SBIRT Implementation Guide

Health Educator Model and Hybrid Staffing Model

A step by step guide for Screening, Brief Intervention, and Referral to Treatment (SBIRT).
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SBIRT OVERVIEW

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Guide

What is SBIRT?

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an opportunistic health service - it seeks to find and treat individuals who have risky substance use behaviors but are not seeking treatment for addiction. In fact, these people may never develop a substance use disorder, but their substance use puts them at an elevated risk for negative health and lifestyle consequences.

Risky alcohol use amounts (according to NIAAA) are:
- More than 14 standard alcoholic drinks per week or more than 4 drinks on any given day for men
- More than 7 standard alcoholic drinks per week or more than 3 drinks on any given day for women

Drug use that poses risks (according to NIDA) is:
- Any use of illegal drugs or prescription drug use for non-medical reasons

At its most basic, SBIRT has three parts:

1. Universal Brief Screening of all adult patients to quickly assess the severity of substance use and identify the level of treatment.
2. Brief intervention to increase awareness about substance use and motivate behavioral change.
3. Referral to specialty care treatment for those identified as needing more extensive treatment.
Why SBIRT?

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a preventive service to help people whose substance use puts their health at risk. SBIRT has had demonstrated results in primary care settings.

Primary care is an important and convenient point of contact. While most risky drinkers do not seek formal treatment, about two-thirds of them visit a primary care practitioner each year. Furthermore, patients are open to discussing their substance use with their doctor. A survey in 2006 found that 93% of patients felt their doctor should ask how much alcohol they drink and 96% said doctors should advise them to cut down on alcohol if it was affecting their health. And in the same survey, 86% of patients indicated they would not be annoyed if doctors asked about their alcohol use.

SBIRT improved patient health in the short-term, specifically SAMHSA found:

- Less alcohol and/or drug use 6 months after receiving SBIRT intervention
- Improved quality-of-life, including employment/education status, housing stability, and 30-day past arrest rates
- Fewer risky behaviors, including unprotected sexual behaviors and reduction in injected drug use

Here are a few more reasons to use SBIRT in your primary care clinic:

- Among the 25 services recommended by the US Preventive Services Task Force, alcohol screening is ranked fourth highest in terms of health impact and cost-effectiveness—it has more impact than screening for high blood pressure and high cholesterol, for example.
- SBIRT in medical settings reduces health-related diseases, and screening and brief interventions have good outcomes in primary care settings.
- In addition to the clinical benefits, SBIRT makes good financial sense for primary care practices. One study suggested that every dollar invested in an SBIRT-like approach saved $4.30 in future health care costs.
- The process is extremely flexible—it can be implemented in many different settings with many different types of clinical staff (physicians, nurses, behavioral health specialists, health educators, or medical assistants).
Different Models of SBIRT Implementation

SBIRT is extremely flexible and can be adjusted to fit into health care practices using a wide variety of approaches. Some clinics may want to use behavioral health specialists they have on staff, while other clinics may want to use non-licensed health educators, physicians, or have other staff members trained in motivational interviewing to deliver the Brief Intervention step.

We have worked with various primary care clinics across Oregon for the last three years, and these two models seemed to work the best for most clinics and resulted in the best care for patients:

- **Health Educator Model**: Where a Health Educator is a dedicated resource for conducting the Brief Interventions with clinic patients.
- **Hybrid Staffing Model**: Where a wide variety of staff (including physicians) may conduct the Brief Interventions depending on the resources at your clinic.

This guide summarizes information needed to implement SBIRT in a primary care practice in the State of Oregon. We focus on screening all adult patients, but adolescents can also be screened.¹

Note that many existing SBIRT online resources identify a physician-led model of SBIRT where the primary care physicians conduct most of the Brief Interventions. The Hybrid Staffing model is an overarching model that can encompass many different staff performing the Brief Intervention, including physicians in clinics that have chosen that staffing model. However, in Oregon, interventions shorter than 15 minutes are not reimbursable, therefore if a physician does a 7-minute Brief Intervention during a clinic visit, your clinic will not be reimbursed.

See the Appendix: **Decisions about SBIRT Implementation Model** for a break down of the pros and cons of each model and a worksheet to help you determine what would work best in your clinic.

¹ NOTE: Adolescent SBIRT has its own unique challenges, circumstances, different guidelines, and validated screening tools (see the [CRAFFT](#)) and for that reason this guide focuses on adults, 18 and up.
SBIRT Implementation: What you will Need

Leadership

• Leadership Support: Clinic leadership will need to be on board to support the necessary changes in patient care processes and the time required by staff to implement SBIRT.

• Clinic Champion: Creating a culture that embraces SBIRT requires a shift in how people think about substance use and the benefits of intervening as part of primary care. The Clinic Champion is someone who champions SBIRT at the clinic. They should have insight into the work environment and influence in the clinic.

• Implementation Team: You will need a team responsible for implementing SBIRT, to ensure that the process maximizes efficiency and effectiveness. The project’s leader should convene the implementation team frequently (even weekly during initial roll-out) to work through details, and to improve upon the workflow in real-time. Your implementation team should include the following people:

  → Project Lead: A staff member should be dedicated to leading the SBIRT implementation, initiating clinic changes, communicating the plan, and ensuring staff are hitting targets for screening patients and conducting brief interventions. The Project Lead could be a nurse case manager, a front desk manager, a provider, a Health Educator, or any staff who is highly engaged and able to fill this role. The Project Lead might be the same person as the Clinic Champion, or you might have an operational lead in addition to the Clinic Champion.

  → Physician Sponsor: In addition to leadership support, we recommend having a physician sponsor on the team to help support the changes. Even if physicians are not delivering the bulk of the intervention, they need to be supportive and part of the team.

  → Staff Member Conducting the Brief Interventions: Depending on which model you choose, this person could be a Health Educator, Physician, or Behavioral Specialist. The staff member(s) who is assigned to conduct the patients’ brief interventions should be on the implementation team, and needs to be proficient in Motivational Interviewing.

  → Representatives from each staff position: Your team should include one representative for each clinic position or role (such as a Front Desk representative, a Medical Assistant, a Nurse, etc.) to provide input on how the new process will affect their work and communicate changes back to their teams.

  → Behavioral Health Staff: If your clinic has behavioral staff, we recommend including them so they can provide input on referrals and community resources.

Staffing

Implementation
SBIRT Implementation: What you will Need

STAFFING

- **Staffing Plan:** Screening for substance use can be performed by many types of clinic staff. Follow this guide to select the appropriate staff members for each step based on which roles can be budgeted to handle the extra responsibilities (and given additional time or FTE).

  → **Project Lead:** .1 FTE is recommended for the lead when you have not implemented SBIRT before. If you have already implemented SBIRT and are changing your implementation method this staffing level would be smaller.

