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Practice Facilitation to Guide an Unhealthy Alcohol Use Intervention; the experience across six grantees

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Hi, everyone. My name is Dawn Bishop. And I'm from the Michigan team, but I'm gonna somewhat be moderating the discussion questions. So, you'll hear from each one of us in just a little bit, but we really wanted to present this information because although we all worked on the same grant or the same funding, we all approached it a little bit differently. So we wanted to share our experiences and our techniques and the different things that we did. And I think you'll find it kind of interesting, some of the similarities and things how we came up with it. Not really as we have known each other, we, were able to collaborate a little bit. So and the unhealthy alcohol use is tje third leading cause of preventable death in the United States. However, only 13% of primary care actually screened for it. So really the foundation for this was to implement that screening and follow up and brief intervention in primary care. So that's really what we worked on and though each grantee designed their things differently, you're gonna find, you're gonna see as I mentioned, a lot of similarities. So what we're gonna do today is we're gonna, we've designed a panel discussion. So we have some seed questions and then we've each person is gonna share their information with you and then we're gonna open it up for some questions at near the end and hopefully have some interactive discussions around it. So, Gabby, what we're gonna do next is introduce, we're gonna spend some time introducing each one of the groups that are here represented. And then we do have a group that's not here and Gabby is gonna cover their slides just so you can kind of get to know us kind of what our group formation was and what our layout

GABBY VILLALOBOS
was and just to add. So, I'm Gabby. I'm from the Virginia team, just to add a little bit more to what Dawn mentioned the AHRQ Award of this grant in September of 2019 before the pandemic. So, we were supposed to each recruit 100 and 25 primary care practices to work with. and the pandemic happened and we all had to revise our process, our protocol, how we were collecting data, how we were gonna work with practices. So, we also got a one year no cost extension which is ending. In that time combined, we work with 300 primary care practices. So that's still a very good accomplishment. So, to tell you a little bit about the Virginia team, which, by the way, that's, that's everyone who's presenting. So this is from the Virginia Team. We enrolled 76 primary care practices. And again, the goal was to work with practices, find out what their screening methods were for alcohol, provide education as part of the intervention. But we do, we did a randomized control trial. So we did upon enrollment, we randomized practices. So they either started the intervention immediately or in six months. We did data collection as well. And that was timed based on

their intervention start point. Our intervention consisted of 6, to 9 months of support and education. What we did at baseline was we did an assessment of their practice environment. So, you know, what are they doing and evaluating their current state of screening? That was with our data collection and also doing interviews with the practice teams. So with the practice teams, we verbally asked them, you know, what, what is it that you're doing? And then with the data collection, we actually saw what is being done and documented. We met with practice teams on average 4 to 7 times. That was the plan to meet with them 4 to 7 times to share information on recommended drinking limits, alcohol use disorder criteria. The recommended alcohol screening tools and how to interpret them, treatment options for patients, including brief counseling and motivational interviewing. We also reviewed medication options, printed resources which we're gonna touch on provided referrals. A few practices wanted information on billing and we also did that as well. From the data collection standpoint, what we did was from each practice, we selected 60 patients at three different time points.

SPEAKER 6
We randomly selected patients who had recent visits to that a doctor if it was a solo provider or participate, we just selected from them.

GABBY VILLALOBOS
The practice facilitators did all the data collection and we reviewed a total of 11,789 patient charts and we also assembled and mailed those same patient surveys. and our surveys and resources were provided in Spanish as well.

STEPHANIE KIRCHNER
So I'm Stephanie Kerscher. I'm from Colorado and we enrolled 43 practices across Colorado. This map is a little bit tiny, probably up on the big screen, but they were kind of spread across the state but pretty heavily focused in the metro area where you see kind of that clump. That's really Denver. We had 11 practice facilitators who worked on our, as we call, it FAST (facilitating alcohol screening and treatment) in Colorado. The I sit at the University of Colorado which is in Aurora. We're very near Denver, but our practice facilitators are all over the state. So we kind of subcontract out with practice transformation organizations that have local practice facilitators. And we had 11 of them, but that represents some turnover. We had some people kind of rotate out. We started in June of 2020 as Gabby talked about, we were really recruiting practices just as COVID was rearing its head. I think that's universally true and which created some challenges. And we had six facilitated sessions. We tried to encourage practice facilitators to get them done in six months, but they didn't always do that. was kind of trying to meet practices where they were especially given the situation with COVID. I think when we're gonna talk about this a little bit more about trying to be flexible around what practices can handle, I think was really essential in keeping practices enrolled in the unhealthy alcohol use work. We also had a follow up assessment with them at a nine month period or a nine month point. So if they didn't finish their practice facilitation in six months, we just kind of use that last visit the last of the six and then three months later, did a follow up with them. And then kind of

our little flair in Colorado was the randomization of just practice facilitation or practice facilitation that was accompanied by our e-learning modules. So the e-learning modules were a little bit more prescriptive in pre-post planning gave practices and the facilitator a little bit more guidance around expert. And so they were, that's how the two groups were randomized. So we're gonna talk a little bit more about what was in the E learning modules in a little bit

GABBY VILLALOBOS
Michigan.

