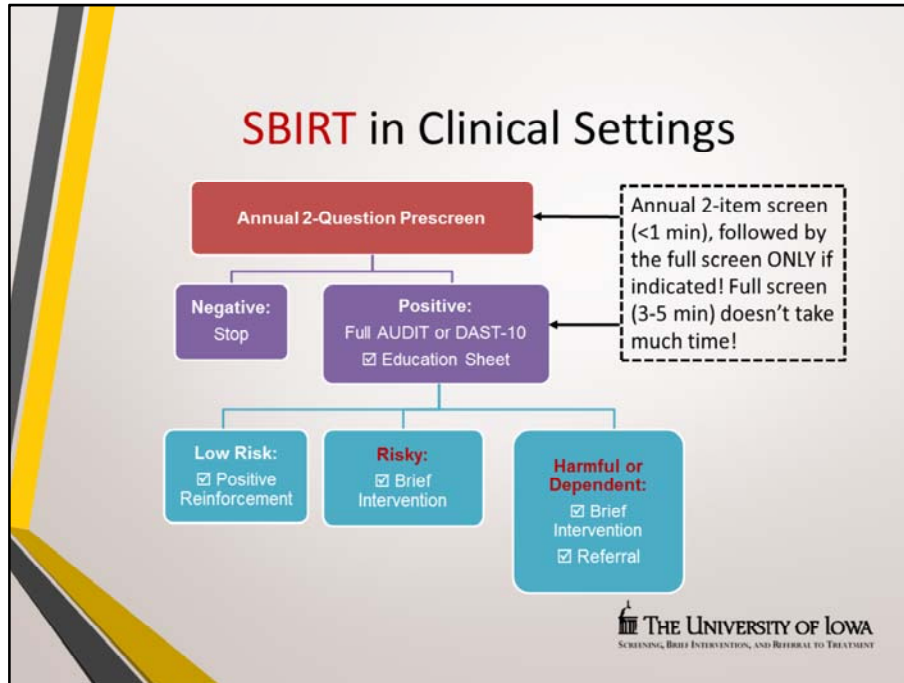


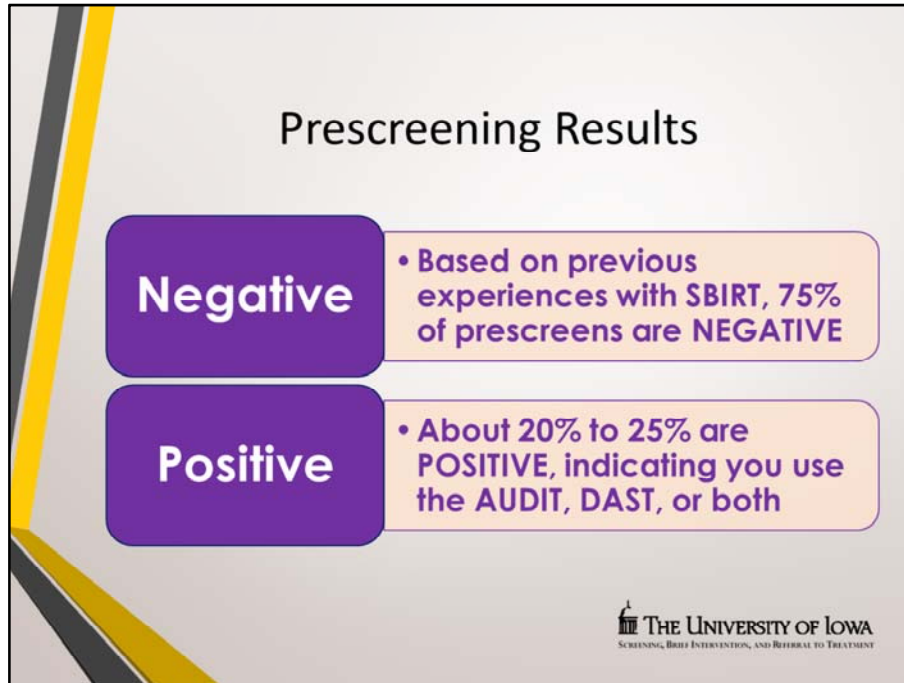
Welcome to our program about approaches that help to integrate SBIRT practices into clinical settings.

Screening, Brief Intervention, and Referral to Treatment (SBIRT): Getting SBIRT into Practice



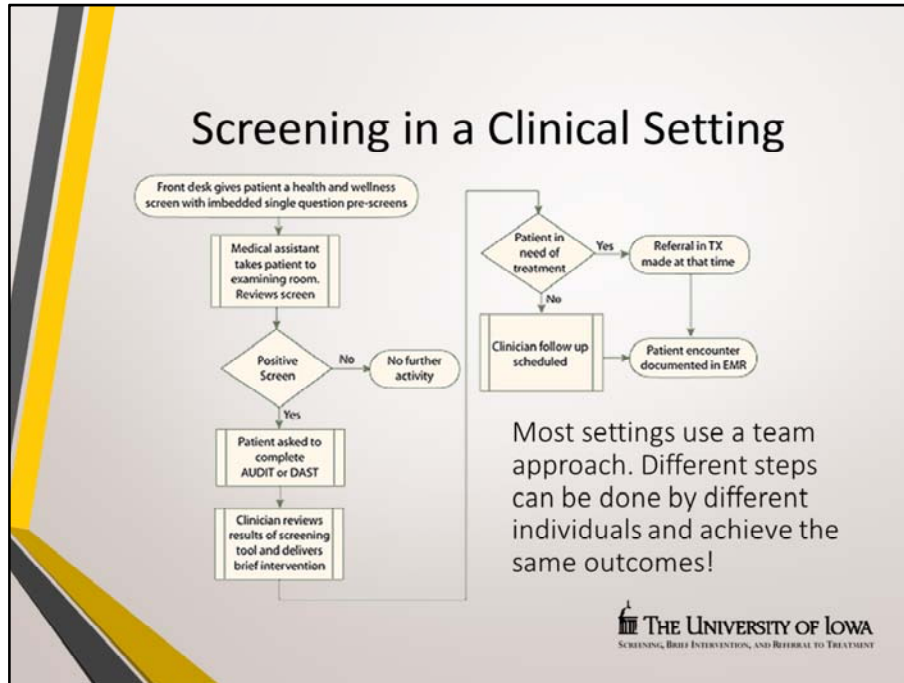
Let's start by quickly reviewing the process that's involved in using SBIRT in clinical practice.

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.

Screening, Brief Intervention, and Referral to Treatment (SBIRT): Getting SBIRT into Practice



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.

Using SBIRT in Practice

Like other evidence-based practices...

