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Implementing SBIRT in Primary Care: A Study of Three Mat-Su Borough Health Care Practices

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Acronyms

AUDIT	Alcohol Use Disorders Identification Test - SBIRT Screening Instrument
AUDIT-C (or AUDIT 1-3, US)	The first three questions of the AUDIT
BHES	Behavioral Health Environmental Scan
CDC	Centers for Disease Control and Prevention
CHNA	Mat-Su Community Health Needs Assessment
EHR	Electronic Health Record
MI	Motivational Interviewing
MSHF	Mat-Su Health Foundation
QA	Quality Assurance
RE-AIM	<u>R</u> each, <u>E</u> ffectiveness, <u>A</u> doption, <u>I</u> mplementation, <u>M</u> aintenance of the Intervention
REP	Replicating Effective Programs
SBIRT	Screening Brief Intervention and Referral to Treatment
USPSTF	U.S. Preventive Services Task Force

INTRODUCTION: IMPLEMENTING SBIRT IN THE MAT-SU BOROUGH

Addressing alcohol misuse is a public health priority. In Alaska, alcohol is recognized as a causal or contributing factor in **9 out of the 10 top causes of death**.¹ Alcohol and substance use is a factor in **1 of 4 accidents** with serious injuries requiring hospitalization and **nearly half** of all Mat-Su suicides and homicides.²

How is alcohol misuse addressed as part of Healthy Alaskans 2020? A leading health indicator for Alaska is to **reduce** the percent of adults and adolescents who report **binge drinking**. A strategy for addressing this was to promote screening for alcohol misuse within healthcare settings, and train healthcare professionals to provide effective brief interventions or referral for patients whose drinking exceeds recommended limits for their age, sex, or health condition.

What is SBIRT?

The U.S. Preventive Services Task Force recommends that “clinicians screen all adults aged 18 years or older at least annually for alcohol misuse and provide persons engaged in risky or hazardous drinking with a brief behavioral counseling intervention to reduce alcohol misuse.”³

Alcohol screening, brief intervention and Referral to Treatment (SBIRT) is a cost-effective way to fulfill the USPSTF recommendation.⁴ SBIRT components include:

- **Screening** – risky drinking is assessed by a healthcare professional using a standardized, scorable tool, such as the US Alcohol Use Disorders Identification Test (AUDIT).
- **Brief Intervention**—a healthcare provider shares screening results and provides brief education and advice, tailored to the patient’s readiness and specific health needs.
- **Referral to Treatment**—a healthcare professional provides higher risk patients with a referral for further assessment or treatment, that could include a meeting with a co-located behavioral health professional, information on local community resources (e.g., AA), or a formal referral to treatment.

Why Study SBIRT Implementation within Healthcare Practices?

Despite decades of research evidence that SBIRT is effective for addressing unhealthy patterns of drinking and reducing binge drinking, its adoption within healthcare practices continues to be slow. Providers have identified numerous reasons for not routinely screening and intervening on alcohol, including limited time, training, and resources for patients requiring treatment; lack of confidence in their ability to help patients reduce their drinking; inadequate reimbursement for SBIRT services, and worry about stigmatizing patients.^{5,6}

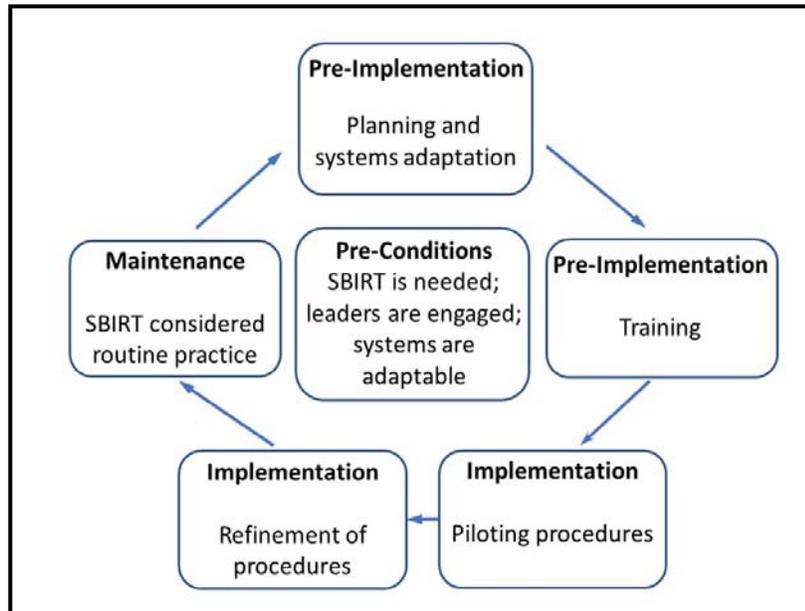
In 2015, the Mat-Su Health Foundation funded the University of Alaska’s Center for Behavioral Health Research & Services, (CBHRS) to study how three healthcare organizations serving the Mat-Su Borough implemented alcohol SBIRT. The study goals were to:

