Implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Risky Drug Use in FQHC Primary Care Clinics in the COVID-19 Era: The QUIT-Mobile Study

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INTRODUCTION

- Implementation science is increasingly used during efficacy trials to understand healthcare contexts, and provide “diagnostic” evaluation of barriers and facilitators to implementation
- The Quit Using Drugs Intervention Trial (QUIT)-Mobile study is a NIH / NIDA-funded Hybrid Type 1 effectiveness-implementation RCT of the multi-component QUIT evidence-based SBI (screening and brief intervention), ***“Living Well Program”***
  - PCP brief advice, video doctor, 2 telehealth coaching sessions
  - Reduced moderate risk drug use (ASSIST score 4-26) by 33% (44% in the replication) among primary care patients over 3 months
- QUIT-Mobile adds mobile self-monitoring and automated tailored text-message feedback to enhance and sustain QUIT’s effects over 12 months
- During the COVID-19 telehealth expansion, the QUIT-Mobile protocol was adapted from prior QUIT trials (that used clinic waiting room screening) to become fully remote

OBJECTIVE

To determine barriers and facilitators to adopting and implementing QUIT-Mobile in FQHCs in the context of COVID-19 and inform adaptation for optimal sustainability in primary care clinics

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METHODS: IMPACT OF COVID-19 PANDEMIC (HUGE!)

- COVID-19 pandemic hit right when our study started
  - It was not safe at that time to do waiting room patient recruitment
  - We could not have study staff interact in real time with the PCP during the visit for the PCP Brief Advice and Implementation Plan
  - High absentee rates and turnover of PCPs and clinic staff for illness in themselves or their family and staff were burned out
  - FQHC priorities were focused on the massive continual changes to be responsive to the changing COVID-19 health policies
- We had to adapt all methods to telehealth: screening/recruitment, enrollment, intervention, follow-up, urine drug screening

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METHODS: DATA FOR THIS PRESENTATION

- Meeting notes from weekly, monthly and ad hoc meetings with stakeholders, Spring 2020 - present
  - Clinics: 2 multi-clinic FQHCs early adopters, plus other clinics that declined participation
  - Providers: CMOs, behavioral health leads, clinician champions, primary care providers
  - Staff: IT managers, health education managers, research coordinators
  - Payers: local county health administrators, managed care organizations, and insurers
- All Los Angeles County FQHCs approached
  - Presentations at community clinic association meetings
    - 2 CMO subgroup meetings and 2 behavioral health subgroup meetings
  - Outreach via investigator networks and prior QUIT RCT clinic partners

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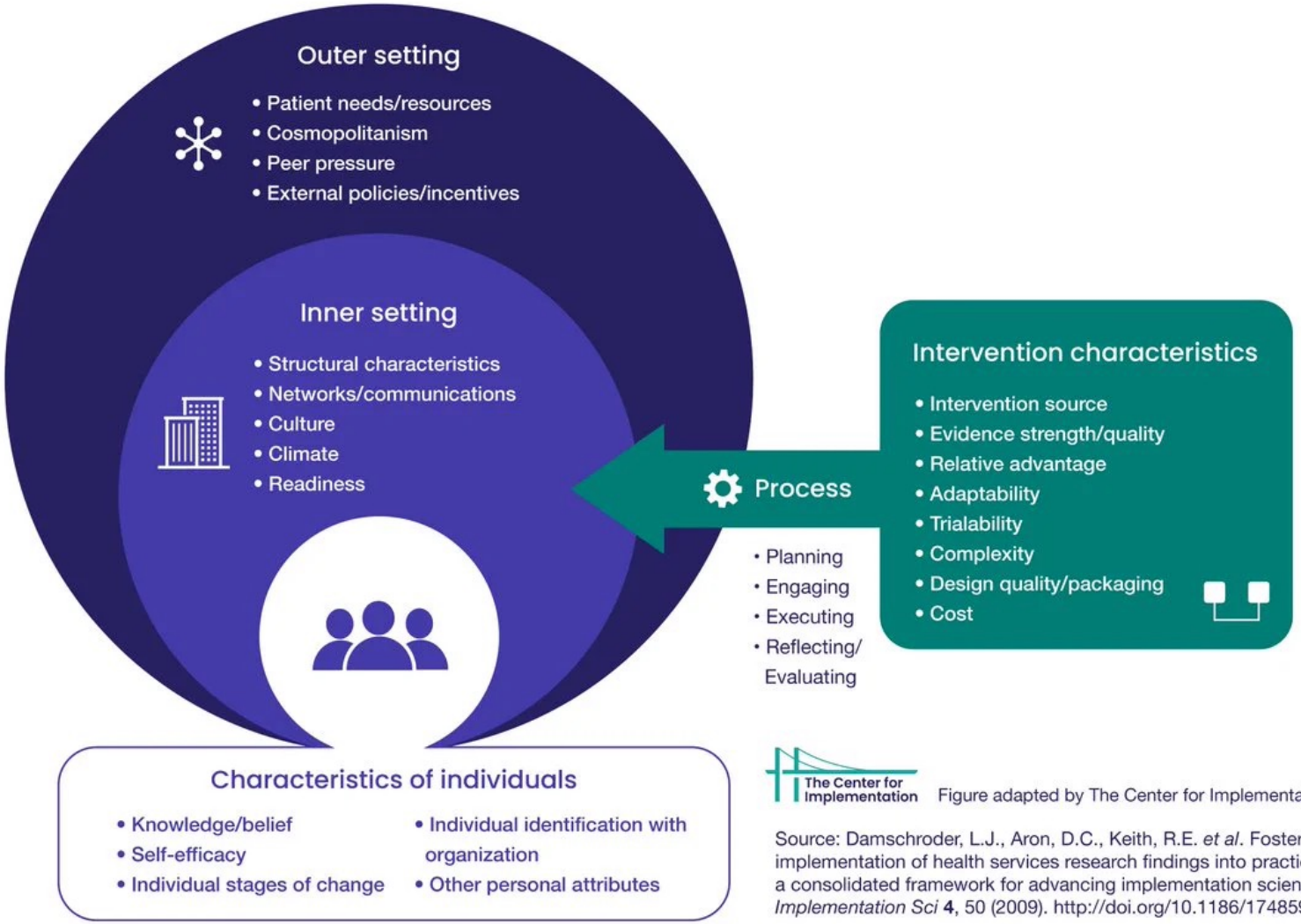
METHODS: DATA ANALYSIS AND IMPLEMENTATION FRAMEWORK