- **Great to know about** evidence/success
- **Hard to implement** in daily practices!!!
 - ✓ Too busy
 - ✓ Too much paperwork already
 - ✓ Not enough staff to help
 - ✓ Not comfortable with substance use discussions

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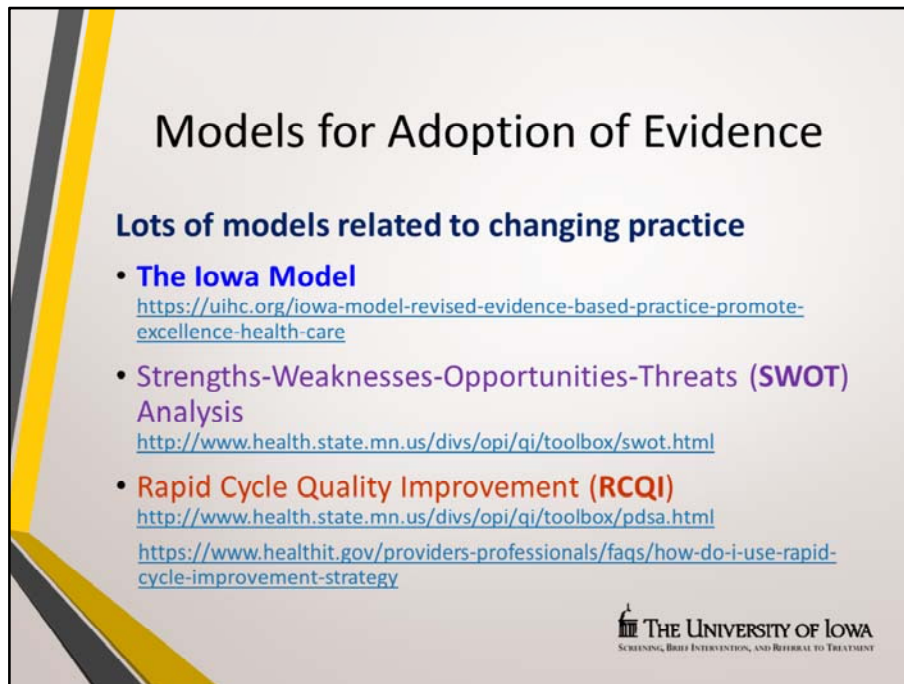
We've known for a long time that getting evidence-based practices into daily care – in any setting – is often difficult. There's a long list of reasons as to why busy clinicians may “push back” on adding something new to their already hectic schedule!

However, as noted previously, SBIRT doesn't need to take a lot of time. In 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.



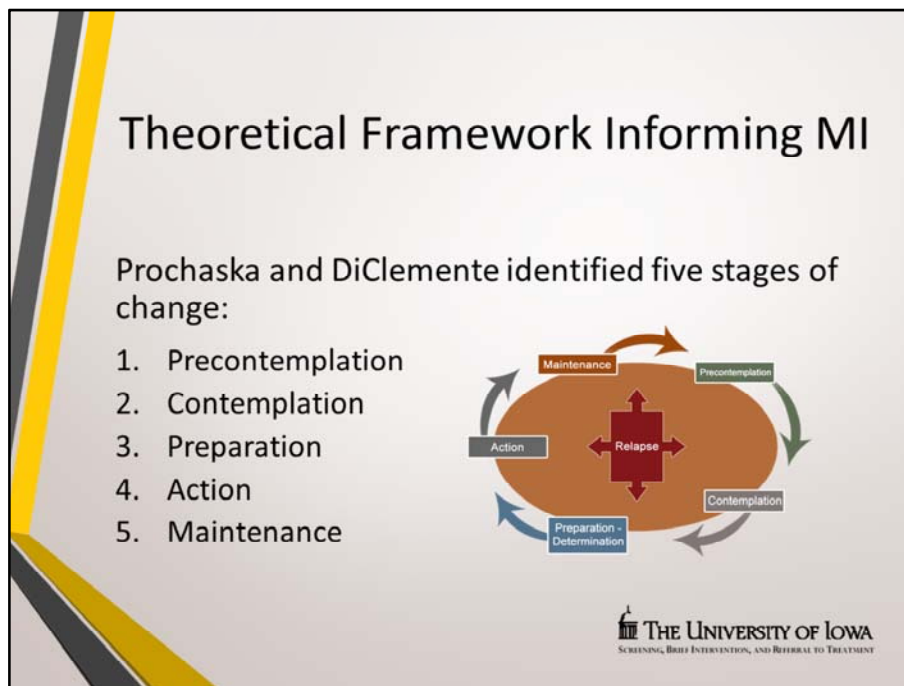
Models for Adoption of Evidence

Lots of models related to changing practice

- **The Iowa Model**
<https://uihc.org/iowa-model-revised-evidence-based-practice-promote-excellence-health-care>
- **Strengths-Weaknesses-Opportunities-Threats (SWOT) Analysis**
<http://www.health.state.mn.us/divs/opi/qi/toolbox/swot.html>
- **Rapid Cycle Quality Improvement (RCQI)**
<http://www.health.state.mn.us/divs/opi/qi/toolbox/pdsa.html>
<https://www.healthit.gov/providers-professionals/faqs/how-do-i-use-rapid-cycle-improvement-strategy>

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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.

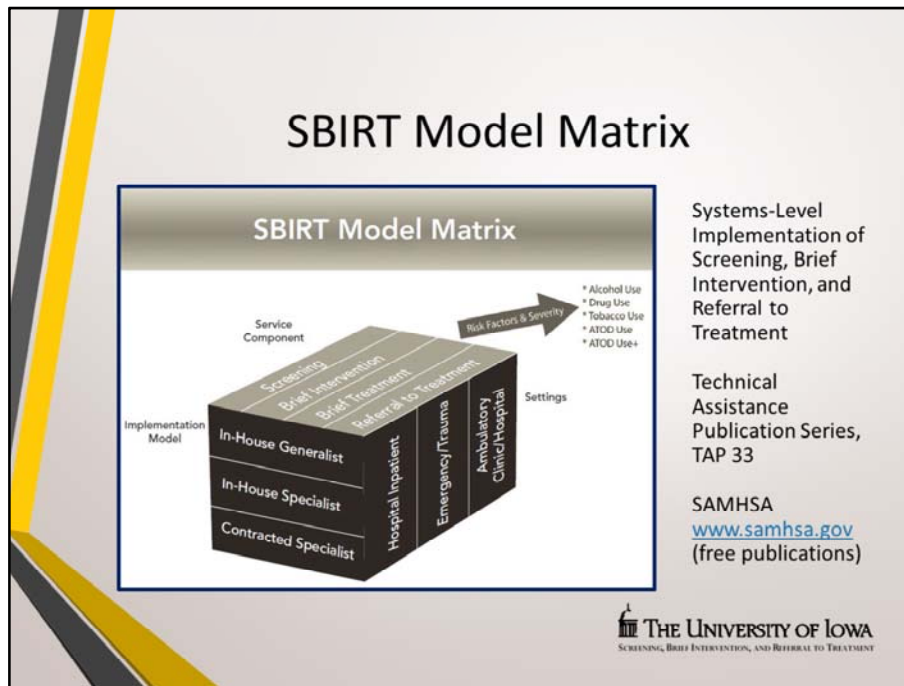


In fact, the very same theoretical model that we discussed when using motivational interviewing with patients can be applied to system-wide changes, such as the adoption of SBIRT.

