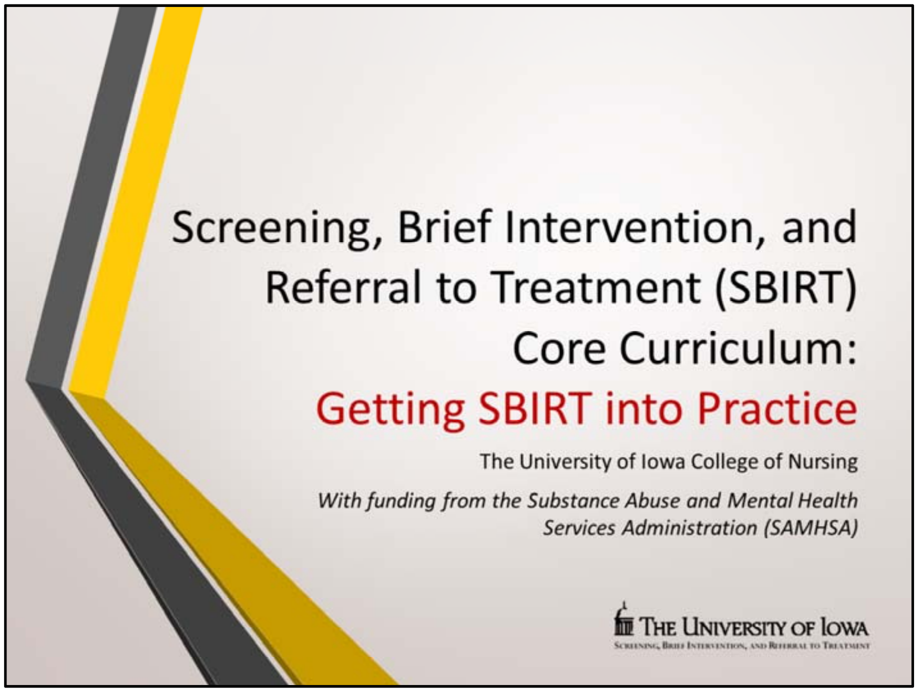
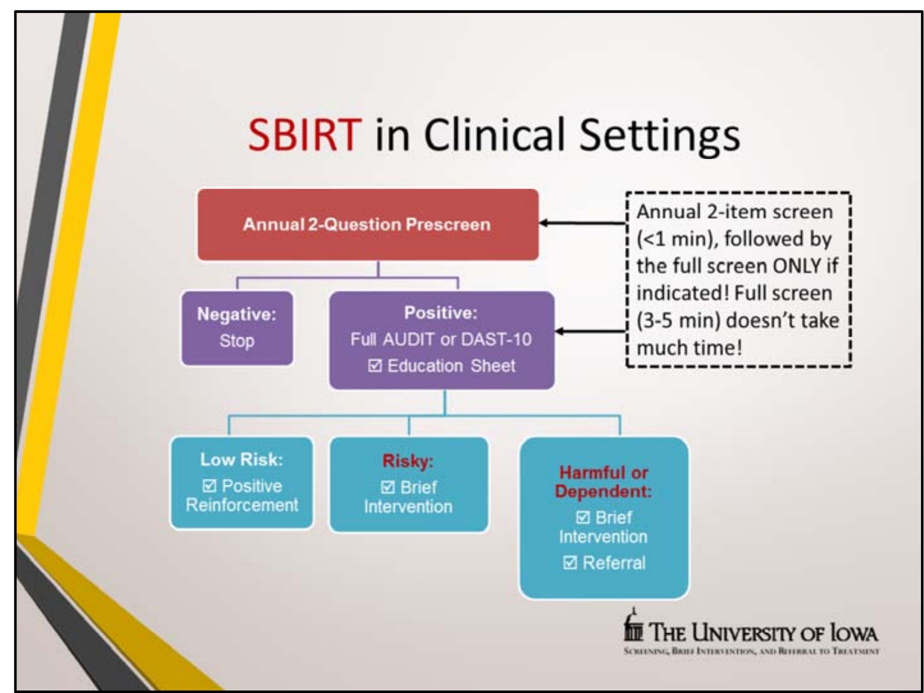
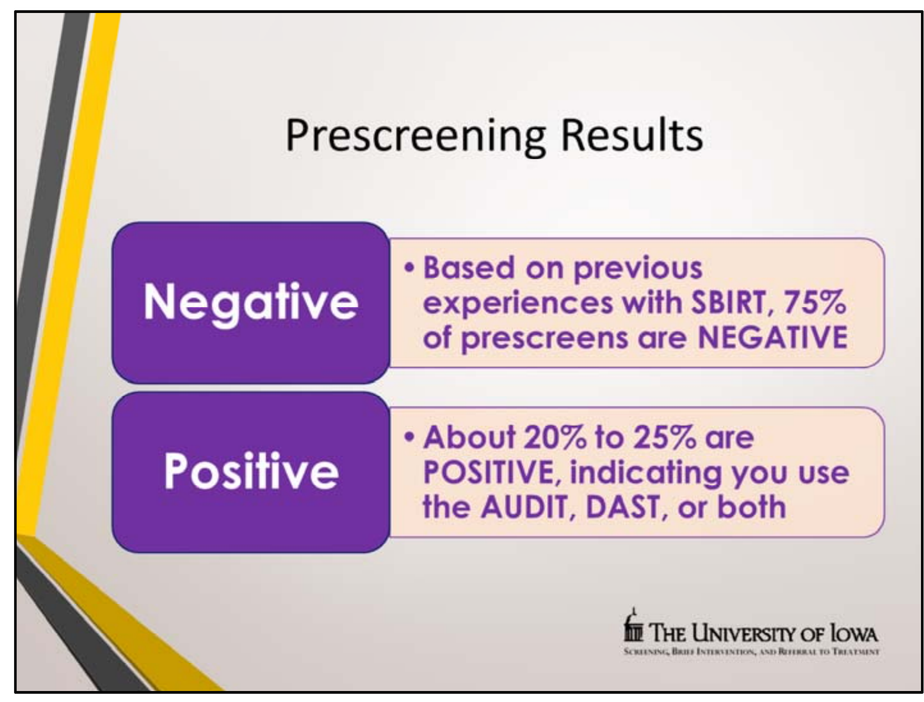


Welcome to our program about approaches that help to integrate SBIRT practices into clinical settings.

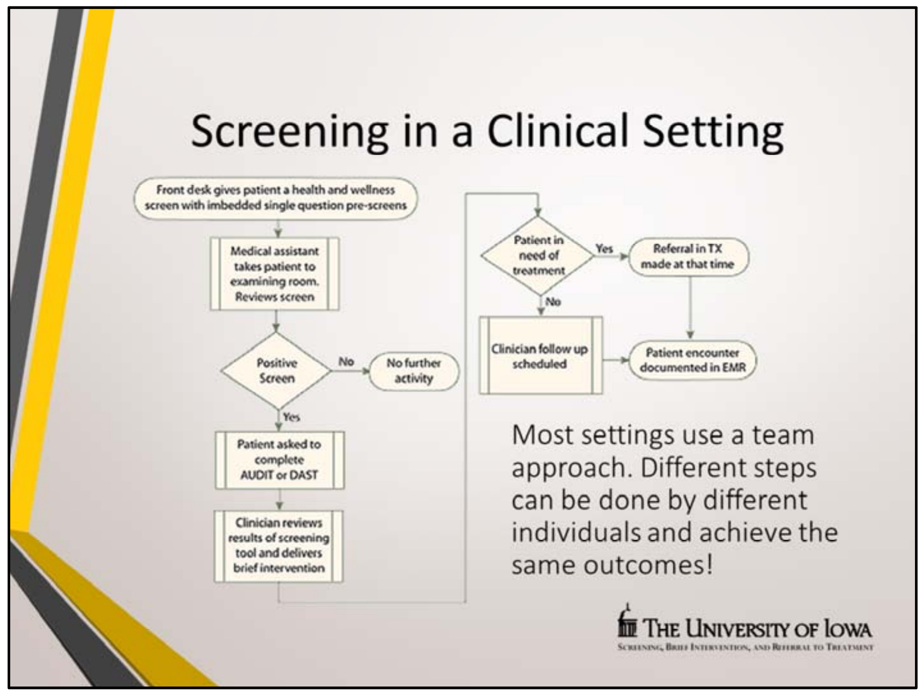


Let's start by quickly reviewing the process that's involved in using SBIRT in clinical practice.