- Thematic content analysis of detailed meeting notes using Dedoose
- Guided by the Consolidated Framework for Implementation Research (CFIR)



CFIR DOMAIN 1: INTERVENTION CHARACTERISTICS

Evidence Strength & Quality: *Stakeholders' perceptions of the quality and validity of evidence supporting the belief that the intervention will have desired outcomes*

Facilitators

- ***Prior QUIT RCT studies' results*** demonstrated reductions in drug use over 3-months with LAC FQHCs with diverse low-income adult patients
- General agreement among clinician champions regarding the ***value of screening for drug use***
- ***USPSTF 2020 Recommendation*** to screen adults for drug use

Barriers

- None noted – **stakeholders did not question evidence or value of SBIRT for preventing SUD**

Relative Advantage: *Stakeholders' perception of the advantage of implementing the intervention versus an alternative solution*

Facilitators

- Clinics ***do not routinely screen*** for drug use
- ***Perceived rise in risky drug use in COVID-19***
- Ongoing concerns about opioids, plus cannabis legalization
- ***QUIT's screener (WHO ASSIST) more sensitive*** than other brief screeners
- ***Automated electronic patient self-administered*** **pre-visit screening**
- **Additional *appointment reminders*** for patients
- ***PCPs given drug use reduction brief advice script***

Barriers

- Some clinics ***already screening*** for risky drug use,
- Using ***briefer and/or paper screening tools***
- Some behavioral health teams **already getting reimbursed** for SUD reduction counseling

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Adaptability: *The degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs*

Facilitators

- Screener domains ***adaptable to clinic priorities***,
  - must include WHO ASSIST
- **In-person anonymous to pre-visit *confidential***
  - *via text-message and email links to web-app*
- ***Brief advice okay delivered by others***
  - *Clinic champion, behavioral health*
  - *Separate telehealth visits*
- **Brief advice reminder methods**
  - EHR messages, texting, email, chart notes

Barriers

- ***Fidelity of aims to replicate original QUIT***, plus 12-mo f/up
- ***PCP Brief Advice Delivery***:
  - **White coat effect** dependent on ***"trusted relationship" with PCP***
  - PCP ***continuity limited*** due to shortages/turnover
  - ***Quality of delivery*** might be more important than PCP
  - ***PCP discomfort, lack of skill, judgment, stigma***
  - **Hard to *keep advice brief*** (3-4 minutes)

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Complexity: *Perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement*

Facilitators

- ***QUIT Mobile team implements*** the more complex intervention elements

Barriers

- ***Pre-visit remote screening more complex*** **than in-person**:
  - **Getting patient contact info**
  - **Data entry** or data uploads
  - ***HIPAA compliance***
  - **Patient mistrust** re: text-messages, scam
  - **Brief advice prompts**
- ***PCP limited bandwidth,*** **burnout, turnover**
- ***High staff turnover*** (front office/back office),
  - new staff awareness, confirming legit. for patients

<u>Costs</u>: Costs of the intervention and costs associated with implementing the intervention including investment, supply, and opportunity costs

Facilitators

- **No direct intervention costs to clinic or patients**
- **Clinic site fees** ($12k)
- Participant **study incentives**
- **<u>Future opportunities</u>:**
- ***Billing for brief advice***
  - PCP visit
  - Behavioral health
- ***Value-based care***
  - potential reduction in healthcare costs
- ***FQHC capitation model*** of reimbursement
  - **Support CHWs** to do telehealth SUD prevention

Barriers

- Clinics providing patient contact info
- EHR user access fees
- PCP time to deliver brief advice
- Staff time for coordinating implementation