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

Reference: Prochaska and DiClemente (1984).

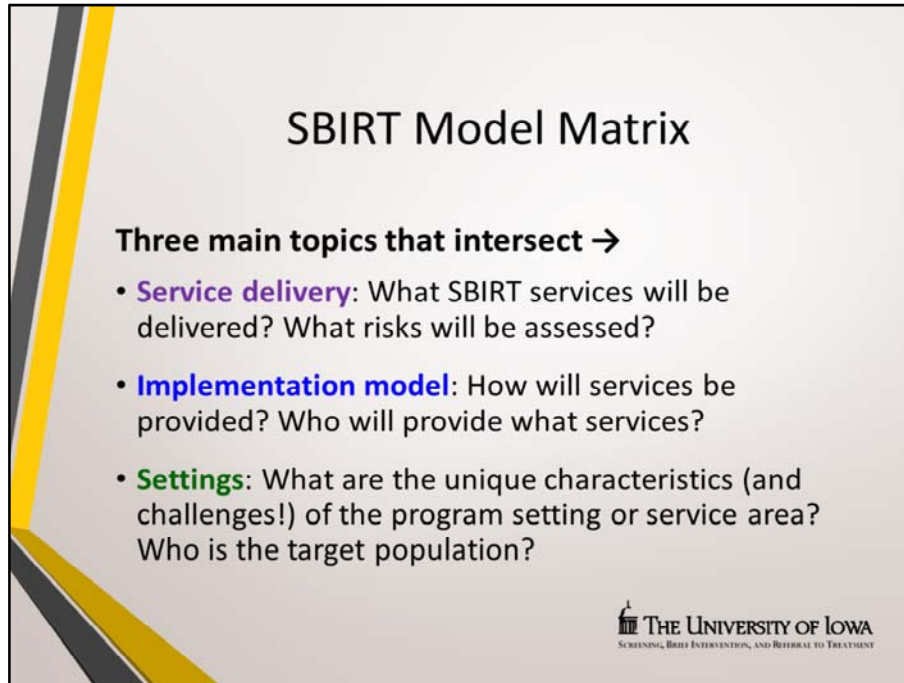
Screening, Brief Intervention, and Referral to Treatment (SBIRT): Getting SBIRT into Practice



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.


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

The slide features a light gray background with a decorative graphic on the left side consisting of several overlapping diagonal stripes in shades of gray and yellow. The title "SBIRT Model Matrix" is centered at the top in a bold, black, sans-serif font. Below the title, the text "Three main topics that intersect →" is followed by a bulleted list of three items. The first item, "Service delivery", is in purple; the second, "Implementation model", is in blue; and the third, "Settings", is in green. The University of Iowa logo and name are in the bottom right corner.

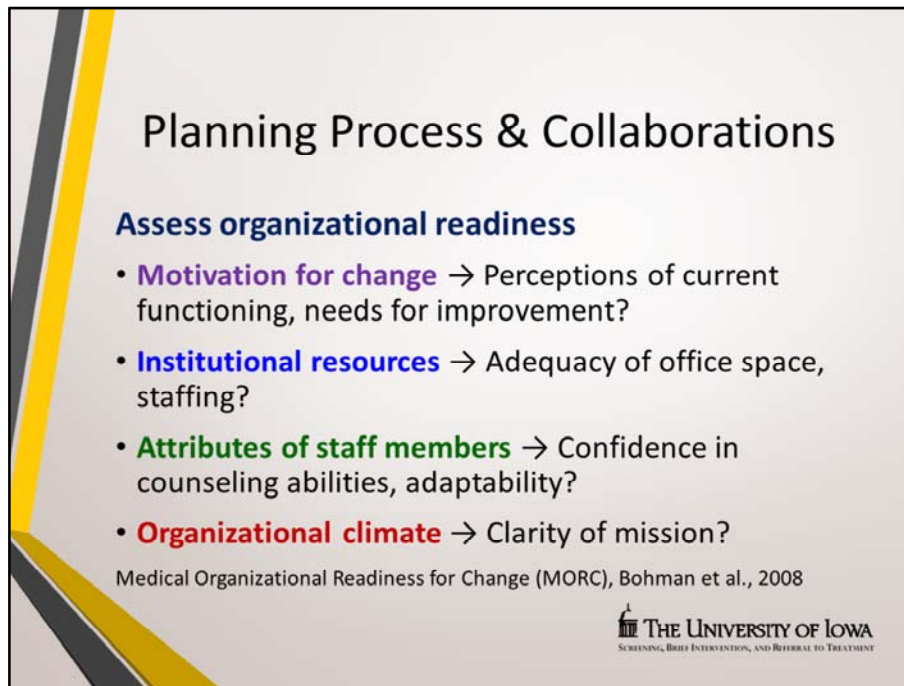
SBIRT Model Matrix

Three main topics that intersect →

- **Service delivery**: What SBIRT services will be delivered? What risks will be assessed?
- **Implementation model**: How will services be provided? Who will provide what services?
- **Settings**: What are the unique characteristics (and challenges!) of the program setting or service area? Who is the target population?

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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.




Planning Process & Collaborations

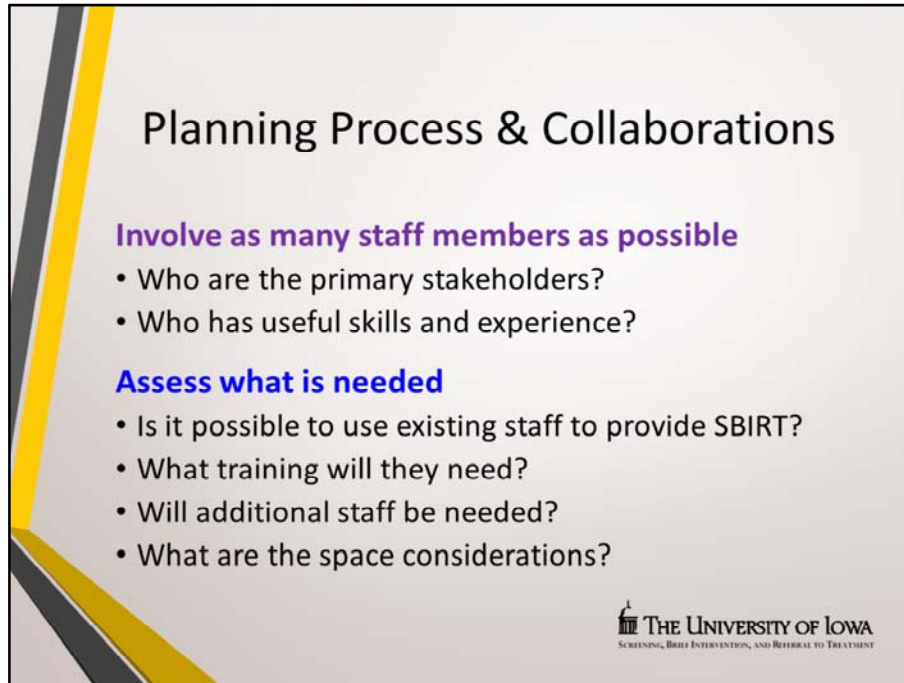
Assess organizational readiness

- **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

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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.




