we ended up with 13 practice facilitator periodic reflections, 19 practice facilitator interviews, 28 clinic exit interviews, and 696 implementation field note forms. And I'm going to hand it over to Chrystal to start discussing what we're finding.

CHRYSTAL BARNES
Thanks. Ok. So let's talk a little bit about some of the qualitative findings of this study. So to start off clinics participated in this project for a variety of reasons. Some of them had a desire to address their patient population unhealthy alcohol use needs. Some of them were motivated by incentive metrics like Medicare and Medicaid, you know, payment models. Some of them had an interest in particular project resources that we were offering. A really popular one was our HIT expert providing customized EHR support to clinics. Clinics also often had experiences working with our network and practice facilitators previously and had sort of a general positive impression of working with us and practice facilitation and QI. And so simply because we were offering it, they were willing to, to jump in and participate. And we also found that clinics had practice champions who had personal investment either in QI in general or in SBIRT specific activities or addressing unhealthy alcohol use. And some of these motivations are highlighted in this quote from a practice facilitator that says, "SBIRT was a huge passion of the former manager. She facilitated a need survey that showed that very few screens were completed and when they were patients were reporting high alcohol and that providers were not addressing it. They see a lot of patients who drink at unhealthy levels, but many do not have AUD or UAU Further patients who drink at unhealthy alcohol levels often do not receive any sort of intervention." So similar to having a variety of reasons for participating in the study, clinics also had a variety of goals that they set. And because we had the flexible implementation model that we used, clinics sometimes came into this study knowing exactly what they wanted to work on and what they wanted to get out of the project. And other times, they really had to rely on the support of a practice facilitator to identify and develop those goals. And clinics worked on quite a variety of goals. Some of the most common being improving screening workflows or starting a screening workflow and improving their skills interventions and then also reporting--improving reporting in their EHR. And the study team thought that MAT was going to be a key goal area and something that a lot of clinics were going to want to work on. And we found out that that actually wasn't true for our clinics. Most clinics either already had a MAT program in place or they didn't really have clinic buy-in into MAT as an approach to UAU. And so they were just not interested in engaging with that. And some of these goals are described by this practice facilitator that says, "the clinic really wanted to focus on how to do an effective brief intervention for those people who are kind of in the middle. They said that screening is pretty straightforward and if someone needs to be referred out, they're pretty clear on when to call in behavioral health. But how do their physicians do brief intervention in the moment for those patients who don't need behavioral health?" So that was an example of a clinic that had a little bit---needed a little bit more support from the practice facilitator to kind of identify what they were going to work on. And our study, like many, were going during the height of COVID. And so there were a lot of barriers and challenges and so a lot of those were related to the COVID-19 pandemic and either competing priorities, modified operations, all of those sorts of things. Part of that was staffing turnover, there was a huge amount of staffing turnover for clinics during the course of this study. And a lot of that was COVID related. However, a lot of it was also related to a lot of other reasons, but a lot of staffing challenges. And clinics, some of them changed EHRs during their participation in the study. And that pretty much always

