

## The SBIRT Evolution for Adolescents: A Recipe to Drive Behavioral Health and Primary Care Integration

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# Faculty Disclosure

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The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

# Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at [https://www.cfha.net/page/Resources\\_2019](https://www.cfha.net/page/Resources_2019) and on the conference mobile app.



# Learning Objectives

## **At the conclusion of this session, the participant will be able to:**

- Define a change package as a tool for driving nationally applicable Screening, Brief Intervention, and Referral to Treatment (SBIRT) adolescent practice transformation.
- Identify SBIRT clinical and operational change concepts that maximize opportunities to promote integration by enhancing population health, generating outcome-informed policies, and creating community partnerships.
- Implement practical applications of SBIRT change concepts tested by pilot participants to integrate upstream prevention, education, and early intervention.

# Bibliography / Reference

1. U.S. Department of Health & Human Services, Office of Adolescent Health. (2018). Substance Use and Adolescent Development
2. SAMHSA. (2010). Results from the 2009 National Survey on Drug Use and Health
3. Stanhope, V., Manuel, J. I., Jessell, L., Halliday, T. M. (2018). Implementing SBIRT for adolescents within community mental health organizations: A mixed methods study. *Journal of Substance Abuse Treatment*. 90, 38-46.
4. Borus, J., Parhami, I., Levy, S. (2016). Screening, Brief Intervention, and Referral to Treatment. *Child and Adolescent Psychiatric Clinics of North America*, 25(4), 579-601.
5. Gryczynski, J., Mitchell, S. G., Schwartz, R. P., Kelly, S. M., Dusek, K., Monico, L., O'Grady, K. E., Brown, B. S., Orso, M., Hosler, C. (2018). Disclosure of Adolescent Substance Use in Primary Care: Comparison of Routine Clinical Screening and Anonymous Research Interviews. *Journal of Adolescent Health*.

# Why an Adolescent SBIRT Change Package?

People are most likely to **begin misusing substances** during adolescence & young adulthood<sup>1</sup>

The #1 **predictor of adult substance use disorder** = youth substance use problems<sup>2</sup>

Widespread SBIRT adoption often hindered by a **lack of** uniform and clear implementation guidance

Successful models are built on agreed upon, codified & replicable: ✓**Screening tools** ✓**Processes** ✓**Interventions**

<sup>1</sup> U.S. Department of Health & Human Services, Office of Adolescent Health. (2018). Substance Use and Adolescent Development

<sup>2</sup> SAMHSA. (2010). Results from the 2009 National Survey on Drug Use and Health

# Learning Assessment

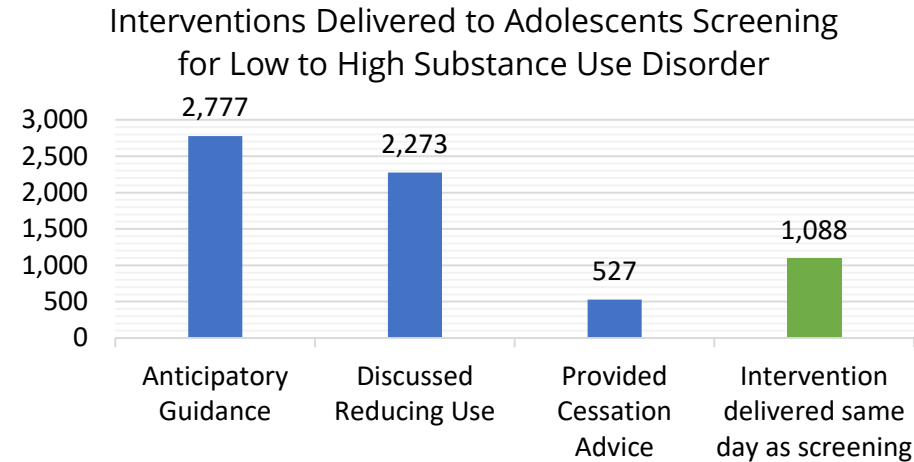
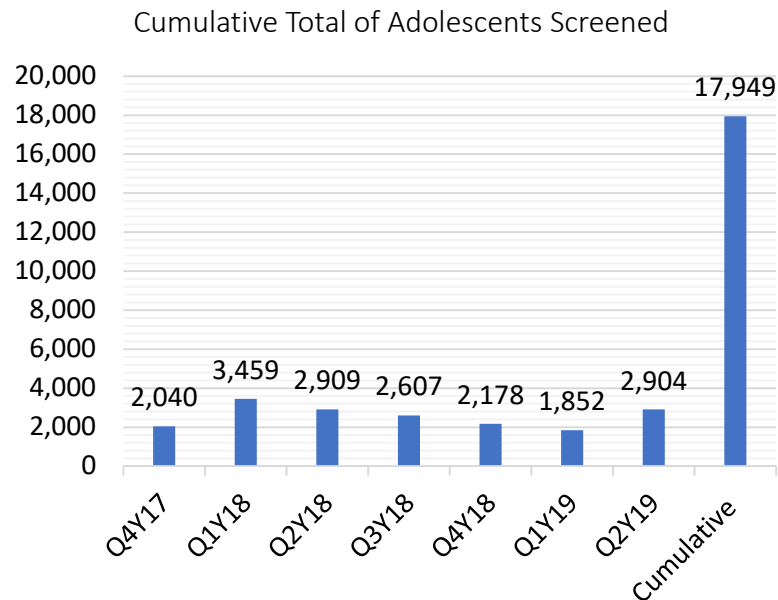
- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