Planning Process & Collaborations

Involve as many staff members as possible

- Who are the primary stakeholders?
- Who has useful skills and experience?

Assess what is needed

- Is it possible to use existing staff to provide SBIRT?
- What training will they need?
- Will additional staff be needed?
- What are the space considerations?

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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)?

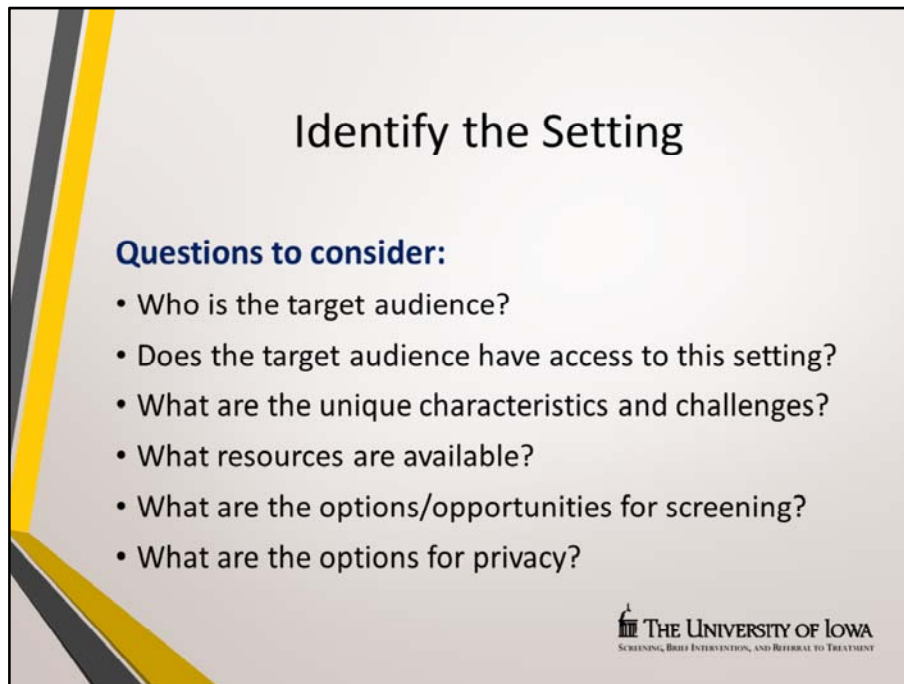
Develop collaborations and partnerships

- Other departments in your health system?
- Agencies or services outside your setting?

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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.



Identify the Setting

Questions to consider:

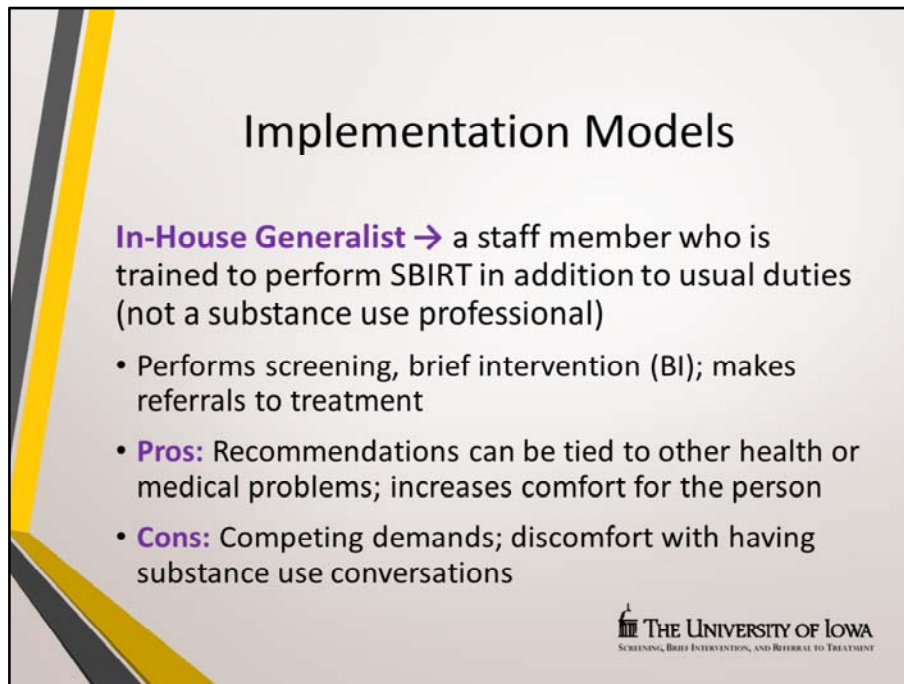
- Who is the target audience?
- Does the target audience have access to this setting?
- What are the unique characteristics and challenges?
- What resources are available?
- What are the options/opportunities for screening?
- What are the options for privacy?

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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)

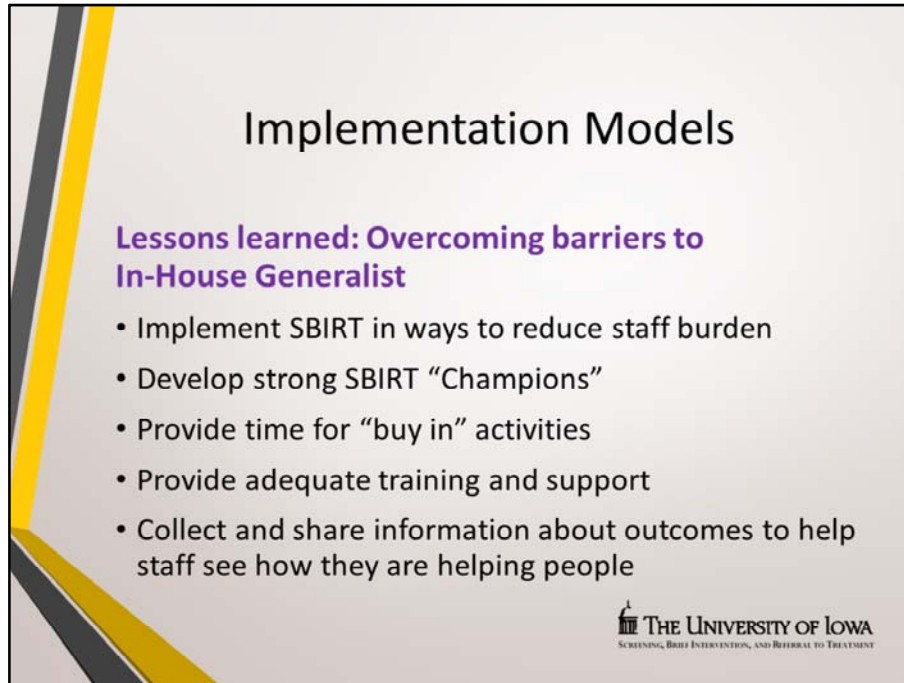
- Performs screening, brief intervention (BI); makes referrals to treatment
- **Pros:** Recommendations can be tied to other health or medical problems; increases comfort for the person
- **Cons:** Competing demands; discomfort with having substance use conversations

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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.