- **Understand the facilitators and barriers** to adopting SBIRT within the context of primary care.
- **Share lessons learned** about factors that contribute to its successful and sustained implementation.

STUDY DESIGN: HOW WAS THE STUDY CONDUCTED?

Three primary care practices (referred to as Sites A, B, and C) serving the Mat-Su Borough participated in the study over 24 months. The implementation process followed the CDC model for Replicating Effective Programs (Figure 1).⁷

Figure 1. Conceptual Model of SBIRT Implementation



The design of this study was to compare three different healthcare practices (i.e., “Sites”) on how they implemented SBIRT, using implementation strategies that are recommended by experts in the fields of Dissemination and Implementation.⁸ Each practice formed an SBIRT planning team consisting of 4-6 leadership, administrative and frontline employees. The planning team participated in a 3-hour meeting that was facilitated by CBHRS researcher, to develop procedures and identify systems changes that would support routine incorporation of SBIRT into each clinic’s operations; including modifications to the Electronic Health Record (EHR) to document and monitor implementation quality, and patients reached for SBIRT Screening. Onsite 3-hour training was provided for providers and staff, including opportunities for role play and a review of clinic-specific protocols. Once screening commenced, CBHRS checked-in regularly with each clinic by phone, to obtain feedback, identify issues, and assist in problem resolution/refinement of the SBIRT procedures. Towards the end of the study, CBHRS conducted interviews with 13 administrative and healthcare professionals (4-5 individuals at each site).

Evaluation Framework

We used the RE-AIM framework to analyze, describe, and compare factors relevant to both patient outcomes (i.e., Reach and Effectiveness of SBIRT), and setting factors that may be associated with the successful integration of SBIRT as a part of routine practice (Adoption, Implementation), and factors that may be associated with the likelihood that SBIRT will be sustained after the study (Maintenance).⁹

DATA ANALYSIS: HOW WERE DATA ANALYZED?

EHR Screening and Brief Intervention Data

Monthly clinic data, extracted from each site's EHR, were analyzed at CBHRS using the Statistical Package for the Social Sciences (SPSS). Visit data and unduplicated patient data were analyzed independently to understand screening rates and overall patient reach. Monthly frequencies were created by patient demographics (age, sex, and race) to describe the patient population eligible for SBIRT screening by visit and by patient. Patient age was recoded into age groups, depending on the eligibility criteria at each site: ages 12 to 17 (for site A only), ages 18 to 64, and ages 65 to 110. Screening rates and screened patient demographics were also analyzed by visit and by patient, in order to monitor trends, and identify potential inequities in screening rates by patient demographics over time. Time periods analyzed were the 12-month implementation period with CBHRS monthly technical support (all Sites) and the 3-month sustainability period without technical support (Sites A and B only).

