

| San Diego Integration Summit (September 2011) | | | | |
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| Personal Action Plan Summary: SUBSTANCE ABUSE | | | | |
| Action Item | | Benefits | Barriers | Resources Needed |
| 1 | SBIRT implementation at Patient Care clinics | Access to services | Funding & Structure | Recalibrate how we define a physical healthcare visit |
| 2 | Use of GPRA | Identify early | Time per provider | MHSA Involvement |
| 3 | Train PCPs with screening tools | | | |
| 4 | Have everyone using county services get drug tested | Early identification | Won't be able to help large numbers | Money/Funding |
| 5 | Over 50% have substance abuse & BCH Health Issues | All JRS's certified | Costs; Over 80% of funding is for Adults | Funding |
| 6 | Full Integration in MH-Universal SBIRT screenings | On-going conversation & physical health | Unknown variables that cannot be solved due to lack of available resources | MOAs for program access; reverse trend coming from black coats?? |
| 7 | Integrate screening for all patients in clinics | Early prevention | Training Personnel | Trainers |
| 8 | Universal training | Partnership shared information | Lack of resources | White coat & Black robe working together |

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| 9 | Combine with Mental Health more | More people recover | Money; Knowledge; Red tape; Communication | More funding; More Collaborative Partnering; More publicity |
| 10 | Collaborate with the schools in more open discussions | Prevention | Denial | |
| 11 | Link to Peer Counseling & PCP- Always ask about alcohol/drug usage | | Confidentiality | More education; More providers |
| 12 | Communication | More people can be helped | Too many duplicated services not enough dialogue between agencies | Increased communication; More efficient/clear communication between agencies |
| 13 | Encourage patients to speak with their MDs | Integration | Time; Funding; Insufficient staffing | Time; Funding; Staff |
| 14 | Increased prevention and education for teenagers | Increased prevention | Denial; Lack of motivation for change | Trained professionals/Programs |
| 15 | Find out who is familiar with SBIRT already | Solid research which asks SBIRT type questions makes a difference at a minimal cost | Lack of familiarity with SBIRT and lack of efficacy | Need to publicize the top three SBIRT questions |
| 16 | Integrate Mental Health with ADS | Seamless care for patients | Funding stream conflicts | Already have it |

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| 17 | Increased collaboration between SA providers and MH providers | Less stigma; More collaboration between agencies | |
| 18 | Explore opportunity to include SBIRT in mental health literary classes | Inter-related: Using opportunity for prevention | Using MA's or someone trained in all classes Funding |
| 19 | Identify treatment options; Understand 42 CFR; Identify SBIRT \$ | | Funding; Training on SBIRT; Awareness of resources Training; Education |
| 20 | Access to updated SA resources and Addition of SA Social Workers | Quick referrals; Opportunities for follow-up | Cuts to budgets; Outdated referral lists Money |
| 21 | Develop referral network | | Space; Local referrals not available |
| 22 | BHS clinician paired with ADD clinician to complete assessments | More thoroughness; Comprehensive initial assessments | Lack of collaboration between systems Need shift in structure of programs |
| 23 | Increased in screening | Prevention and early detection | Referral sources and space Networking; Referral partnerships |
| 24 | Get PCP's to integrate SBIRT | Screen early; prevent pain and sickness | Physicians may not do it Providers needing to integrate changes |

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| 25 | Early screening/Education for Medical Assistants | Prevention | Not enough training | Printed materials for training use |
| 26 | Have Specialists using SBIRT train people in primary care & do supervision oversight | More SBIRT use around the county and more people being helped | Need more SBIRT trained specialists | Money for training in Administration, Clinic Management, Program Applications within clinics |
| 27 | Use SA treatment for children and teens that are prove to work | Education for families about SA | Children/Teens resist and uninterested in recovery | Programming |
| 28 | Try to develop MOU's with primary care | Collaboration resources | Resistance | Staff time |
| 29 | Encourage reporting of MOA/U's between SA and PC at collaborating health meetings | Increased familiarity in SA resources by PCP's | PCP reluctance and lack of knowledge with SA recovery | More residential and OP SA care |
| 30 | Introduce our services to healthcare professionals | Relationships with unknown positive benefits in future | Time consuming | Knowledge of who healthcare providers are and what services they offer |
| 31 | Review screening and brief intervention tools being used for admission | Standardizing | EMR already has questions on assessments and hard to add | What tools are being used for screening? |
| 32 | Regular cross training with ADS programs; Staff training on COD | Screen early for early treatment and prevention | Developing and maintaining collaborative agency relations | Funding for trainings |