DARLA PARSONS
Michigan. Hi, my name is Darla Parsons. I'm from, we're all from the Ann Arbor area. Dawn is from Out Grand Rapids along Lake Michigan. So we're: Cheryl and Dawn and I are from Michigan. And I just found out I'm gonna talk to the slide. So bear with me for a minute here. You'll hear again, we're trying to focus on the differences between the way we all approach the program, but yet we all had successful outcomes. So in Michigan, we ended up bringing it back, We only had 24 primary care practices, which does include one OBGYN and one home health care agency that we're calling primary care. So that was kind of unique. There were the three practice facilitators, Dawn and Cheryl and myself and we partnered with Kaiser Permanente. And so we were very fortunate that we had Doctor Catherine Bradley who is just a renowned expert on unhealthy alcohol use and introducing expert into practices and ways to help patients avoid the stigma and help teach people that there's not just one answer anymore for unhealthy alcohol use. There's a whole plethora of different options that are available. So that was the message that we were trying to bring to practices and to physicians. We had a two hour CME class that they would take either virtually or we did some in person. And so we were offering huge CME amount, 20 MOC credits and 20 to 30 CMES for PAs and other providers other than physicians. And so we got all that education to them by offering that CME, they would take those two hour, two one hour sessions that we presented. And so we were getting all the information to the folks right at the beginning of the program. Now, there were some that didn't want the CME, they were involved in other programs and they said to us, I or they just didn't have the commitment to two one-hour sessions. So we customized for those offices if you didn't want the CME just kind of tailored it down and summarized our slides and the things that we normally would have presented and gave it to them in a more summarized fashion. So, and it worked both ways, still got the information to the people that needed it. And those that wanted to CME got the, the longer version, I guess I would say. We offered six months of support. After that, we started out that we were going to randomize the program. But because we ended up with so few participants because as Gabby mentioned, like our goal at the beginning was like close to 100 practices.

GABBY VILLALOBOS
We ended up with 24 because it all started, Dawn

DARLA PARSONS

and Cheryl and I were recruiting right at the beginning of COVID. So in March of 2020, we were trying to get people to listen and they were really busy and we were sort of very fortunate that we got the ones that we did, but it was tough. And so they worked with us for six months during which time we took a baseline, a mid and an end reading of number of patients that were screened and of those patients that were screened, how many tested positive or the results were positive screen and all those that had a positive screen, did any of the practices get to the point where they were prescribing meds for that unhealthy alcohol use. So those were the things that we were researching with Kaiser. That's Michigan, and the data collection that was done by the practice facilitators. And, if any of you have ever done that, you know, depending on the EHR system that they're using, depending on their it infrastructure, depending on the size of the practice, whether or not they actually have access to make changes in their EHR or if that or, or is it a bolt on piece that they didn't buy? We found that the location or the availability of screening tools or even treatment tools for unhealthy alcohol use was extremely limited. So, and in six months, you know, although we were able to make some changes, we really didn't get to change the world the way we would have liked to because it was just so different in each practice.

TIFF WEEKLEY
All right. Hi, everyone. I'm Tiff and I'm part of the Oregon team, which is for ANTECEDENT, which is "partnerships to enhance alcohol screening treatment and intervention." We enrolled the 75 practices to participate in ANTECEDENT. Practices participated between April, or I'm sorry, May of 2020 until April of 2023, so sometime within a three year period, all practices are enrolled to participate for 15 months with us. And one key piece of our model is we use a flexible implementation model. So what that meant is that when practice enrolled with us for 15 months, we would spend some time in the 1st 1 to 3 months depending, collecting some baseline data, figuring out their data reporting capabilities and then just really figuring out, setting up the foundation for the rest of our time together. And then after that, the rest of their time was a lot less cookie cutter with us. We had a lot of different options that they could choose from to help them reach their goals. We had practice facilitatprs, that helped them set their goals and then also to try to tailor support to them, to help them reach their goals and to fit their specific clinic context. So each practice really had a different experience, which as we come to find out, some practices really had a good experience having a flexible implementation model. They didn't have a problem setting their own goals. They were really intrinsically motivated. They knew what they wanted to participate in. And then we also had some other practices who maybe that didn't work quite well for them. They wanted something that was more of a checkbox to complete A B and C and you know, you did the project. Congratulations. So that was something that was really unique about our project. And I will get into that a little bit more as we go through the rest of this panel, I will mention though that for supplemental support, things like that, things that were included in supplemental support, included monthly practice facilitation meetings. And maybe that was a little more, a little less. We had access to experts for certain types of trainings. We had a lot of different types of resources. We had an online toolkit and then we also just tailored to anything else that they needed, whether that was maybe a little bit more information, for example, one practice wanted more information on

addressing marijuana use with their patients, really just anything that they needed. So that time was really flexible with us.

SPEAKER 6
So the North Carolina team had enrolled 32 practices. 19 completed the full study. They had 15 practice facilitators that provided 1 to 2 hours of direct support each month for 12 months of the intervention period. The practice facilitators help practices form clinical quality improvement teams, establish workflows, and optimize their EHR use. They were able to support practices by providing referral resources, patient and clinician materials, and provide expert consultation as well. And again, similar to all of us, they did that through either in person workshops, video modules or and then the Midwest team enrolled 23 practices across Wisconsin and Illinois, focusing on FQHCS, solo and network based providers. They had five practice facilitators and one PF lead who worked with practice teams to provide online and in-person education, promoting the use of work flows in EHRs. They planned to evaluate the effectiveness of the PF education and its impact on screening and treatment of patients with unhealthy alcohol use.