  → **Staff Conducting Brief Interventions:** Depending on the model, this could be a Health Educator, MA who received extra training, Behavioral Health Specialist, or Physician. 1.0 FTE is recommended if you are expecting one person to provide all Brief Interventions to your patient population full-time; .5 FTE minimum is needed to be effective. Each patient population is different, these numbers are meant to be rough guidelines. When physicians are delivering the Brief Intervention to patients, you will need to budget for some additional time with patients that screen positive on the full screening, and time for the other staff who will conduct the longer interventions.

  → **MAs, physician and front desk time:** Exact FTE varies depending on implementation, but this FTE is typically absorbed into patient rooming and intake.

  → **Behavioral health or other referrals staff:** .1 FTE is typically needed for additional referrals to treatment, and is usually absorbed into current staff role.

IMPLEMENTATION

- **Training:** The personnel who are delivering the Brief Intervention regardless of clinical licensure or background, will be most effective if they are proficient in motivational interviewing, which is a key component of the evidence-based intervention style for SBIRT. The typical length for an introductory motivational interviewing training is 2 days (15 hours) which provides trainees with the necessary skills to gain proficiency in motivational interviewing. Additional and on-going training is recommended for advancing skills. (See Resources for Motivational Interview training information.)

- **Space:** Clinic space is needed to perform behavioral interventions in private, and if screening is done using a face-to-face interview, private space will be needed for that step as well. Some clinics use the exam rooms that patients are already in for their primary care visit, while others have set aside separate spaces for the behavioral intervention time.

- **Available Treatment and Referral Process:** Reliable connections to mental health and substance use disorder treatment agencies are crucial for success. Referral to treatment needs to be available to those who are willing to engage with more intensive services. The availability of mental health and substance use disorder treatment and the effectiveness of your referral process is key to setting up SBIRT in your health care system. See Referral to Treatment for more information.

- **Technology Plan:** SBIRT can be enhanced with technology, such as computer-based screenings that can score patient responses, categorize their level of substance use, and send reports to providers. In addition, EHRs help track patients information along each step of the workflow. EHRs also can help flag appropriate staff when a brief intervention is necessary, and staff can document important patient information to help with patient follow-up and clinic metrics.
## Health Educator Model: SBIRT Implementation

### SBIRT Workflow: Team Composition and Overview

Here is an overview of one model of implementing SBIRT in a primary care practice using Health Educators to deliver the brief intervention. Many different workflows can work well depending on the specifics of your clinic. Take the below recommendations as suggested workflows, and utilize a Quality Improvement process such as a PDSA to ensure the workflow is best suited to your clinic.

<table>
<thead>
<tr>
<th>Workflow Step</th>
<th>Who Does It</th>
<th>What Happens</th>
<th>Resources &amp; Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer Brief Screen</td>
<td>Medical Assistant (MA)</td>
<td>Medical Assistant conducts the annual screening when taking patient vitals. Looks at brief screen to identify patients needing further screening. Informs Health Educator (HE) if further screening is needed.</td>
<td>Paper screen or electronic screening tool. Exam room space. EMR tool would enable MA to send an electronic alert to HEs with screen results.</td>
</tr>
<tr>
<td>AUDIT and DAST, possibly PHQ-9</td>
<td>Health Educator</td>
<td>Administers additional screening (AUDIT and/or DAST depending on brief screen response) either before or after physician sees patient. Recommended prior to physician visit.</td>
<td>Private space to conduct screening: Either stay in exam room or move to new space. AUDIT D or PHQ-9 Screening Tools MI Tools (see Resources)</td>
</tr>
<tr>
<td>Deliver Brief Intervention</td>
<td>Health Educator</td>
<td>Uses MI techniques to talk about substance use.</td>
<td>Private space: same space as above step. MI Tools (See Resources)</td>
</tr>
<tr>
<td>Referral to Treatment</td>
<td>Health Educator</td>
<td>Depending on stage of change and severity of substance use, provides internal and/or external referral options to the patient. Optional self-referral for Health Educators to set-up additional meetings with patients.</td>
<td>Referral services need to be available, such as warm hand-off to Certified Alcohol and Drug Counselor (CADC), referral to a detox center, or a comprehensive resource guide.</td>
</tr>
</tbody>
</table>
Health Educator Model: Case example with EMR Support

The following sections will walk through how to implement each of these steps in a primary care clinic, highlighting the decision points for your clinic. Note that using a Health Educator will have the least impact on your other staff, but you will have to hire and train someone for this position. To be effective, the Health Educator doing the Brief Interventions should have at least 50% of their time dedicated to SBIRT.

Use Plan-Do-Study-Act (PDSA)

To roll out new interventions to clinics with the best results and least clinic disruption, we recommend making small incremental changes and using a Plan-Do-Study-Act (PDSA) cycle. PDSA cycles are beneficial for any clinic improvement project because they give you a chance to test the change on a small scale, study the outcomes, and improve the process. Your Implementation Team should meet frequently while establishing the workflow to collect data and evaluate the roll-out. See the PDSA Templates and SBIRT Example in the Appendix of this guide.
Health Educator Model: Screening

Administer Screening
You will need to select screening tools and define your clinic’s procedures for administering the brief substance use screening. To implement SBIRT in a primary care clinic, consider the comparative costs, training requirements, space, and time of each screening option—some are more costly, and others are more time-intensive.

Think about these key questions:
- Consider your population—is there a high prevalence of substance abuse?
- Who will be doing the screening? Whatever staff you select will need enough time for the screening as well as the appropriate training for that step.
- How comprehensive will the screening be? Are you able to screen for multiple substances or include other health screenings (i.e., domestic violence, food insecurity, depression)? Your practice may already have wellness checks or other screening processes that can be leveraged for SBIRT.

Screening Population
While the ultimate goal of SBIRT is to screen all adults, if you have not yet implemented SBIRT in your clinic, it works well to start with a population sub-group. You could choose one provider’s panel as a starting point, a target demographic group (i.e., people with diabetes), or even a day of the week (on Tuesdays we will conduct SBIRT). By taking on the process incrementally, it is easier to work out the kinks before rolling out to the whole clinic. When selecting a sub-group, be sure that the target population is clearly defined. You do not want to have the front desk or MA only screening individuals who “look like they might need the SBIRT.”

Ways to Deliver Screening
The Oregon Health Association’s (OHA) Guidance document recommends a brief annual screen for adults consisting of 2-3 questions given annually, with a full screening given to those who test positively. The recommended brief screening questions are:

1) How many times in the last year have you had:
   a. 5 or more drinks a day (for men)
   b. 4 or more drinks a day (for women)

2) How many times in the last year have you used a recreational drug or used a prescription medication for non-medical purposes?