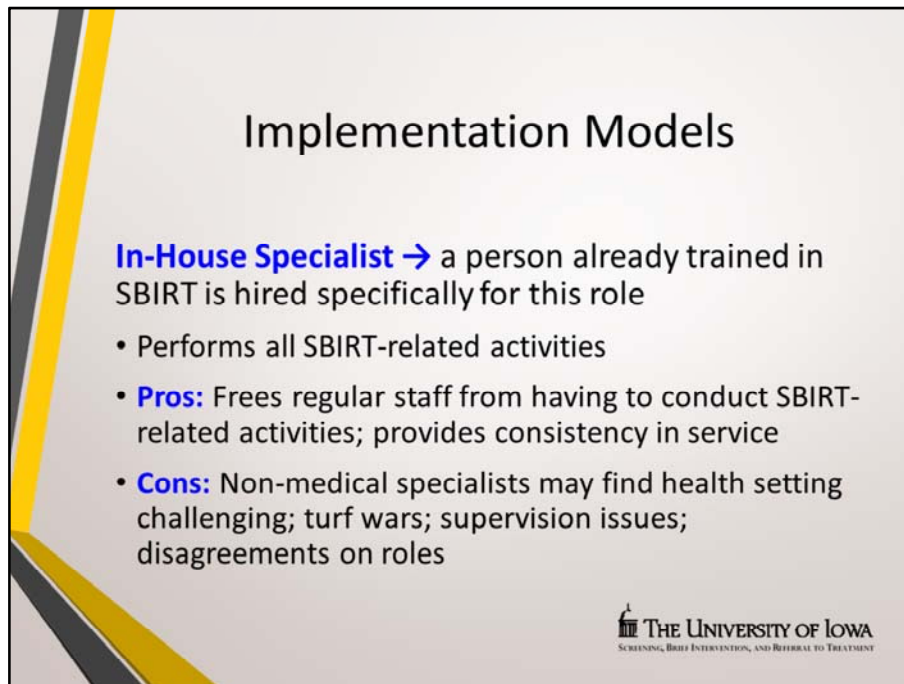
Implementation Models

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

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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.



Implementation Models

In-House Specialist → a person already trained in SBIRT is hired specifically for this role

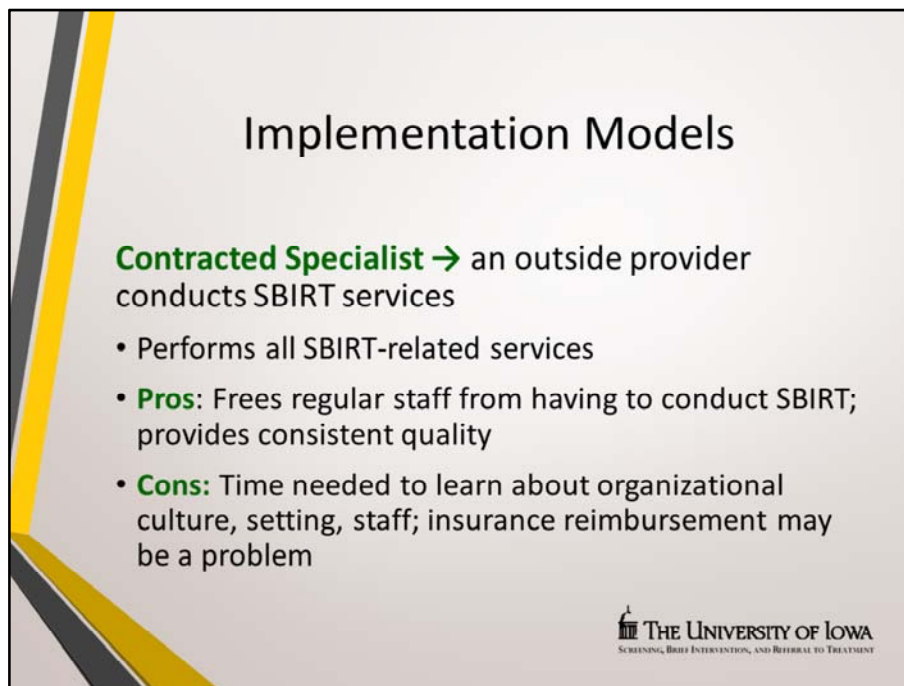
- Performs all SBIRT-related activities
- **Pros:** Frees regular staff from having to conduct SBIRT-related activities; provides consistency in service
- **Cons:** Non-medical specialists may find health setting challenging; turf wars; supervision issues; disagreements on roles

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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.



Implementation Models

Contracted Specialist → an outside provider conducts SBIRT services

- Performs all SBIRT-related services
- **Pros:** Frees regular staff from having to conduct SBIRT; provides consistent quality
- **Cons:** Time needed to learn about organizational culture, setting, staff; insurance reimbursement may be a problem

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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

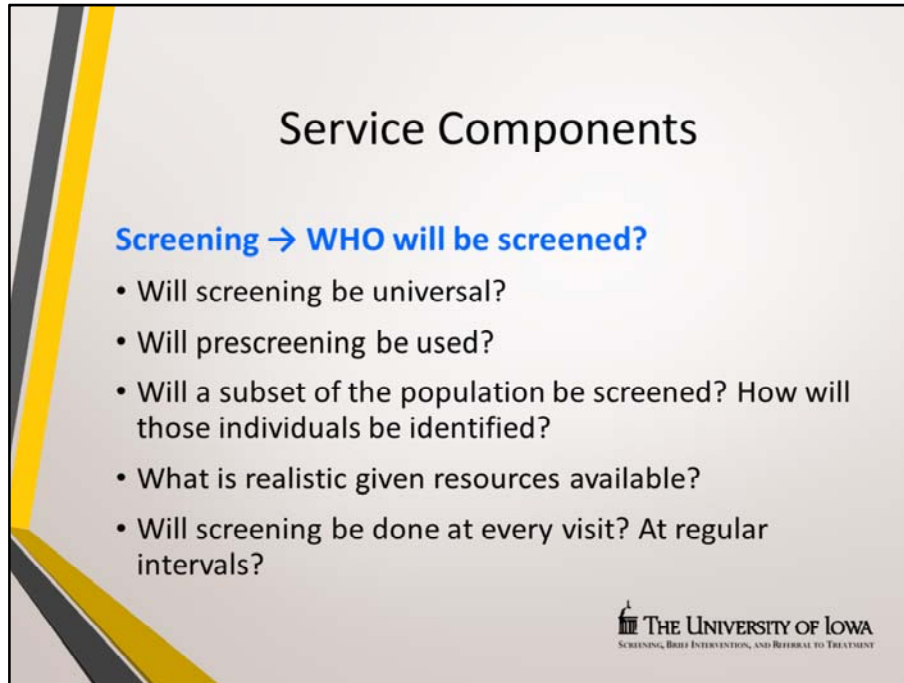
- In-house generalist does prescreening and screening; a contracted specialist does the brief intervention and referral
- Options and choices depend on:
 - ✓ Volume of patients seen
 - ✓ Accessible community resources
- No matter which model, many different professionals and paraprofessionals use SBIRT!