This is to help remind you that the process of screening doesn't take much time, and that both the AUDIT and DAST can be self-scored.



On average in primary care settings, 20 to 25 percent of individuals screen positive, and the rest are negative. So again, about a fourth of people seen in primary care will need the AUDIT or DAST.



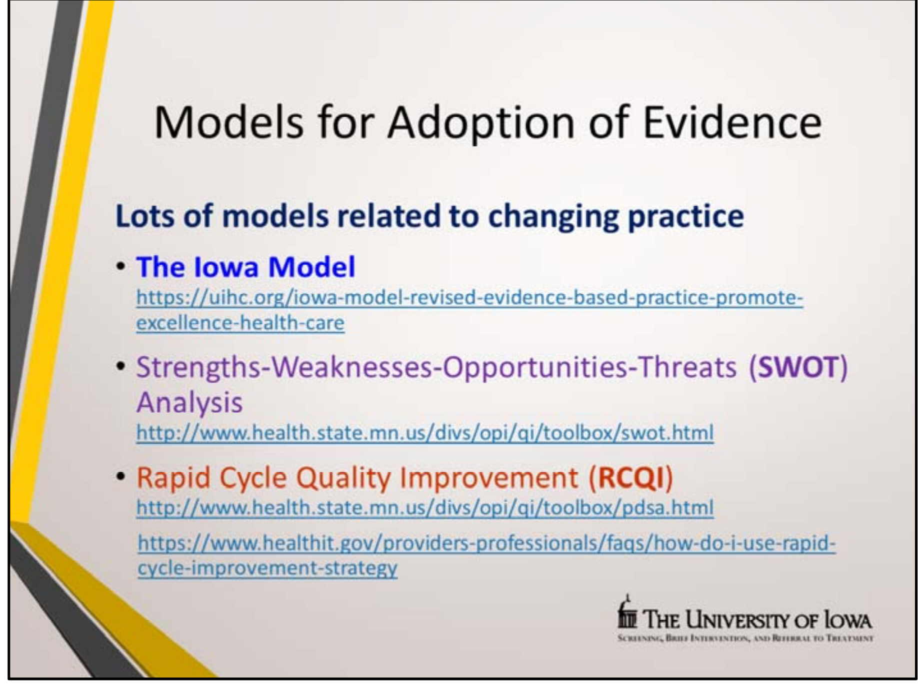
The process can be applied in many different ways. Most settings use a team approach, but there are additional options, which we'll talk about today.

We've known for a long time that getting evidence-based practices into daily care – in any setting – is often difficult. There's a long list of reasons as to why busy clinicians may "push back" on adding something new to their already hectic schedule!

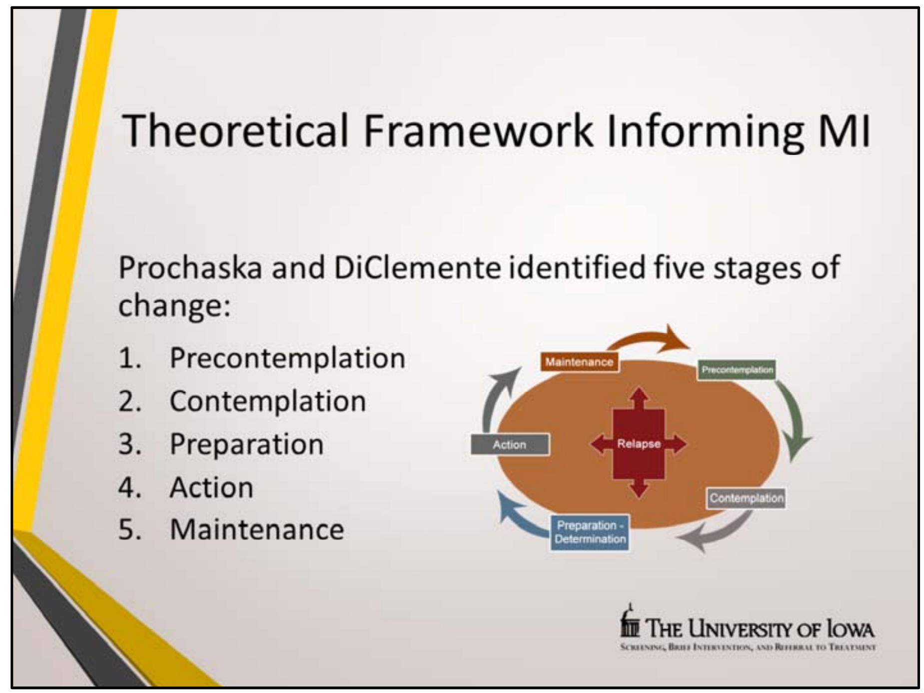
However, as noted previously, SBIRT doesn't need to take a lot of time. It actuality, many sites are already screening, but not in a standardized manner. This ends up being more time-consuming – trying to determine the next step – and the results are often more difficult to analyze than when using a screening tool with specific response options.

Some individuals may think there's too much to learn or there's no time to learn, but keep in mind that you don't need to learn everything at once! Introduce SBIRT in increments, and take advantage of the free online training modules – no more than 20 minutes each – that can be viewed as your schedule allows.

We'll address some of the other concerns later in this module.



It’s beyond the scope of this training module to go over some of the common models for implementing changes in practice, including the adoption of evidence-based practices. However, you may want to review one or more of the websites shown here to learn about change models that may help guide the use of SBIRT.



In fact, the very same theoretical model that we discussed when using motivational interviewing with patients can be applied to system-wide changes, such as the adoption of SBIRT.

Like people, the organization you are working in may be in various states of "readiness" to change: Precontemplation, Contemplation, Preparation, Action, and Maintenance.

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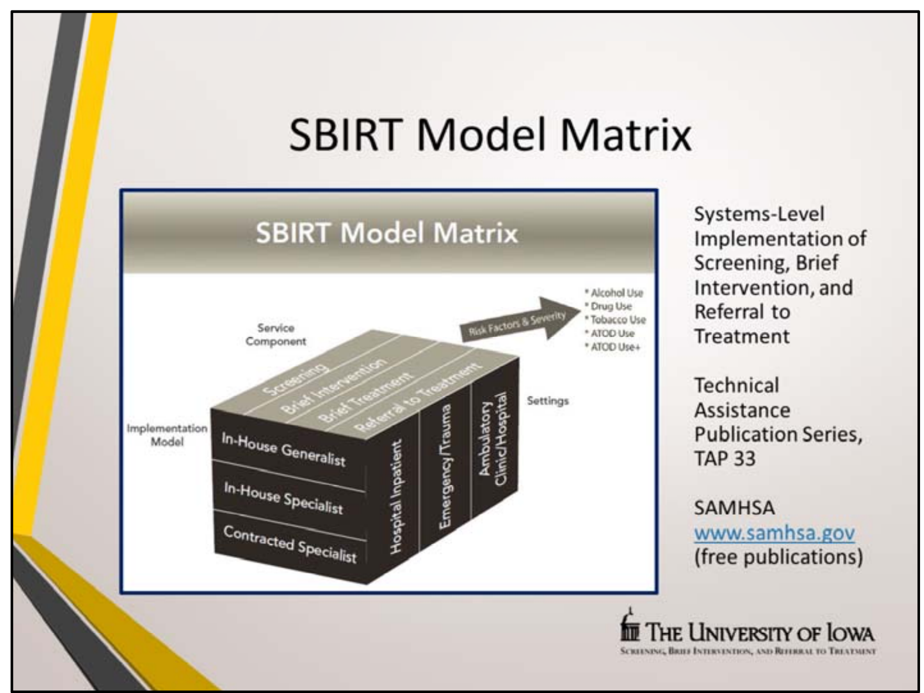
Reference: Prochaska and DiClemente (1984).