DAWN BISHOP
Great. So that's kind of the layout of where we're located. And as you can, as you heard from everyone in the introductions, we all kind of approached it a little bit differently, but now we've kind of come up with some questions that we're hoping we'll be able to give you just a little bit more information about exactly how those things were different and how they were the same as well. So, our first one is for Gabby and

JESSICA REED WILLIAMS
Darla.

DAWN BISHOP
Can you share how practice facilitation created success during implementation of the unhealthy alcohol use intervention at your site?

GABBY VILLALOBOS
Yeah. So, I think, you know, like we all started at a difficult period with COVID. Once we started providing the education to the clinicians, they thought one, it was very timely and as we got through it, they overcame personal barriers and you know, being somewhat scared to approach the topic with patients thinking patients were not going to be receptive or feel judged. But it was kind of perfect timing, like I mentioned, because with COVID, alcohol use rates went up. So both the clinicians felt more confident, they felt comfortable, they knew they had the knowledge to address all these issues with, with clinicians. So that was a big plus that we saw. They also noticed that it made a difference using validated tools. So a lot of the practices we work with were asking patients already. They were screened some way, you know, typically it was, do you drink alcohol? Just yes or no? That's what we found in the documentation. And they thought we had some clinicians who said I know my patients, you know, they're not drinking at unhealthy levels. OK? Once they started, they

noticed that, oh I thought, you know, that they were not, but now using these validated instruments and a scoring system. And I noticed that, you know, they actually scored in maybe a lower threshold of they were still at risk. So they did, they did appreciate being able to have some concrete guidelines for what is unhealthy alcohol use.

DARLA PARSONS
And like Gabby, my practices that I worked with were so thankful for the tools I heard comments like finally, finally, some tools to help me talk to my patients or to send them with something. if they're not comfortable talking about this today in the practice, I'm gonna send something home with them. They can think about it, sort of some questions to ask themselves. They were so appreciative that like there were handouts, Cheryl's gonna talk a little bit about tools and resources. They were so creative in finding ways to put reminders in the office, whether it be posters, whether it was comments about, we care about your health and that's why we're screening. We want you to think about the way that alcohol can affect the whole you, it affects hypertension, it affects diabetes, it affects your liver, it affects everything. And so they were just so thankful to have those kind of validated tools to share with patients. One of the offices, they took stacks of brochures and put them in the lobby. So that while I'm not in the lobby, I'm sorry, the waiting room. So that while patients were waiting, maybe they would see them. We had other offices who were just handing those out to everybody and some that saved it for just the patients that maybe they were having a little bit of trouble getting them to open up and it was something they could send home with them. So, flexiability and in tools is what everybody was so excited about that we worked with.

GABBY VILLALOBOS
Yeah, it's surprising that they had that specifically the MAT information, medications, We really found that they were very useful. a lot of, we did not see it in the data and the data collection. We did not see that, but we had, we completed a qualitative interviews with the those who participated. They also filled out, you know, post intervention, they filled out surveys, optional surveys. And what we heard back was that, that made a difference. They may not be prescribing it as often. and so, you know, but when they do, or when they come across a patient, especially someone who's already been to an outside resources is now coming in. As a patient, they feel comfortable like continuing that care, which is, is the point. We had, we're lucky to have a psychopharmacologist as part of the research team. So for those clinicians that were already familiar with medications, but they wanted to talk a little bit more in depth, we invited him to meet with them and he was also very very receptive to receiving communication from them, if they had a particular case that they wanted to run by him, that he would provide feedback on perhaps what he recommended.

DAWN BISHOP
Tiffany, Gabby and Cheryl, can you share what types of resources that you use to help engage and overcome that stigma that was really kind of at the forefront of this project?

TIFF WEEKLEY

Yeah, absolutely. So, again, I'll mention that for us in Oregon, we used that flexible implementation model. And so each practice had a different experience and no one had really the same exact experience. So we did offer some pocket cards and brochures and things that they could use, each practice got something a little bit different. However, there was one resource that was offered to all practices at baseline that ended up being really helpful. And that was a website created called SBIRTOregon. and that's SBIRTOregon.org. SBIRT stands for "screening brief intervention and referral to treatment." And that's a way to address unhealthy alcohol use. And so SBIRTOregon ended up being less of a website and more of a really established online tool kit. And that toolkit has a lot of different tools such as workflow examples, different demonstration videos, training videos in order to improve expert efficiency in clinical settings and also to empower clinicians to improve expert as well. Another piece of this toolkit is that we did align our project in Oregon with the state expert quality metric. And so something that was super helpful for providers is that this toolkit also had billing codes, documentation examples, more information on the SBIRT measure, just something that they could continuously refer to whenever they needed it. And that's something that we offered at baseline and it is still up today for them to refer to. And so that's super helpful. And another piece on this resource for us was that Jim Winkle is someone who is a consultant who really created this website and managed it. And he was also available to our practices to provide training on motivational interviewing, which ended up being really valuable that included a roleplay as well. And we have heard from practices that that was super helpful, seeing something happen in practice letting their staff get things in practice. And then he also did expert 101 training for them as well. So overall, just having the SBIRTOregon tool kit and having access to Jim Winkle to go in and talk to these folks and give those trainings was just super valuable for us and something that was available to all of our folks right away.

