

Reducing Adolescent Substance Abuse Initiative: Adolescent SBIRT Implementation in the Behavioral Health Setting Final Report

November 2017



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EXECUTIVE SUMMARY

In 2014, with funding from the Conrad N. Hilton Foundation, the National Council for Behavioral Health (National Council) developed the Reducing Adolescent Substance Abuse Initiative (RASAI). The initiative focused on prevention and early intervention of youth substance use, as this represents a critical period for identifying risky behavior and providing early intervention.

The RASAI project included implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) within community behavioral health settings and facilitating a learning community among sites and states.

RASAI components included in-person meetings and trainings, bi-monthly coaching calls, online trainings including role-based and content-specific webinars, video demonstrations, data-focused trainings and tools, resource and file-sharing, and monthly newsletters. Financial guidance and support were key components of technical assistance

(TA) provided. The National Council developed platforms to monitor and evaluate activities, and encouraged RASAI sites to utilize electronic health records (EHRs) for data collection and reporting.

Of participating sites, 100% implemented SBIRT, met program requirements, and tracked and monitored key performance indicators. More than 4,637 youth were screened across 27 sites. Despite challenges related to staff turnover, complex workflows, and billing and EHR complexities, this work proved feasible—and sustainable. Participating sites developed policies and procedures to routinize SBIRT practices into their organization and more than 50% of sites have or plan to scale-up their SBIRT practices. The RASAI project saw strong engagement across states and cross-organizational sharing of lessons learned. This final report summarizes key activities, developments, outcomes, and recommendations.



BACKGROUND

The majority of people who meet criteria for substance use disorders at some point in their lifetime began using alcohol or drugs in adolescence.¹ Adolescence is therefore a critical period to identify risky behavior before a substance use disorder develops and to intervene appropriately along the continuum of risk, wherever a client may be.

In 2014, with funding from the Conrad N. Hilton Foundation, the National Council for Behavioral Health (National Council) developed the Reducing Adolescent Substance Abuse Initiative (RASAI). The Initiative focused on prevention and early intervention of youth substance use. RASAI aligned with the Foundation’s overarching Youth Substance Use Prevention Strategic Initiative goals. **These include:**

1. Increase knowledge and skills among providers



2. Improve funding for, access to, and implementation of screening and early intervention services



3. Conduct research and advance learning to improve screening and early intervention practices



¹ U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016. Available from: <https://addiction.surgeongeneral.gov/>

Effective implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a focal point within the Conrad N. Hilton Foundation Youth Substance Use Prevention Strategic Initiative. **The Foundation supports efforts to explore how SBIRT may be used effectively in multiple settings to prevent and identify risk for addiction at the most crucial window for its development: adolescence. The model is an upstream approach, meaning that it seeks to identify the potential for addiction before it starts.**

SBIRT gives providers the tools and skills they need to identify adolescents who are using substances, provide brief interventions to negotiate safer use, and refer to specialty addiction treatment if necessary. While SBIRT has historically been implemented within primary care, the RASAI project focused keenly on embedding and sustaining adolescent-focused SBIRT interventions within community behavioral health settings and facilitating a learning community among sites.



“We are so grateful for this opportunity. We have learned a lot and, as a result, have improved our quality of care. We feel a lot more equipped to take an integrated approach to mental health. We also have developed some great collaborations that would not have taken place without RASAI.”

A learning community is a group of organizations committed to improving health outcomes for the people they serve and working together to implement or improve specific practices and processes. RASAI was designed to help community-based organizations that provide behavioral health care services systematically implement the SBIRT framework to address substance use among adolescents ages 15-22 receiving services for an emotional disturbance or a psychiatric disorder.

Through an active two-year learning community, 27 community behavioral health organizations (CBHOs) received training and technical assistance and peer collaborative support to implement, fund, monitor, evaluate, and sustain SBIRT practice within their agencies. Each CBHO worked in partnership with an addiction treatment provider and its state behavioral health provider association (known as their State Lead). State Leads supported any needed state-level negotiation over the use of Medicaid and its Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, as well as other funding streams and strategies to finance SBIRT.²

Key objectives of the RASAI project included:

- ▶ Ensuring providers have necessary clinical knowledge, skills, and processes to implement effective SBIRT among adolescents
- ▶ Building capacity for durable SBIRT protocols in organizations through pursuing the necessary policy and regulatory environment, and state-specific financing strategies
- ▶ Developing comprehensive monitoring and evaluation of learning community participants
- ▶ Sustaining project implementation and successes following the conclusion of the learning community
- ▶ Facilitating dissemination of project findings and materials to the broader health community

² Under the EPSDT benefit, Medicaid mandates well-child visits (periodic screening) and covers an array of preventive, diagnostic, and treatment services for Medicaid-eligible children under age 21. For any condition identified, the EPSDT benefit covers medically necessary treatment costs. On January 26, 2015, the Centers for Medicare & Medicaid Services (CMS) clarified that EPSDT includes age-appropriate mental health and substance use screening as part of well-child exams. EPSDT may serve as a funding vehicle for adolescent SBIRT.

California

*California Council of Community Behavioral Health Agencies

- Bill Wilson Center
- Hathaway-Sycamores Child and Family Services
- Hillsides
- Pacific Clinics
- Turning Point of Central California, Inc.

