SBIRT Utilization and Billing among Prenatal Providers in Hawaii

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Abstract

This report presents findings from key informant interviews that were conducted to understand Hawaii prenatal providers' use of screening, brief intervention, and referral to treatment (SBIRT) in everyday practice. Five prenatal providers who practice in Hawaii participated in the interviews. Although participants acknowledged the importance of utilizing SBIRT in prenatal care, SBIRT appeared to be underutilized. Most did not have standard SBIRT procedures incorporated within their practice. Participants' primary concerns regarding routine use of SBIRT included time constraints, lack of technology within the electronic health record, and stigma. Recommendations from prenatal providers regarding SBIRT decision-making, billing process improvements, and provider incentives to enhance reimbursement practices are discussed.

To achieve a goal of healthier families and communities described in the Hawaii Governor's State Health Innovation Plan, Hawaii MedQUEST Division (MQD) has engaged in a pilot project since November 2016 to reimburse prenatal care providers for screening, brief intervention, and referral to treatment (SBIRT). The pilot program allows Medicaid contracted prenatal providers (e.g., obstetricians, midwives) to complete designated SBIRT training and receive reimbursement, separate from prenatal care, for SBIRT interventions addressing alcohol, drug, and/or tobacco misuse. The pilot program excludes providers practicing in federally qualified health centers.

Researchers conducted key informant interviews to understand prenatal providers' utilization of SBIRT, to understand billing practices, and to also solicit suggestions for incentives that would increase providers' submission of SBIRT claims. Overall findings were intended to inform key stakeholders of opportunities for process refinements and of possible incentives to support increased SBIRT utilization in obstetrical practices.

Method

Participants

Interviews were conducted with five prenatal providers who practiced in Hawaii. Participants represented obstetrics and midwifery backgrounds and provided care in urban and rural settings across three islands as part of high-risk clinics, academic group practices, and private individual and group practices.

Interviews

A semi-structured interview guide was developed by the authors with input from MQD and members from the Hawaii Maternal and Infant Health Collaborative. Questions regarding SBIRT decision-making, delivery, and billing practices were asked, as well as prompts to solicit suggestions for billing process improvements and provider incentives to enhance reimbursement practices.

Procedure

A total of 119 potential participants were initially contacted via email and invited to participate in a brief interview. Invitations explaining the purpose of the interviews and participation information were sent through listervs of partner groups and by key stakeholders. Reminder emails were sent to MQD-specific SBIRT trainees and known contacts (n=23) identified by a stakeholder key informant. Of those who received reminder emails, 19 individuals also received a reminder phone call.

Telephone interviews were conducted by a trained doctoral student research assistant and lasted approximately 25 minutes. All interviews used the same procedures and were digitally recorded for transcription. Informed consent was verbally presented, reviewed, and agreed upon prior to beginning each interview.

The procedure and interview guide were approved by the University of Alaska Anchorage's Institutional Review Board.

Analysis

Digital audio recordings were professionally transcribed then reviewed and edited for accuracy. A list of key domains, guided by the overall evaluation questions, was established by the research team members. Interviews were then summarized by domain and compiled into a matrix that was cross-checked by a second research team member. Discrepancies were flagged and discussed among the research team. The matrix was used to identify relationships and patterns in the data summaries. Transcripts were also imported into NVivo software for data coding whereby emergent relationships and patterns were verified to test and confirm conclusions.1

Findings

The following summary of findings are grouped into four distinct categories which are described in detail below: *SBIRT Utilization, SBIRT Billing Practices, Incentives,* and *Overall Feedback*.

SBIRT Utilization

Participants recognized a need for SBIRT in their practices, regardless of practice location or patient type. Screening was noted to occur when gathering a patient's initial medical history and participants described different approaches to both identify and to manage positive cases. Very few were formally trained in SBIRT or other evidence-supported methods used to systematically identify at-risk alcohol or other substance use, and most expressed limited familiarity with SBIRT techniques (e.g., brief intervention, motivational interviewing). Those who were formally trained either had a personal interest in the issue or did so as preparation for grant-funded opportunities.

[1] Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative Data Analysis: A Methods Sourcebook (3rd Edition)*. Thousand Oaks, CA: Sage.

Time constraints, lack of follow-up resources, and stigma were primary concerns about routinely using SBIRT. One rural provider described being apprehensive to identify at-risk patients because of colleagues who preferred to "get them out of here and go somewhere else."