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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!



Service Components

Screening → WHO will be screened?

- Will screening be universal?
- Will prescreening be used?
- Will a subset of the population be screened? How will those individuals be identified?
- What is realistic given resources available?
- Will screening be done at every visit? At regular intervals?

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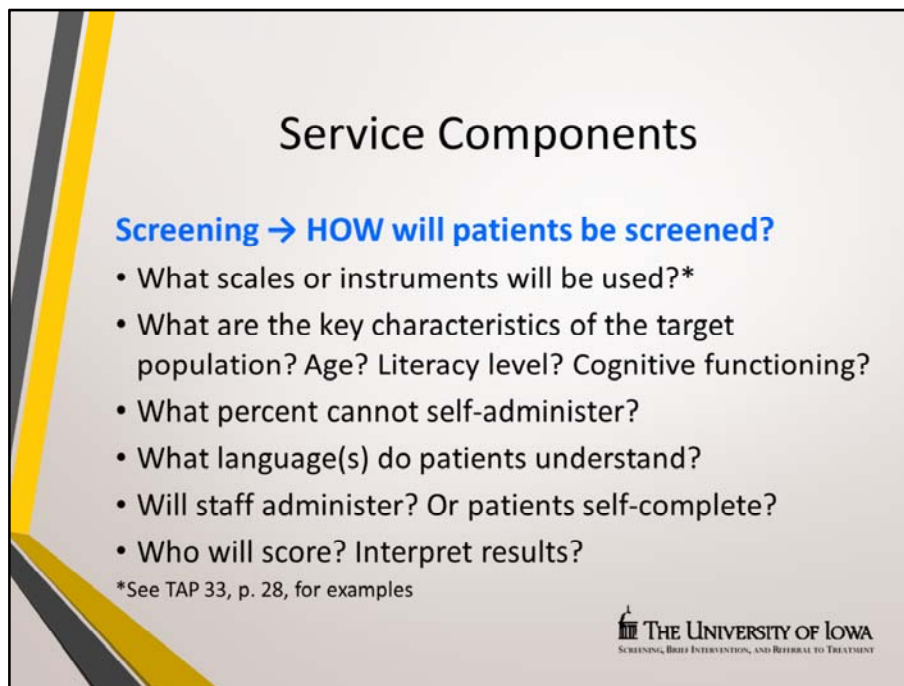
The third major area to think about in getting SBIRT into practice is the actual service package you want to offer.

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!




Service Components

Screening → HOW will patients be screened?

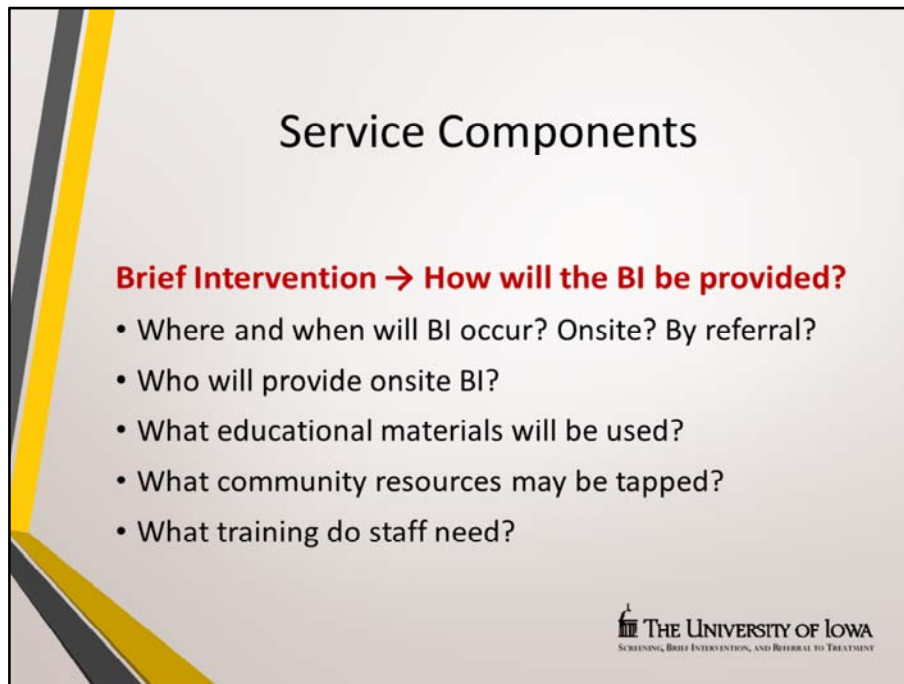
- What scales or instruments will be used?*
- What are the key characteristics of the target population? Age? Literacy level? Cognitive functioning?
- What percent cannot self-administer?
- What language(s) do patients understand?
- Will staff administer? Or patients self-complete?
- Who will score? Interpret results?

*See TAP 33, p. 28, for examples

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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.



Service Components

Brief Intervention → How will the BI be provided?

- Where and when will BI occur? Onsite? By referral?
- Who will provide onsite BI?
- What educational materials will be used?
- What community resources may be tapped?
- What training do staff need?

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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.

Service Components

Referral to Treatment → What processes best fit resources and needs of patients and the setting?

- Who will make the referrals to treatment?
- What **resources** are available? **Know in advance!!!**
- What processes best support a “warm handoff”?
- What follow-up methods are needed?

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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.



Service Components

Referral to Treatment → Lessons learned

- Make the referral from your clinic (warm handoff)
- Talk through transportation issues
- Consider use of supportive services
 - ✓ Peer/mentor health educator support
 - ✓ Case management
- Negotiate dedicated treatment slots for SBIRT patients

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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.

Service Components

Evaluation plan and records → What is the best way to track SBIRT practices for individuals and the system?

- What are the best ways to easily identify patient level information?
 - ✓ Initial screen score(s)?
 - ✓ Interventions used?
 - ✓ Progress notes?
 - ✓ Referrals made?
 - ✓ Follow-up activities/outcomes?

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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.

Service Components

Evaluation plan and records → How do staff think SBIRT is working for them? Patients?

- What is the plan for staff evaluations?
 - ✓ Frequency? Type of feedback? Who is involved?
- What improvements can be made?
- What is working well/should be continued?
- What resources are needed to maintain progress?


