PS3-5:

Extending HMORN Partnerships: The New Midwest Research Network

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Background/Aims: The HMO Research Network's (HMORN) key values center on collaboration and teamwork to improve individual and population health. The HMORN has a renewed interest in forming external partnerships beyond current HMORN members. Minnesota has historically been on the forefront of health reform and innovation. Providers, payers, higher education, and government agencies in Minnesota have worked collectively in the areas of quality improvement and measurement, payment reform, and public health. Building on and extending the success of the HMORN model of research, HealthPartners Institute for Education and Research (the Institute) initiated a regional model of collaborative research in Minnesota. **Methods:** The Institute hosted discussions with other regional health care organizations in 2010. By the end of 2011, a core group formally launched the new Midwest Research Network (MWRN). Members of the original steering committee represent several research and provider organizations (including the Institute and Essentia Institute for Rural Health); the University of Minnesota CTSI; Minnesota's Medicare Quality Improvement Organization; and the Institute for Clinical Systems Improvement. The committee drafted a mission statement focused on collaborating "in the development, implementation, and application of research that improves the health outcomes, experience, and affordability of health care for all of the people in our region." General principles of the network were formalized, and rules for engaging in grants and projects were established. **Results:** During the first six months in existence, MWRN members jointly submitted three partnership grants focused on primary care decision support tools; patient engagement in quality and cost measures; and testing data sharing protocols. Smaller interest groups have formed around topics in Informatics, Patient Engagement, and Mental Health. The MWRN Mental Health group hopes to define projects that may extend the reach of the national Mental Health Research Network. The new Minnesota Health Information Exchange is also engaged in the MWRN and will be partnering to test using the Exchange to disseminate research findings in the region. **Conclusions:** The HMORN model of collaborative research can be successfully implemented at a regional level, which may be a valuable source of new external partnerships for the HMORN.

Keywords: Collaboration; New Partners; New Networks

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Mental Health / Chemical Dependency

C4-1:

As the Clock Ticks… Are Questions the Answer? Audio-Recordings of Primary Care Visits Among Patients with Mental Health Needs Show Room for Improvement in Physician Communication

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Background/Aims: Encouraging patients to ask questions in clinical visits is seen as a key to engaging patients. Multiple interventions have focused on activating patients to ask questions when visiting physicians. We know little about whether patients with mental illness ask questions in primary care visits, how their question-asking behavior is associated with physicians' relational communication and the length of visit. **Methods:** We conducted in-depth mixed method analyses of 322 audio-recordings of periodic health exams (PHE) made by patients 50-80 years of age. Patients included those with mental health (MH) needs, based on 2-item Personal Health Questionnaire (PHQ2) scores (2 or greater), on having filled or been prescribed a psychotropic medication, on having a MH diagnosis or visited a MH provider in prior 12 months, or on having a MH discussion in the visit. Using transcribed recordings, each conversation was categorized into "topics," which were grouped into three categories: biomedical, MH, or other. Multivariate models were estimated using generalized estimating equations. **Results:** About 99% of patients (319 of 322) asked at least one question. Patients asked questions throughout the visit, averaging 18 per visit. Half of them asked their first question within the first 1.4 minutes. Patients were more likely to ask a question if a topic discussed a medication (OR = 1.57, P <.01) and less likely if the topic was about MH issues compared to biomedical issues (OR = .51, P <.01). PHQ2 score was not a significant factor. The number of patient questions was negatively correlated with ratings of their physicians' relational communication. Each additional question was associated with a 12-second increase in visit length (P <.01). **Conclusions:** Patients ask many questions, and they ask them early and often. The number of patient questions was associated with unfavorable views of physician relational communication and with slightly longer visits. Patient engagement efforts need to move beyond simply encouraging them to ask questions.

Keywords: Patient Engagement; Mental Health; Patient-Physician Communication

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C4-3:

Implementation of a Screening Brief Intervention and Referral to Treatment (SBIRT) Protocol in Primary Care

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Background/Aims: Substance abuse in the United States is a serious public health concern; however, routine screening is inconsistent in primary care. In partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), Kaiser Permanente Colorado (KPCO) implemented the Screening Brief Intervention and Referral to Treatment (SBIRT) protocol in one primary care clinic over a 3-month period in order to determine staff perceptions, barriers, and solutions for wide-scale implementation. **Methods:** Based on prior feasibility studies, clinic staff were engaged in order to anticipate barriers and solutions to improve implementation success. A quantitative survey of team functioning and clinic priority for implementing SBIRT was also conducted prior to implementation. Screening was conducted by front desk staff of all adult Health Maintenance Visits (ages 19-64 years) using a 3-question paper questionnaire, followed by Brief Intervention delivered by the behavioral medicine specialist (BMS) in the case of positive screening result. This workflow was determined by the clinic despite prior feasibility results indicating optimal workflow consisting of screening by Medical Assistants and Nurses during the rooming process due to multiple competing demands from the organization during the implementation period. **Results:** A total of 1097 eligible patients were seen during the 3-month implementation, 321 (29%) were screened for alcohol use, and 15 (5%) required additional Brief Intervention with the BMS. Positive results of implementation included improved awareness by physicians of alcohol use, better communication among members of the care team, and integration of the BMS as a resource for the care team. Barriers included patient resistance, competing demands on the clinic, and lack of information on screening recorded in the medical record. Post-study debriefing with primary care and BMS staff led to a commitment by clinic leadership and staff to revise workflow and explore regional implementation strategies. Solutions include additional training regarding clinical utility of screening and options for normalizing screening for patients and solutions for recording screening in the EMR. **Conclusions:** Through continued use of SBIRT, this clinic will also demonstrate the value of screening for drug and alcohol use to the region in order to promote wider dissemination.

Keywords: SBIRT; Screening and Brief Intervention in Primary Care; Alcohol and Drug Prevention

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