The SBIRT model matrix shown on this slide is from TAP 33, which discusses strategies related to implementing SBIRT in practice settings. We highly recommend getting a copy if you're leading a team to adopt SBIRT in your practice.

Much of what we'll review in this module is based on this report, which incorporated the experiences of SBIRT Service grantees when they've implemented SBIRT in a variety of clinical sites. These sites included emergency departments, primary care clinics, and community-based service settings.

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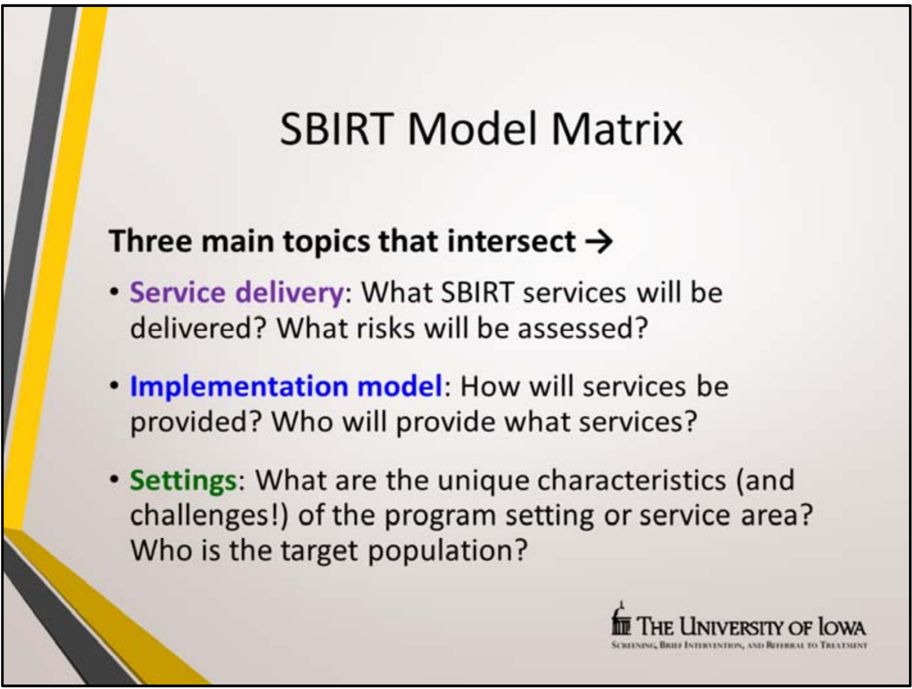
Page 21: ATOD stands for alcohol, tobacco and drugs and ATOD+ means other behavioral risk factors are also involved, like inactivity, poor diet.



The matrix pictured on the previous slide gets at the "who," "what," and "where" questions that need to be addressed to implement SBIRT in practice.

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Page 21

Planning Process & Collaborations

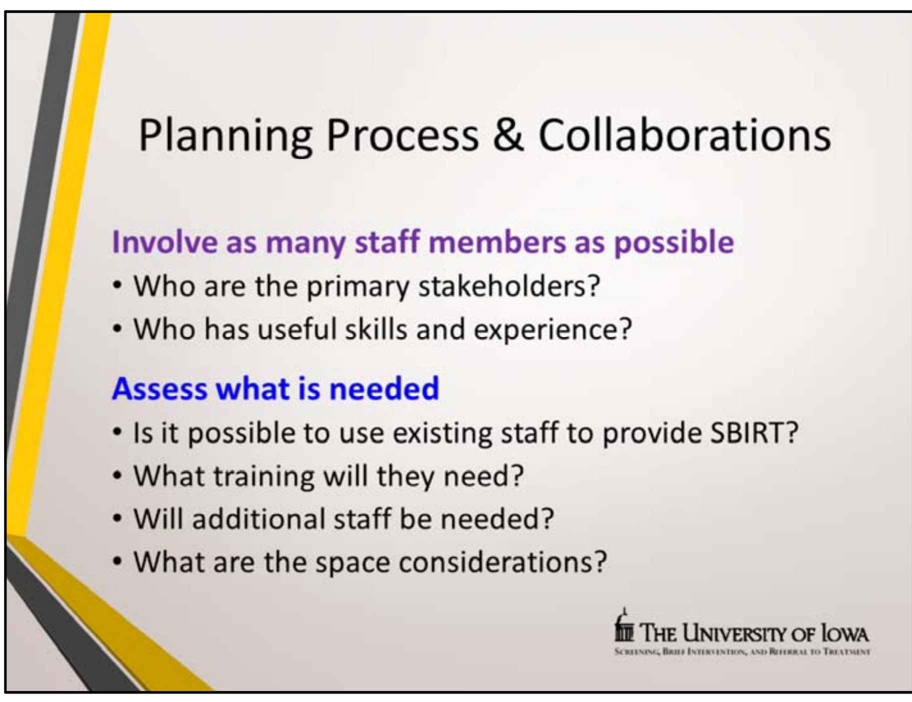
Assess organizational readiness

- **Motivation for change** → Perceptions of current functioning, needs for improvement?
- **Institutional resources** → Adequacy of office space, staffing?
- **Attributes of staff members** → Confidence in counseling abilities, adaptability?
- **Organizational climate** → Clarity of mission?

Medical Organizational Readiness for Change (MORC), Bohman et al., 2008

The University of Iowa

As we said earlier, organizations can differ dramatically in their readiness and capacity to implement new practices. The four main ideas listed on this slide are actually part of an assessment tool that Bohman and colleagues used to assess organizational readiness for implementing SBIRT.



Involving as many staff stakeholders as possible in planning discussions can help identify positives but also negatives, which will need to be overcome. An important starting point is to determine what staff will be needed, and what training and support they need to be successful.

Planning Process & Collaborations

Set clear goals
- What is realistic given resources available?
- What is a logical starting point?

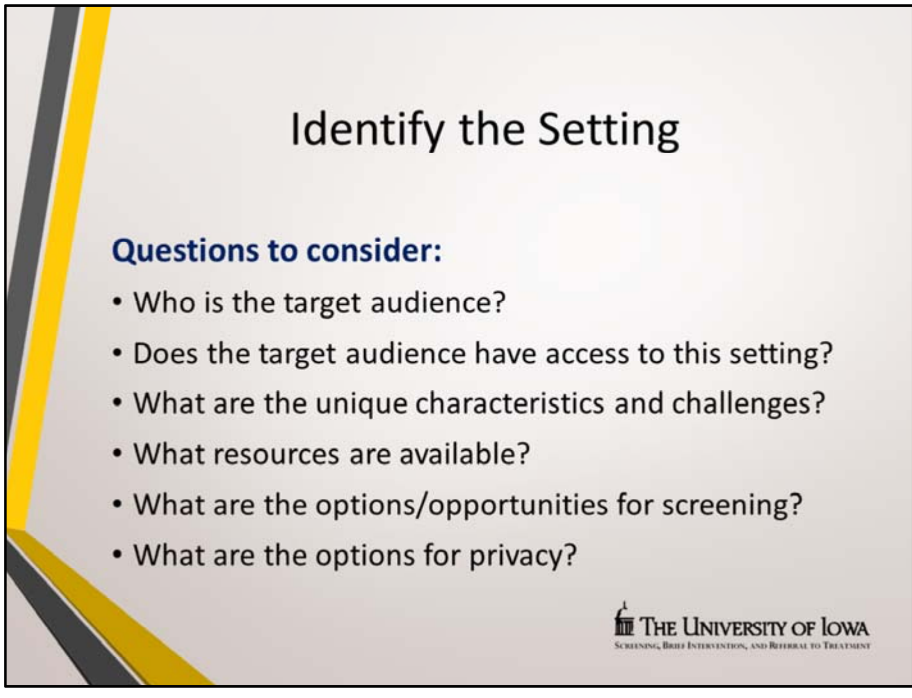
Assign clear roles and responsibilities
- Who is the logical coordinator?
- Who can help with specific tasks (billing, EHR)?