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| 33 | Continue to Use MHSDAS | Screen all clients for ADS | Training new staff | Forms |
| 34 | Use SBIRT all the time | Early intervention or prevention | No Time | Find time |
| 35 | Reach out to more adolescent girls | Can focus on becoming a better parent | Girls are less likely to step up due to lack of trust | |
| 36 | Screening need to ID a way to screen for problems with pain meds | Reduce drug seeking; increase personal honesty | Tool not developed other than those for drug/alcohol related problems | Research support |
| 37 | Bring a substance abuse counselor | Understand their role in recovery | | Connect with a program who already has a peer program in place |
| 38 | Create pairing with AOD programs like PC within region | | Fear of becoming overwhelmed with referrals | |
| 39 | Universal screening tool | Covers all entities | Money | Develop the screening tools |
| 40 | Ensure clients are aware of site for services | Clients have access to continued support | Lack of client follow through on referrals | Facilities near clients home |

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| 41 | Continue with SBIRT services | Acknowledgement of risks | Grant based programs, needs to be on going | |
| 42 | Work to increase the identification of females who need services | Increase in HOD/MH services | Females not being referred for treatments or MH services | Access to juvenile females |
| 43 | More training for PCP's asking early; More BHC's | Early detection; immediate intervention/referral | Financing | Funding and training |
| 44 | Visit health clinics and provide information on how to refer | More people in need getting access to services | Doctors may be too busy | Time |
| 45 | SBIRT | Identify and Intervene early on | Lack of health insurance and funding | Training |
| 46 | Evaluate regularly for abuse and written exams | Early identification | Reluctance by participants in screenings | |
| 47 | Train staff to do screenings and on the resources needed | Health educators | Money | Staffing |
| 48 | MOU's with SA providers | Facilitated access | | |

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| 49 | Networking | | Lack of program awareness | Networking |
| 50 | Educate Staff | Appropriate interventions | Funding | Funding |
| 51 | Think of a way to include screening by peer support | Additional help with screening support | Need to increase training PSS to help | Training; Time; Trainers |
| 52 | Increase close collaboration with ADS providers and regular communication | Continuity of care | Time and resource constraints | Agency commitment to meetings |
| 53 | Obtain MHSDAS | Better screening | ACCESS | Research |
| 54 | MHSDAS screening implementation assess stage of change | Standardized assessments | More paperwork tracking | Tools and trainings |
| 55 | Use of standardized integration tools | Ability to target various issues; Multi-disciplinary | Staff at different levels may not be able to identify issues | Training; stardized, encompassing tools |
| 56 | Coordinate with PCP the identification of patients with SA counselor onsite | Identification and easy access to services; Empowerment for families/parents of SA | | Funding and space |

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| 57 | Implementation of SA screenings | Early identification | Lack of Care Managers and information systems | Resources lists; Training; and Educational materials |
| 58 | Collaborate with chemical dependence providers covered under medi-cal | Increased sobriety among people and less visits to the ER | Budget and lack of services | United committees; BHS/SA offices |
| 59 | Connect medical providers with peer SA services | Better patient outcomes | Openness by providers to connect with peer navigators | |
| 60 | Integrate: Work together not separately | Less judgment; Higher success | Lack of unity; people split | Awareness of program; People working together and integrating |
| 61 | Integrating D&A into Care Plan | Guide clients into care | Denial; Stigma | Facilities willing to take in clients with low income households or clients without income |
| 62 | Promote CCISC Network with AOD service providers | Integration with continued support | Lack of consumer interest | Information on resources |
| 63 | Explore screening tools | | | |
| 64 | Look into how we are screening SA at the clinics | Raised awareness | Time | |

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| 65 | Expand SBIRT in the ER | Improved attendance and outcomes | HIPPA issues | Legal/Risk Management |
| 66 | Create MOU/MOA with treatment facilities | Access to treatment for patients | Costs; Reimbursement | Assist with funding; Educate providers on available caregivers |
| 67 | Fold into primary care | | Practice patterns | |
| 68 | Look into implementing SBIRT using our own MA's; work with better health plans on this | | Time | SBIRT Screening/questions; Resource Lists |
| 69 | Increased screening in primary care | Prevention and early intervention | Referral sources and space | Networking and referral partnerships |
| 70 | Model after AA | | | |
| 71 | Education on Community Communication | Safety net; Closed cracks | Shame/guilt | |
| 72 | Contact local recovery centers ask for them to come | Staff knowledge | | Time |

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| 73 | | Treat the whole person | Training of staff and CEO | On-going training with Mental Health, AOD, Primary Care |
| 74 | Early screening; Increased referrals; Know wait times | | | |
| 75 | Integrate SBIRT | Identify patients who need treatment earlier | Inadequate resources | Screen for abuse |
| 76 | Screenings to each individual | Develop an action plan | Lack of information | |
| 77 | Development of a referral network in each community or MOU | Program coordination between PCP, AOD, and BH | No Room | AOD assessor come in and treat; Hire pediatrician |
| 78 | Instruct for SA of BH/Medical | Improved BH/Medical integration | Patient denial | |