Key Informant Interviews, Field Notes and Contact Logs

All interviews were transcribed verbatim and uploaded to NVivo data analysis software. In addition to interviews, field notes and relevant emails were uploaded to NVivo for analysis. All documents were coded using a priori codes derived from the key informant interview questions and the **Program Sustainability Assessment Tool (PSAT)**.¹⁰ The PSAT was used as an empirical framework to categorize and code for variables that are considered important to sustaining practice change. The PSAT consists of 8 domains:

1. Environmental Support - strong champions, leadership, public support
2. Funding Stability - stable and sustained funding
3. Partnerships - community members, organizations, leaders are committed to the program
4. Organizational Capacity - program is well integrated into operations and supported by leadership, adequate staff, organizational systems
5. Program Evaluation - program reports short-term and intermediate outcomes, and results that inform planning, monitor fidelity to protocols, and demonstrate success
6. Program Adaptation - periodic reviews of evidence base and adapts to assure continued effectiveness
7. Communications - strategies are in place to maintain public support, market the program, and increase awareness of issues it addresses
8. Strategic Planning - program plans for future resources and financial needs, and program goals and roles are understood by all stakeholders

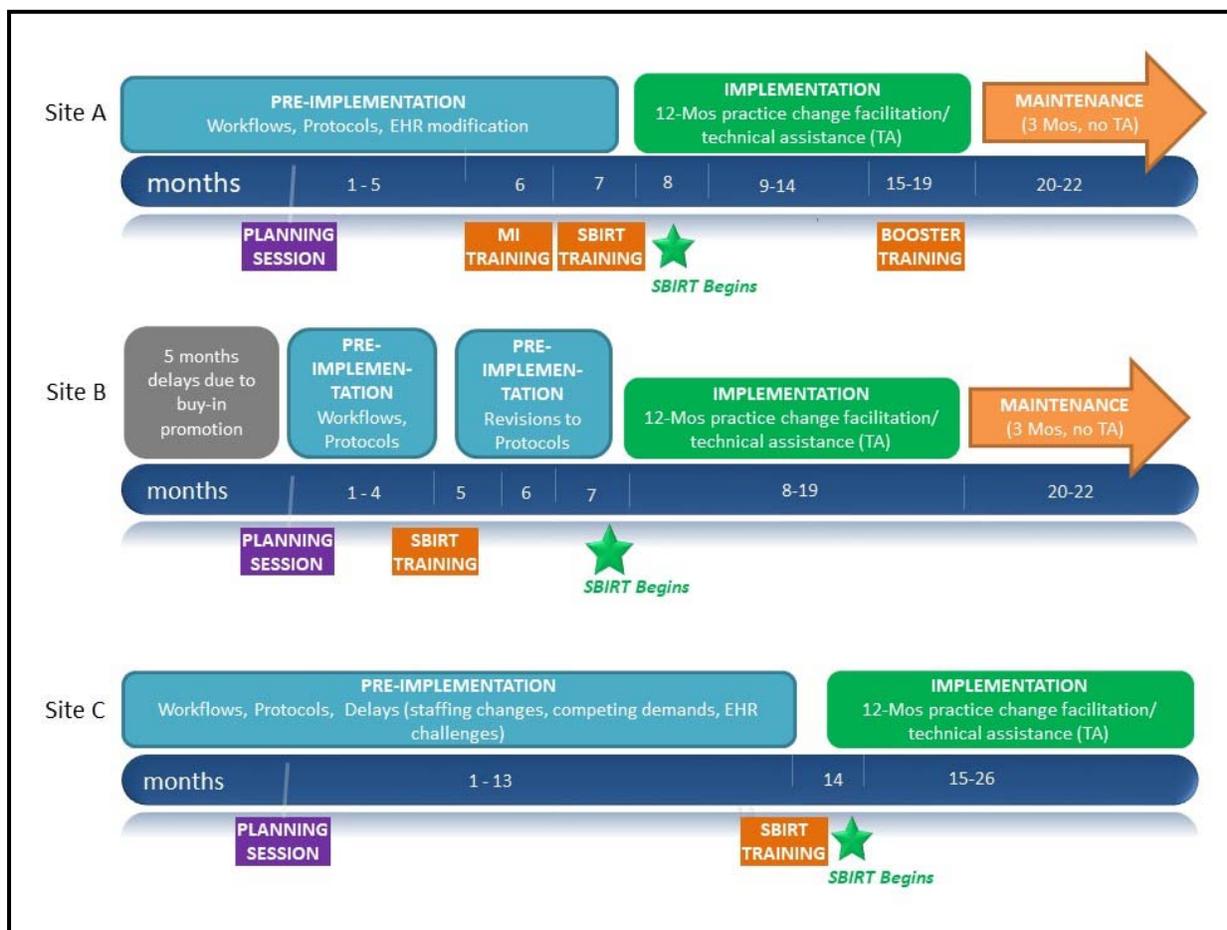
RESULTS: WHAT DID WE LEARN?