Colorado

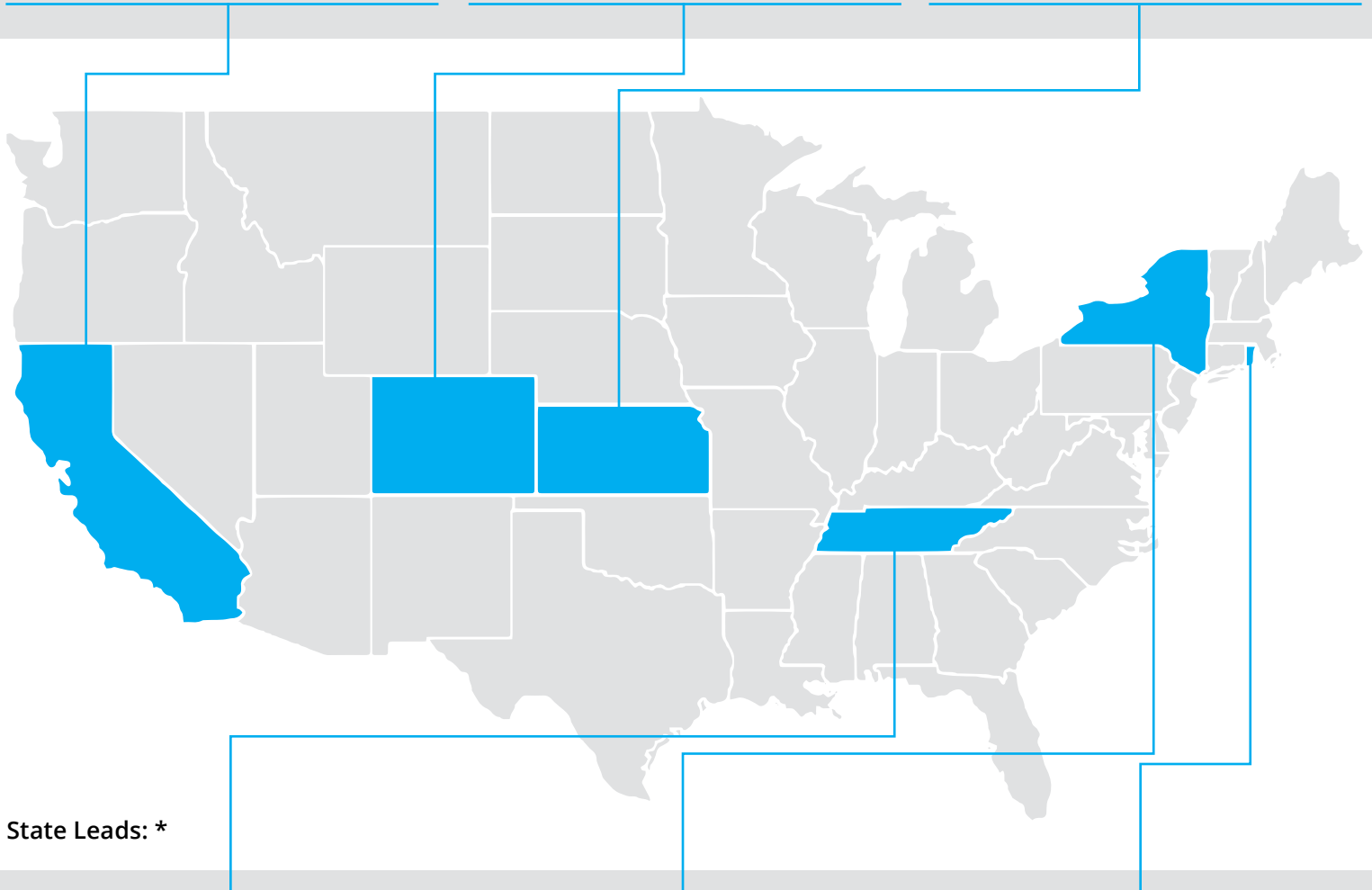
*Colorado Behavioral Healthcare Council

- Community Reach Center
- Jefferson Center for Mental Health
- Mental Health Center of Denver
- San Luis Valley Behavioral Health Group

Kansas

*Association of Community Mental Health Centers of Kansas

- Central Kansas Mental Health Center
- Compass Behavioral Health
- Elizabeth Layton Center, Inc.
- Four County Mental Health Center
- South Central Mental Health Counseling Center
- The Center for Counseling & Consultation



State Leads: *

Tennessee

*Tennessee Association of Mental Health Organizations

- Alliance Healthcare Services
- Carey Counseling Center, Inc.
- Frontier Health
- Helen Ross McNabb Center

New York

*New York State Council for Community Behavioral Healthcare

- Astor Services for Children and Families
- Child & Adolescent Treatment Services
- Hillside Children's Center
- ICL
- Northeast Parent & Child Society

Rhode Island

*Substance Use & Mental Health Leadership Council of RI

- Gateway Healthcare, Inc.
- Newport County Community Mental Health Center
- The Providence Center



METHODS

LEARNING COMMUNITY PARTICIPANT SELECTION

Through its vast membership network of CBHOs and state behavioral health provider associations, the National Council released a competitive request for applications for both potential participant sites and state associations. Interested organizations were required to apply in coordination with the association in their state, who then fulfilled the State Lead Association role. State Lead Associations were selected based upon level of commitment and understanding of statewide need for improved adolescent substance use prevention and early intervention. Out of 19 applications received, six successful applications were chosen: California, Colorado, Kansas, New York, Rhode Island, and Tennessee.

Among 65 site applications across those six states, 27 organizations were selected to participate in the learning community. Successful organizations attested to the following:



Serving a sufficient number of youth with serious emotional/psychiatric illness, aged 15-22 years;



Licensed to provide comprehensive substance use treatment to adolescents, or having an established relationship with a specialty substance use treatment organization to support referral to treatment for youth identified as needing this level of care;



Enrolled or empaneled with its state Medicaid agency or designee;



Commitment of a CBHO “Core Implementation Team,” encompassing its CEO/Executive Director, Chief Clinical Officer, Chief Financial Officer, at least two clinical staff, and one designated data collection staff member to participate in all project activities, including a formal quarterly report.

TRAINING & TECHNICAL ASSISTANCE MECHANISMS

Participation in learning communities brings the knowledge of thought leaders and subject matter experts to organizations who value innovation and best practices while also building on the collective knowledge and real world experiences of fellow learning community members.

RASAI training and technical assistance (TTA) activities included:



In-person meetings and trainings. Each year of the RASAI project included an in-person meeting. This supported engagement across sites, provided hands-on subject matter trainings, and tracked SBIRT implementation and sustainability progress. Across all of these meetings, the National Council requested that sites send staff with diverse expertise, including clinical, data, leadership, and finance, to ensure various perspectives were available in the room when discussing workflow, workforce, and sustainability.

To officially launch the learning community, the National Council convened a 2014 Kickoff Summit. This included in-person meetings within each of the participating states to train a total of 230 site staff on:

- ▶ **SBIRT**
- ▶ **Learning community structure and goals**
- ▶ **Evaluation/data collection requirements**
- ▶ **Roles and responsibilities of core team members**

The 2015 SBIRT Summit in-person meetings aimed to highlight and discuss successes and lessons learned in Year 1, and equip sites with the resources and knowledge needed for long-term sustainability and scalability of SBIRT. During the 2016 SBIRT Summit final in-person meetings, the RASAI project team collaborated with site staff to discuss successes and lessons learned in Year 2, and equip sites with the resources and knowledge needed to continue their sustainability and scalability of SBIRT after the conclusion of the learning community.