CHERYL
So, yeah, my name is Cheryl. and as Darla had mentioned, I worked with one clinician in Northern Michigan and she was very apprehensive about even talking to patients about their alcohol use. She had a lot of male patients who were in federal, you know, police officers. And so it wasn't a conversation she was comfortable with. And after our initial meeting and I shared with her the resources like for the alcohol and health brochure, you're welcome to come up and see it. But inside, Doctor Bradley has developed this through Kaiser and her pilot program and the solo cup, it actually measures the ounces of drinks. And Doctor Marshall didn't know that. And so, and then the next time I went back there and she said, "Cheryl, I put this brochure into a solo cup and I put them on the

NUHA WAREG
counters. So now when I walk in the room, I don't

CHERYL
have to initiate the conversation." The patient says to me, "what is that?" And you know, and takes it out and she even said that she's had so many people that have come to her and say, "I love this brochure." Can I have another one? Like I want to talk, share this with

somebody. So, you know, the resource was invaluable. The other resource that we provided, thanks to Doctor Bradley was a decision aid and it is available on the NIAAA website. It's a decision aid for unhealthy alcohol use. So my other clinician when I gave this to him and he gave it to his patient. He said the patient came back, she read through the whole book and she, I'm gonna start to cry. She came back and she had filled this out and she was crying and she said "I want to make a change in my life." And by, with the training that we had provided them, you know, the two trainings, the second training is devoted to medication (MAT) and having Doctor Bradley there for one on one support. He was very comfortable in prescribing Naltrexone, which I have no, what do you call that thing bias or anything?

SPEAKER
Right. Right.

GABBY VILLALOBOS
Right.

SPEAKER
Right.

CHERYL
But you know, those tools are just, you know, with what we were able to provide to them was just invaluable.

GABBY VILLALOBOS
And the Virginia team did couple of things we created these patient flyers. We took the idea or the idea with permission from the North Carolina team. So this, this is for patients that has a lot of great information, including, you know, what are the standard drinks. We also created this in Spanish once we started kind of recruiting practices and saw primarily Spanish speaking patients, we also have a clinician facing one that kind of gives them, I call it a little cheat sheet. Like if they don't know how to guide the conversation, there's literally quotes here of what to say, depending on where the patient is at. The other tool that we created early on was our study website and a lot of the information that's on here, in the top right, is our study website that Doctor Huffstetler created. We had videos on there that we tried to depending on how our meetings were set up with practices, we would watch the videos with them and then talk about them. All the videos were created by our study team members. We also had created resources that was, as we touched on, something that they really valued. So our team, we had a great group of students, met students that are with us during the summer and they helped us call and verify every single resource that we put on our website. We had specific questions to vet them. And we created that and so that map of Virginia, the practices could click on their area and see all their local resources with a lot of information that they could just direct patients to if they needed. As we started working with practices, we heard them request specific tools, resources. So we created that. A lot of the EMRs were not set up to capture the audit C or the SASQ. So some of them asked for

a laminated pocket card with it that they could just, you know, have in the room, the patient just completes it. And that's how these came about. So then we offered them to the remaining practices. We also had a standard drink equivalent because a lot of us don't know what a standard drink is. So this, it had and even the clinicians, you know, this is very helpful because when you're asking someone, you know, how much they drink and they say a glass of wine, it makes a difference. And so my, my colleague Michelle, she she has a really good, I'm not sure if I put it on here a glass. Yeah. What, what's five ounces of one really looks like depending on the glass. So she created something like that. And then I think she took Michigan's idea with the solo cup as well and did the same thing. It's a conversation starter while you're waiting in the, in the exam room, you just, you know, glance at everything there is. So yeah, so we created a lot of resources tailored to what the clinicians wanted. And we offered them, mailed them to them, had them on our website, emailed anything they wanted we created.

STEPHANIE KIRCHNER
And the resource that I wanted to talk about that we created in Colorado is more of a resource for practices and practice facilitators than it was for patients. And that was the e learning modules that accompanied the project. So as I was describing earlier, the practices were randomized to have access to the e-learning modules or not. And they created a guided, just, pathway for the facilitator to walk practices through implementation of SBIRT. E-learning modules, it's interesting from the perspective of a practice facilitator. We had really strong reactions from both directions. Some people wildly loved them. It created a road map, it gave practices tools, it provided scripting, it was a way of educating staff. It was a way of destigmatizing the conversation around alcohol. Other practice facilitators. I think it was more people who had been doing this for a long time were kind of like, oh, this is really prescriptive and it's too much, especially given the circumstances of where we are with COVID and practices kind of just need dosing in a different way. But then they came back to the e-learning modules, they wanted them later. So there's there's kind of this just repository of good information and how they're used. I think we learned a lot about in FAST or in this unhealthy alcohol use opportunity. I think that for me, the biggest piece of this resource for staff is really just giving people who may be uncomfortable approaching the conversation with patients, something to a way to practice and a way to use a script of sorts until they're comfortable asking the question in a way that just rolls off the tongue. Because I think, you know, everybody or a few of us have been talking about this. This isn't just an issue for patients that are seen in primary care. It's often things that our own families and our ourselves are going through as well. And there was an uptick of unhealthy alcohol use during COVID. And so these are conversations that are challenging, I think for practices to broach. It reminds me I, that in my other life was a registered dietician. I mean, I guess I, I actually still am, I don't really do anything related to that anymore. But it's the same thing with talking to you about unhealthy eating habits and you know, weight management kinds of things. These are things that are very personal to most of us at some point in our lives. And so, the e-learning modules are just a way for practice to be able to delve in in kind of a neutral way. And also really makes this kind of program a little more scalable. It's something that we can give to other states, we can give to other

entities who are interested in in implementing and just sort of need a little bit of a road map. So that was the resource, the biggest resource that kind of came out of Colorado.