Factors Relevant to Adoption and Implementation

(1) Planning and Preparing for SBIRT Takes Time - 6 Months or More.

Delays in start-up were related to challenges in modifying the EHR, competing priorities, staff turnover, provider resistance, and staff confidence. Site B recognized a need to do some additional planning after staff were trained, to rethink their procedures prior to start-up. Site C visited Site A, to observe how they implemented SBIRT, which was helpful in improving their administrator confidence. Site A also received Motivational Interviewing (MI) and Booster training as a part of their implementation (Figure 2).

Figure 2: Cross-Site Comparison of Timelines and Processes



(2) SBIRT Implementation Strategies, planning, development of written protocols, training, technical assistance calls, were similar across the three sites; SBIRT protocols differed.

Table 1 summarizes the implementation protocols and decisions made by each practice site. A primary goal during planning and implementation stages were to adapt SBIRT procedures to fit and be feasible for the specific sites, while still maintaining the core or “active” components of SBIRT, i.e., that all adult patients would be screened using the AUDIT or AUDIT-C (first three questions of the AUDIT)¹² at least annually, and that those identified as drinking above recommended limits are provided a brief, behavioral intervention by a healthcare professional. Brief acknowledgement and educational materials is also recommended for patients drinking at low risk levels, to reinforce healthy behavior.

“There is always going to be trial and error”
–Medical Director

Table 1. Summary of Implementation Protocols and Decisions Made by Practice

Practice Sites	A	B	C
Site Locations	2	1	1
Planning Participants	Medical Director, Provider, QA lead, LCSW.	Executive Director, Medical Director, Behavioral Health Director, QA lead.	Clinic Director/ Provider, Practice Manager, QA lead.
SBIRT Champions/Liaisons	Medical Director	QA lead	Practice Manager, QA lead
Target Population	Adults (ages 18+); adolescents (ages 12-17)	Adults (ages 18+)	Adults (ages 18+)
Screener	AUDIT-1,2,3; AUDIT (US)	AUDIT-C (full AUDIT, provider discretion)	AUDIT-C; AUDIT
Screening Administration	MA Oral (AUDIT-1,2,3) Oral (AUDIT) Responses entered	MA Oral Responses entered	CMA/Nurse Oral (AUDIT-C) Paper (AUDIT) Score entered Form scanned
Brief Intervention	Provider	Provider	Provider
Eligible SBIRT Visits	Primary care, non-transient, non-acute	Primary care	Primary care
Screening Frequency	At least annually	At least annually	Every visit
Brief Intervention	Intervention based on AUDIT zones I - IV (low risk to dependent)	Intervention based on AUDIT-C scores	Intervention based on AUDIT zones I - IV (low risk to dependent)
EHR Used	Centricity	Next Gen	Athena
Billing for SBIRT	No	No	No
Data Used By	Medical Director	QA Lead	QA Lead
TA Requests	Documentation Booster Training	Additional Data Reports	Assistance with EHR data pulls

(3) Engagement of practice leaders, communication with providers and staff, and skill building activities varied by site.

The importance of practice champions, who advocate for, reinforce, and encourage SBIRT, was identified as a key success factor that was difficult to quantify.

“There’s a piece that I feel ... I’m constantly doing, and it’s needed for this [SBIRT implementation] to be successful...it’s not significantly impactful on my day, but it’s certainly something that I feel like you need ... someone on the clinical floor who’s constantly [saying], “this is an opportunity for us to think about, or do this, or whatever, so that it doesn’t get lost.”

–Medical Director

“They [the Medical Assistants] are really the key to the whole castle. So if they have appropriate information, everything else will fall into place.”

–Behavioral Health Provider

While all three sites had acceptance from their top Executive, agreement that SBIRT would improve their current practice procedures was inconsistent between sites. Communication gaps and turnover may have contributed to a lack of buy-in for some key practice personnel, including providers, which in turn were reflected in lower screening rates.

“It wasn’t a choice. We didn’t get the data saying that you’re doing a bad job. It was like this is something you need to do, so we’re doing it.”