Develop collaborations and partnerships
- Other departments in your health system?
- Agencies or services outside your setting?

The University of Iowa
Screening, Brief Intervention, and Referral to Treatment

Working to be as clear as possible about what you are doing and who can help is really important to moving the process along. Establishing partnerships and collaborations with others – both inside and outside of your organization – can help support your sustainability and success over time.

Using your target population can help guide the type of collaborators that might be most useful. For example, a youth-focused SBIRT program might involve athletic advisors or staff from student housing, student counseling services, or crisis services.



An important starting point is to determine your target audience. What population of people do you want to include in SBIRT screening?

The target group might be defined by age, health risk factors, or sociodemographic variables. Other setting-related questions pertain to characteristics and challenges that might include things like staffing, space, or access by consumers.

In short, a number of setting-specific questions will guide what is practical to do. After thinking about the setting in general, the next step is to consider which implementation model makes the best sense.

Implementation Models

In-House Generalist → a staff member who is trained to perform SBIRT in addition to usual duties (not a substance use professional)

- Performs screening, brief intervention (BI); makes referrals to treatment
- **Pros:** Recommendations can be tied to other health or medical problems; increases comfort for the person
- **Cons:** Competing demands; discomfort with having substance use conversations

The most common and effective approach is to train existing staff in the health center or clinic to use SBIRT as part of their regular practice.

The In-House Generalist model affords providers the opportunity to talk with their own patients. This often increases comfort for the person and can help the provider tie substance use to other issues.

The downside is that providers are busy and might omit SBIRT, and perhaps not all of them will be comfortable with having the needed conversations.

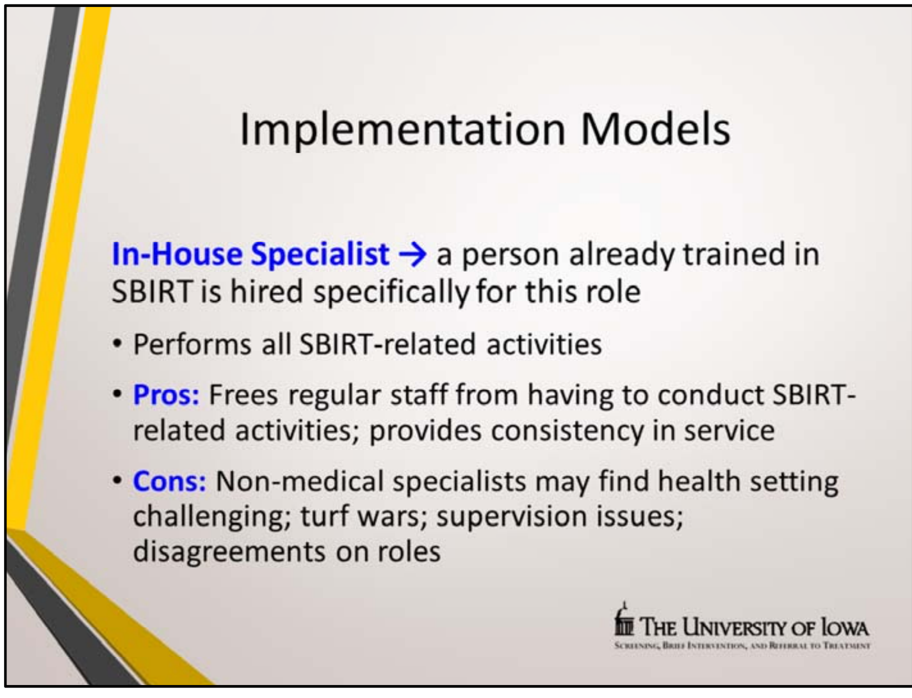
Implementation Models

Lessons learned: Overcoming barriers to In-House Generalist

- Implement SBIRT in ways to reduce staff burden
- Develop strong SBIRT "Champions"
- Provide time for "buy in" activities
- Provide adequate training and support
- Collect and share information about outcomes to help staff see how they are helping people

The University of Iowa

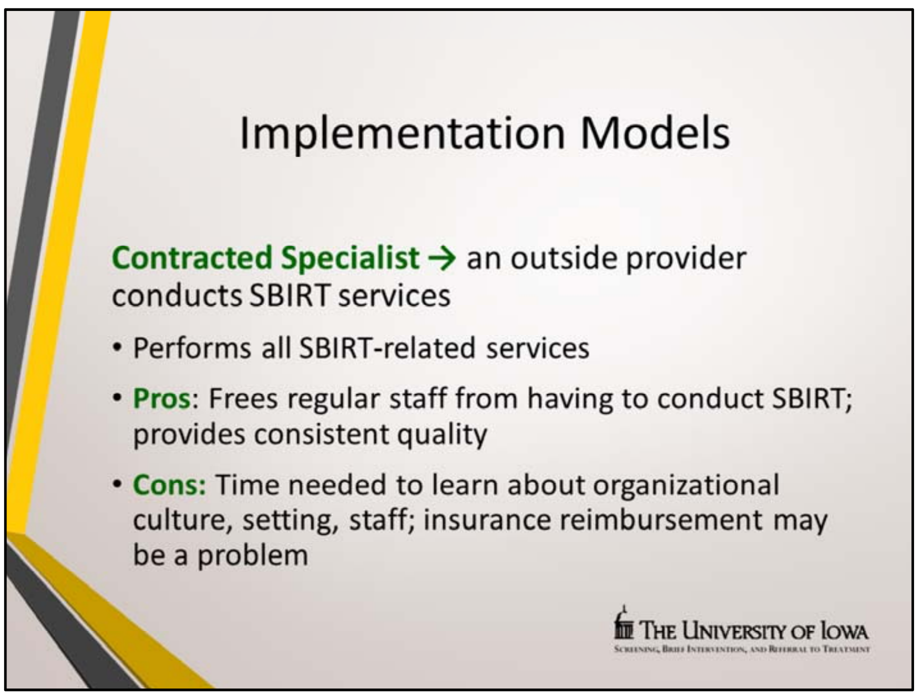
Over time, SBIRT Service grantees found that the approaches listed here made a big difference in the successful adoption of the In-House Generalist approach.



Another approach is to hire a specially-trained staff member to conduct all SBIRT-related work in the clinical setting.

While this may sound good to those who usually staff the clinic, it has the downside of creating situations in which differences of opinion arise between the substance use counselor and the medical providers.

These pitfalls can be overcome with clear organizational planning, but both the plan for practice and the person hired should be carefully considered.



A third approach is a variation on having an In-House Specialist. Instead of the clinic actually hiring a specialist to be part of the clinic team, this approach "co-locates" an outside provider – a Contracted Specialist – in the clinic and lets them do all the SBIRT work.

No One Best Way!!!