DAWN BISHOP
Great. Thank you. So, as you're gonna hear each one of us kind of approach what we supplied to the practices for education a little bit differently. So it, you can see we've kind of got our table stacked. So at the end, we're sharing all the information because that's kind of one of the things we wanna do, we, we move on, we want to share, share with you. So now we want to talk about beyond some of this education that was developed, which was obviously very supportive for the practices and learning and talking with patients and the reminders of how to do that. But we wanted to ask Darla and Stephanie to share some of the unanticipated accomplishments. So what did we not anticipate was gonna happen and it happened for us.

GABBY VILLALOBOS
I think it was that it was pretty easy to implement this in your practice. It felt scary and it felt really overwhelming. But once they got started, they were just adding one more thing, they were adding a screening at check-in prior if they could get it on their portal for new patient, you know, forms or they were doing the screening inside the exam room as part of their natural screening. If the MAs were doing it before the clinician, see the patient and overall people were just kind of it, it went well, it was smooth. They thought patients were really going to push back. I don't want to fill that out or why are you asking me those questions, being defensive. None of my practices found that patients addressed it that way. People told us I'm getting this in all my other doctor's offices too. Like, oh, I had to do one of these last week at my OBGYN. It was, it was starting to feel more normal, which is great news for us as a nation, right? But so it was just easier than they anticipated. It also opened a window to some patients that maybe they never thought they were gonna see. I don't want to call it a new revenue stream. But technically for a, you know, a single practitioner that's trying to pay the bills. This was some new patients that they were able to add to their practice that they never could before they implemented this. One of the examples, they had a, somebody called the office, this was an internal med specialist, and called the office and the doctor overheard her say to the patient on the phone. "What are you coming in for?" It was a new patient asking to be seen. Patient said I just need a refill. I've just been discharged from rehab. I just need to refill on some medication and her immediate answer was well, we don't do that. We don't, we don't prescribe those meds and Doctor M stopped her and said, wait, wait, wait. What are you talking about? Remember now, do now we've been trained, we know how to do that. That patient came in as a new patient where they would have turned her away before that. And she told a friend and they told a friend and now that this particular rehab location is depending on Doctor M. They're sending her as many patients as they can because they know she will refill that 30 day supply of meds that a lot of other internal specialists in the area or primary care doctors are not comfortable refilling. So that was just a great unanticipated piece. One of the other things that we think stood out was that, you know, if you use certain wording, I can call this a quality initiative program or we can call it workflow changes. We words that we use sometimes don't really

click with people. No one really thought about this. That what we're doing is quality improvement work. Once we started doing it and we tried to tell them you can do this for other things you can use this for other diagnosis. This is quality improvement work. Oh! This is quality improvement work? Like it wasn't that hard for us to implement. So that was a great unanticipated result. I think that, that we found.

STEPHANIE KIRCHNER
So I think the two that I wanted to mention are very closely related to AHRQ and how the funder of all of this work really allowed us to weave our way through a tough few years. One was that we had initially not plan to do virtual practice facilitation in this project. And we immediately shifted to 100% virtual practice facilitation. And at the beginning, I mean, Andrew, you can pipe in here too. We were like, oh what's gonna happen? And it worked, it really worked and we were able, I still think there's nothing that can replace those relationships that you build when you show up once in a while. But like, we really were able to do that to shift to a virtual model that gaud practices and kept them going. The other piece, I want to just like a shout out to AHRQ in the, in the midst of all of this was that they really, they kind of said, you know, practices are gonna need their practice facilitators for other things right now. And so letting the workforce kind of shift to helping practices deal with something that was really urgent for them in the, in the kind of height of COVID. And then it kind of got, you know, it gets them in and gets them used to working with you. And then the unhealthy alcohol use work came along. So, it, that was just an unexpected, I think, gift and thing that we experienced that made this project really successful. And I think something that we'll probably always remember was like, oh my gosh, we really went in with one plan and came out with another. I think those were the two that I wanted to share.

DARLA PARSONS
I think that one of the other things we wanted to share is that as we mentioned before is we, we collaborated, this whole multistate group of people collaborated on all, I mean, steal shamelessly is kind of a theme amongst all of us. Hey, can I get that electronically? Sure have it, you know. So I think that's really important. Something that was kind of unanticipated. But that was also because of the funder and the people that helped bring us together and kept us organized and kept us moving along. So I think that was very important too.

DAWN BISHOP
So thank you for sharing that. And so Cheryl and Tiffany, can you talk about practice facilitation, contextual factors and engagement strategies that were used.