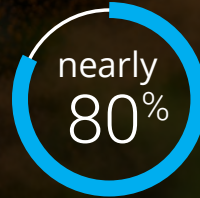
During these final SBIRT Summits, the National Council provided aggregate summaries of quarterly data reports to facilitate across site and across state benchmarking. Sites also heard state-specific policy updates from the State Leads and developed detailed [sustainability objectives and action steps](#) that they would use to ensure long-term sustainability and scalability of SBIRT.

On-Demand Expert In-Person Training: An Example

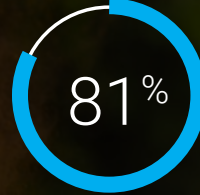
Brie Reimann, RASAI TA Coach and Deputy Director of the Center for Integrated Health Solutions, conducted a SBIRT training on March 3, 2017 for RASAI site Community Reach Center in Denver, Colorado. Over 40 clinicians, administrative staff, and nurses participated in the session. The training was comprised of a structured presentation and group activities focused on practical applications of SBIRT in real-life settings, followed by 1:1 consultation sessions with site staff.



of post-training evaluation respondents either agreed or strongly agreed that the session content was relevant to their practice



either agreed or strongly agreed that the training gave them the necessary tools and knowledge to effectively integrate SBIRT into their daily practice



would recommend the training to their peers



Webinars and online trainings. Regular interactive webinars and online trainings helped clinicians and support staff hone their brief intervention and motivational interviewing skills and expand their knowledge on topics identified by site staff. Webinar and training content included:

- ▶ **Screening and brief intervention**
- ▶ **Referral best practices**
- ▶ **Trauma and adolescent substance use**
- ▶ **Motivational interviewing**
- ▶ **Pathways to adolescent substance use treatment**
- ▶ **SBIRT supervision**
- ▶ **Protocols for sustaining SBIRT**
- ▶ **Addressing marijuana use with adolescents**

The National Council hosted additional role-based webinars of particular interest to sites, including two specifically for Project Leads: project leadership and organizational change management. In addition, “Data Jam” webinars targeting site Data Leads focused on using a project-specific database and utilizing data and data dashboards to inform continuous quality improvement.

Based on site feedback from the quarterly narrative reports, the National Council team filmed three short BI fidelity videos and hosted video demos with sites. The demo sessions acted as useful ways for clinicians to engage in an open dialogue, and discuss questions, such as “What might you do differently in this interaction?”



In 2014, the RASAI project team began working with Relias Learning, LLC, a strategic partner of the National Council. Through RASAI participation, sites were granted free access to Relias’ individualized online courses on a web-based learning management system. Selected training courses were voted on by sites based on their most pressing staff needs and which topics they would find most useful as they continued implementing SBIRT in their agencies. Over the course of the learning community, RASAI site staff completed more than 260 Relias training certifications and earned over 400 credit hours in the following topics:

- ▶ **Motivational interviewing**
- ▶ **Adolescent substance use disorder clinical pathways training**
- ▶ **Evidence-based practices in treating substance use disorders**
- ▶ **Advanced motivational interviewing**
- ▶ **Practical strategies for engaging families and children**

In the RASAI Project Exit Survey, over 45% of participating sites ranked the Relias trainings as being among the most helpful aspects of the learning community.

Bi-monthly coaching calls. Each site was assigned an expert Technical Assistance (TA) Coach and received bi-monthly, individualized coaching calls where they discussed topics such as policies and procedures, electronic health record (EHR) optimization, data-informed practice, supervision, and staffing considerations. The National Council team facilitated statewide coaching calls in July and August 2016 for all sites in each of the six participating states. The purpose of the coaching calls was for sites to connect with one another and share lessons learned, all the while receiving individualized and group TA coaching expertise. Attendees lauded the value of this geographic affinity group.





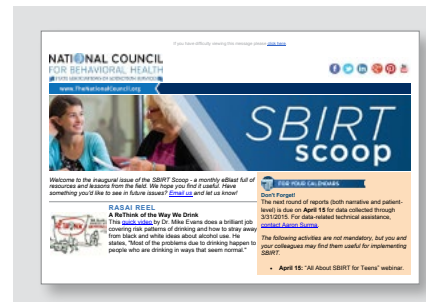
Resource and information sharing.

To help facilitate information sharing among participating sites, project activities, materials, and resources were regularly added to a RASAI-specific file-sharing site. The National Council also disseminated useful resources and information via regular email correspondence. For example, many sites shared their SBIRT clinical protocols/workflows which the National Council posted to the file-sharing site to facilitate peer-to-peer practice improvement.

Beginning in April 2015, the National Council released the first issue of SBIRT Scoop to participating sites, a regular eNewsletter comprised of helpful resources, sustainability and implementation tips, and lessons from the field. The [SBIRT Scoop](#) was extremely well-received, as illustrated by above-average open and click rates.

While the initial issue was sent to a distribution list of approximately 300 learning community participants, requests from additional site staff and external stakeholders contributed to the distribution list growing to more than 1,300 recipients.

RASAI also highlighted and leveraged the stellar work of fellow Conrad N. Hilton Foundation grantees. Notable resources included the Mosaic Group's [Adolescent SBIRT Implementation Checklist](#)—a tool designed to provide organizations with a set of essential steps to ensure that SBIRT becomes a sustainable, integrated part of routine care. The Partnership for Drug Free Kids also provided training and resources to two RASAI sites to implement [Community Reinforcement and Family Training](#), or CRAFT—a scientifically proven approach to help parents understand and influence their child's substance use behavior by staying involved in a positive, ongoing way.



“Thank you for all of the **great resources and support** throughout the process. The resources that were made available (most often through the update emails) provided **wonderful opportunities** for many staff to engage with the material and enhance our services.”



Financing Guidance

The National Council contracted with Health Management Associates (HMA) to provide consultation and customized TA to state executives and sites on state-level coverage and sustainability of SBIRT services. HMA delivered consultation through a variety of mechanisms including webinars, coaching calls, resource development, and dissemination. The National Council also conducted webinars on topics specific to billing and financing, including one session in coordination with the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

State Leads were tasked with pursuing policy and regulatory changes for SBIRT financing and providing policy expertise and leadership at the state level. State Leads engaged in monthly coaching with healthcare policy consultants at HMA to formulate advocacy strategies related to SBIRT financing, discuss the state-level policy landscape relating to SBIRT, and determine SBIRT sustainability strategies. The National Council also held bi-monthly conference calls with State Leads and HMA to connect on project updates, state-level policy landscapes, and any state political developments impacting SBIRT delivery and financing.