Blended models are commonly used

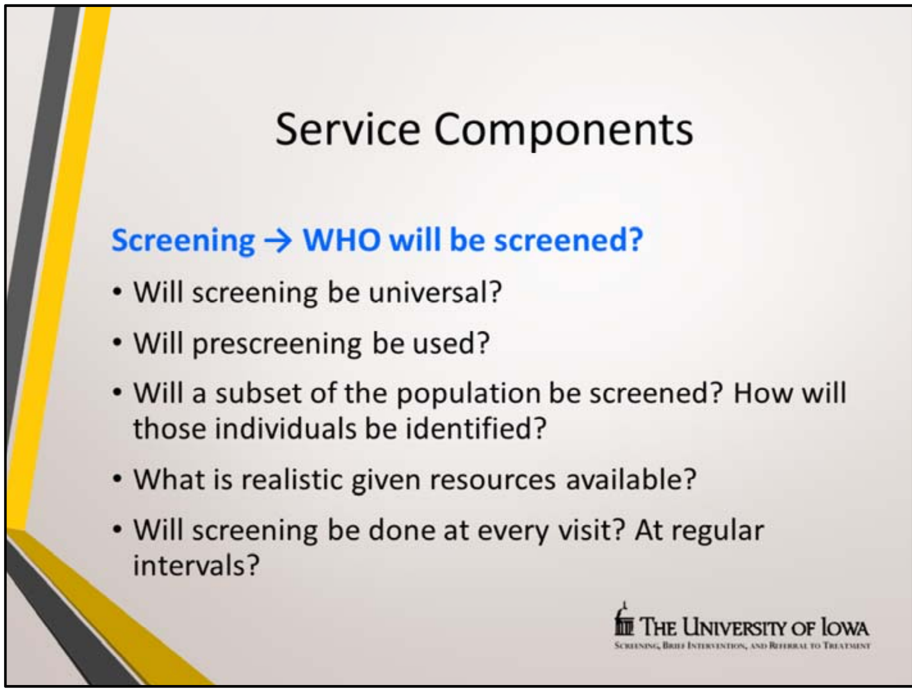
- In-house generalist does prescreening and screening; a contracted specialist does the brief intervention and referral
- Options and choices depend on:
  - ✓ Volume of patients seen
  - ✓ Accessible community resources
- No matter which model, many different professionals and paraprofessionals use SBIRT!

The University of Iowa

An important consideration is that most SBIRT Service grantees eventually found one or more “blended” approaches to using SBIRT. One of the most common is having In-House Generalists do the prescreening and screening. If a brief intervention is needed, either another In-House Generalist or a Contracted Specialist takes it from there.

There is really no one “best” way since it depends on the resources and characteristics of the setting.

One thing about SBIRT use that is consistently true is that nearly anyone who is willing and is appropriately trained can provide SBIRT! Nurses, physicians, nurse practitioners, physician assistants, social workers, psychologists, health educators, hospital residents and interns, medical assistants, school counselors, and additional professionals, can all provide SBIRT!

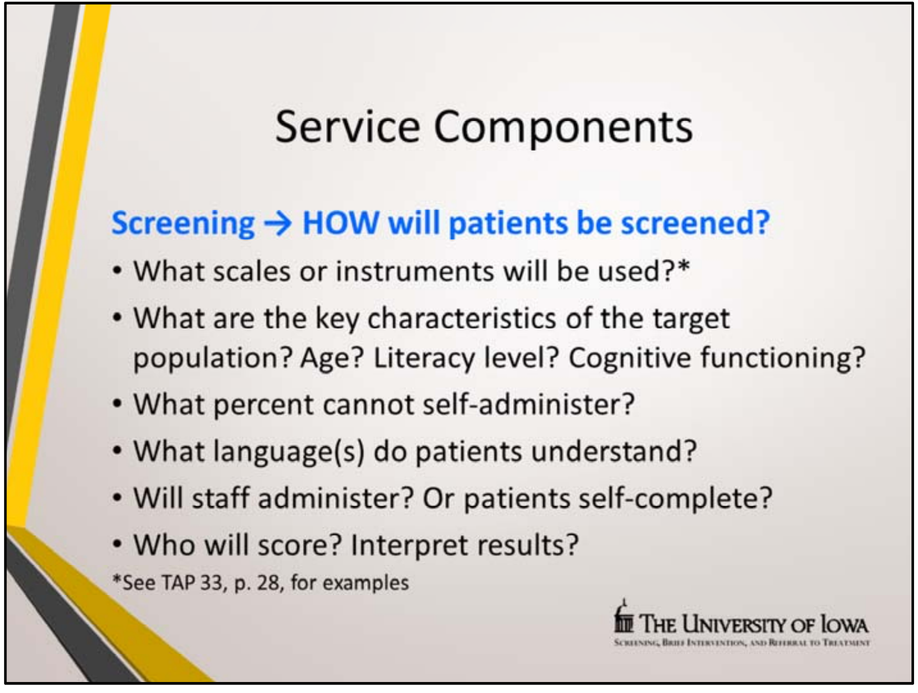


The third major area to think about in getting SBIRT into practice is the actual service package you want to offer.

We encourage doing universal screening on an annual basis for all patients in primary care. However, there may be variations on what you decide to do – particularly at the beginning when you're working to get SBIRT started. So, start with screening. What specifically are you asking the team to do? What makes the best sense?

Our training highly recommends screening for alcohol and drugs, both illicit and prescription. However, what you decide to implement in your practice setting may depend on both the needs of the community and the comfort level of the providers.

While we highly endorse the AUDIT and DAST, there are other options available. The most important factors are to understand the benefits and uses of the tools, and then use them consistently. TAP 33, on which this module is based, reports that there are more than 25 validated self-report screening tools available!



Another set of questions pertains to the "how" of screening patients related to the unique needs and characteristics of the target population.

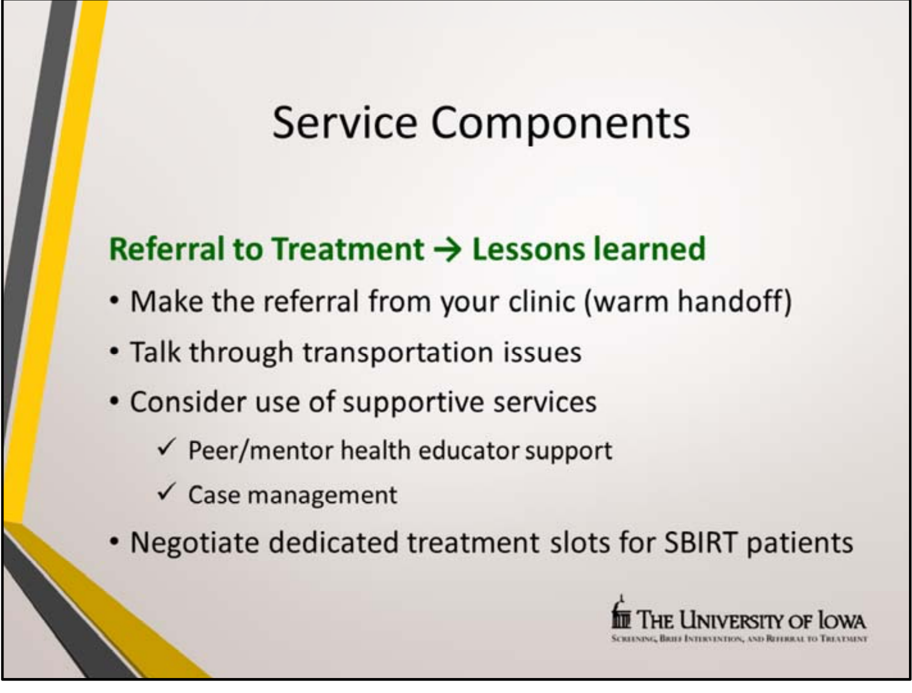
There are likely big differences in the patients who come to federally qualified health centers for treatment compared to the patients in private health centers. Factors like age, literacy, abilities, and language are all important to factor into the planning process.

Although our curriculum offers training for providers to complete screenings, use the brief intervention, and make referrals to specialty treatment, in practice you and your clinic may decide on another model.

As you consider the options, it’s important to think about workflow and how patients will be provided the brief intervention. In lots of ways, this may be the most challenging part of implementing SBIRT in practice.