CHERYL
Oh, so, I mean, if we talk about EHR challenges, you know, we have a whole entire paper that Doctor Bradley is developing about EHR challenges then standardization of audit scoring as the what is that? You said the word earlier? I'm losing. Yeah, say it again, validated, validated tool. I'm on Michigan time. I'm sorry, I usually do. But you know, just I

think EHR and pulling reports was just, it was a challenge because we as practice facilitators, the practices that we worked with were small. So having to pull those and learning, I learned so much about Epic that it was phenomenal. So I, I mean, strategies, you know, just engaging them and keeping them engaged in and showing them that it can work. As far as the audit, see and, and all the patients that they were helping that me was the biggest takeaway.

TIFF WEEKLEY
Yeah, you know, you mentioned EHR challenges and that's kind of what I want to jump on. A big strategy for the Oregon team was really utilizing and looping in we had an HIT expert on board with our team.

DAWN BISHOP
And we all wanna steal James.

TIFF WEEKLEY
If you don't, if you don't know James McCormack, he's great. We sing his praises all the time. So anyways, we had James and he was really on board to help, you know, troubleshoot EHR issues, pull reports, help them build custom reports, pull data, really anything that they needed. And that was just super valuable and that was whether it was like a larger, well known EHR or maybe a smaller one with less capabilities. And I mean, for this project, it was also just really impactful because some of our practices that enrolled couldn't even tell how they were performing or where they needed to improve because they couldn't see the data to see how they were doing. And so even just having James being able to go in and pull that for them or teach them how to pull it, which is more sustainable if we're teaching them how to do it so they can do it in the future. For them to be able to see that and then be able to set a goal from there was just so helpful for them and even for other folks who in other practices who maybe already had some work flows set in, he was still really instrumental in helping, you know, still troubleshoot, still customizing their reports and even just helping them build out a better workflow that's less burdensome on providers or staff. Because we know that if it just takes one less screen or one less button, that's one less barrier for us to do it, right. So yeah, I think just, just having James was just so instr ental to our team and I think we're just really all love him.

DAWN BISHOP
Yeah, thank you. Thank you both. I think as we begin to wrap up, if each grantee could share kind of what did you, what, what's the final lesson learned out of this and relate it a little bit back to practice facilitation and some of the things that we've talked about here today. So Gabby, I'm gonna start with you and we'll just move down.

GABBY VILLALOBOS
One is that a lot of us were more than practice facilitators. We did not have James. So though the data analysts, the data collectors, so we wore many hats. And with our team, we talk about how we also intended it to be in person. And thankfully, it turned into mostly

you know, virtual because how we would be able to do all the work that we did if we had to drive everywhere would have been challenging. So thankfully, we did virtual mostly, but we did do some in person. The relationship building was also very important. So there were some practices that preferred that we go in person to do their data collection and I would schedule, you know, to spend a whole day there and one solo doc practice, I would go spend the day doing data collection, just going through charts in the front by the receptionist. And I learned so much by just being there, not interacting, just watching them. And, and I'm thinking how this one doctor, she, she did everything, she didn't have a nurse, she didn't have anyone. How am I gonna ask her to do one more thing because she does it all. So it was great to be able to be there in person and actually observe to see how I can then tailor what I'm gonna ask her to do into her work flow. So that was something that was really good. The other thing was that involved everyone, all practices. We tried very hard to involve the nursing team. because most for, for our practices, most of them are the ones who are doing the screening. So by them being part of the learning sessions, knowing why we're asking them to do, you know, this one thing, which is not just one thing for them. So they already have so much to do, but that would prepare them to take that on. However, we had a lot of challenges with them being able to attend because they had less flexibility in their time. So it was one of those things where I would make, you know, maybe a second meeting where I just met with the nurses or, you know, brought them coffee from on my way in, brought them coffee or brought

SPEAKER 6
them donuts, you know, to just say, hey, thanks

GABBY VILLALOBOS
for meeting with me while we chat. So things like that just figuring out how to make it work so that we involve everyone, everyone has a say to hear everyone's perspectives.

CHERYL
And I mean, just working and thinking of what Gabby was saying I mean, ours was, mine experienced the same thing I worked with. Crosswalking workflows to me is part of the biggest part of practice facilitation. It's not one more thing that the clinician needs to do. It's just wrapping all of the incentive programs into one. So how can I help Doctor A meet all of these objectives and still meet what I would like him to do? So I revamped entire ACO routing sheet and added my little Audit C down here at the bottom. So yay and you know, now that Medicare pays for alcohol screening on an annual basis. So I mean, we're moving in steps when we started the program, I don't believe Medicare had that on their annual screening. So, I mean, doing a lot of that is, I mean, it's not only helping the patients but it's helping the revenue generation for these small practices that are struggling to not be bought out by the larger orgs. And that's what they want to do is take care of patients. So to me, that was the most important takeaway.