The National Council worked with HMA to develop a financing matrix document highlighting SBIRT coding and reimbursement requirements for RASAI participating states, as well as a brief overview of federal initiatives that provide opportunities to finance SBIRT. This document illustrates not only the variation in policies across states, but also details licensing and reimbursement requirements that can act as barriers for behavioral health providers. HMA found key similarities across RASAI-participating states, such as the types of professionals and training expectations required to bill for SBIRT. Variation between states was indicated in payment rates, permissible screening tools, and billing codes.

HMA recommended key questions that states should ask and answer in their efforts to successfully promote widespread SBIRT adoption by health care providers. Finally, a description of four federal initiatives, including Certified Community Behavioral Health Clinics (CCBHCs), Medicaid Health Homes, Managed Care, and State Innovation Model grants, provide an overview of other opportunities to sustainably bill for SBIRT. The National Council continues to work with HMA to develop a white paper that provides a lay-person's understanding about the federal EPSDT mandate. The white paper explores why there may be different perspectives on the coverage of specifically identified SBIRT codes and how such differences may be bridged.



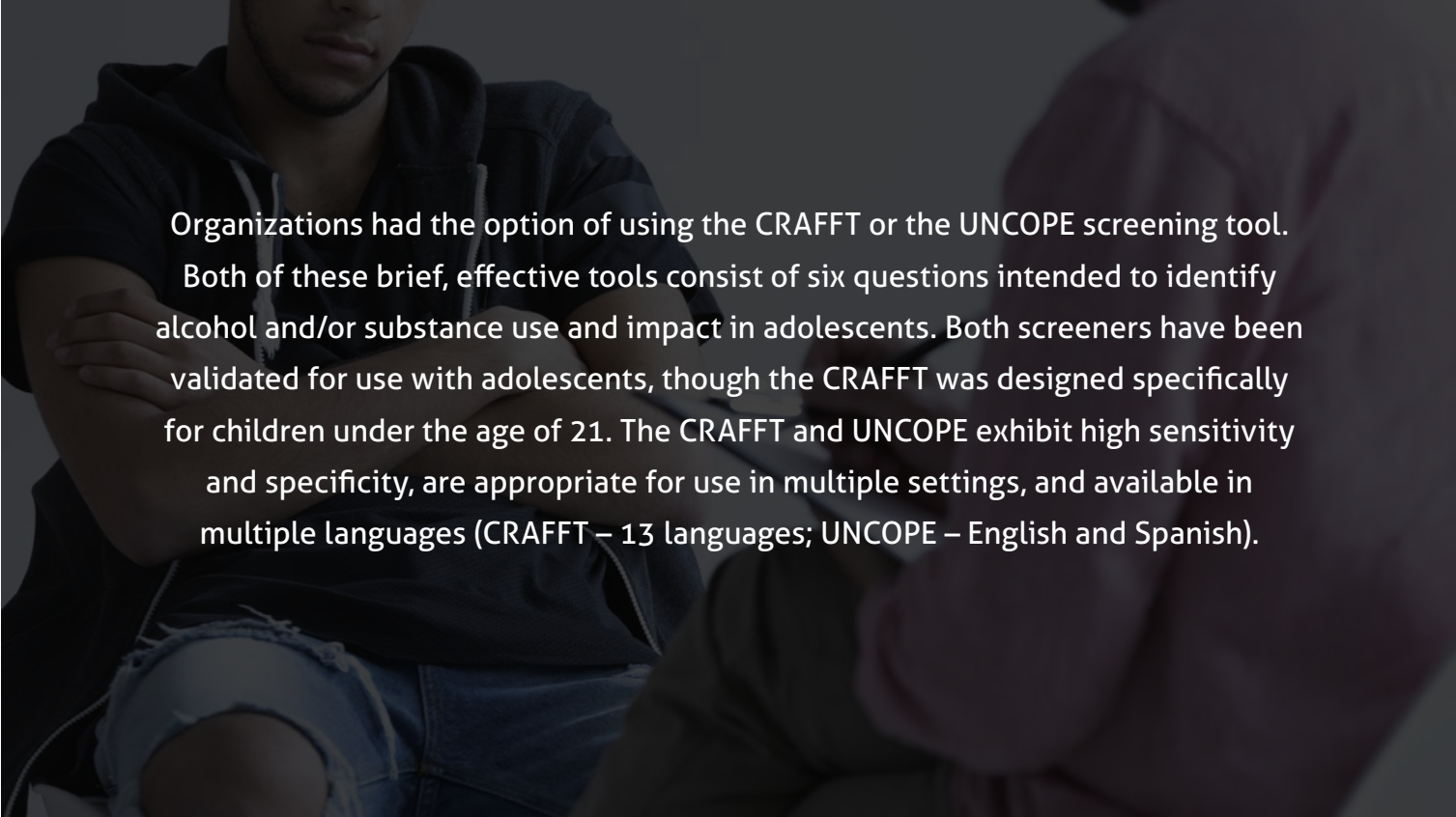
Monitoring and Evaluation Activities

The National Council developed a project monitoring and evaluation plan, including both qualitative and quantitative data collection processes, with which 100% of sites consistently engaged. On a quarterly basis, sites were encouraged to submit two forms of data:

- 1. Sites submitted an organization-level qualitative narrative report based on an evolving template highlighting implementation activities, successes, barriers, and TA requests.**
- 2. Patient-level data was submitted, including demographics, behavioral health diagnosis, screening results (CRAFFT or UNCOPE screening tool score), ensuing intervention, including referral to treatment, and follow-up.^{3,4}**

Qualitative feedback was used to evaluate the success of TTA provided, as well as to inform future content and delivery mechanisms. Approximately one-half of participating sites successfully employed EHR systems to extract and report patient-level data. Those without this capability utilized an access database developed by the National Council to suit their needs and the reporting requirements. Patient-level data were analyzed and presented in quarterly dashboards, at the site, state, and aggregate level. (See Outcomes section.)

[Dedicated TA enhanced competency in data interpretation and utilization, promoted staff buy-in, illuminated client-base characteristics, and supported continuous quality improvement.](#)



Organizations had the option of using the CRAFFT or the UNCOPE screening tool. Both of these brief, effective tools consist of six questions intended to identify alcohol and/or substance use and impact in adolescents. Both screeners have been validated for use with adolescents, though the CRAFFT was designed specifically for children under the age of 21. The CRAFFT and UNCOPE exhibit high sensitivity and specificity, are appropriate for use in multiple settings, and available in multiple languages (CRAFFT – 13 languages; UNCOPE – English and Spanish).