–Quality Manager

“I think I was out of town and I came back, and I was told [we were] volunteered to participate in this program, and we’re going to have SBIRT screening in our electronic records that your MA is going to fill out and you can look at.”

–Physician

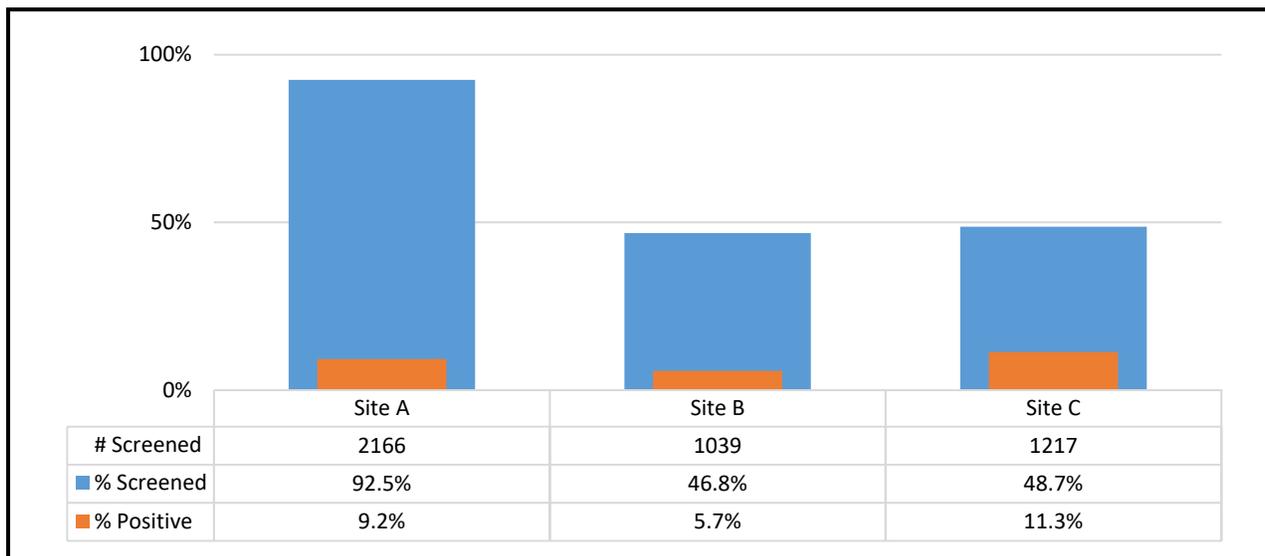
Booster training to enhance skills and confidence was offered, but only accepted at Site A.

“Any time you learn something it helps to have additional follow up training. There was not additional follow up training. And I’ve never really been trained in counselling on alcohol. I have never been trained for that. We watch a little video of the scenario and that doesn’t immediately make someone comfortable with it.”

–Nurse Practitioner

The relatively low percentage of patients that screened positive was surprising (see Figure 3), and may be an indicator of how the screener was administered, and possible need for more training in its use, but further investigation would be needed. Across the U.S., approximately 25% of primary care patients exceed alcohol limits.^{13, 14}

Figure 3. Cross-Site Comparison of 12-Month Screening Rate and Percent Positive for Drinking More than the U.S. Recommended Limits.



(4) The availability of usable data, and leadership’s interest in using data, was a facilitator of, or barrier to, process improvement.

All three sites made adjustments to their SBIRT processes during their 12-month implementation period, however, the extent that their practice leaders were able and interested in using data to improve or reinforce processes varied greatly (Figure 4).