# Practice Transformation Learning Community



# Practice Transformation Learning Community

Screened **91%** of all adolescents who visited for well visits from October 2017 to June 2019



***Independent evaluators of the SBIRT Change Package Pilot Program after an 18-month study found:***

- Providers delivered the appropriate intervention based on screening results
- Increase in behavioral health and primary care integration
- Higher integrated care correlated with increased communication and cohesion
- Clinicians who perceived more supportive organization structures reported greater confidence in conducting SBIRT
- Nurses saw the greatest gains in positive attitudes toward screening and brief intervention indicating they are champions for adolescent SBIRT

# Change Concepts & Lessons Learned

# Change Concepts: Screening

1. Use the S2BI (self-administered version) to **screen for substance use risks** in adolescents
2. Ensure capacity for **evidence-based response** based on screen results

S2BI: Screening to Brief Intervention	
In the past year, how many times have you used	
<ul style="list-style-type: none"><li>• Tobacco?</li><li>• Alcohol?</li><li>• Marijuana?</li></ul> <p><b>STOP if all "Never." Otherwise, CONTINUE.</b></p> <ul style="list-style-type: none"><li>• Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?</li><li>• Illegal drugs (such as cocaine or Ecstasy)?</li><li>• Inhalants (such as nitrous oxide)?</li><li>• Herbs or synthetic drugs (such as salvia, "K2", or bath salts)?</li></ul>	<p><input type="radio"/> Never</p> <p><input type="radio"/> Once or twice</p> <p><input type="radio"/> Monthly</p> <p><input type="radio"/> Weekly</p>

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# Screening: Practical Application

## Create a conducive environment

- Culturally relevant posters that promote and normalize screening as a part of standard health care. Localized data helps too.
- Add screening to others already done with child alone.
- Staff practice, create workflow

Starting at age (x) all patients are seen for at least a portion of their visit without parents so they can start having opportunities to take ownership of their health.

It's understandable to be conflicted as a parent. Our goal is to have a trusted relationship with you and your child so we have accurate information for providing the best care possible. When confidentiality is not assured, young people are less likely to disclose sensitive information and more likely to forego care.

# Change Concepts: Brief Intervention

1. Clearly communicate age-appropriate risks of alcohol, tobacco, and substance use **to health and well-being**, with patients reporting any past year use
2. Leverage PCP/primary **care team-patient relationship** to discuss behavior change, negotiating and documenting a reasonable change plan
3. Ensure PCP and primary care team members receive BI training **tailored to defining risk and developmental level**, to ensure effective BI that is responsive to screening results



# Brief Intervention: Practical Application

## 2. CONFIRM SCREENING RESULTS & EXPLORE/ASK FOR MORE DETAILS ABOUT USE

- **Explore** perceived benefits versus downsides:  
*"How does \_\_\_\_\_ fit into your life?"*  
*"What, if any concerns do you have about...?"*
- **Express** empathy:  
*"I am so sorry that you went through that."*  
*"I can't imagine what that was like."*
- **Validate** the experience/event:  
*"Going through something like that must be so difficult."*
- **Educate** about the connections between substance use, trauma, physical health, and behavioral health.

- **Listen** intently to understand results and their context.
- **Commit** to setting aside your own judgements and thoughts about screening results to strengthen your ability to be patient and persistent.
- **Maintain** awareness of the language, tone and volume used when responding. Use person-first language and avoid a judgmental tone and generalizations.