TIFF WEEKLEY

No, and as you mentioned, I think really that sweet spot between what do they need and what do I need and how do we, how do we really meet in the middle? So I think for us that was a lot of flexibility or maybe adaptability is the better word. I know for our project, as I mentioned, we aligned our project with the state SBIRT quality metrics. So we thought that this would be a big motivation for practices to enroll and to participate with us. And maybe unsurprisingly, it turned out that practices had a lot of different goals and motivations. And not that they end up having a lot of different motivations and goals, but also a lot of different capacities and context, especially during the peak of COVID and maybe coming out of the peak of COVID. So we really just had to pivot our approach in ways that we didn't think that we would, we had a lot of practices take pauses because, you know, they were overcapacity. We had practices that were super engaged with us and wanted to take on everything that we offer. And then because it was a flexible implementation model, we also had practices who wanted a lighter touch. And maybe just wanted to chat with us every few months or to just create a little bit of space to talk about it. Also lots of practices, a lot of all the improvement experiences and some with none. So, depending on goals, motivation, capacity context, we just really had to adapt because it was such a range and be flexible and try to offer them what we could and help them set and support meeting their goals, even if it wasn't goals that we thought that they would have going in mind. So that adaptability I think was really key for us and it sounds like it's key for everyone.

DARLA PARSONS
Well, you didn't have a choice. It was COVID. They all learned to do something very different that maybe we thought before then might not work. But it, it lends though to that sense that we need to meet them where they're at just like we had to meet COVID where it was at. We had to find a work around. You got to do the same thing in a practice. I had some offices that wanted to start with only screening patients that were there for their annual physical, that's fine. Other practices wanted to start with everybody or they were only gonna screen people of certain ages and whatever worked for them, I was not there to tell them what was going to work. I was there to learn what was going to work for their practice. And so, just having that ability to, to be a good listener to what's gonna work for them. We produced the information and said, this is how you do it and here's what you do and here's all the steps and here's all the tools, but they are the ones that have to walk, that walk, they had to adapt to their culture of their practice. And like Tiffany mentioned, you know, all of a sudden you'd call and they, all staff's gone, entire staff is gone. They all got sick with COVID or they all quit. Right. It's like you call and ask for a person or they don't work here anymore. What happened? Oh, they left. It was such constantly changing throughout this six month period that we had with each practice. So, really what I took away would be just be adaptable to whatever it is that's gonna work for them and back off when they're signaling you to do so and, and, you know, forge ahead and get them the things they need when they're begging, because sometimes they were begging can, you can, you also do this show and I mean, I'll do my best and I could try. But yeah, it does evolve sometimes into, well, I don't know how to get the data and, and we're like, oh man, you know, so now we, we, we're a team and we're doing more. We can. But that's, I think that's what, you know, the beauty of it is. I'm a practice facilitator. Hi I'm Darla, I'm here from the government and I'm here to

help you. I, you know, and, and you know, you gain their trust and what not. And so just starting small or starting huge, it didn't matter, didn't matter. They still ended up being successful. Even if they only helped a handful of patients during that time, I think it embedded it into their practice and you guys are now quality improvement people. Yeah.

CHERYL
Right.

STEPHANIE KIRCHNER
Yeah. And to just kind of build on what both Tiff and Darla have described. I think it, where it's tough, I think is how do you find the sweet spot of prescriptive intervention, like, when you're proposing work to a funder versus the reality on the ground, like, how do you move back and forth between those things when you have someone like Darla who is just like, I'm here to help, I'll do whatever you need. When really we're trying to meet the demands or the expectations of a grant. And so trying to figure out what is the sweet spot when you're running and managing a program, I think is something that was something that we really learned a lot about in this project. And, I'm not sure we can totally name it yet, but, with that iteration, we get closer. But that was kind of, I think my biggest takeaway. Right?

GABBY VILLALOBOS
Great.

DAWN BISHOP
Well, thank you. I think we've shared a lot of everything that we've kind of talked about over the last couple of months, but I think that we wanna open it up to see if you guys have any questions for us. Oh, go ahead.

SPEAKER
I'm walking up from Asheville, North Carolina. I know that each, each of you, each state had their own website that has all this information. But is there a universal website that you can go to that has the guidelines of the education?

DARLA PARSONS
NIAAA is the National Institute of Alcohol and Abuse and treatment you can start there. That's a really great website. A lot of our tools come from that.

DAWN BISHOP
Sinead is on there.

CHERYL
and Dr. Bradley.

DARLA PARSONS
So it will tell you like, you know, over this

GABBY VILLALOBOS
many drinks because like, so if someone doesn't know that

DARLA PARSONS
information there.

DAWN BISHOP
Plus we've got some other resources, all of our, all of our websites too then and ours is more like

DARLA PARSONS
a what, what do we call it? We include a tool kit.

DAWN BISHOP
So everything that we use, including the two hours of training and all of the brochures and the decision aid and all of that, those we compiled into a toolkit, but is actually more like a website. So if we really wanted it, so if you wanna do this too, go to our place and we will walk you through, step by step by step and here's the printable tools for you.

SPEAKER
OK. Thank you. Do you guys know how long the sites will stay up the website?

DARLA PARSONS
Ours is like a and what is our html? It's stay forever.

SPEAKER
Are you guys gonna be available?

GABBY VILLALOBOS
We're hoping to move it

SPEAKER 6
so, hopefully, yeah, hopefully the information will be available.

DAWN BISHOP
Any other questions?

SPEAKER
I know that you've had to adapt through COVID with pretty much every aspect of what you're doing. How did you have to change things when visits went from face to face to either over the phone or virtual? How did that change your whole projects?