has resulted in at least delays to implementation, if not stopping implementation altogether. Clinics also had a variety of QI experience and QI capacity and also a variety of buy-in to QI from leadership again, particularly during COVID, there was some sometimes pushback on doing QI during COVID. And so that really led to a variety of kind of engagement and participation levels from clinics and, and practice facilitators really to work with that. And clinics also often described addiction stigma even, you know, amidst their own staff and some resistance to wanting to address unhealthy alcohol use or just discomfort around addressing that with patients. And that really affected buy-in for implementing SBIRT. And we worked with a lot of rural clinics, that's kind of one of the things our network specializes in, and for those rural clinics, there was definitely an increased concern in privacy for patients because for small communities, clinicians were concerned about having a brief intervention with a patient, having an uncomfortable conversation about alcohol and then seeing them at the one and only grocery store in town later that day. So that was a challenge that we had to work with. And then like Tiff mentioned, we co implemented an additional study called Pinpoint with ANTECEDENT and that created some challenges, right? Some competing, we kind of created our own competing priorities for clinics at times. And so sometimes their, their efforts were a little bit lessened because of that co-implementation. Some of the challenges that clinics experience are described by this practice facilitator that says, "I think part of it is they're a small clinic trying to piecemeal things together. They have doubts about their population and resistance to filling out the screen at all and how truthfully patients will answer it. There's some pushback on that. They're also just hard technology-wise, they huddle around a laptop and I can't actually see any of them and I can't get a read on their energy." So overall clinics described a positive experience with ANTECEDENT and with the practice facilitators that they worked with and some of the benefits that they described about practice facilitation included having a dedicated time and space to think about SBIRT or unhealthy alcohol use or just QI in general. And also during COVID, some clinics described having a break from talking about COVID was nice and increasing their understanding of their own improvement needs. Like I said, since some clinics entered into this study without goals in mind, sometimes just assessing, where are they at? What could they improve on, was really helpful for them and brought up some, some new areas. Again, clinics that had varying QI experience, just learning some basic QI skills was really helpful and establishing or improving workflows was a a big part of the work that facilitators did. And clinics really appreciated that. In addition, training for brief intervention or motivational interviewing was really popular and clinics really appreciated that support and increasing staff motivation, whether that was for unhealthy alcohol use, SBIRT, or QI in general, just kind of increasing that staff engagement around these topics and also increasing health equity for screening practices. That was a goal that several of our clinics set. And when working on that, they found that to be a really valuable use of their time and effort. And a clinic champion describes some of their experience in the study saying, "I think the whole project and team was great. I had an MA it was her first time being on a QI project. And the two providers that had not been on a project before were all very excited. I think it actually brought some sense of accomplishment to work. We'd leave the meetings and you could feel people came in tired, especially the providers, but it perked them up. And I think it was

a good project, having a scheduled time to meet and blocked is really key." So there were also some challenges with practice facilitation. Shocking, And one of them was that because we had this flexible implementation model and clinics could kind of, you know, choose their own story, they sometimes didn't know what they should be doing, they didn't know if they were being successful. So that was challenging at times for clinics to kind of know where they sat with things. And in addition, even though clinics felt that their participation was positive, practice facilitation was positive, they weren't always certain that their changes were sustainable. And so that was a concern and that's described by this clinic champion who says, "It was successful. I mean, it met what my goals were, but it could have been better. And I wasn't convinced when I left that the changes were all sustainable. Every time we had a training, everything got better right after the training, like for a month after you'd see this spike in doing brief interventions and then it would trail off again." Similarly, even though clinics generally had a positive experience on the study, they also still identified lingering needs after implementation and practice facilitation. Clinics described continued EHR challenges and limitations. They also described a need for more practice and training around brief intervention provision. And they also described a need for just, you know, a more consistent delivery of the workflows that they developed during their time on the project. And clinics also, particularly rural clinics, really struggled with the referral to treatment part of SBIRT because there's limited treatment resources, especially in rural areas. So that continued to be a need and a challenge for clinics. Some of these challenges are described by these two clinic champions that say, "I think the facilitator met our needs within our limitations. And I'd love to figure out our reporting capabilities more closely. It's gonna give us a lot of information on where to intervene, moving forward." And another champion says that they would, "really like to have on demand training videos because motivational interview training sessions don't always align with what works for the staff schedule. If we have a new faculty member and we want them to know what this is as part of their training. It would be nice to have a one hour on demand video that's got everything we need for them." So to kind of sum all this up and what this has meant for practice facilitators, our clinics, the goals and motivation of clinics varied widely and so practice facilitators in this study really had to use a lot of tailoring to choose what support they were going to offer clinics. And then similarly, because there was a lot of ranges of disruptions and challenges that clinics faced during this time, the way that practice facilitators approached clinics and their support and engaging them in the study also had to be highly tailored and this took up a lot of practice facilitator effort in just getting in touch with the clinic, keeping them involved in those kinds of nuts and bolts pieces. But overall, clinics cited practice facilitators as valuable and as one of the best parts of their participation in the project. So we were really happy about that. And though practice facilitators were able to make positive changes at the clinics and there was positive feedback about their presence, the sustainability of the implementation that they were able to support is questionable long term. And so considering what implementation looks like post practice facilitation is an important consideration for the future. And that's all we have for you today. If we have a couple minutes, we can take some questions.