Referral to treatment should follow the same basic principles that were discussed in the Core Training Curriculum. Knowing the community ahead of time and establishing partnerships with specialty substance use services in advance of needing their help is critically important.

Deciding what constitutes a "warm handoff" from you to the specialist is another really important process to consider ahead of time. Identify the type and extent of follow-up that your clinic offers as the "standard of practice" for patients who are referred. Remember, the goal is to have organizational standards that everyone follows.



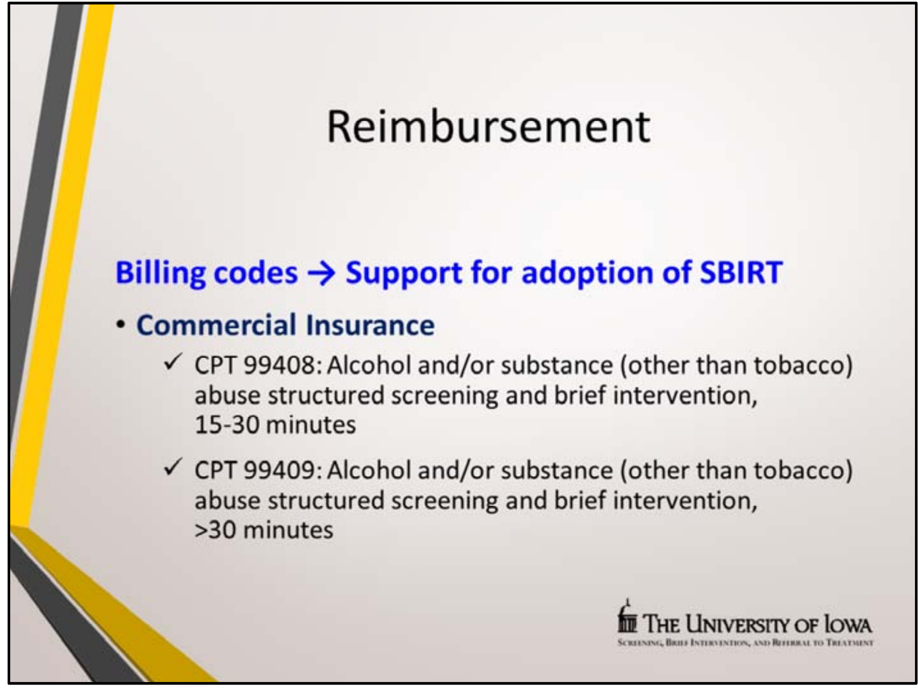
Referral procedures should both motivate patients to enter treatment and connect them with a convenient, accessible, acceptable, and affordable specialty treatment program.

Some of the strategies that have helped SBIRT Service grantees make successful referrals are listed on this slide.

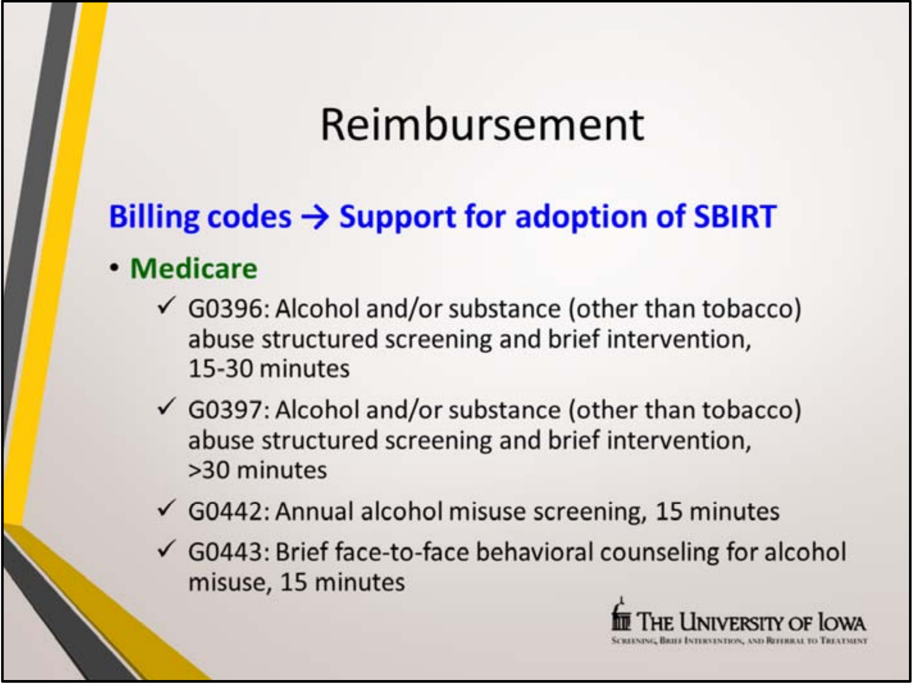
Evaluation is critical to sustainability. Both process and outcome data can guide additional changes, encourage staff that they are making an important contribution to the health of the patients, and provide justification for ongoing use.

As you think about implementing SBIRT in practice, be sure to consider how key evaluation points can be easily accessed and summarized.

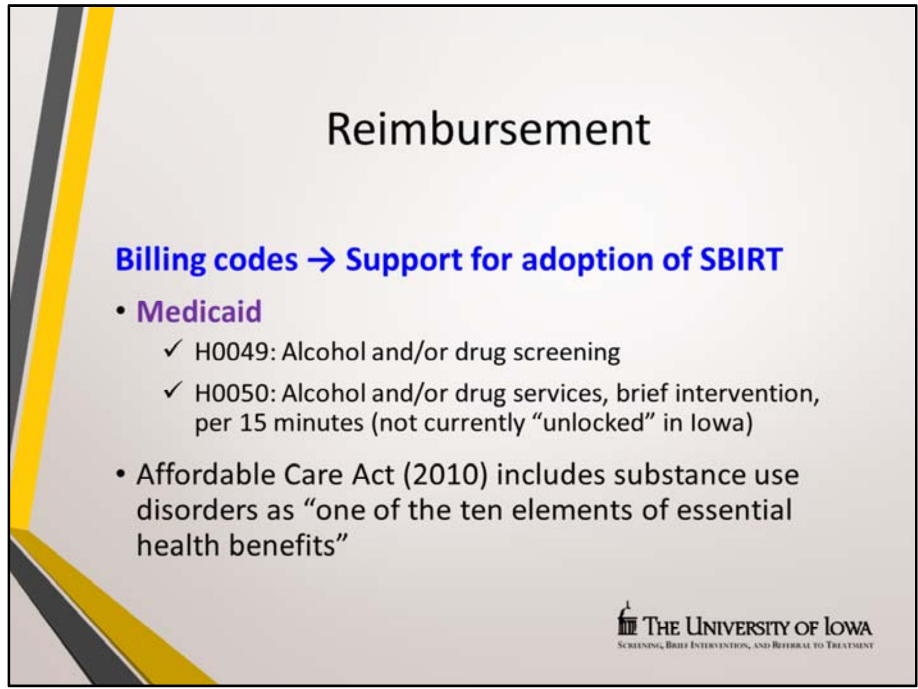
Staff who are participating in SBIRT implementation and use in daily care should also be included in evaluation plans. Their input related to what works or not is critically important to adoption and sustainability. As you think about implementing SBIRT in practice, make staff evaluation and input part of the process.