Any answer of “1 or more” triggers the need for further screening for alcohol or substances (see the screening tools in Table 1). **NOTE:** Even though marijuana use is legal in Oregon, federally it is still considered an illicit drug. Be sure to check your FQHC’s internal guidelines and follow your clinic’s policy regarding screening for marijuana use.

Depending on your staffing, existing procedures for patient intake, technology resources, and available space, you might choose any of the following ways to deliver both the brief and more in-depth screenings:

- Face-to-face interviews: Staff ask the questions, document answers on a scoring sheet, and calculates a score (i.e., range of severity). For example, the Medical Assistant asks the screening questions while rooming the patient and taking vitals.
- Paper-based screening: A supplemental sheet could be added to a medical history form. A staff member needs to be assigned to review and score the forms, often someone at the front desk.
- Electronically-delivered: SBIRT measures can be adapted to an electronic format and delivered on a desktop computer in the office or via mobile applications depending on your office infrastructure. Computerized screening can also calculate and score a patient’s answers.
- Phone screening: Some organizations deliver the brief screening on the phone prior to an office visit (such as during an appointment reminder call). Note that this approach would only work if the front desk staff can input the results directly into the EMR.
Health Educator Model: Screening

Administer Screening

Keep in mind, the brief screening will be delivered to all adults annually, but further screening is only given to those who screen positive. Your clinic might implement different delivery methods for the brief screening and full screening. Training is needed for all staff who are going to provide the brief and full screens.

Using scripts when staff give patients the screening will help normalize and de-stigmatize the screening which will reduce patient resistance and increase the number of completed screens.

**Front Desk Script:**

*Mr./Ms.________, please fill out these forms while you’re waiting. We’re having all of our patients fill them out every year to help us provide better care. You can hold onto them and give them to _________ when he/she calls your name.*

**Medical Assistant Script:**

*It looks like the front desk gave you our annual questionnaire, would you mind if I take a look? If positive: Based on the answers you gave us, it would be really helpful if you could fill out one more questionnaire. We are giving these to everyone once a year to provide better care to all of our patients. You can fill this out while you’re waiting for your doctor, and be sure to give it to them when they come in. Thanks.*

*Note that the script should accurately describe the actual workflow, so they may need to be adjusted to fit in your clinic.*

**Screening Tools**

Validated tools are available for screening your population and count towards CCO metrics in the State of Oregon.

<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Spanish Version</th>
<th>Drug (D): Alcohol (A)</th>
<th>Number of Items</th>
<th>Administration Time (Minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Alcohol Use Disorders Identification Test (AUDIT)</td>
<td>YES</td>
<td>A</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>The Drug Abuse Screening Test (DAST-20)</td>
<td>YES</td>
<td>D</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Combination Brief Screening Tool (with the PHQ-2 for Depression)</td>
<td>YES</td>
<td>A, D Depression</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

To download these screening tools, see [http://www.sbirtoregon.org/screening.php](http://www.sbirtoregon.org/screening.php).
Health Educator Model: Screening

The SBIRT screening process can also be added to existing patient intake forms or combined with other wellness or health screenings, such as depression screening (PHQ-9), food insecurity, or domestic violence screening. Additional screening tools for alcohol and other wellness screening are listed in Resources.

Further Screening

In the Health Educator model, when someone screens positive on the brief screening a Health Educator is notified. This can be done using EMR tools if your clinic has the technological capabilities to add the alerts to your system. See below for an EMR example:

Without an EMR alert, your clinic will need a process by which the Medical Assistant (or whoever scored a written screening tool) notifies Health Educators. The Health Educator then comes to the exam room and administers a full AUDIT screening to determine the level of substance use.

SBIRT can also be implemented by having a staff member, such as a Medical Assistant, administer the full AUDIT or DAST on paper or electronically, and then having the Health Educator come in for the Brief Intervention. In this case, your clinic will need a process for getting the results of the screening to the Health Educators before they interact with the patients.
Health Educator Model: Brief Intervention

Brief Intervention

The Brief Intervention is a brief person-centered conversation based in Motivational Interviewing principles that focuses on supporting patient’s healthy behaviors by increasing personal insight and awareness. A brief intervention can range from a few minutes to 30 minutes or more, depending on the person.

In most implementations of the Health Educator model, the person performing further screening is already in the room to deliver the Brief Intervention of motivational interviewing. So the transition between these two steps is simplified.

Essential elements of a brief intervention are:

1. **Build rapport**: Raise the subject of substance use.
2. **Provide feedback**: Give information about screening results.
3. **Share information**.
4. **Build readiness** to change using motivational interviewing skills.
5. **Negotiate a plan for change**. Set a goal. Use the readiness ruler (see Resources). Identify barriers and solutions.
6. **Establish a follow-up plan** or provide a referral for those who need specialty treatment.

*Note that it is unlikely that a patient will be open and ready to change in a 15-minute encounter. Often follow-up appointments are very beneficial.*

Motivational Interviewing Training

Regardless of who does the intervention, they need to be properly trained in motivational interviewing techniques in order for SBIRT to have positive impacts. The patient’s willingness to either make changes in behavior or accept referral to treatment hinges on the ability of the interviewer to successfully motivate the patient to act on the agreed upon plan.

Note that proficiency in the skill of Motivational Interviewing (MI) takes time to acquire. All staff can benefit from MI training to improve patient interactions throughout your clinic. An introductory training in Motivational Interviewing should take about 15 hours (or the equivalent of a 2-day course) to gain a baseline of proficiency (see Resources). After the basic training, staff can benefit from advanced training in the method and practice in clinic to become skilled in working with patients effectively. (While crash course MI trainings are available, we do not recommend those for staff conducting the Brief Interventions for SBIRT.)
Referral to Treatment

When (and if) the patient and Health Educator have determined the patient is ready for further treatment, the Health Educator will help set up timely referrals or follow-up appointments. If the patient has agreed to or requested an external referral or community-based behavioral health services, then the Health Educator makes a referral to alcohol and drug treatment experts for more in-depth assessments, if needed, and treatment.

Providing a patient with a specialist’s contact information is typically not enough to ensure they get treatment. In some SBIRT implementations, the Health Educator uses a warm hand-off to a Certified Alcohol and Drug Counselor (CADC) or actually walks the patient to an in-house detox center if this is available. If this is not possible, the Health Educator will need to work with the patient to diminish their uncertainty about pursuing further treatment, assess treatment options with the patient together, and address any financial barriers. Health Educators will find that building relationships with local treatment providers and facilities will be exponentially helpful in ensuring quality and timely care for their patients.