KATHY CEBUHAR

You've got about three minutes.

AUDIENCE MEMBER
How did you decide on the 15 month intervention?

CHRYSTAL BARNES
So it started out as 12 months and that was the initial plan. And then we found that onboarding clinics took some time just getting them, getting their baseline data, doing needs assessments, all of those kinds of things. Again, we started in March of 2020. So it was really challenging during that time. And so we added that three month kind of onboarding just to get their like bureaucratic things done and then be able to actually start implementation for 12 months,

TIFF WEEKLEY
And that, that did vary by clinic. So for some of them, it took maybe a few weeks to onboard and get started and for others, it took the full three months. So it really depended on their capacity and what they could do.

CHRYSTAL BARNES
Yeah. Yeah.

AUDIENCE MEMBER
Any thoughts about sustainability and what could be done and what we should be looking for there?

CHRYSTAL BARNES
Yeah, that's a good question. I think that I don't have a great answer for that. I think that one of the things that practices have often communicated is that the attention drawing that practice facilitators do particular area of care is really helpful. So I think that if there can be a built in sort of, you know, reminders that practice facilitators help clinics structure before they leave. Whether that's having an agenda item on a team huddle or something like that, might be helpful. But yeah, that's, it's a hard question.

AUDIENCE MEMBER
That's all of human endeavors.

TIFF WEEKLEY
So yeah, I'll also add, I know that we also heard from some clinics and practice facilitators that it's also helpful to really like, teach them how to do something even if it takes longer instead of just doing it for them just to get the results that we want to see or the data we want. So that way they can do it themselves, whether that's report building or whatever. Yeah.

AUDIENCE MEMBER

In the practices that we're participating was there some recognition around use of SBIRT and motivational interviewing with other lifestyle kind of related issues? And so are they building on a position of strength or an opportunity to take what they have learned here and then grow in other dimensions?

CHRYSTAL BARNES
Yeah, that's a great question. And that was definitely how probably most clinics approached it and we didn't really get into it, but we had a lot of clinics that actually sort of made the adaptation of going beyond unhealthy alcohol use with some of these skills and strategies and applying it to other areas and substance use and stuff. So that was definitely especially with motivational JENNIFER HALFACRE
Hi, everyone. My name is Jennifer Halfacre and I'm a practice facilitator at the Department of Family Medicine in Colorado. And then, I have a couple of team members that will also be coming up, too, and I'll let them introduce themselves here in a minute. Our objective is we wanted to define the scope of need for our SBIRT program, describe kind of our lessons learned, and then review opportunities and successes for you all. So we were also funded by the AHRQ grant. This was a three year grant and Colorado was one of six sites nationally chosen. Our purpose was to increase our efforts around SBIRT screening and unhealthy alcohol use and referral to treatment. We had 43 practices that completed FAST. And we started in June of 2020. We actually did some training in March of 2020 but the practice facilitation actually started in June of 2020 we just completed February of this year. Our scope and need was really to identify practices, or help practices identify unhealthy alcohol use and potentially risky, unhealthy alcohol use. We provided evidence based interventions and we provided training to medical staff providers and behavior health providers. Ours was a little--we did six facilitated sessions where we did like a baseline assessment and then each session kind of went about. We did screening and then we did brief intervention, referral to treatment, MAT, team based care, and sustainability. We...it didn't always go straight to plan. Sometimes they would, they would do screening and then they would move on to referral and then they would realize they'd have to move back to screening. So they did not have to move through them as, as they went, they could kind of help the practice as they needed. Then the practice would do three months of independent work and then they would come back for final assessments and kind of check for sustainability and what they needed to do. All--everything was virtual facilitation and they were randomized, practices were randomized either into e-learning and practice facilitation or practice facilitation only. And the e-learning modules covered all the sessions, covered everything. There was space for pre and post intervention planning and then practice, but we did have resources in there, like CDC resources, addiction medicine resources, we had a lot of resources, those are available to every practice that participated in FAST. Now, I'm gonna hand it over to Carolyn for some lessons learned.