³ CRAFFT is a mnemonic acronym of first letters of key words in the six screening questions: CAR, RELAX, ALONE, FORGET, FRIENDS, and TROUBLE.

⁴ UNCOPE is a mnemonic acronym of first letters of key words in the six screening questions: USED, NEGLECTED, CUT DOWN, OBJECTED, PREOCCUPIED, and EMOTIONAL DISCOMFORT.



Participants also completed evaluative surveys following TA events, which included both qualitative and quantitative questions, allowing program staff to gain informative feedback on participants' perceptions of logistics, effectiveness, preparedness, and the ability to meet objective goals. Exit data indicated that participants were satisfied with their ability to use screening and other tools, and that implementing these improved clinical capacity to respond to adolescent substance use. Across three annual in-person summits, preparedness scores increased by almost a full point (3.77 in 2014 to 4.63 in 2016). The top 6 most helpful aspects of this project were:

1.  Year 1 in-person meeting
2.  Year 2 SBIRT summit
3.  Relias online training
4.  Weekly Project Lead email updates
5.  Agency on-site trainings with RASAI Clinical Lead
6.  Brief interventions fidelity support

Cumulative outcomes across all project years, included:

- **100%** of sites implemented SBIRT
- **100%** of sites completed program requirements
- **100%** of sites tracked and monitored key performance indicators related to SBIRT
- **7 in-person** kick-off meetings convened in Year 1, with 230 staff in attendance
- **11 in-person** SBIRT Summit meetings convened—6 in 2015 and 5 in 2016—with **297 staff** total in attendance, including front-line clinicians, supervisors, data leads, senior leadership, and finance representatives
- **Over 250 site staff** (including clinicians and administration) received on-demand expert in-person training
- **20 webinar** trainings presented exclusively for RASAI site staff, with more than **1,500 training completions**
- **4,637 youth screened** across 27 sites

OUTCOMES



“[Our] participation in the RASAI project has provided a major impetus in moving this agency toward becoming a more co-occurring capable service provider. We are greatly appreciative of being selected to participate and for the guidance and resources you have provided to us.”

Site Characteristic Averages



Of the 27 selected sites, just over one-half maintained an in-house adolescent substance use treatment license. Those sites without this license had to rely on new or existing partnerships with external specialty substance use treatment providers. Sites that maintained such a license had a higher proportion of clients that showed improvement in their CRAFFT/UNCOPE scores at follow-up. This may indicate that a disruption in flow of service provision to an external specialty treatment provider negatively affected client outcomes.

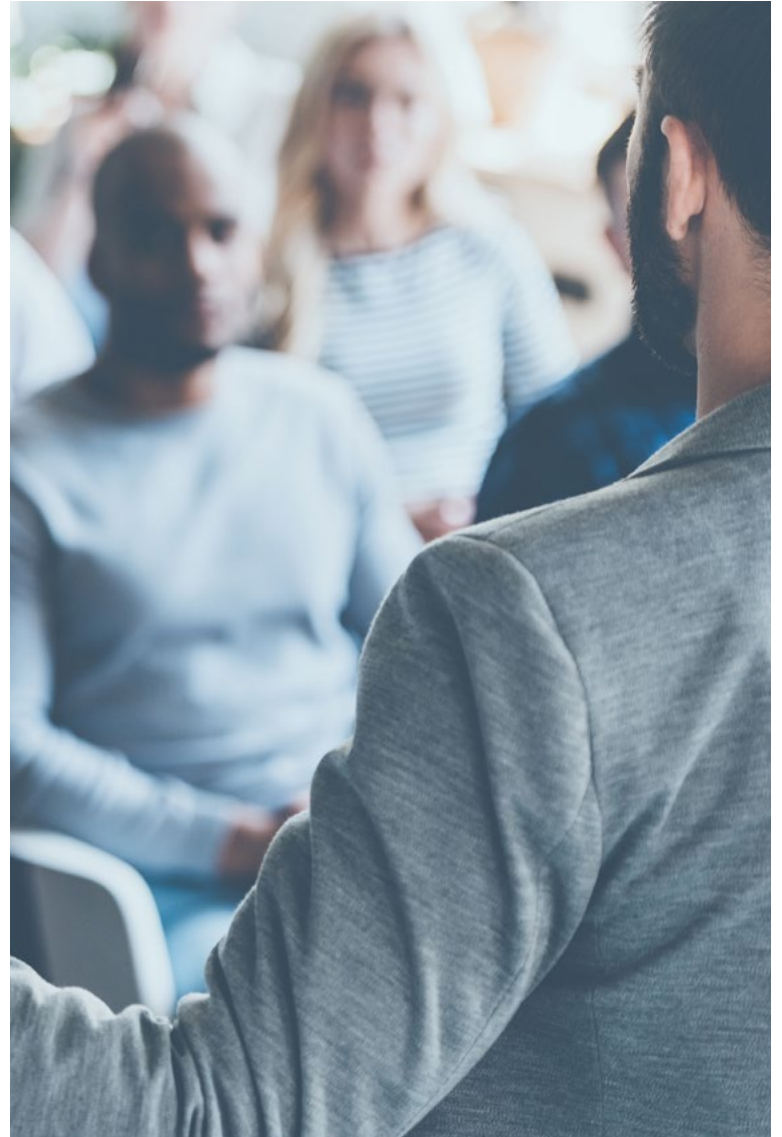
On average, participating sites responded that organizational change was relatively easy within their site. This factor likely affected site engagement and success in the RASAI program, as site staff had to adapt to new workflows and protocols as part of participation in the RASAI project. In fact, sites who indicated the greatest ease of change completed a higher proportion of follow-up assessments with their clients. While 100% of the sites maintained EHRs, adapting these systems to include SBIRT-related measures proved difficult for some sites. Inability to adapt an organization's EHR caused difficulty with tracking and monitoring provided services and client outcomes.