SBIRT Decision-Making. To understand when participants used SBIRT in prenatal care, several questions regarding decision-making were asked. Participants described screening for all substance use, including alcohol and tobacco, as part of general prenatal visits, prenatal consultations, women's health visits, and family planning visits. The frequency of SBIRT use was estimated to range from "every visit" to only initial visits or to "those I'm concerned about", and depended on practice environments. One provider who used a structured approach described:

> I'll definitely talk about it with them on their first visit, and then if they screen positive, we address it almost every visit... Towards the end of the pregnancy they're coming in every week, so I might not discuss it every week, you know, if they just talked about it the previous week. But certainly in the beginning, we'll talk about it at every visit.

Others screened infrequently; reasons included lack of "concrete" protocols or basing decisions on perceived patient needs. One participant explained, "if there is no disclosure to drug or substance abuse [during the initial visit], then we just look for signs that we might see as we continue prenatal care." Additionally, some providers, particularly those in more rural settings, believed that they knew patients' substance use behaviors and therefore did not see the need to screen at every visit. One participant shared, "...sometimes I know by word of mouth that someone has a drug problem. So [the patient] might not tell me right away, but I'll already know."

Electronic medical records (EMR) played a role in SBIRT decision-making and subsequent utilization. One participant described:

> I wouldn't say it's a policy, but I would say that it's a standard practice, and it probably has to do partially with our EMR...There are spaces where that information needs to be inputted into the prenatal record, and so we try to fill it out as completely as possible at the patient's first visit.

Other participants worked in clinics where SBIRT utilization was up to the individual provider including one participant who stated SBIRT was likely "ignored" because it "has not been built into the EMR and it's not a requirement."

Very few participants reported using a validated screening instrument. Most relied on open-ended questions or "an open-ended history" approach with new patients or throughout care. Of those who did use an instrument, the T-ACE and 4Ps Plus were provided as specific screening tools. Lack of physician training, time restrictions, and limited EMR capabilities were barriers to routine screening.

All participants stated that financial compensation had little to no influence on whether or not to use SBIRT in prenatal care. For those who routinely screened, reimbursement had no impact. One participant shared, "Billing is not a motivation for me to do it, and it's also not a hindrance either." Another acknowledged reimbursement provided "something for the effort" but described that reimbursement was not a strong factor for doing it since "you get so little for it."

Delivery. Most participants indicated that they and their clinical settings did not have standard SBIRT procedures. All preferred to screen and deliver brief interventions themselves in order to follow indicated patients; as explained by one participant, "...so that we can talk about the effects on their pregnancy and discuss whether they're interested in either quitting or getting a referral for treatment." Many conveyed a need for assistance to coordinate referrals while some preferred to contact specialists personally when a referral was indicated.

Participants differed in their descriptions of addressing positive cases. For example, one participant who screened at every visit shared, "...patients who are using substances will get short counseling during their visit, depending on whether or not they're interested in that at the time." Others only described a positive response to substance use inquiry was documented as part of the initial visit, with no description of any type of procedure to address the issue at that visit or monitor in the future. Additionally, some participants addressed only positive tobacco use and not alcohol or other substances. When it was described, follow-up and monitoring ranged from occurring at nearly every visit to sporadically throughout care; however, a majority patients who screened positive for substances other than tobacco were described as being referred to an outside provider or specialist. No participants mentioned working in an integrated care setting or having any type of in-house referral sources.

Impact. Some participants perceived that SBIRT was "fairly effective" for addressing risky alcohol use among their patients while others expressed some degree of uncertainty towards the effectiveness of SBIRT. Outside of improving challenges of time constraints or lack of support to coordinate care, participants were unable to identify ways to improve SBIRT effectiveness. One participant explained, "That's probably our fault that we're not really doing it and it's simply because of the level of training and also the lack of support in order to make it happen."

When asked about potential impacts SBIRT has had on their prenatal practice, some participants stated that SBIRT has had "a positive impact", including one participant who reflected, "I think if anything, it's just a big awareness." Others indicated SBIRT had little impact beyond increased personal awareness of community resources for substance use. One participant explained,

"...otherwise, even before SBIRT was being discussed, we did talk about those things with prenatal patients so I don't feel like it's increased my screenings necessarily." However, standard SBIRT procedures made participants more comfortable in their provider role and reduced stigma; one provider shared that universal screening ensures patients "don't feel like they're being picked on." Standardizing SBIRT also seemed to impact provider assumptions; participants shared that positive cases were not necessarily among the patients that providers would have anticipated to screen positive.

Finally, participants described promotion of awareness of various community resources as a positive impact of SBIRT. Similarly, the referral aspects of SBIRT promotes necessary partnerships to effectively address substance use during pregnancy.