Having a system of team-based care or Care Coordinators can help with follow-up of patients that need referral to treatment. If the patient is hesitant to getting treatment, in-person or telephone follow-up sessions with Health Educators might be possible.

When you are planning for SBIRT, it will be important to establish links with treatment agencies and a process for referrals and follow-up care. The SAMHSA treatment finder (https://findtreatment.samhsa.gov/) can help you find treatment providers that are easy for patients to reach by public transportation. The State of Oregon also has a Substance Use Disorder treatment provider directory (http://www.oregon.gov/oha/amh/publications/provider-directory.pdf).

Key steps for making referral to treatment run smoothly

1. Have a list of treatment services and providers in your area with which your clinic works. Know who can refer patients to treatments in your clinic.

2. Identify the types of services offered by each provider, the type of program (e.g., in-patient or out-patient), and the languages they can support (e.g., Spanish).

3. Find out whom to contact to refer a patient and the procedures for referral. Develop a working relationship with the treatment agencies, and have the providers come describe their services to the clinic’s SBIRT team.

4. Compile a training manual for staff on how to refer to local addiction treatment providers and specialists. Include information about help groups in the community (such as Alcoholics Anonymous).

5. Have written materials for patients about the different treatment options (such as a Reference Guide of alternative approaches).

6. Keep track of wait-list times to be able to set clear expectations with patients wanting treatment. It is important to know if the wait-time is 1 week or 3 months.

7. Establish a process for tracking referrals and scheduling follow-up care within your own clinic for the patient (such as scheduling a follow-up appointment at the end of a session). See Resources.
# Hybrid Staffing Model: SBIRT Implementation

## SBIRT Workflow: Team Composition and Overview

Here is an overview for implementing SBIRT in a primary care practice using a hybrid model for staffing of the brief intervention step of SBIRT. Many different workflows can work well depending on the specifics of your clinic. Take the recommendations below as suggested workflows, and use a Quality Improvement process, such as a series of PDSA cycles, to ensure the workflow is best suited to your clinic.

<table>
<thead>
<tr>
<th>Workflow Step</th>
<th>Who Does It</th>
<th>What Happens</th>
<th>Resources &amp; Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer Brief Screening</td>
<td>Front Desk</td>
<td>Front Desk gives the patient the brief screening questions at check in.</td>
<td>Paper screen or electronic screening tool.</td>
</tr>
<tr>
<td>Deliver Full Screen</td>
<td>Support Staff or MA</td>
<td>MA or Support Staff looks at brief screen and gives the full screening form when needed (AUDIT and/or DAST depending on brief screen response). Calculates responses and provides a warm handoff to the physician.</td>
<td>AUDIT or DAST Screening Tools. EMR tools could automate form or enable support staff to send an electronic alert with screening results.</td>
</tr>
<tr>
<td>Triage</td>
<td>Physician</td>
<td>The physician triages to assess if the patient needs a brief intervention from a behaviorist or external referral from a care coordinator. If warm handoff is not available, BH follows up by phone (with patient consent).</td>
<td>Private space: typically done in exam room</td>
</tr>
<tr>
<td>Deliver Brief Intervention</td>
<td>Behavioral Health (BH) Specialist (or Other Professionally Qualified Staff)</td>
<td>BH (or Other Staff) goes over the results of the full screening with the patient and provides a brief intervention. Uses MI techniques to talk about substance use. NOTE: In some clinics, physicians will deliver brief interventions to patients and only hand off those patients needing more intensive intervention or external referrals. The Decisions about SBIRT Appendix details the trade-offs and billing/quality implications of this approach.</td>
<td>Private space: either exam room or a separate space for the BH to meet with patient. MI Tools (See Resources)</td>
</tr>
<tr>
<td>Referral to Treatment</td>
<td>Care Manager or BH</td>
<td>Depending on stage of change and severity of substance use, BH or a care manager provides internal and/or external referral options to the patient. Optional self-referral can also be used to set-up follow-up meetings with patients.</td>
<td>Referral services need to be available, such as warm hand-off to Certified Alcohol and Drug Counselor (CADC), referral to a detox center, or a comprehensive resource guide.</td>
</tr>
</tbody>
</table>
Case Example: Hybrid Staffing Model

In a hybrid staffing model, many different staff members take part in the workflow, and different types of staff can provide the Brief Intervention depending on the screening results of each patient and staff availability. Some clinics use behavioral health specialists they have on staff, while other places need to rely on their physicians to implement most brief interventions. The staffing needs to work within the skillsets of your clinic’s professional staff. A hybrid staffing model is often used when drug and alcohol use screening tools are combined with other screening, such as depression or domestic violence. In this case, the patient works with the staff member who can address their most urgent need.

Case Example: Physician Model with BH Staff Assistance

To be effective, the Physicians doing the Brief Interventions should have training in Motivational Interviewing (MI) and access to Behavioral Health staff for longer interventions. Also, note that interventions shorter than 15 minutes are not reimbursable in Oregon; therefore very brief physician-patient discussions would not be covered.

The following sections will walk through how to implement each of these steps in a primary care clinic, highlighting the decision points for your clinic.
Hybrid Staffing Model: Screening

Administer Screening

You will need to select screening tools and define your clinic’s procedures for administering the brief substance use screening. To implement SBIRT in a primary care clinic, consider the comparative costs, training requirements, space, and time of each screening option—some are more costly, and others are more time-intensive.

Think about these key questions:

- Consider your population— is there a high prevalence of substance abuse?
- Who will be doing the screening? Whatever staff you select will need enough time for the screening as well as the appropriate training for that step.
- How comprehensive will the screening be? Are you able to screen for multiple substances or include other health screenings (i.e., wellness, depression)? Your practice may already have domestic violence, food insecurity, or other screening processes that can be leveraged for SBIRT.

Screening Population

While the ultimate goal of SBIRT is to screen all adults, it works well to start with a population sub-group if you have not yet implemented SBIRT in your clinic. You could choose one provider’s panel as a starting point, based on provider availability, or a target demographic group (i.e., people with diabetes), or even a day of the week (on Tuesdays we will conduct SBIRT). By taking on the process incrementally, it is easier to work out the kinks before rolling out to the whole clinic. When selecting a sub-group, be sure that the target population is clearly defined. You do not want to have the front desk or MA only screening individuals who “look like they might need the SBIRT.”

Ways to Deliver Screening

The Oregon Health Association’s (OHA) Guidance document recommends a brief annual screen for adults consisting of 2-3 questions given annually, with a full screening given to those who test positively. The recommended brief screening questions are:

1) How many times in the last year have you had:
   a. 5 or more drinks a day (for men)
   b. 4 or more drinks a day (for women)
2) How many times in the last year have you used a recreational drug or used a prescription medication for non-medical purposes?