### *For Example:*

#### **Say This**

*Alcohol or drug poisoning*

*Person with substance use disorder*

*Unhealthy substance use*

#### **Not That**

*Overdose*

*Addict*

*Substance misuse*

- **Focus** on competence and internal capacity for change versus knowledge or skills deficits. Strengths-based approaches increase the effectiveness of interventions.

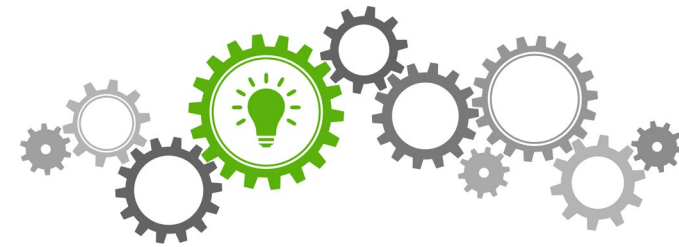
# Change Concepts: Referral to Treatment

1. Establish criteria for referral linked to patient substance use, **and physical and mental health**
2. Develop **protocol and procedures** to link patients to internal and/or external care, leveraging provider/organizational **partnerships**
3. Ensure capacity, protocols, and documentation standards for **ongoing care management** (including interim management, supporting client readiness, facilitating treatment entry and follow-up)



# Change Concepts: Operational

1. Conduct an **Organizational Self-Assessment** (needs assessment)
2. Identify and develop **sustainable financing strategy** to support SBIRT, including identification of relevant policy, reimbursement processes, and opportunities within existing service incentive programs
3. Maximize **data** collection and utilization strategy, including use of electronic medical records, to translate data into action and foster **continuous quality improvement**



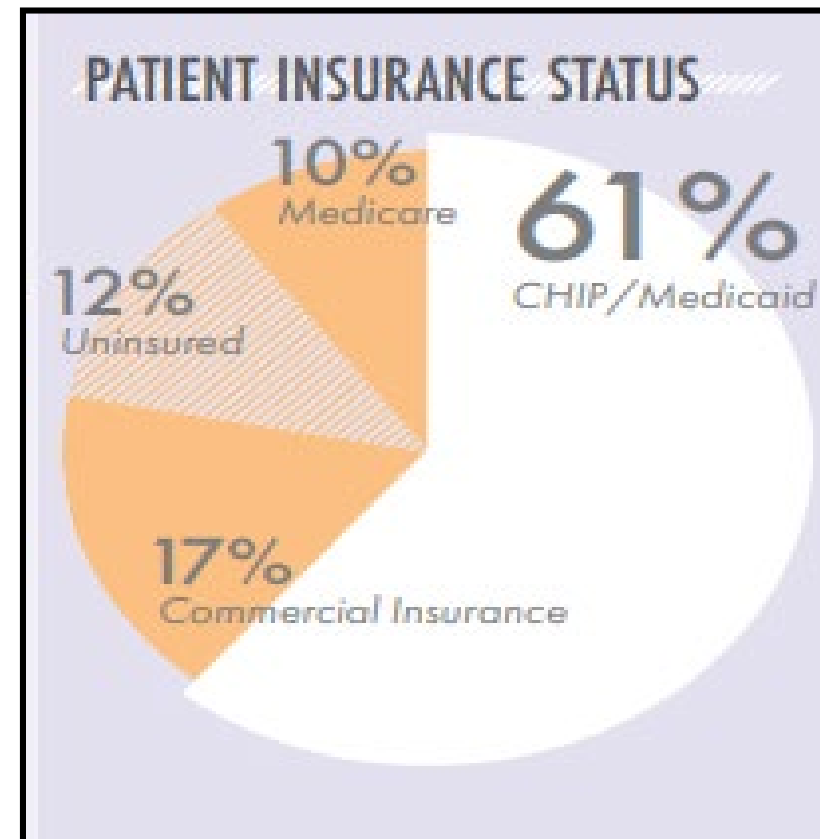
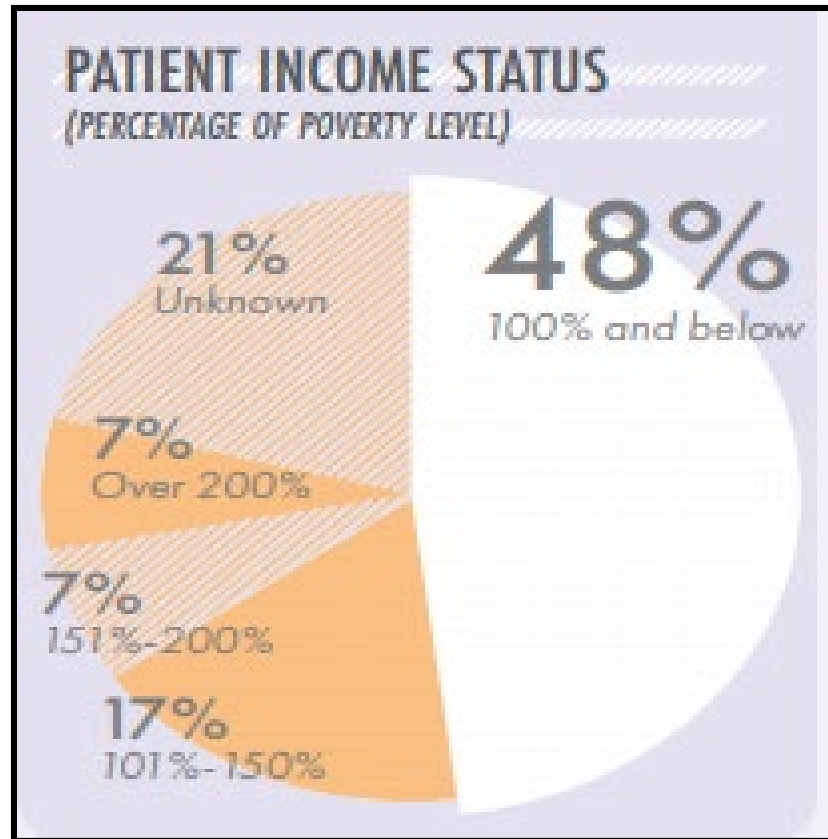
# Success Stories