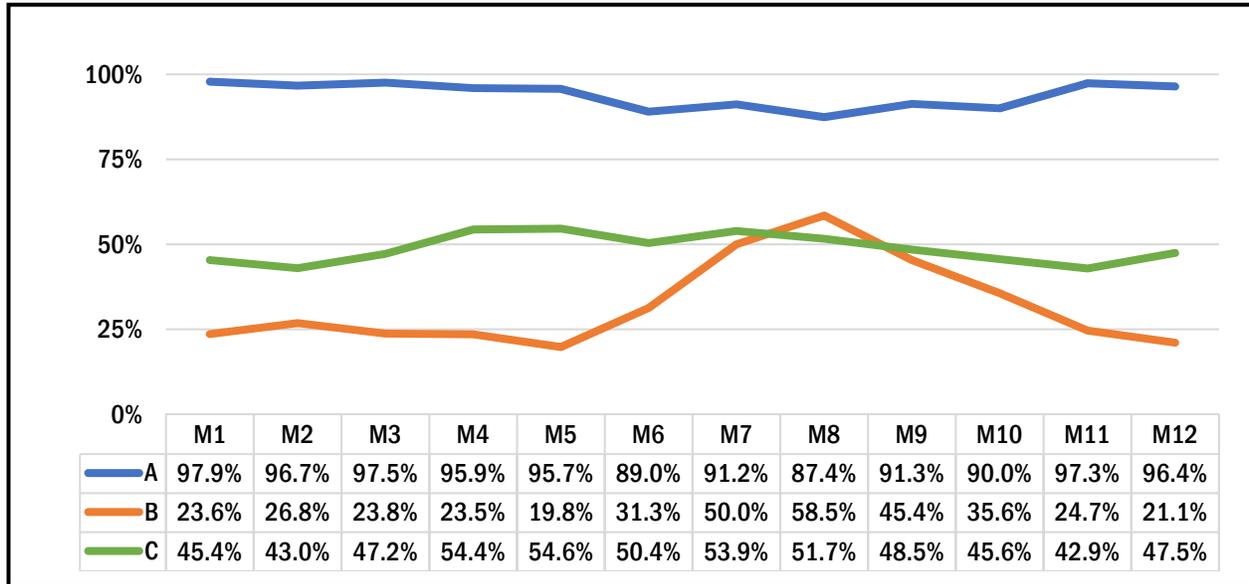
“The hardest part for us was creating those reports and tweaking them, trying to continue – the EMR is hard, and getting that [AUDIT] into [the EMR].”
 –Quality Manager

Site A’s leadership team actively used their EHR screening rate reports to identify problems and engage with CBHRS. They focused on improving their systems and staff confidence, including requesting booster training for their medical assistants. Site B used their data to make some system adjustments, including changes to their EHR, which improved screening rates temporarily, but improvements were not sustained.

Site B requested additional data analysis to further their understanding of their unscreened eligible patients, but declined booster training to enhance staff skills.

Site C had no usable data from their EHR, which greatly limited CBHRS’ ability to provide meaningful technical assistance. The Quality Manager performed chart reviews, however, and provided feedback and reminders to individuals who were not consistently screening. Their screening rates were relatively flat throughout the implementation period.

Figure 4. Cross-Site Comparison of SBIRT Monthly Screening Rates.



(5) Time for conducting a brief intervention was emphasized as a barrier, even when directly relevant to the reason for their visit. This was especially true for providers.

“I think it [SBIRT] is important to be part of a holistic look at a patient’s care, but sometimes I feel very pressured in the visit where if they’re coming in for a broken leg and I’m behind on patients—it’s really challenging to address their drinking which might have contributed to their fall that gave them the broken leg. But I only have so much time in that visit.”
 –Physician

“It’s just really hard for providers, and it’s hard in these EMRs to document what intervention you did in a succinct, quick way, because we’re being challenged to see 20-plus patients a day”
 –Quality Manager

“I mean, seriously, that’s about the only thing we could do to make anything more effective is to have the time, and that’s the one commodity we’re short on. Because education takes time. Helping do interventions takes time.”
 –Nurse Practitioner

Factors Relevant to Patient Reach and Effectiveness

(1) Patients who were eligible and reached for SBIRT tended to be white, female, adults, which was representative of overall demographics of eligible patients for these sites (Table 2).

Staff indicated that administering SBIRT screener universally to all patients helped normalize it, and provided potentially useful information.

“I think it’s [substance use] probably good to know because usually there are some things that if you don’t ask people they won’t tell you.”

–Nurse Practitioner

“There’s no magic pill. But it’s [screening] not super time-consuming, like some of the other things that we have to do and screen for, so it’s a quick kind of way to get to see where your patient’s at.”