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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.

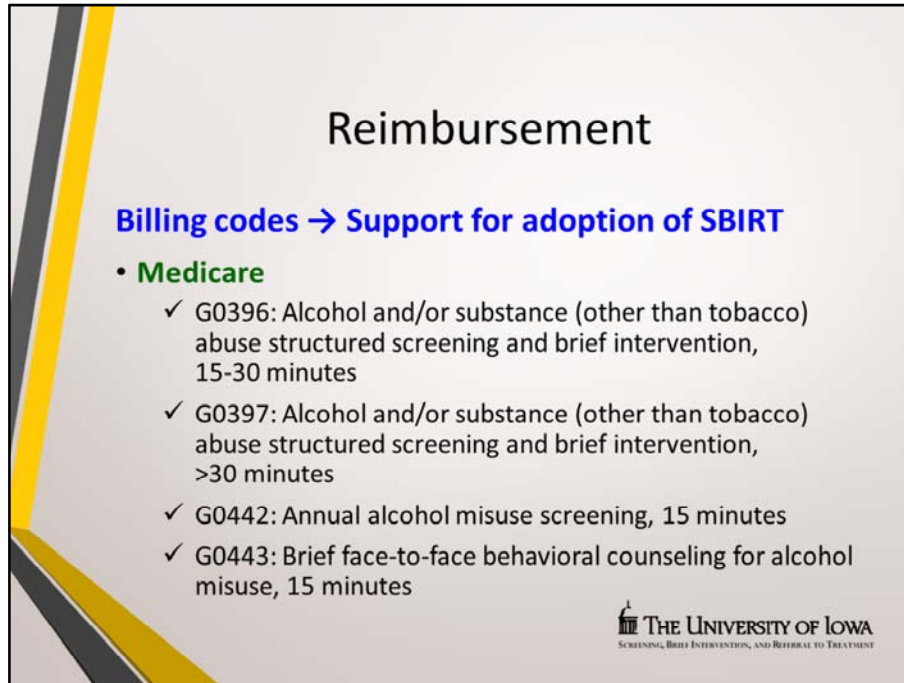
Reimbursement

Billing codes → Support for adoption of SBIRT

- **Commercial Insurance**
 - ✓ CPT 99408: Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention, 15-30 minutes
 - ✓ CPT 99409: Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention, >30 minutes

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




The slide features a light gray background with a decorative yellow and gray diagonal stripe on the left side. The title 'Reimbursement' is centered at the top. Below it, the text 'Billing codes → Support for adoption of SBIRT' is written in blue. A green bullet point labeled 'Medicare' is followed by four checkmarks, each with a corresponding billing code and description. The University of Iowa logo and name are in the bottom right corner.

Reimbursement

Billing codes → Support for adoption of SBIRT

- **Medicare**
 - ✓ G0396: Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention, 15-30 minutes
 - ✓ G0397: Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention, >30 minutes
 - ✓ G0442: Annual alcohol misuse screening, 15 minutes
 - ✓ G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes


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

Reimbursement

Billing codes → Support for adoption of SBIRT

- **Medicaid**
 - ✓ H0049: Alcohol and/or drug screening
 - ✓ H0050: Alcohol and/or drug services, brief intervention, per 15 minutes (not currently “unlocked” in Iowa)
- Affordable Care Act (2010) includes substance use disorders as “one of the ten elements of essential health benefits”

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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.

Cost Effectiveness

Why SBIRT? Cost-benefit analyses suggest...

- **Screening and BI for risky alcohol use** → \$43K in future healthcare use for every \$10K invested
 - ✓ Fewer hospital days
 - ✓ Fewer ED visits
- **Meta-analysis of 15 studies of unhealthy alcohol use** → Cost-saving benefits met or exceeded standard preventive healthcare services – like immunizations and colorectal screening

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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.

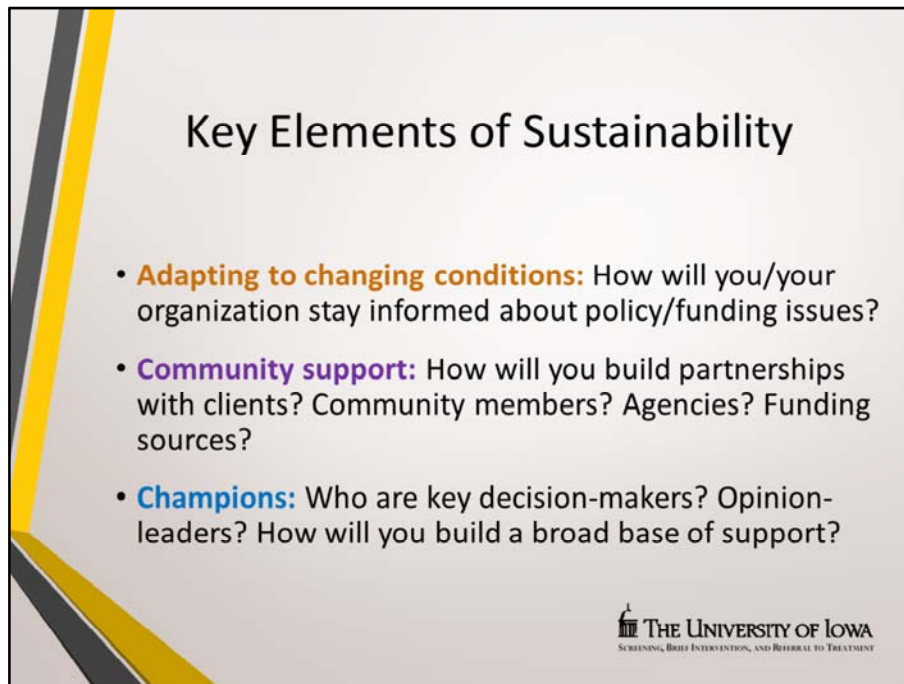
Key Elements of Sustainability

- **Vision:** What is the scope, scale of operation, and timeline? How does it fit in the larger community?
- **Results Orientation:** What results will be achieved for the target population? What indicators and performance measures will be used to track progress?
- **Financing:** What are expected fiscal needs? How can existing resources be best used?

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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.




Key Elements of Sustainability

- **Adapting to changing conditions:** How will you/your organization stay informed about policy/funding issues?
- **Community support:** How will you build partnerships with clients? Community members? Agencies? Funding sources?
- **Champions:** Who are key decision-makers? Opinion-leaders? How will you build a broad base of support?

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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.