Any answer of “1 or more” triggers the need for further screening for alcohol or substances (see the screening tools in Table 1). **NOTE**: Even though marijuana use is legal in Oregon, federally it is still considered an illicit drug. Be sure to check your FQHC’s internal guidelines and follow your clinic’s policy regarding screening for marijuana use.

Depending on your staffing, existing procedures for patient intake, technology resources, and available space, you might choose any of the following ways to deliver both the brief and more in-depth screenings:

- Face-to-face interviews: Staff ask the questions, document answers on a scoring sheet, and calculates a score (i.e., range of severity). For example, the Medical Assistant asks the screening questions while rooming the patient and taking vitals.
- Paper-based screening: A supplemental sheet could be added to a medical history form. A staff member needs to be assigned to review and score the forms, often someone at the front desk.
- Electronically-delivered: SBIRT measures can be adapted to an electronic format and delivered on a desktop computer in the office or via mobile applications depending on your office infrastructure. Computerized screening can also calculate and score a patient’s answers.
- Phone screening: Some organizations deliver the brief screening on the phone prior to an office visit (such as during an appointment reminder call). Note that this approach would only work if the front desk staff can input the results directly into the EMR.
Hybrid Staffing Model: Screening

Keep in mind, the brief screening will be delivered to all adults annually, but further screening is only given to those who screen positive. Your clinic might implement different delivery methods for the brief screening and full screening. Training is needed for all staff who are going to provide the brief and full screens.

Using scripts when staff give patients the screening will help normalize and destigmatize the screening which will reduce patient resistance and increase the number of completed screens.

Front Desk Script:

Mr./Ms.__________, please fill out these forms while you’re waiting. We’re having all of our patients fill them out every year to help us provide better care. You can hold onto them and give them to _________ when he/she calls your name.

Medical Assistant Script:

It looks like the front desk gave you our annual questionnaire, would you mind if I take a look?
If positive: Based on the answers you gave us, it would be really helpful if you could fill out one more questionnaire. We are giving these to everyone once a year to provide better care to all of our patients. You can fill this out while you’re waiting for your doctor, and be sure to give it to them when they come in. Thanks.

Note that the script should accurately describe the actual workflow, so they may need to be adjusted to fit in your clinic.

Screening Tools

Validated tools are available for screening your population and count towards CCO metrics in the State of Oregon. Table 1 Screening Tools for Oregon Clinics

<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Spanish Version</th>
<th>Drug (D) Alcohol (A)</th>
<th>Number of Items</th>
<th>Administration Time (Minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Alcohol Use Disorders Identification Test (AUDIT)</td>
<td>YES</td>
<td>A</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>The Drug Abuse Screening Test (DAST-20)</td>
<td>YES</td>
<td>D</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Combination Brief Screening Tool (with the PHQ-2 for Depression)</td>
<td>YES</td>
<td>A, D Depression</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

To download these screening tools, see [http://www.sbirtoregon.org/screening.php](http://www.sbirtoregon.org/screening.php).
Hybrid Staffing Model: Screening

The SBIRT screening process can also be added to existing patient intake forms or combined with other wellness or health screenings, such as depression screening (PHQ-9), food insecurity, or domestic violence screening. Additional screening tools for alcohol and other wellness screening are listed in Resources.

Further Screening and Triage

When someone screens positive on the brief screening, a Medical Assistant (MA) provides the patient with the full screening tool when rooming the patient (or any time before the physician sees the patient). This screening can be automated if your clinic has the technological capabilities to automate the screening tool and add EMR alerts to your system. In some workflows, the MA collects the form and scores it for the physician. The full screening will indicate the severity of substance use.

The physician will review the screening results (whether electronic or paper-based) during the patient visit. The physician will then triage the patient based on their results. In a hybrid model, many types of staff may be giving the brief intervention. The physician will determine how best to handoff the patient to the appropriate clinical staff person when the patient is given their visit summary. This scenario will vary depending on your clinic’s staffing model and the capacity of your physicians. It will also vary if your clinic is combining the drug and alcohol screening with a process to screen for depression or other health measures. In some clinics (for example, where behavioral health staff are not readily available), physicians will do most of the interventions and only hand off the most complicated patients to work with other clinical staff.
Hybrid Staffing Model: Brief Intervention

**Brief Intervention**

The Brief Intervention is a brief person-centered conversation based in Motivational Interviewing principles that focuses on supporting patient’s healthy behaviors by increasing personal insight and awareness. A brief intervention can range from a few minutes to 30 minutes or more, depending on the person.

When the physician has introduced the patient to the behavioral health specialist or other clinical staff trained to do the brief intervention, then the behaviorist will introduce themselves and conduct the brief intervention. In a physician-led SBIRT model, the provider will go over the results of the full screening with the patient during the visit and move directly into the brief intervention.

Essential elements of a brief intervention are:

1. **Build rapport**: Raise the subject of substance use.
2. **Provide feedback**: Give information about screening results.
3. **Share information**.
4. **Build readiness** to change using motivational interviewing skills.
5. **Negotiate a plan for change**. Set a goal. Use the readiness ruler (see Resources). Identify barriers and solutions.
6. **Establish a follow-up plan** or provide a referral for those who need specialty treatment.

Note that it is unlikely that a patient will be open and ready to change in a 15 minute encounter. Often follow-up appointments are very beneficial.

**Motivational Interviewing Training**

Regardless of who does the intervention, they need to be properly trained in motivational interviewing techniques in order for SBIRT to have positive impacts. The patient’s willingness to either make changes in behavior or accept referral to treatment hinges on the ability of the interviewer to successfully motivate the patient to act on the agreed upon plan.

Note that proficiency in the skill of Motivational Interviewing (MI) takes time to acquire. All staff can benefit from MI training to improve patient interactions throughout your clinic. An introductory training in Motivational Interviewing should take about 15 hours (or the equivalent of a 2-day course) to gain a baseline of proficiency (see Resources for a list of MI Training). After the basic training, staff can benefit from advanced training in the method and practice in clinic to become skilled in working with patients effectively. (While crash course MI trainings are available, we do not recommend those for staff conducting the Brief Interventions for SBIRT.)
Hybrid Staffing Model: Referral to Treatment

Referral to Treatment

When (and if) the patient and provider have determined the patient is ready for further treatment, a behavioral health specialist or care coordinator will help set up timely referrals or follow-up appointments. If the patient has agreed to or requested an external referral or community-based behavioral health services, then the behavioral health specialist or care coordinator makes a referral to alcohol and drug treatment experts for more in-depth assessments, if needed, and treatment.