Characteristic	Response	Proportion
Organizational Description	CBHC	100%
	Hospital-based	11.1%
	Part of comp. health system	14.8%
	Gov't entity	3.7%
Geographic Location	Rural	48.1%
	Frontier	3.7%
	Urban	51.9%
	Suburban	22.2%
	Other	3.7%
Revenue Source (average proportions)	Medicaid	58.2%
	Medicare	3.3%
	Private third party	7.1%
	Self-pay/state grant	9.5%
	Mental health block grant	1.3%
	Substance abuse block grant	0.9%
	Other	19.75%
Standardized Screening	Yes	85.2%
Medical Records	Paper	3.7%
	E-form	3.7%
	Electronic	100%
Ease of Change (1 to 5 scale; 1=very easy)	(Average rating)	2.5
Adolescent Substance Use Treatment License	Yes	55.6%
Medicaid Enrolled	Yes	100%
Substance Use Referral Partnership	Yes	88.9%
Project Lead Turnover	Yes	29.7%

“SBIRT use has been expanded into additional agency programs not involved in the RASAI project for the purpose of meeting the substance use screening requirement of the ACA’s ‘meaningful use’ criteria. Staff in those programs are utilizing the RASAI archived webinars to become trained in conducting SBIRT.”

Aggregate Data

Individuals served:
4,637 individuals screened



DEMOGRAPHICS

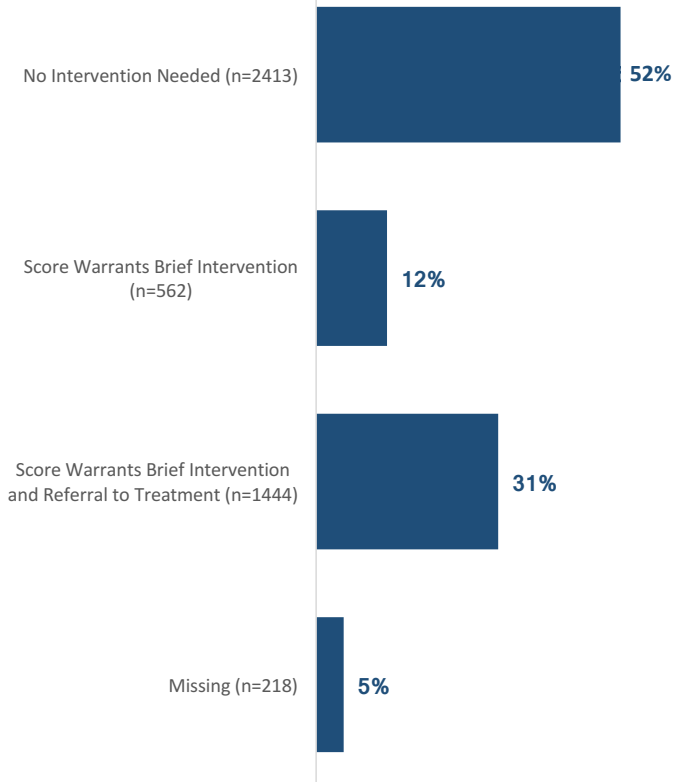


Aggregate demographic data provide a picture of the client population served by RASAI sites. The majority of adolescents served were aged 15 to 16 (54%). Most were White (52.8%), 27% were Hispanic, 14.4% were Black, and 5.7% identified as other. The most common behavioral health diagnoses were depressive disorder (41%), anxiety disorder (21%), and learning/ADHD diagnoses (18%). Around 25% of adolescents reported being a current or former smoker.

Some percentages may not add up to 100% due to rounding and, in the case of behavioral health diagnoses, youth may have more than one diagnosis.

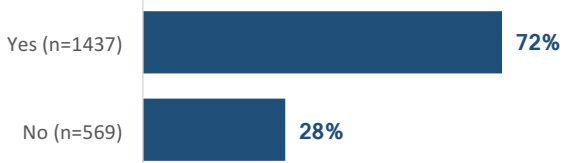
LEVEL OF RISK

8. Recommend Follow-Up for CRAFT/UNCOPE Score

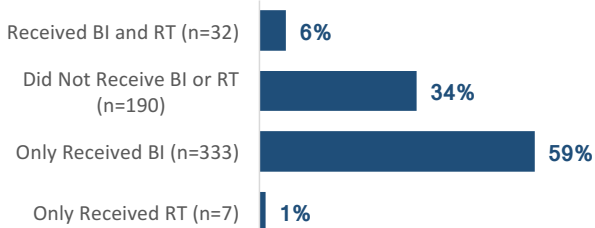


SERVICES RECEIVED BY PEOPLE WHO ARE ONLY RECOMMENDED FOR BRIEF INTERVENTION

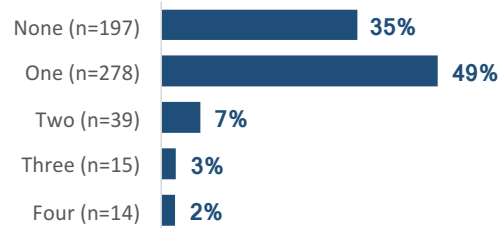
9. Were BI or BI/RT Interventions Provided for People With a Positive Screen?



10. Components of SBIRT Received by People whose Screen Indicates the Need for Brief Intervention Only



11. Number of BIs Received by Participants Recommended for Brief Intervention Only

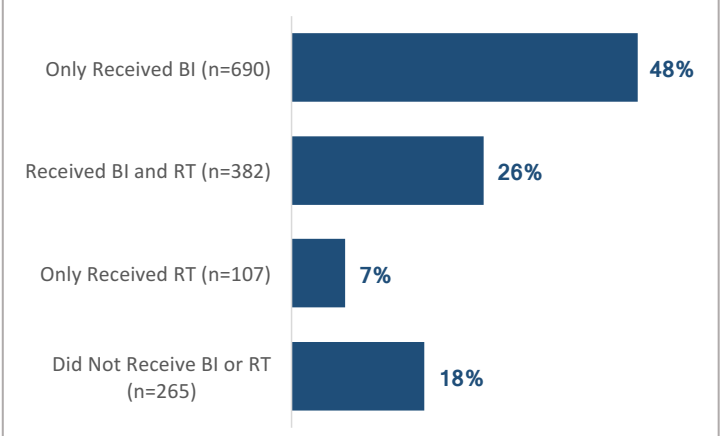


While the majority of youth screened were not recommended for intervention, data indicate high rates of positive scores warranting BI and RT (31%). Clients recommended for BI (12%) tended to receive a single session (49%), followed in frequency by those who did not receive a session as their score suggested.