CAROLYN SWENSON
Thank you. So, hello everyone. I'm Carolyn Swenson. My background is in nursing and public health and I was a consultant on the FAST project. I've been working on related issues for a number of years teaching motivational, interviewing, suicide prevention,

substance use prevention in Colorado and actually beyond Colorado, and you'll see some overlap with the great Oregon project in terms of lessons learned, sustainability, challenges and we don't have a background section. Thank you for that on the importance of unhealthy alcohol use in our country and actually across the globe. So here are some key things, just a few of the most important lessons and some of these really relate to how we're going to sustain these practices in primary care. So, first of all, is to clarify what is the real purpose of screening? Because most unhealthy alcohol use will not be obvious unless you ask questions about how much alcohol does someone consume on a regular basis. Or occasionally, many practices started out assuming they were primarily looking for patients who would meet diagnostic criteria for alcohol use disorder when actually most unhealthy alcohol use is not going to be obvious and can affect health in many ways and never result in alcohol use disorder. You know, the addiction level of alcohol, unhealthy alcohol use. So we really had to clarify that you're often missing this if you don't ask. You can use a very brief screener to find it and connect it to anything that matters to the patient, that motivational interviewing approach. Many times unhealthy alcohol use will not have resulted in any health, social problems, mental health problems at this point when you first identify it, but the goal would be we can prevent future problems and connect it to things that matter to you. And help you find your own best reasons to cut back. Usually, usually quitting alcohol entirely is not necessarily the ideal goal for all patients. So, that was a major part of sort of clarifying, what are we really looking for? What do you do next? And a clinical decision support tool turns out to be a really valuable part of helping clinicians and the whole practice team actually figure out is there a concern and how would we talk about it? What information and feedback would be meaningful to the patient to help them decide? Should I make a change? How does this relate to my life overall? And how do I do a brief motivational intervention in a really short amount of time in primary care? Earlier this morning, we saw about those reimbursement codes. You're supposed to spend 15 minutes or longer. In Colorado we're actually. we just spoke to our legislature and asked them to cut that down to three minutes or longer. And this little structured example of a motivational interview that you can apply to all kinds of health behaviors is as a way to do this in a really short amount of time and weave it into things that matter. SBIRT is a team effort. It really is care coordination and a lesson learned is that often because it relates to alcohol, a substance that clinicians, the whole practice team figures if this is a concern, we're gonna immediately hand it off to the behavioral health provider and they're gonna do all the discussion of alcohol. And the reality is many patients are very receptive to getting feedback from their medical provider. They don't necessarily view this as a behavioral health concern that needs counseling, for example. So a challenge sometimes is to prepare those nurses, those physicians, advanced practice providers, to talk about alcohol and just weave it into, you know, overall health, cardiovascular health, cancer prevention, depression management. Coordination, I mean, documentation is really critical and there are some challenges some concerns about, should we even put this in the patient's record? What are the implications of that? How do we explain to patients that this is really just part of your health? And it needs to, you know, we need to document it to track changes for reimbursement, to basically give a whole picture of your health. So a a major part of sustaining SBIRT, because behavioral health is often overtaxed in primary care, is