–Medical Assistant

Table 2. Demographics of Patients Screened for Alcohol During 12-month Implementation Period

Practice Sites	A		B		C	
	Eligible	Screened	Eligible	Screened	Eligible	Screened
Total Unduplicated Patients	2,341	2,166	2,219	1,039	2,501	1,217
Percent	100%	92.5%	100%	46.8%	100%	48.7%
Sex						
Males	47.6%	47.6%	37.0%	38.8%	32.3%	29.6%
Females	52.4%	52.4%	63.0%	61.2%	67.7%	70.4%
Age Groups						
12 to 17*	5.5%	5.8%	0.2%	0.3%	-	-
18 to 64	75.2%	74.9%	79.5%	77.3%	74.1%	77.2%
65 to 110	19.4%	19.3%	20.3%	22.4%	25.9%	22.8%
Race/Ethnicity						
White/Caucasian	90.9%	91.2%	90.1%	90.1%	92.2%	91.9%
Black/African American	0.6%	0.6%	1.3%	1.7%	1.5%	1.4%
Asian	0.7%	0.6%	1.4%	1.3%	0.4%	0.5%
American Indian/Alaska Native	3.7%	3.8%	1.7%	0.6%	0.4%	0.2%
Native Hawaiian/Pacific Islander	0.2%	0.2%	0.6%	0.6%	-	-

*Sites A and B screened patients between the ages of 12 and 17.

**Site C did not report data for Native Hawaiian/Pacific Islander

(2) Sites with higher screening rates perceived SBIRT as more effective for their patients, particularly for identifying problematic use in patients, but also for reducing and preventing problem use (Table 3).

“There was a patient that I had no idea how much she was drinking, and I think it really did help that particular individual, because I think we had to have that teachable moment, because they were having health issues.”
 –Nurse Practitioner

“People had a realization of like wow, only that much? Well, all my friends drink that much. And so that education point, I think that’s good where people sort of get an idea of what’s normal, what really is the recommended [limits] and when does it become problematic?”
 –Physician Assistant

Table 3. Perceptions of Practice Site Key Informants on SBIRT Effectiveness

How effective SBIRT is for...	A (N=5)	B (N=4)	C (N=4)
Identifying Problematic Use	4.00	3.00	3.75
Reducing Problematic Use	3.00	1.75	1.50
Preventing Problematic Use	3.00	1.75	2.50
Avoiding or Lowering Costs Related to Problematic Use, Abuse and Dependence	3.20	2.00	2.00
Overall Average Effectiveness Scores*	3.30	2.10	2.50

*Effectiveness score are based on a 5-point scale:
 1= “Not Effective”; 2= “Slightly Effective”; 3= “Moderately Effective”; 4= “Effective” and 5 = “Very Effective”

“The behavioral changes really are more dependent on the patient and their interest in changing. Because if I say ‘hey, it looks like you’re drinking more than is recommended,’ and [they say] ‘I don’t care, I’m not changing, let’s talk about something else,’ nothing’s gonna happen. Then for someone who is interested in changing, then, what resources are available? And how easy is it to get people to [go to treatment].”
 –Physician

Costs and Benefits of Implementing SBIRT

As more patients are reached for SBIRT, projected societal benefits increase- however, returns on investment for implementing sites are limited and difficult to quantify, based on barriers to billing.

A separate cost analysis, funded by the Alaska Mental Health Trust Authority, was conducted to estimate the potential benefits of spreading SBIRT across the Mat-Su Borough. The analysis looked to the literature to estimate a cost-saving ratio, which included pre-implementation expenditures plus estimated costs associated with delivering SBIRT, minus any returns associated with billing for services, and downstream savings, primarily accrued at the societal level. While reported benefits-cost ratios were as high as 5.6 to 1 (i.e., \$5.60 savings to every \$1.00 of expenditure), when projected reductions in broader alcohol-related statistics, such as accidents, violence and employee absenteeism were

included, we used a more conservative ratio of \$3.2 in costs associated with healthcare utilization that would be saved for every \$1 spent by the clinics on SBIRT-related costs.¹⁵

Our three sites varied in dollars spent in pre-implementation and implementation activities, particularly with regard to providing staff with additional training, and direct involvement of practice administrators, including Medical Directors. The cost of time spent in delivering SBIRT also varied between sites, based on the extent that behavioral health professionals were integrated into the visits and the amount of time that providers spent in counseling their patients on alcohol. These differences in costs and projected returns are summarized in Table 4.