DARLA PARSONS

I'll, I'll say the same way sometimes they were gonna go gung ho and try to screen everyone. Doctor felt it was important that we get this information in every chart. When visits went virtual, they scaled it back and said, you know what, let's just start with annual visits because they were gonna try to do those virtually to at least get patients keep them on the schedule and touch base with them. So they just changed. They, they narrowed it down and that's fine. We, they still got that foundation, get this to be a policy and practice in this office so that it stays and and grows as time goes by or people come and go.

CHERYL
Well, I feel like I can build on that too as far as doing implementation in a virtual setting. I mean, the number one thing, I don't know if you guys have run into it, but there are some practices out there that don't know how to use Zoom. They don't, especially at the start of COVID. So teaching them that, that took a little bit and teams like some like teams, some like Zoom and then there was Webex and then there was some other one and yeah, so to me that was like one of the big barriers I had to overcome. So it just ended up being a phone call or, you know, and then it's virtual, then they don't have cameras. So it was me looking at myself and that wasn't good. So, shut up my camera and, you know, meet with them. But I was, I was happy that when we could go back into the office, but still very apprehensive and fearful for them because I sat in a room at Doctor M's office and they all had masks on and I was like, oh gosh, I didn't bring a mask because, and she gave me one and she said, we're just protecting you. And I thought, wow, ok, thank you. You know, I'm really naive. I've been sitting in my bedroom at this old desk, you know, in lockdown. So it was a challenge. But I, I think I really built a lot of great relationships. The one clinician that I worked with that his patient was crying, I'm doing another ARHQ grant and he has a horrible EHR and he came to me and he

JESSICA REED WILLIAMS
said you have another one for me. And I said, no, it's like why? I know you

CHERYL
have another program that I can be involved in for opioids. I saw it. I said, oh gosh, I said, OK, you know, so, yeah, there I am all day long at the front desk, like Gabby was saying, but unlike Gabby, when you're sitting at his front desk, the patients are coming the window. I'm like, hello. Good morning. And I'm trying to pull my, you're new? Oh, yes, I am. I'm Cheryl.

GABBY VILLALOBOS
I had that too and actually it was fine. The receptionist left at the end of the day, her shift and the doctor's like, when someone knocks, can you please open the door? And I'm like, am I working here?

DAWN BISHOP
Thank you. I think we have another question too.

SPEAKER

I might have missed it. How did you call it? How did you do the screening actually? Was it done on paper, electronically, a variation of that, whatever?

DARLA PARSONS
All of the above. What they were able to do. We , if they could, we couldn't get, we spent quite a bit of time trying to get that audit into their EHR if we couldn't and it did not have structured fields, we recommended they do it on paper and then scan it into their EHR so a lot of them

GABBY VILLALOBOS
had to do that as well.

CHERYL
The screener also had Doctor Bradley recommended that we give them like an annual screening which had a PHQ2 and then you turned it over and it was the nine on the back. Then the Audit C and then illicit drugs and then marijuana use. Some clinicians didn't care for the PHQ2. So I rebuilt it and did a PHQ 9, 3 questions to the Audit C, and then added a tobacco, he wanted the tobacco on there. So agility is like the biggest thing is some, some want it this way and some want it that way.

SPEAKER
Any of you tried ipad?

CHERYL
They were not able, none of them were able to get to that point.

DARLA PARSONS
But that was the--whole, that it was in a kiosk available on an ipad they could take into the room. Because the one of the things too is that it's not recommended that someone ask the patient these questions, it's recommended that they take that screening themselves because there's just all kinds of reasons that our tone or our demeanor can maybe change their answer. But we were not lucky enough to have anybody that got to that point in that little six month period,

ALEXANDER MANSOUR
More practices that I use as [inaudbile] as a tool to do the screen.

GABBY VILLALOBOS
I was just gonna add that for the practices that were able to change their screening instrument in EHR or like Epic already had it. I work with them to try to make the questions accessible to patients via the patient portal ahead of time. I also promoted that because it would cut down time for from their nursing teams to actually have to ask the questions as brief as they are. So that's something with VCU, my university, I'm still working be with them to try to make that happen. And it's, it's challenging, you know, and I just.

STEPHANIE KIRCHNER
I just feel like, I mean, you know how, when you're doing these projects, you pay attention when you go to the doctor or you take your kids to the doctor, we have a long way to go with this still very much like a verbal, like, are you drinking and kind of just this, like this over thing? And I'm with my teenagers, like, don't you have any other questions? I'm sorry, I, I definitely think that, you know, and I the ipad kind of modality or something where patients can self go through and is where we should be going. But I think we still have ways to go.

MELINDA DAVIS
A little pitch on the SBIRT Oregon website. There is a interface that you can potentially program to the EHR we did not get there, but that was definitely one of the tools that's available. The other thing I'll just pitch is we brought on James McCormick in Oregon because of Colorado's use of Andrew and the prior Healthy Hearts initiative by AHRQ. So as you guys are sharing, we also do the same as like project lead. So please write in your HIT specialist in the future and buy that all these projects.

DAWN BISHOP
Yes, I think that's a good point. So as we wrap up, thank you everyone again and thank you for your questions. I think it's, it's really helpful. Also, stop by the desk up here and participate in [inaudible]

DARLA PARSONS
We'll be asking questions. Go ahead.

GABBY VILLALOBOS
Thank you everyone. Thank you.

SPEAKER
That it was great.