figuring out how can the whole team play a role in providing this service to patients and not necessarily immediately make it a behavioral health concern. And also because there's a lack of referral resources for the more concerning higher level of of risk, primary care can be doing a lot more to manage unhealthy alcohol use and preparing practices to do that and feel confident and sustain that care over time so that not everyone needs to go to a specialist for care. Stigma was already mentioned. And this is definitely a challenge across all substance use and across other health issues as well. Think in practice facilitation and preparing practices, it's really important to be prepared to identify that sometimes starting with, what language are we using? How are we talking about these issues? So that we immediately role model for patients, that this is a health concern this, well, we don't use derogatory terms. Think about the, the practice staff's own experiences with their own alcohol use, for example, their family experiences, community experiences so that we reframe that unhealthy alcohol use and the level that reaches addiction is really just another health concern, a chronic health condition that can be identified well treated, that people can recover from it and go into long term recovery. So being prepared to talk about, if you're reluctant to put this in the patient's medical record, let's talk about that. What what what are those concerns about? We also experienced that in smaller practices, rural areas, there was even greater reluctance to even talk about alcohol use. Encourage conversation about the staff experiences of their own alcohol use, their their family experiences. Provide resources to help them start to practice different terminology such as "alcohol use disorder" instead of "addict" or "alcoholism" and address parity. We have parity regulations that should provide equal services for mental health and substance use. But those regulations aren't always fully implemented. And, you know, we need to advocate on behalf of patients who do need addiction care. And then one motivating factor for some practices was the recognition that this is a big concern in our community. And I would like to do better for my patients and help patients earlier in their own experience of excessive alcohol use to help prevent the most devastating consequences. So, being aware of what is the prevalence of unhealthy alcohol use, how is that affecting overall health? Not just mental health. How is it affecting social issues, employment, things like that? And addiction does not happen overnight, it takes a long time to develop. So we want to help practices understand that the earlier you intervene and especially i ideally in adolescence, the greater the likelihood you are going to help prevent addiction in more and more patients. At the same time being honest about the lack of treatment options that we, we need to become more creative and what we, what do we mean by treatment? It doesn't have to be a specialty substance use treatment disorder center for all patients and the underutilization of medications for alcohol use disorder is something that we have a long way to go on yet. But some clinics really were convinced that we can do this and we can help more patients by offering medications. But that was something that took a lot more education and kind of time for them to become confident using the medications. So I'm gonna hand it off to Andrew.

ANDREW BIENSTOCK
I'm Andrew Bienstock. I work a lot with the measurers and with coaches on this project. This is kind of initial data, so not final yet, but we looked at some of the areas that we

screen for. So patient screening for unhealthy al alcohol use. We saw with, across all of our practices, a big jump from kind of baseline to final. We found that practices definitely spent quite a bit of time on that. Like Jennifer said, you know, they, they have the first month to work on that, but they really probably spent a couple of months getting it set up, getting us out in the EHRs to track the data and, but we did see a nice jump from baseline to final. We did see with that increased screening kind of what you'd expect an increase in patients actually screening positive for unhealthy alcohol use. So we saw a jump in that as well over time and then the other really big jump was practices using brief intervention, which is what we're hoping. Right. So you're working with these coach practices, coaches are really focusing on getting the practices to start SBIRT and seeing that big jump in brief intervention as well. We did see an increase in medication assisted treatment and we did see an increase in referrals as well, but this is really kind of the the big, the big bang for the buck that we saw the practice is number one to all the practice spending the most time on and seeing kind of the most change over time. That's. Yeah, questions?

AUDIENCE MEMBER
Can we go back one slide? I had a question regarding the patients who received basic intervention. So one of the comments I usually get on with the measures is that they were doing the practice just not documenting it. Is this a, is this a documentation issue or is this a practice issue?

ANDREW BIENSTOCK
It depends on the practice.

AUDIENCE MEMBER
Ok.

ANDREW BIENSTOCK
So some practices definitely started from scratch. Hadn't been doing any unhealthy alcoholic [inaudible] for brief intervention. And some have been doing it like you said, they just weren't documenting it. But I'm guessing that we, we did ask for that thing. I can't remember kind of numbers, but we thought, you know, Carolyn, what just in different practices that how--

CAROLYN SWENSON
How many were already documenting? There's not easy way necessarily to document and even if you put it in the notes, then you sometimes have to extract that. So I think that we need better templates for documentation so that we can say, you know, at least I did something/ I did nothing and postponed it. I did something or you know, we didn't do something so that we have at least something.

AUDIENCE MEMBER
That's by no means a criticism. I'm so glad that we actually have numbers that we can have the conversation about. So thank you.

ANDREW BIENSTOCK
And just general comments, questions, anything else?