Providing a patient with a specialist’s contact information is typically not enough to ensure they get treatment. In some SBIRT implementations, the behaviorist uses a warm hand-off to a Certified Alcohol and Drug Counselor (CADC) or actually walks the patient to an in-house detox center if this is available. If this is not possible, the behaviorist will need to work with the patient to diminish their uncertainty about pursuing further treatment, assess treatment options with the patient together, and address any financial barriers. Clinics will find that building relationships with local treatment providers and facilities will be exponentially helpful in ensuring quality and timely care for their patients.

Having a system of team-based care, care managers, or care coordinators can help with follow-up of patients that need referral to treatment. If the patient is hesitant to get treatment, in-person or telephone follow-up sessions with behavioral health specialists or the physician might be possible.

When you are planning for SBIRT, it will be important to establish links with treatment agencies and a process for referrals and follow-up care. The SAMHSA treatment finder (https://findtreatment.samhsa.gov/) can help you find treatment providers that are easy for patients to reach by public transportation. The State of Oregon also has a Substance Use Disorder treatment provider directory (http://www.oregon.gov/oha/amh/publications/provider-directory.pdf).

Key steps for making referral to treatment run smoothly

1. Have a list of treatment services and providers in your area with which your clinic works. Know who can refer patients to treatments in your clinic.
   - Identify the types of services offered by each provider, the type of program (e.g., in-patient or out-patient), and the languages they can support (e.g., Spanish).

2. Find out whom to contact to refer a patient and the procedures for referral. Develop a working relationship with the treatment agencies, and have the providers come describe their services to the clinic’s SBIRT team.
   - Compile a training manual for staff on how to refer to local addiction treatment providers and specialists. Include information about help groups in the community (such as Alcoholics Anonymous).

3. Have written materials for patients about the different treatment options (such as a Reference Guide of alternative approaches).

4. Keep track of wait-list times to be able to set clear expectations with patients wanting treatment. It is important to know if the wait-time is 1 week or 3 months.

5. Establish a process for tracking referrals and scheduling follow-up care within your own clinic for the patient (such as scheduling a follow-up appointment at the end of a session). See Resources.
Tools and Implementation Worksheets

I. Decisions about SBIRT Implementation Model

SBIRT is extremely flexible and can be adjusted to fit into health care practices using a wide variety of approaches. We present the three most common models, and then provide a worksheet for you to help make preliminary decisions for your own organization’s implementation of SBIRT.

### Health Educator Model

**PROS**
- Using a Health Educator (HE) for Brief Interventions will have the least impact on your regular clinic staffing.
- Often HE will have more in-depth training in Motivational Interviewing, which makes intervention more successful than cross-training other clinic staff.
- More equal power relationship (HE to patient) encourages patient-centered conversations about substance use (compared to doctor-patient power differential).
- Requires less physician time.

**CONS**
- You will have to hire and train someone for this position.
- If you have turnover in the HE position, then you need to train someone new and have to allow for ramp up time for the new staff member.

### Hybrid Model

**PROS**
- More equal power relationship (HE to patient) encourages patient-centered conversations about substance use (compared to doctor-patient power differential).
- Requires less physician time.
- Can be more easily combined with other wellness screening processes, such as domestic violence or depression screening.

**CONS**
- Staffing model and clinic workflow is more complicated.
- Specialty staff need to be available on the clinic floor to conduct Brief Interventions.

### Physician Model: Physicians lead the Brief Intervention

**PROS**
- Using a Health Educator (HE) for Brief Interventions will have the least impact on your regular clinic staffing.
- Requires less physician time.
- Often HE will have more in-depth training in Motivational Interviewing, which makes intervention more successful than cross-training other clinic staff.
- More equal power relationship (HE to patient) encourages patient-centered conversations about substance use (compared to doctor-patient power differential).

**CONS**
- You will have to hire and train someone for this position.
- If you have turnover in the HE position, then you need to train someone new and have to allow for ramp up time for the new staff member.
Tools and Implementation Worksheets

I. Decisions about SBIRT Models

The following table is intended for your health center to talk through the different models and decide which works best for your organization’s environment.

<table>
<thead>
<tr>
<th>When to Screen</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Medical Care (Waiting Room)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Medical Care (Exam Room)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During Formal Medical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Medical Care (Waiting for Labs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How to Screen</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Screening on Intake Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paper and Pencil Full Screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computer Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where to Screen</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Waiting Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who Screens</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Front Desk (Pre-screen Survey)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Educator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury Prevention staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hybrid Model (Many Different Staff)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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1 Adapted from the Columbia University National Center on Addiction and Substance Abuse, An SBIRT Implementation and Process Change Manual for Practitioners, November 2012
# Tools and Implementation Worksheets

## I. Decisions about SBIRT Models

<table>
<thead>
<tr>
<th>When to Conduct Brief Interview</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Medical Care (Waiting Room)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During Formal Medical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Medical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where to Conduct Brief Interview</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conference Room/Meeting Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who Conducts Brief Interview</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Educator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordinator</td>
<td></td>
<td></td>
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<tr>
<td>Nurse</td>
<td></td>
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<tr>
<td>Social Worker</td>
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<td>Injury Prevention staff</td>
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<tr>
<td>Hybrid Model (Many Different Staff)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What</th>
<th>How to Integrate</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up Appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral Follow-up</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Tools and Implementation Worksheets

II. PSDA Cycle Template & Example

PDSA Cycle
Plan-Do-Study-Act (PDSA)

Identify aims of PDSA cycle and predict results. Determine data needed to answer questions.

Carry out the change and collect data. Document what happened.

Determine the next steps. Rework, modify, or revise the plan? Expand the scope?

Analyze data. Summarize what was learned. Identify new questions/issues.

Tools and Implementation Worksheets

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Guide
A Cycle Worksheet

Directions: Use this Plan-Do-Study-Act (PDSA) tool to plan and document your progress implementing clinic changes. Remember that a typical improvement project will usually involve multiple PDSA cycles in order to achieve your aim.

Cycle #: _______ Start Date: ________ End Date: ________

Aim Statement: State the improvement idea to test.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Predictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What change are you testing with this PDSA?</td>
<td>Give specific predictions of outcomes.</td>
</tr>
<tr>
<td>What is the current process?</td>
<td></td>
</tr>
<tr>
<td>What are the key steps to attaining the goal?</td>
<td></td>
</tr>
<tr>
<td>What solutions are being tested?</td>
<td></td>
</tr>
<tr>
<td>What are the barriers?</td>
<td></td>
</tr>
</tbody>
</table>

**Data to Be Collected**

<table>
<thead>
<tr>
<th>Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will be involved with this PDSA?</td>
</tr>
<tr>
<td>Assign who will implement PDSA steps and collect data needed</td>
</tr>
</tbody>
</table>

**PLAN:** Identify aims of PDSA cycle and predict results. Determine data needed to answer questions.

**DO:** Carry out the change and collect data. Document what happened. (+/-).

Document what happened during the test. List observations.