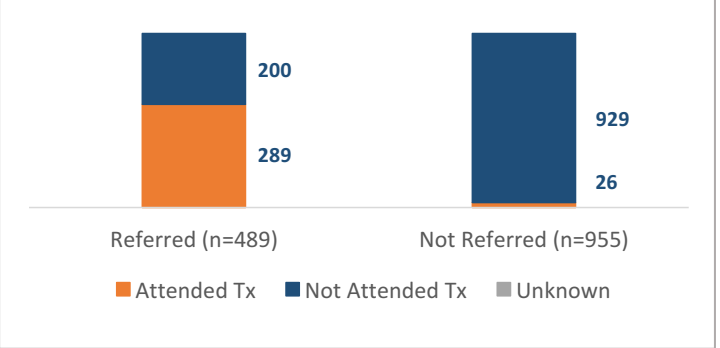


SERVICES RECEIVED BY PEOPLE WHOSE SCORE WARRANTS BRIEF INTERVENTION AND CONSIDERATION OF REFERRAL TO TREATMENT

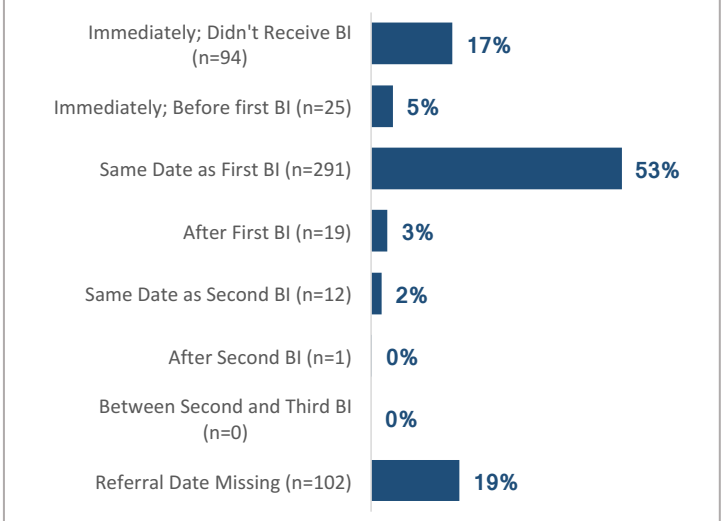
12. Interventions Received by People whose Screen Warrants Brief Intervention and Referral to Treatment



13. Treatment Attendance Among Referred and Non-Referred Participants



14. Timing of Referral to Treatment

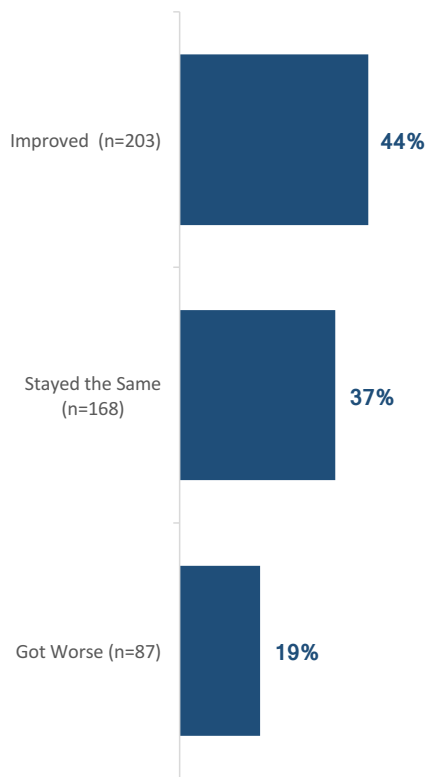


15. Number of Days Elapsed Between Referral and Treatment

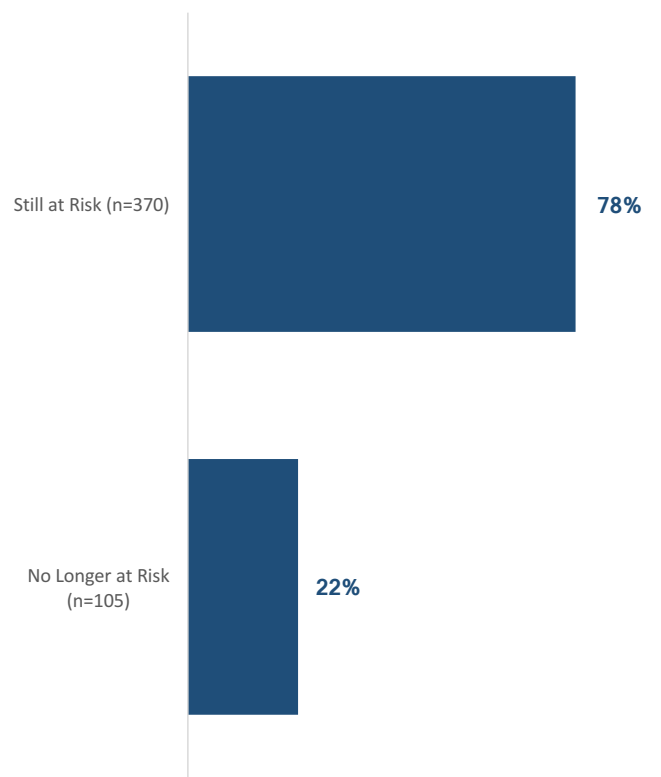
Average number of days between referral and treatment attendance: **13.95**

Amongst the 72% of clients that received some kind of intervention, most received BI only (48%) followed by BI and RT (26%), with 7% receiving RT only. RT typically happened on the same day as the first BI, with more than one-half (59%) attending treatment with an average time lapse of 13.95 days. This is noted as a considerable success in the context of the current lack of research base supporting efficacy of RT.

16. Percent of people who, after completing a follow-up CRAFFT or UNCOPE screen, reduced their risk for substance-related problems by at least one point



17. No Longer Recommended BI and/or RT at Follow-Up



Follow-up data indicate that 44% of adolescents decreased their screening score and, thus, their level of risk for substance-related problems, by at least one point. Of clients who scored positive, 22% decreased their score to the point at which no intervention was recommended. The complex and dynamic nature of this transitional age range means that adolescents are never considered truly 'not at risk,' and therefore benefit from consistent repeated screening and appropriate levels of intervention, where appropriate.

BARRIERS TO SBIRT IMPLEMENTATION

During the RASAI project, several barriers to implementation emerged. These included:

Staff turnover. Significant staff turnover was consistently highlighted by participating sites as an implementation barrier, and a threat to maintaining momentum. As new implementers, sites relied on National Council SBIRT training to orient clinical staff to the SBIRT model. Departure of trained staff produced a significant reduction in organizational knowledge, while untrained incoming staff were unable to benefit from a stable SBIRT onboarding infrastructure.

Competing priorities and complex workflows. Competing agency priorities and complex clinical workflows were a common barrier to implementation of new practices within this healthcare setting. In a shifting and unpredictable policy and financing landscape, administrators and staff alike can find difficulty in stretching to adopt practices that, while inarguably clinically important, may require cost outlay before they become economically favorable.