# Family First Health

- **FQHC located in South Central PA**
  - **6 locations – serving 3 counties**
    - Primary Medical Care
  - Dental at 4 sites and mobile for SBHC
- Integrated Services – Behavioral Health and Substance Use Services integrated with medical care
  - 5 MAT prescribers at 4 locations
- Caring Together serving over 600 HIV+ patients
  - Nurse Family Partnership
- Connections for a Health Pregnancy
  - Guided Care Coordination

# Family First Health Demographics



# Family First Health

TOTAL PATIENTS SERVED

25,368

TOTAL MEDICAL/DENTAL VISITS

80,003

COLLABORATIVE CARE

1,923

*Patients connected with behavioral health services as part of routine primary care visit*

SUBSTANCE USE SERVICES

399

*Patients provided comprehensive support to reach & maintain recovery*

# Journey through SBIRT Integration – The Beginning

- Introduction of Center of Excellence and Substance Use Services in January, 2017
- July 2017 FFH was invited to participate in National Council's Learning Collaborative focusing on implementation of the S2BI Change Package for screening adolescents in primary care
- Prior, the only screening was the PHQ2 universal screening for all patients 13+

# Initial Critical Decisions

- Universal screenings for patients 12+
- Change from PHQ2 to PHQ9
- S2BI AND Adult substance use screenings
- Implementation across all sites as standard practice
- Assuring confidentiality to minor patients
- Training of staff on:
  - PHQ9 – Wellspan Psychiatry – all medical staff
  - SBIRT – University of Pittsburgh – MR, PCT, PCP's

# Challenges and Considerations

- Medical staff buy in – Why in Primary Care?
- Paradigm shift that substance use disorders are chronic health conditions
- Workflow development
- **EHR** – unable to add S2BI as a screening tool; had to be built into Social History, pulling data was difficult
- Staggered training at each site and implementation
- Defining “brief intervention”
- Integration of Behavioral Health and SUS staff for Warm Hand Off's

# Benefits of the SBIRT

Marie Kellett, M.D.