**STUDY:** Analyze data. Summarize what was learned. Identify new questions/issues.

**What was Learned:** Summarize what was learned. Compare results to predictions.

**Results:**

<table>
<thead>
<tr>
<th>New Issues or Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyze the collected data.</td>
</tr>
</tbody>
</table>

**ACT:** Determine the next steps. Rework, modify, or revise the plan? Expand the scope?

Are you going to:

- Adopt? (expand the changes in your organization to additional patients, staff, or units)
- Adapt? (modify the changes and repeat PDSA cycle)
- Abandon? (change your approach and repeat PDSA cycle)
PDSA Cycle Worksheet: \textit{SBIRT Example}

\textbf{Aim Statement:} Implement SBIRT in all of Dr. Smith’s panel of patients to increase the number of patients screened for unhealthy substance use.

\textbf{PLAN:} Identify aims of PDSA cycle and predict results. Determine data needed to answer questions.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Predictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Can we increase the % of patients screened for substance use by introducing SBIRT?</td>
<td>The % of patients screened will increase to 80%.</td>
</tr>
<tr>
<td>• Can the front desk incorporate brief screening into current process? (Currently the clinic gives patients a wellness screening questionnaire on paper when they check in.)</td>
<td>The clinic will add brief substance use questions to the current screening form.</td>
</tr>
<tr>
<td>• Can we use/incorporate the Physician model of SBIRT for all of Dr. Smith’s panel of patients?</td>
<td>SBIRT will be rolled out to Dr. Smith and her care team.</td>
</tr>
</tbody>
</table>

\textbf{Data to Be Collected}

<table>
<thead>
<tr>
<th>Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of patients who received brief screen, # of positive brief screens</td>
</tr>
<tr>
<td>2. Number who received brief intervention by physician, by behavioral staff, total, as a % of positive screens</td>
</tr>
<tr>
<td>3. Number who received referral to treatment</td>
</tr>
<tr>
<td>4. Outcome metric: Patients who previously screened positive, who did not need a Brief Intervention at their most recent screening</td>
</tr>
</tbody>
</table>

\textbf{DO:} Carry out the change and collect data. Document what happened. (+/-).

SBIRT was implemented for Dr. Smith’s panel. Dr. Smith, MAs on the care team were trained in MI. Front desk is distributing new questionnaires. Full screening and MI tools have been made available to all clinic staff.

\textbf{STUDY:} Analyze data. Summarize what was learned. Identify new questions/issues.

A ‘resource’ issue has been a lack of dedicated space to conduct the SBIRTs when the exam room needs to quickly turn-over. Need to find additional space for Brief Interventions.

\textbf{Results}

<table>
<thead>
<tr>
<th>Brief Screening Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Screen and Brief Intervention Rate Following Positive Brief Screen</td>
</tr>
<tr>
<td>Full Screen and Brief Intervention Overall Rate</td>
</tr>
<tr>
<td>Referral to Treatment Rate</td>
</tr>
<tr>
<td>Outcome Metric</td>
</tr>
</tbody>
</table>

\textbf{ACT:} Determine the next steps. Rework, modify, or revise the plan? Expand the scope?

If the analysis shows a significant increase in referral rates as a result of SBIRT, incorporate workflow into the intake protocol for a larger group of primary care patients. Otherwise revise procedures.
## III. Outcome Tracking Metrics

### OPCA Project Screen and Treat

**SBIRT Metric Specifications**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBIRT Project Metric Brief screening rate</td>
<td>Number of patients 18+ seen within the last month that received a brief screening PLUS the number of patients 18+ seen within the last month that had previously received a brief screening within the last year</td>
<td>Total number of patients 18+ who have been seen for a visit in the last month¹</td>
</tr>
</tbody>
</table>
| SBIRT Project Metric Full screen and brief intervention rate² following positive brief screen | Number of patient 18+ seen within the last year who received a full screen (AUDIT and/or DAST) and brief intervention²  
If you are using billing data to track the full screen/brief intervention rate, use these codes:  
- 99420, with diagnoses code v79.1 or v82.9—used for patients who received a full screen based on responses to the annual brief screening. There are no time limitations or requirements for this code. This is also used when a brief intervention lasting less than 15 minutes is performed.  
- 99408 – used for patients who were screened and received a brief intervention (15-30 mins).  
99409 – used for patients who were screened and received a brief intervention (> 30 mins). | Total number of patients 18+ who answered yes to one of the brief screening questions |

¹ Clinics should use the CPT codes outlined in the CCO definitions to determine visit type when constructing their reports (see the OHA’s webpage on CCO definitions for more information). Since we are aligning the definitions for this project with CCO definitions, patients that refuse a brief and/or full screening or intervention should not be excluded from the denominator.

² The full screen and brief intervention rate metric assumes that you are using the model promoted by this project, where the full screening questionnaire (AUDIT and/or DAST) is conducted as part of the brief intervention.

³ CCO-Metric Aligned: the numerator and denominator for this metric are defined in the same way the OHA defines the SBIRT metric for the CCO Quality Pool, but the denominator should include the total patient population, rather than the Medicaid population only.

⁴ For patients that refuse a referral / are already receiving treatment, this data should be captured within the patient’s chart as well and included in the numerator, as an assessment was performed and the patient was referred.

⁵ Positive full screening is indicated by an AUDIT score between 20 and 40 and/or DAST score between 6 and 10.
**TOOLS AND IMPLEMENTATION WORKSHEETS**

**IV. Implementation Checklist - Part 1**

**WORKSHEET 6 | SBIRT Implementation Checklist**

The following checklist provides you with an overview of crucial steps to consider when introducing SBIRT to your agency. Depending on your work environment (medical vs. non-medical), you may need to modify some of the bullet points (e.g. staff professions) to reflect the special circumstances of your agency.