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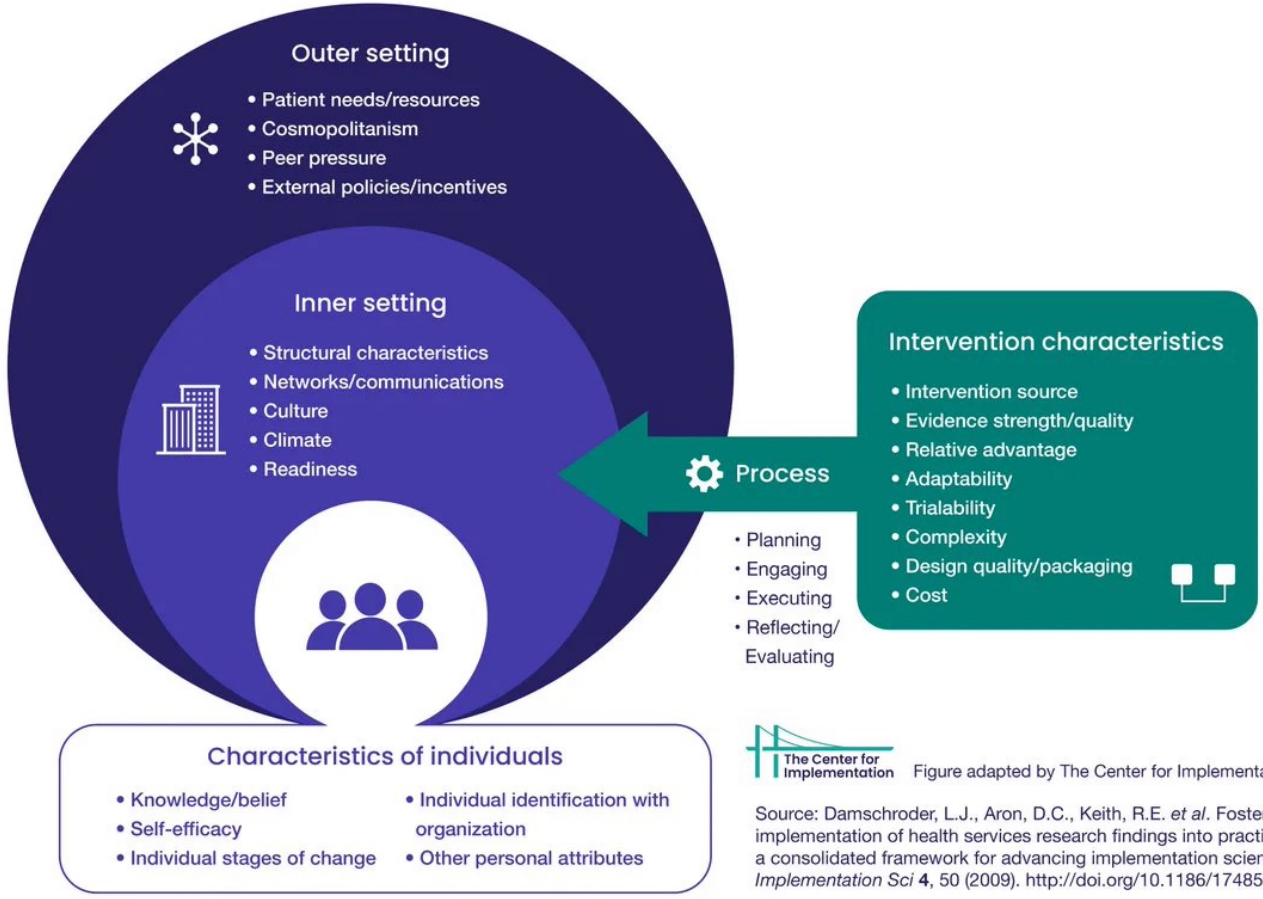
OTHER CFIR DOMAINS:
OUTER & INNER SETTINGS, CHARACTERISTICS OF INDIVIDUALS, PROCESS

- Intervention Characteristics intersect with other levels and organizational domains:
- OUTER SETTING
  - Patient needs & resources, Cosmopolitanism, Peer pressure, External Policy & Incentives
- INNER SETTING
  - Org. Characteristics, Networks & Communication, Culture, Implementation Climate, Readiness
- CHARACTERISTICS OF INDIVIDUALS
  - KABs, Self-Efficacy, Stage of Change, Identification with Org (not just patients & clients, also org. leaders, PCPs, staff)
- PROCESS
  - Planning, Engaging, Executing, Reflecting & Evaluating



CONCLUSION

- Results show the challenges inherent in shifting screening and enrollment procedures to ***telehealth***, while navigating clinic challenges resulting from COVID-19
  - ***Close and frequent contact with clinic partners*** was the most essential ingredient as was the ***flexibility of the study team*** to adapt, adapt, adapt during the waves of the pandemic
- The findings serve as a model for clinics to implement new evidence-based practices ***remotely and safely***
  - Telehealth screening and intervention might become the new normal!
- If effective, QUIT will be integrated into routine primary care behavioral health efforts following the U.S. Affordable Care Act and Mental Health Parity Act recommendations for early prevention of substance use disorders in primary care

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