AUDIENCE MEMBER
But I mean, after the panel yesterday and then listening to both of the more in depth presentations today from two states, I think one of the things that I still honor is the like Colorado's approach is way more prescriptive than Oregon's approach. Both had good outcomes, both had unique challenges like pros and cons and so where, where do we go? Like, what's the right best way to propose the next thing? And what is the balance of having like an open-- because we're about to go into a huge open ended practice to propose what they want to do project, which is great and also terrifying. So there's, I'm still kind of trying to figure out like, what do we take away from this as a, you know, in Jodie's next proposal? Is she prescriptive or is she kind of like we can we, we're gonna take it on a piece by piece basis? So I don't know that I said not a question. It's just a, you know, my own personal kind of question to myself.

CAROLYN SWENSON
Well, if I can make one comment about that, which is having lived in the world of SBIRTsince. well, in 2006, SAMHSA started giving out grants that-- in the US, you know, Substance Use Mental Health Aervices Administration. We need to incorporate the whole spectrum of substance use education into training programs for nurses, for pharmacists, for physicians, et cetera, so that they come out of school ready to understand that this is a whole spectrum. It's not just addiction and there's, it's a preventable condition that we should be addressing in late childhood, you know, across the lifespan, it relates to so many aspects of aging, for example, fall prevention so that they're, it's just natural that they talk about it. And then of course, what gets measured gets done sometimes. So it's like, how do you document it? How do you look for changes and patient satisfaction, patient health, right? So that's just big picture of what we could be doing differently.

AUDIENCE MEMBER
The e-learning did that make a difference?

ANDREW BIENSTOCK
So the e-learning did not make a difference that we could tell. The one thing just I think to mention is the e-learning was facilitated by a practice---was a part of the facilitation of the coach. The coach went in with the e-learning module and walk the practice through the e learning module and then the practice would work out a quality program process tied to that module. So it wasn't just on their own. They could do--share it with other folks, their practice, but it was a guided process.

AUDIENCE MEMBER
So if they didn't get a learning, they just didn't get training?

ANDREW BIENSTOCK
If they, sorry?

AUDIENCE MEMBER
If they were a practice without the e-learning, they just didn't know the training?

ANDREW BIENSTOCK
No, the coach would do the same, the same topics just--

AUDIENCE MEMBER
So is that in the methodology, whether it was better e-learning or the practice facilitator chain covering it? Well, what, what are your thoughts about it then? Did it depend on the practice or was one better?

ANDREW BIENSTOCK
I think it also depend on the coach, right? So even if the coach, the coach said, ok, we, we, we, we randomly assigned them so the coach didn't get to choose. Oh, I wanna work with this methodology or not. So, some of the coaches, even though they introduced the e-learning, I guarantee you, they still just kinda coach the way they coached. It didn't really push the e-learning because they weren't comfortable with it. So I think that was a limitation.

AUDIENCE MEMBER
So a little lack of fidelity on that.

ANDREW BIENSTOCK
But part of that, I would think on that part, but there were other coaches that did, they walked through and they went through each module and the practices went through the quality improvement process of doc enting it, doc enting it with each visit. But we didn't see any change even for the coach that really used it.

JENNIFER HALFACRE
I think it was really good for the new PFs though because, like, you know, like none of us all came in as experts on SBIRT for, you know, and it was, I think it was really good for new PFs to go through as well. So it's a good training tool.

ANDREW BIENSTOCK
And the PFS had the same training material to rely on prior to their meeting with the practices, they didn't use the e-learning with. So everybody had the same access to the material before they wanted to work with the practice.

AUDIENCE MEMBER
And we tried to force some fidelity because the e-learning practices had to do a pre and post intervention plan with after each, each module with the practice. So that's how we

tried to just some accountability and fidelity, but some of the coaches didn't like e learning. So, so for whatever reason, not really right, wrong or bad. So anyway, it was, it was, yeah.

JENNIFER HALFACRE
I mean, I guess I just, I will reveal my bias but I think any project implementation needs some facilitation, like as a basis. The question is what goes with it, like, you know, when training and which modalities and when do you use other, you know, all the toolbox of things. So anyway, just--

ANDREW BIENSTOCK
There's a coach definitely with them the whole time, either walking through it or just kind of [inaudible] Great, great.

JENNIFER HALFACRE
Thank you.

CAROLYN SWENSON
Thank you. interviewing a big benefit. Yeah. Thank you.boration.