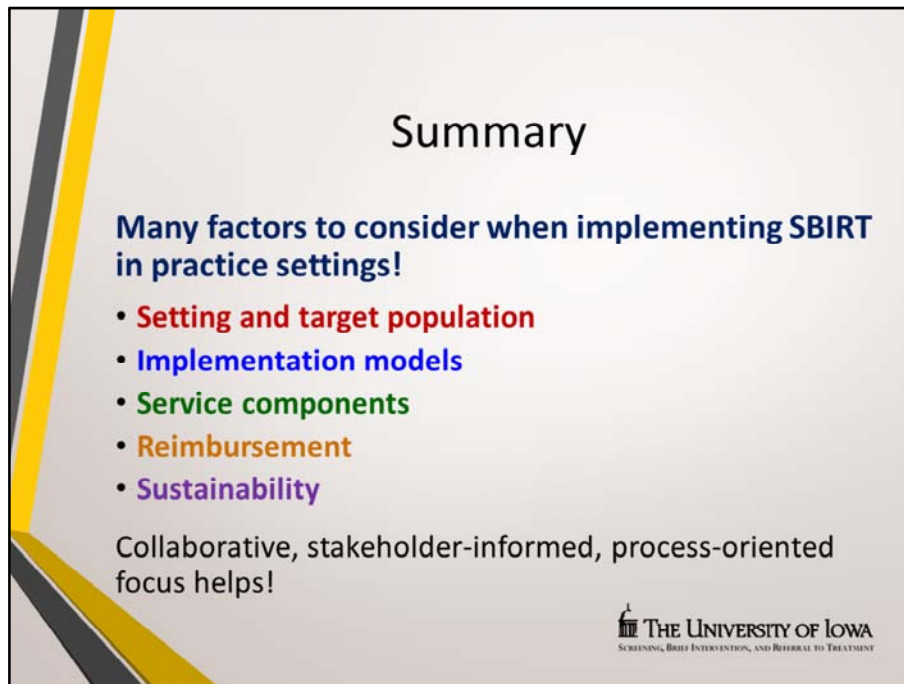


Key Elements of Sustainability

- **Identify internal supports:** Who is most likely/best able to support SBIRT as part of the organizational mission?
- **Make a sustainability plan**
 - ✓ What are your short- and long-term goals?
 - ✓ What challenges or barriers need to be addressed?
 - ✓ What strategies can be used to obtain needed resources?
 - ✓ What are the best methods/approaches to communicate with key partners and stakeholders?

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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.




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Summary

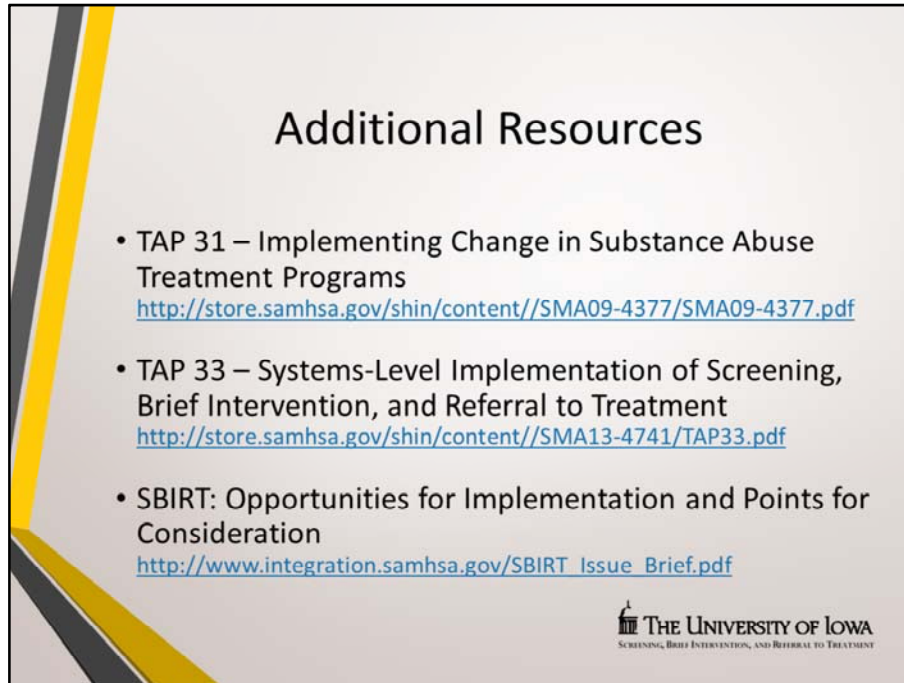
Many factors to consider when implementing SBIRT in practice settings!

- **Setting and target population**
- **Implementation models**
- **Service components**
- **Reimbursement**
- **Sustainability**

Collaborative, stakeholder-informed, process-oriented focus helps!


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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.



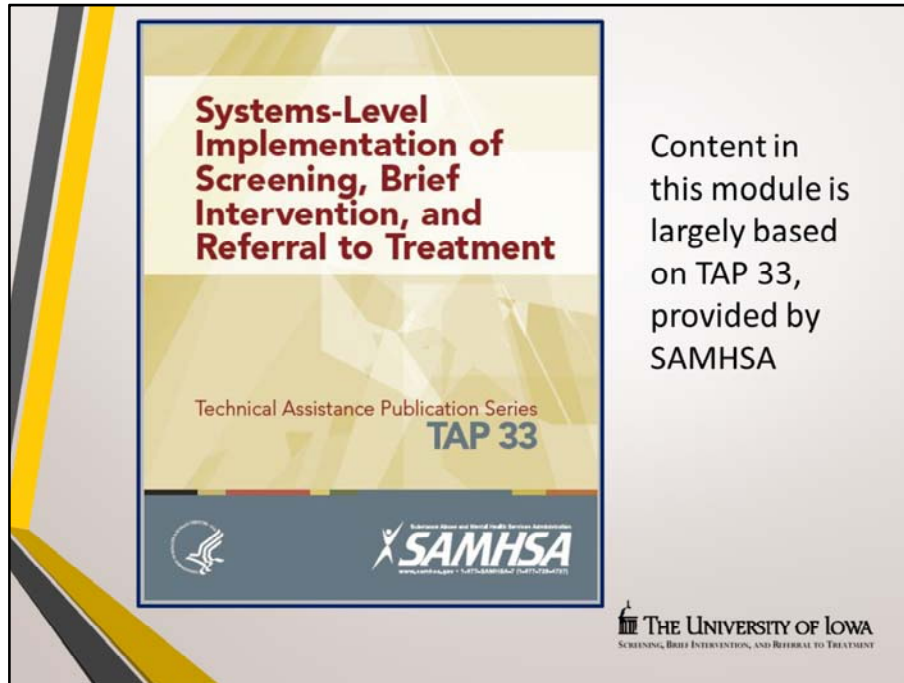
Additional Resources

- TAP 31 – Implementing Change in Substance Abuse Treatment Programs
<http://store.samhsa.gov/shin/content//SMA09-4377/SMA09-4377.pdf>
- TAP 33 – Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment
<http://store.samhsa.gov/shin/content//SMA13-4741/TAP33.pdf>
- SBIRT: Opportunities for Implementation and Points for Consideration
http://www.integration.samhsa.gov/SBIRT_Issue_Brief.pdf

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

Screening, Brief Intervention, and Referral to Treatment (SBIRT): Getting SBIRT into Practice



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

Thank you for your time.