<table>
<thead>
<tr>
<th>Person in Charge</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develop CQI initiatives.</strong></td>
<td></td>
</tr>
<tr>
<td>- Form a Change Team</td>
<td></td>
</tr>
<tr>
<td>- Process Map and Walk Through</td>
<td></td>
</tr>
<tr>
<td>- Identify Barriers</td>
<td></td>
</tr>
<tr>
<td>- Plan-Do-Study Act</td>
<td></td>
</tr>
<tr>
<td>- Performance Monitoring</td>
<td></td>
</tr>
</tbody>
</table>

| **Define your target population.** | |
| Which patients will you screen? | |
| - All patients? | |
| - Certain department within your facility? | |
| - Certain subgroups of patients? | |
| - Adults/Adolescents? | |
| Which patients will you exclude from screening? | |

| **Document a screening protocol.** | |
| Who will conduct screening? | |
| - Nurse | |
| - Medical Assistant | |
| - Receptionist | |
| - Behavioral health staff | |
| - Health Educator | |
| - Substance use counselor | |
| - Injury prevention staff | |
| - Social worker | |
| - Other | |

| When and where will screening be conducted? | |
| - Triage | |
| - Quiet room | |
| - Waiting room | |
| - Exam Room | |
| - Bedside/During care | |
| - Post-appointment/discharge | |
### Tools and Implementation Worksheets

**IV. Implementation Checklist - Part 2**

- **Document a brief intervention and referral protocol.**
  - Who will conduct the brief intervention and RT?
    - Screening staff, MSW, MD, Psychologist, RN, CASAC?
    - If the screener is not the same person that conducts the intervention, what alert process needs to be created?
    - If a referral is needed, who will do this? If not the same person that does the BI, what alert process needs to be created?
    - What linkages and contacts need to be made for a smooth referral process?
  - Which BI support materials will be used?
  - Which patient handouts will be used?
  - When and where will brief intervention be conducted?
    - Triage
    - Quiet room
    - Bedside/During care
    - Pre-discharge
  - When selecting BI providers take the following into account:
    - Time availability.
    - Knowledge and experience.
    - Interpersonal skills.
    - Willingness to take on responsibility.
    - Flexibility in work schedule.

- **Develop a charting and billing protocol.**
  - Where will chart note be kept?
    - Main medical record.
    - Locked files.
    - Separate from the medical record.
  - What information will be included related to the screen and/or brief intervention?
  - What information will not be included?
  - Determine the flow of information, paperwork, and data.
### IV. Implementation Checklist - Part 3

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>How will you inform all staff?</th>
<th>Who needs to be trained?</th>
<th>How will staff be trained?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inform all staff of the SBIRT initiative and set a date for the full initiative to begin.</td>
<td>- General staff meeting &lt;br&gt;- Memo &lt;br&gt;- Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Train all relevant staff.</td>
<td></td>
<td>- Group training &lt;br&gt;- Individual training &lt;br&gt;- Online training</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Billing for SBIRT

The OHA specifies billing codes in its SBIRT Guidance Document. SBIRT has been identified as an incentive measure for Oregon’s CCOs, tied to incentive funding. A brief intervention is a reimbursable service, but it must be provided by a licensed provider or an ancillary provider working under the general supervision of the licensed provider.

To use these codes, the health plan member must be 12 years old by December 31st of the measurement year. These CPT or HCPCS codes cover someone who completed a full, standardized screening tool for alcohol/substance use or received screening and a brief intervention.

While a brief intervention is a reimbursable service, it must be provided by a licensed provider or an ancillary provider working under the general supervision of the licensed provider. Brief Interventions may only be billed in 15 minute intervals, so if a physician does a 7-minute brief intervention, your clinic will not be reimbursed.

**NOTE:** The initial “brief” annual screen is considered an integral part of routine preventive care and therefore not reimbursable. Only patients that need the “full” screen or a brief intervention based on responses to the screening can be identified in claims data with the use of these billing codes.

<table>
<thead>
<tr>
<th>Coding Number</th>
<th>Used For…</th>
<th>Length of Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99420, with diagnosis code v79.1 or v82.9</td>
<td>For patients who received a full screen based on responses to the annual brief screening.</td>
<td>There are no time limitations or requirements for this code. This coding combination is also used when a brief intervention lasting less than 15 minutes is performed.</td>
</tr>
<tr>
<td>99408</td>
<td>For patients who were screened and received a brief intervention</td>
<td>15–30 minutes</td>
</tr>
<tr>
<td>99409</td>
<td>For patients who were screened and received a brief intervention</td>
<td>&gt; 30 minutes</td>
</tr>
<tr>
<td>G0396</td>
<td>For patients who received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention</td>
<td>5–30 minutes</td>
</tr>
<tr>
<td>G0397</td>
<td>For patients who received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention</td>
<td>&gt; 30 minutes</td>
</tr>
<tr>
<td>G0442</td>
<td>Annual alcohol misuse screening</td>
<td></td>
</tr>
<tr>
<td>G0443</td>
<td>Brief face to face behavioral counseling for alcohol misuse</td>
<td></td>
</tr>
</tbody>
</table>

For more information, see [http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx](http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx) and [http://www.sbirtoregon.org/billing_codes.php](http://www.sbirtoregon.org/billing_codes.php).

Additional information about the CCO incentive measures is available online at [http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx](http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx).
SBIRT Resources

**Implementation Checklist for SBIRT**
LINK TO SBIRT Implementation Checklist (Worksheet 6, page 57-59)

**Treatment Locations, Referral to Treatment Resources**
Substance Use Disorder Treatment Provider Directory:

**Screening Tools and Forms**
Download Oregon Screening Forms:
http://www.sbirtoregon.org/screening.php

Scoring the AUDIT:

Additional Screening Tools List (including ASSIST, CRAFFT, and others):
http://medicine.yale.edu/sbirt/curriculum/screening/

CRAFFT for Adolescents:
http://medicine.yale.edu/sbirt/curriculum/screening/CRAFFT_tcm508-100694_tcm508-284-32.pdf

NIDA Drug Use Online Screening Test:
http://www.drugabuse.gov/nmassist/

Online Alcohol Screening Tool:
http://www.alcoholscreening.org/Home.aspx

**Patient Education and SBIRT Clinic Materials**
Reference Sheets and MI Readiness Ruler:
http://www.sbirtoregon.org/tools.php

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Patient Education:

Self-Help Strategies for Cutting Down or Stopping Substance Use: A Guide
http://apps.who.int/iris/bitstream/10665/44322/1/9789241599405_eng.pdf

Motivational Interviewing (Brief Intervention) Training
National Registry of SBIRT Trainers
http://attcnetwork.org/trainers/sbirt-overview.aspx

Training Resources for Primary Care from Oregon SBIRT:
http://www.sbirtoregon.org/training.php

Training Resources from Yale School of Medicine:
http://medicine.yale.edu/sbirt/curriculum/index.aspx
Add...
A Special Thank You...

We would like to thank the extraordinary generosity of Providence Health Plan, Kaiser Permanente Community Benefit Fund and the Oregon Community Foundation in improving the health of our community. Without your support, commitment and vision this project would not have been possible.

We would also like to thank the various FQHCs that have participated over the years. Central City Concern, Northwest Human Services, Neighborhood Health Clinic, Tillamook Family Health Center, Native American Rehabilitation Association, Wallace Medical Concern, La Clinica, Mosaic Medical and all of the incredible staff at these clinics. Your dedication, passion and unending effort to help the lives of Oregonians is inspiring and this implementation guide would not have been possible without your partnership.