Medicaid complexity. The complexity of Medicaid payment for SBIRT services can be a significant barrier to behavioral and mental health providers' implementation of SBIRT. Indeed, securing coverage for SBIRT was noted by many sites as a challenge throughout the first nine months of the learning community. Licensing requirements often prevented mental health specialists from billing for SBIRT services that required substance use certifications.

EHR complications. Approximately one-half of participating sites employed EHRs. Many were in early stages of EHR construction or modification, making it difficult to incorporate additional customization efforts. Variation in EHR vendors inhibited specificity and applicability of TA and sites experienced challenges in working with their chosen vendors.



Data and billing issues. Challenges related to billing and EHR utilization also impacted the precision of data collection and interpretation. Data capture through these methods was hindered due to challenges previously listed, resulting in concern that SBIRT was not being tracked, or not being performed. Further, inconsistencies arose due to misinterpretation of the definition of BI or RT. For example, some sites deemed only external referrals as RT, neglecting to record internal referrals as such. Thus, limitations exist in the client-level data.

Lower bi-directional State Lead involvement. Inclusion of State Leads was a novel element of this learning community, and as such allowed for a creative but experimental approach to state level policy inclusion in an on-the-ground practice-improvement learning community. Interactivity between sites and State Leads was lower than expected, with most information flow educating State Leads as to experiences on the ground, rather than being truly bi-directional and assistive to individual sites.

IMPLEMENTATION SUCCESSES

The RASAI project, however, experienced a number of implementation successes. These included:

Scale up. More than one-half of project sites have or plan to scale up their SBIRT practices by expanding to additional programs/sites. At least one site is undertaking agency-wide implementation.

Sustainability planning. During the 2016 SBIRT Summits, approximately 78% of sites (21 out of 27) developed site-specific sustainability action plans. The National Council drafted an action-planning template that acted as a tool to help teams think through the components that their agency should consider and to create a tangible, realistic yet flexible, plan in order to ensure sustainability.

Advanced trainings. RASAI sponsored the attendance of three site Project Leads at the SBIRT Trainers Academy hosted by the National SBIRT Addiction Technology Transfer Center (ATTC) and the Institute for Research, Education and Training in Addictions (IRETA). The purpose of this advanced training was to enhance the skills of SBIRT trainers with effective strategies for training adults on SBIRT content, with the eventual goal of building organizational training infrastructure and increasing SBIRT sustainability.

SBIRT-specific policies and procedures. Development of policies and procedures was a noted success toward embedding SBIRT as a normalized practice within sites. This activity was also a demonstration of the power of the collaborative nature of a learning community. Sites that were further along the development process openly shared their written policies and procedures as well as their processes for developing them, to facilitate the same for other sites.

SBIRT conference tracks. At the National Council annual conference (known as NatCon), the National Council hosted a dedicated SBIRT track, available to more than 5,000 conference attendees from the fields of behavioral health and primary care. During each of the SBIRT track workshops and sessions, the current project, its successes, and lessons learned were discussed and integrated into the presentations. All presentation materials are archived on the [National Council website](#) for public use.



Click image to view video

SBIRT billing. At culmination of the learning community, the majority of sites reported successful billing for SBIRT services, with some also securing State block grant funding support.

Strong engagement. State associations maintained strong engagement throughout the duration of the learning community, with increased support for SBIRT and affirmation of continued support for sites after project completion.



CONCLUSIONS AND RECOMMENDATIONS

Findings from both qualitative and quantitative data gleaned from sites, TA coaches, and project staff informed the following conclusions and recommendations for behavioral health entities considering or embarking upon SBIRT implementation and sustainability within adolescent-serving organizations.

CONCLUSION

Co-occurring capacity is not guaranteed in the community-based mental health setting. Even among behavioral health providers, a comprehensive understanding of substance use and its relationship with mental health can be lacking. This increases potential for stigma surrounding the topic, and missed opportunities to identify and intervene on risky behavior. Developing this knowledge and capacity will bolster organizational and clinical excellence in identifying and responding to at-risk populations most effectively and supporting the overall mission of the organizations.

RECOMMENDATIONS

- ✔ Promote opportunities to increase staff knowledge of and capacity to recognize heightened substance use risk for adolescents utilizing mental health services/ co-occurring disorders in adolescence.
- ✔ Promote the development of partnerships between mental health providers and specialty substance use intervention providers to ensure that, where capacity is lacking in the mental health setting, it may be reinforced through collaboration. Developing these partnerships with specialty substance use providers can help strengthen organizational capacity to treat co-occurring disorder and better serve clients in need.

- ✔ Develop agreed-upon communication policies, procedures and workflows to support referral follow-through and effective information sharing.
- ✔ Seek solutions for treatment workforce shortages such as telehealth options.

CONCLUSION

Ongoing trainings are essential; a secure internal training infrastructure may help to withstand disruptions due to staff turnover.

RECOMMENDATION

- ✔ Develop infrastructure for sustained staff training. Incorporate repeated clinical training in SBIRT implementation for providers and support staff, paired with organizational change that cements supportive training infrastructure, sustainable policies and procedures, and data collection and utilization.

“We really feel that we have had so many wonderful opportunities to learn, grow, and serve our clients better as a result of our involvement with RASAI.”

CONCLUSION

Behavioral health organizations often lack the means to effectively collect and analyze clinical data, and often fail to fully grasp the importance of interpreting and utilizing data to inform clinical practice.

RECOMMENDATION

- ✓ Recognize that actual, real-time data is necessary for continued quality improvement and effective care. Support the use of EHRs within the behavioral health setting and analyze and share data with clinical staff on a regular basis to support decision-making, policies, and practice.

CONCLUSION

The complex policy landscape can pose difficulties for financing adolescent SBIRT practices; eligibility requirements for providers, settings, and services pose challenges to embedding crucial SBIRT services in community-based mental health organizations—a most critical setting for vulnerable youth populations.

RECOMMENDATIONS

- ✓ Seek state-specific information on Medicaid and EPSDT code usage opportunities and requirements. Seek opportunities for state and federal funding for SBIRT activities, including CCBHCs, Medicaid Health Homes, Managed Care, and State Innovation Model grants.
- ✓ In the absence of established secure funding, investigate opportunities to integrate SBIRT into other billable encounters to ensure that these crucial services are delivered while resolving financing issues.
- ✓ Advocate for supportive policy change through connecting with state associations and Medicaid offices.