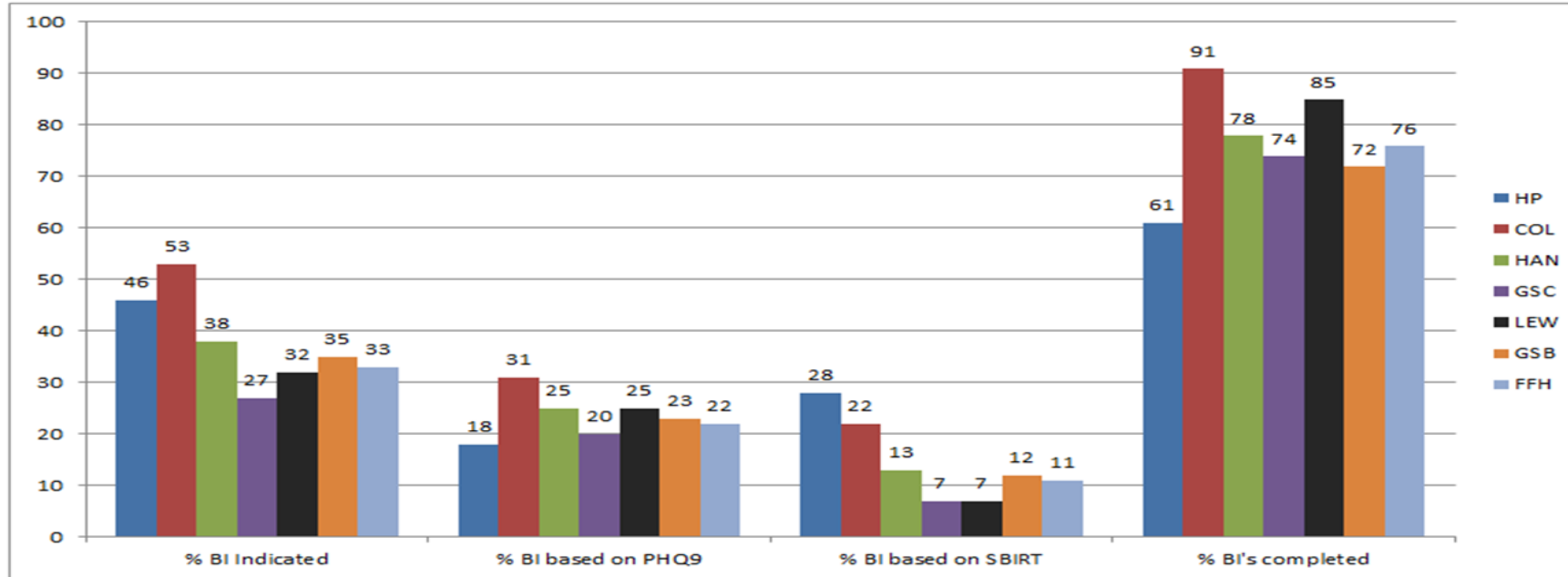
- Case: 14 year old in for new patient, well child care. Father is my patient receiving MAT for opioid dependence. Mother (not my patient) also on MAT. Screening was positive for alcohol. Prompted further conversation with parents in the room and then separately. She admitted to smoking marijuana to me and gave me permission to then discuss this up with her parents. This allowed for further conversation and education about her increased risk of addiction and how marijuana and alcohol can lead to further use. Without screening I wouldn't have been able to impact this family in this way.
- Many of the people I see with later addiction start at ages 12, 13, 14 with alcohol and marijuana

**If you don't ask, you don't know**

# ...the Data...

	Unique Patients	Substance Use Screens	% needing BI's	PHQ9 Screens	% needing BI's	Notes
Ages 12-21	3185	2862	517 <b>18%</b>	7718	1312 <b>17%</b>	Discrepancy due to rooming errors
Ages 22+	12,186	42,543	15,095 <b>35%</b>	43,588	9648 <b>22%</b>	Some pts screen positive for both AUDIT and DAST
Total	15,371	45,405	Referral to Treatment <5%	51,306		

# Communication to Sites



## George Street Center

619 patients 12 + yrs screened  
 166 screened positive for BI (27%)  
 125 PHQ9 BI (20%)  
 41 SBIRT BI (7%)

BI provided 74% of time when indicated

## FFH Organization

1283 patients 12 + yrs screened  
 425 screened positive for BI (33%)  
 287 PHQ9 BI (22%)  
 138 SBIRT BI (11%)

BI provided 76% of time when indicated

## High Risk BI's Provided

HP – 63% (5/8)  
 COL – 60% (3/5)  
 HAN – 55% (11/20)  
 GSC – 62% (23/37)  
 LEW 67% (4/6)  
 GSB 87% (13/15)  
 FFH – 65% (59/91)

# Lessons Learned

- Messaging from Senior Leadership is essential
- Include Operations and QI from the onset
- Strong medical champion with influence
- Identify champions in PCT and MR staff
- Develop workflows that are consistent with medical provider workflow
- Normalize BI's – its what providers do for other health conditions
- Limitations of the Screening Tools

# Remaining work

- Data collection – created “Order Sets” to drop the BI’s
- Ongoing training about BI’s
- Transferring reporting and compliance to Operations and the QI Department
- Identify SBIRT as a Quality Measure

# Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.



**Join us next year in Philadelphia, Pennsylvania! Thank you!**