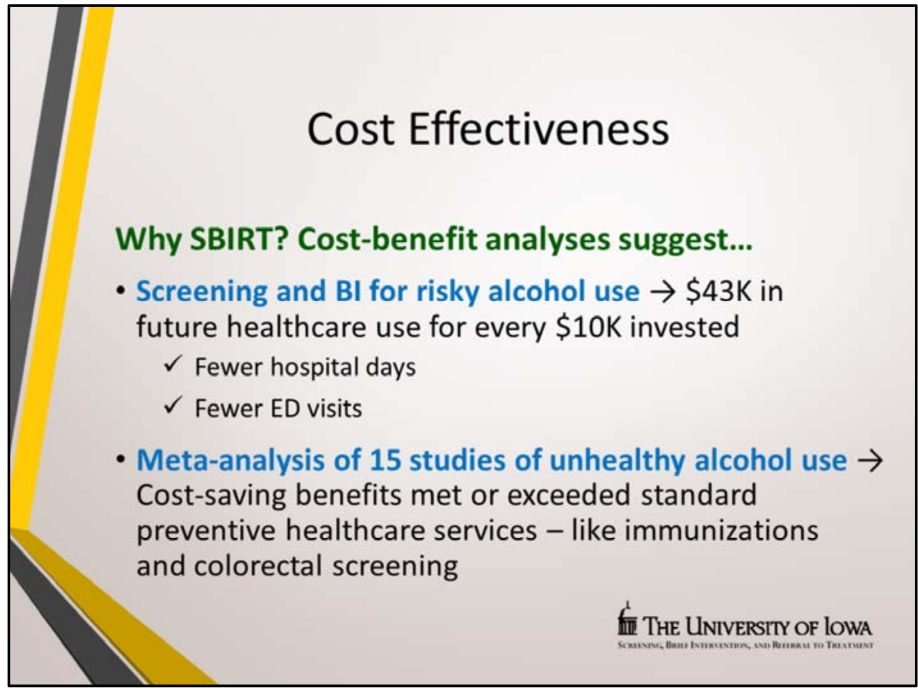
An important consideration in planning SBIRT implementation in practice relates to the funding support that helps offset staff time to use the process.



Discussing billing options that support screening and brief interventions can be an important motivational factor when thinking about adopting SBIRT in a practice setting.

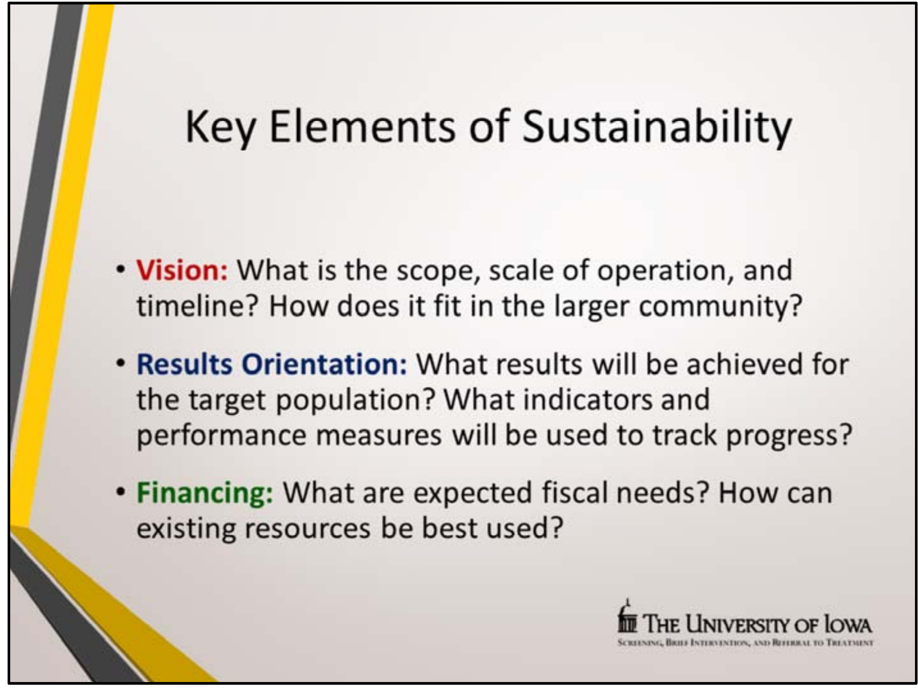


An important shift in Medicaid funding occurred with the Affordable Care Act. Prior to the ACA, the state Medicaid agency had to agree to reimburse for substance use services – it was not a given. Sustained efforts on the part of SBIRT advocates were needed to "unlock" the codes supporting substance use screening and intervention.



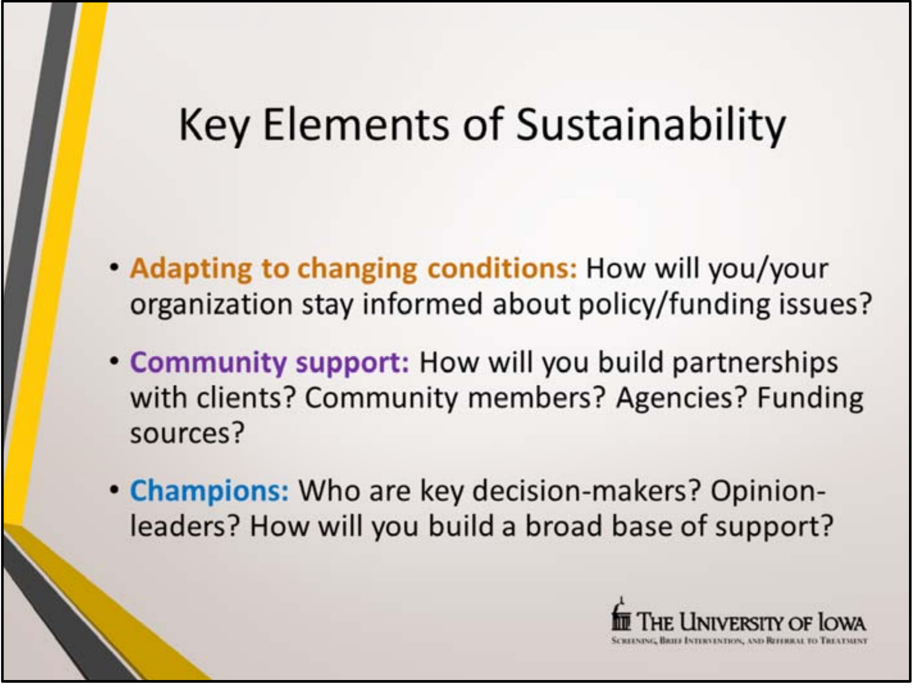
In addition to generating revenue for the healthcare setting, using SBIRT is well-established as being cost-effective. The investment in providing SBIRT in clinical practice settings saves money by reducing risks of later health problems.

Of interest, the meta-analysis of using screening and brief intervention for unhealthy drinking demonstrated that SBIRT was as cost-effective as many standard preventive services – like immunizations and colorectal screening.

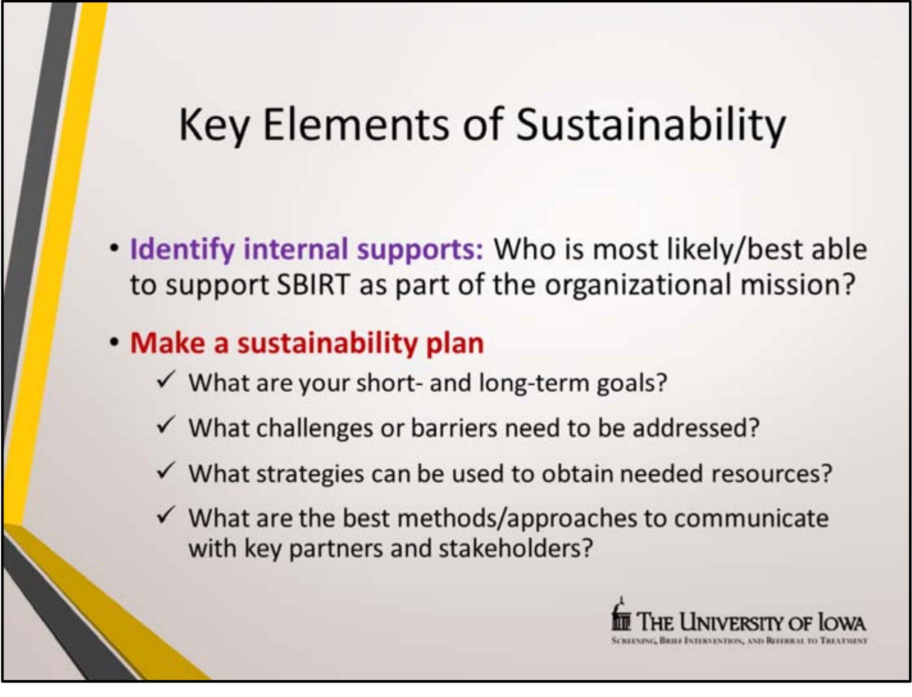


Thinking about factors that will promote long-term sustainability of SBIRT in clinical practice can both guide your planning for adoption and assure that you can keep the program alive over time.