SBIRT Billing Practices

Very few participants worked in practices where SBIRT claims were being submitted. Those that were billing described the reimbursement process as "straightforward" and "pretty simple to do." One participant was billing under "counseling" but did not know what happened beyond entering the billing code. Some were unaware that SBIRT is a reimbursable service.

A substantial obstacle to SBIRT billing was the absence of SBIRT within the "global prenatal outpatient care package," highlighting the connection between packaged maternity care coding to a clinic's electronic medical record software, and to the physician's office billing system which may or may not be set up to code outside of the obstetric package. One participant explained their practice's lack of SBIRT billing and described,

> I don't think we know how to do it. I don't think there is a way to do it...so many things are directed by the electronic medical record, and if it's not easily accessible or built into the system...we tend to overlook it and move onto things that need to be addressed that are in the system or that is the main reason for the patient's referral.

Time was another explicit barrier to billing. One participant explained that interventions can sometimes take too long (e.g., between 40-50 minutes), which would be denied for reimbursement as SBIRT.

Incentives

Providers were asked for their suggestions for incentives to potentially increase SBIRT utilization and billing within their medical specialty. Financial support to add and modify EMR processes specific for SBIRT was suggested, including the development of an embedded SBIRT checklist. "Some type of bonus" was encouraged. Participants described that continued advertising

about SBIRT reimbursement is needed; this advertising was encouraged to be "intense education", structured as brief conversations with providers during a lunch hour, combined with offering food, and with the idea to "explain the whole SBIRT item and emphasize to doctors how they would go ahead and get reimbursement for it."

For some, incentives did not play a role in personal motivation to use SBIRT and they were therefore uncertain whether incentives would actually help to promote SBIRT utilization.

Overall Feedback

Participants gave a range of suggestions to improve SBIRT utilization in prenatal practice. First, they recommended that reimbursement guidelines allow a wider range of health care providers (e.g., social workers, mental health professionals) to receive compensation for SBIRT services in order to facilitate adoption. Second, participants indicated that it is important to streamline systematic processes for SBIRT administration and billing. Specifically, a participant suggested that depression screening could provide an appropriate model (i.e., medical assistant administers screening, physician looks at the result and determines follow-up and referral if necessary).

The third recommendation was to strategically advertise SBIRT to prenatal providers. One participant suggested identifying the right person in each setting who is "most likely going to do it" and communicating information about SBIRT and the incentive:

> If it's the doctor, you would talk to the doctor. If it's the nurses or the HRN or if it's a physician's assistant or if it's the nurse or whatever, we would be talking to them, plus as far as the doctor. And then just keying in on the right people to go ahead. And as far as doing it...then saying well, for your efforts you're going to go ahead and get a monetary incentive.

Fourth, participants suggested SBIRT training focused on communication skills, including how to appropriately ask and answer questions, is essential. In particular, participants recommended continuing education as necessary to increase knowledge about caring for pregnant women who use substances; required education was also proposed. Finally, the fifth recommendation was to foster relationships with referral sources as necessary for SBIRT to be completed consistently. One provider shared, "…the worst thing is to screen and then have somebody who is interested in treatment and not having a place to refer them to."

Conclusions

Providers in Hawaii who participated in this evaluation recognized the important role of SBIRT in prenatal care; however, SBIRT appeared to be underutilized by the participants and in their practices. Financial compensation was not a strong motivator to do SBIRT and participants who were routinely using it described personal motivation to do so based on the clinical implications associated with prenatal alcohol exposure. Thus, continued SBIRT training tailored to prenatal care settings including education about the type of patients who are likely to benefit from SBIRT, as well as the nature of brief counseling and interventions, were viewed as important to support provider adoption.

Integrated care settings were likely to facilitate routine SBIRT utilization. Ancillary staff and technical support at the workflow level could help to address prenatal providers' barriers associated with time limitations and lack of training, as well as to optimize SBIRT capabilities within the EMR.

Participants identified systems- and policy-level barriers to SBIRT billing. The interplay of established EMR software and maternity billing packages restricted several participants' ability to do SBIRT and to bill for it. Some discussed how SBIRT billing is a separate and distinct code outside of the global obstetrics reimbursement schedule and, as such, added confusion about whether or not they could do SBIRT, including uncertainty whether office staff would be able to bill for it. On the other hand, participants who were actively billing for SBIRT described fairly simple procedures. These perspectives underscore the potential for strategic outreach by clinician champions to key stakeholders including providers, coders, and health system administrators, to promote SBIRT uptake and billing in prenatal care settings. Finally, policies allowing a broader range of healthcare providers (e.g., nurse-midwives, social workers, health educators) to receive reimbursement for SBIRT may also enhance utilization in obstetrical care.