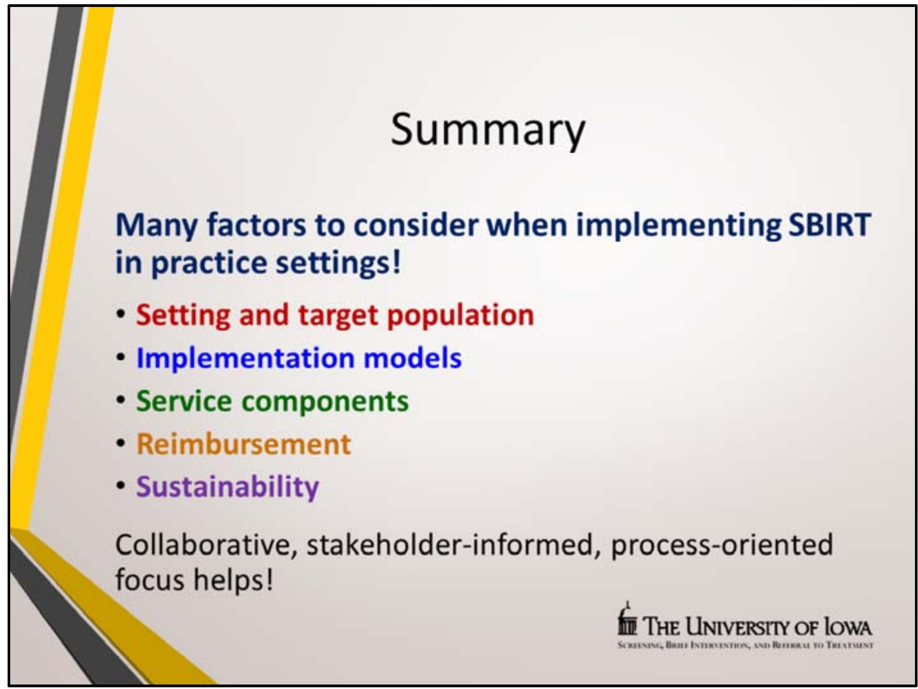
The questions listed on this slide emphasize that sustainability is a lot more than financing.



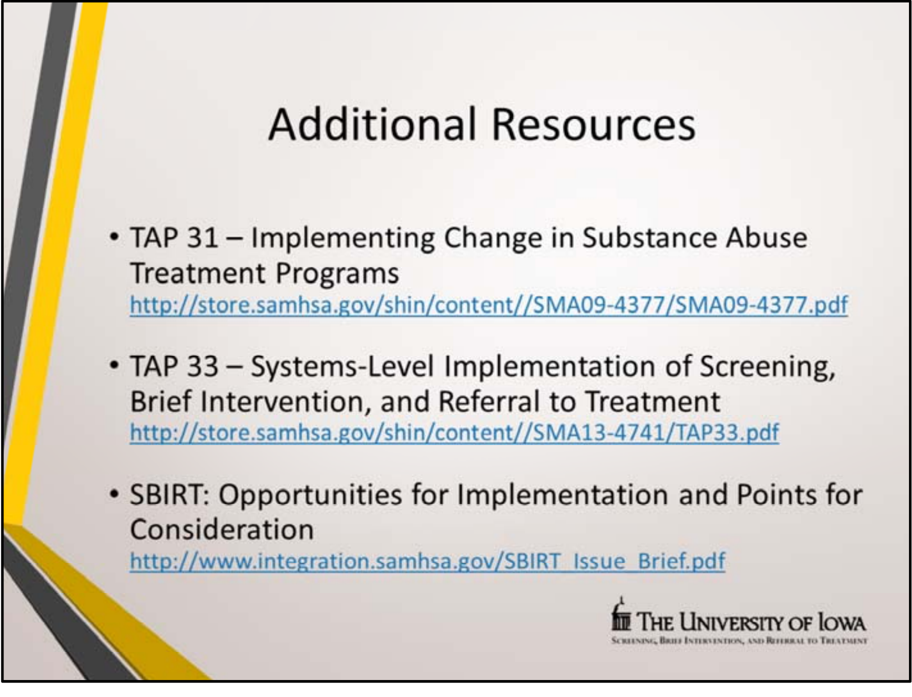
Maintaining staff motivation and support for the program within the community involves thoughtful and systematic review of key features of the program and its use.



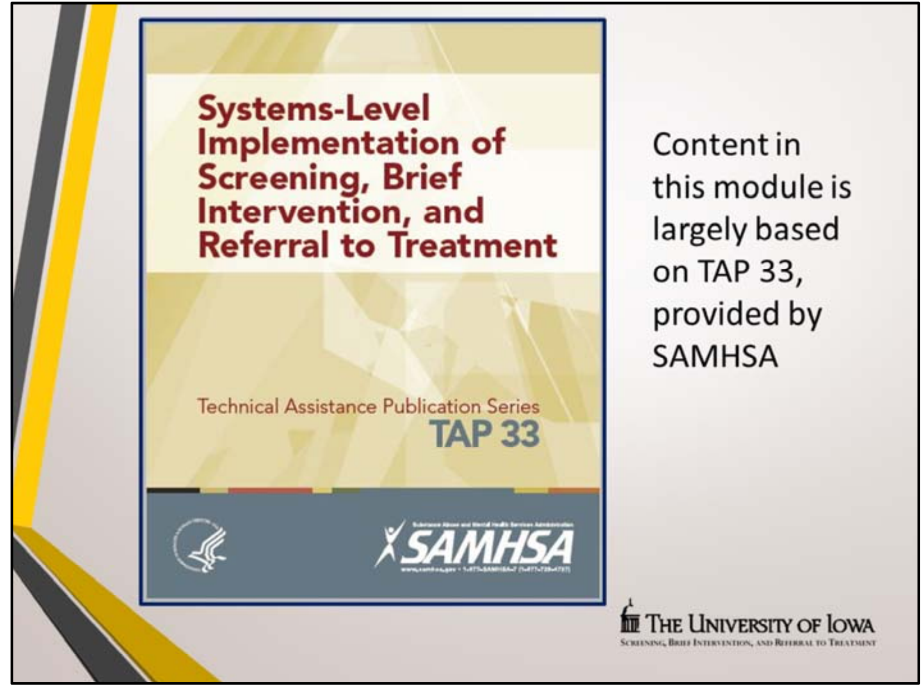
As before, a number of factors that relate to sustaining SBIRT in practice should also be considered as you think about adoption in the first place. Keeping your eyes on the long haul to ensure SBIRT stays "alive and well" in the clinical practice setting can help direct plans for its initial adoption.



In summary, there are lots of things to keep in mind as you implement SBIRT in clinical practice. It's important to think carefully about the target audience and outcome, as well as methods to make SBIRT practical to adopt. In addition, remember that key team members are needed to help gain momentum to get SBIRT in practice and then keep it going.



We highly recommend the resources on this slide to help guide your thinking about best practices for getting SBIRT into practice.



We would like to acknowledge TAP 33 as the foundation of this training module.

Thank you for your time.

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