Table 4. Cross-Site Comparison of Costs for 12 Months* of SBIRT Operation and Projected Savings Due to Reductions in Healthcare Utilization.

Costs	Practice Site		
	A	B	C
Pre-implementation (planning & training)	\$8,231	\$2,664	\$4,330
Infrastructure (EHR modification; patient education materials)	\$6,100	\$177	\$750
Administration	\$5,049	\$682	\$1,125
SBIRT Delivery	\$19,466	\$964	\$5,065
Total estimated SBIRT cost (time x total visits screened)	\$38,846	\$4,487	\$11,270
Benefit-Cost Ratio	3.2:1	3.2:1	3.2:1
Total estimated SBIRT benefits	\$124,307	\$14,358	\$36,064
Benefit projected if 94% of visits were screened	\$123,805	\$21,497	\$44,900

*Table 4 presents 12-month operation costs for cross-site comparisons. In the original study, authors calculated the cost to implement SBIRT for 15 months at Sites A and B, and 12 months at Site C using data provided by each practice.

Regarding revenue generated by billing for SBIRT services, none of the participating sites billed. Their reasons for not billing had to do with a mismatch between time requirements for billing and actual time spent in screening and brief intervention.

“[For SBIRT billing codes to be usable] they need a shorter duration billing option, like, with tobacco cessation, there’s a less-than-three-minute, three-to-five-minute, kind of options, or five-to-ten-minute billing options, and those are really more realistic when you’re talking about a physician or nurse practitioner/physician assistant interacting and doing some brief intervention with the patient. It’s intended to be brief...15 to 30 minutes in a primary care world is not brief.”
–Medical Director

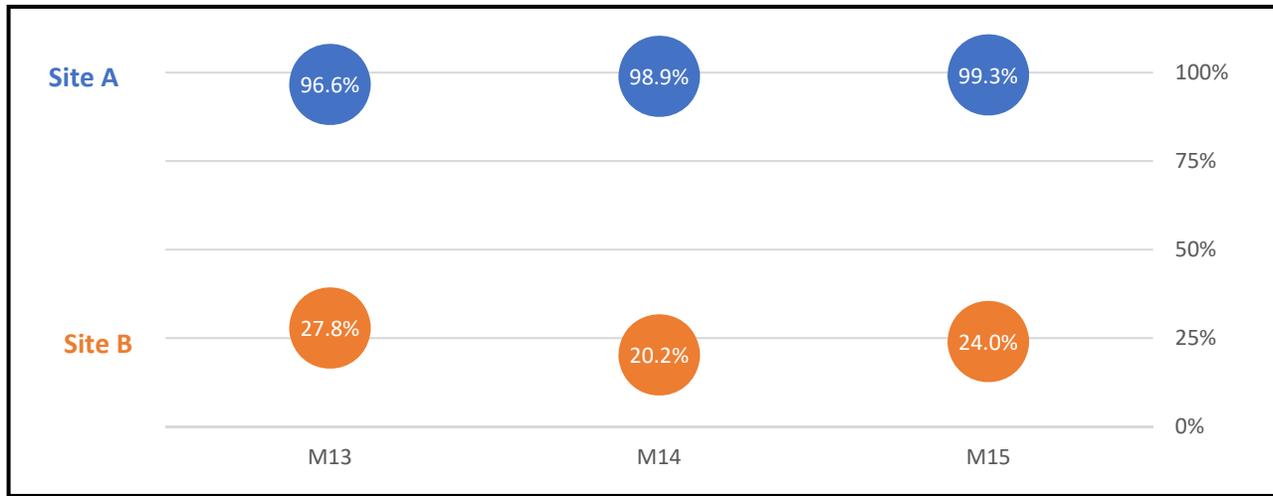
“...there were two barriers. One is the billing code – it requires a minimum of 15 minutes of counselling in order to bill under that code. But another barrier is that for many of our patients, if not most – as an FQHC, we bill under the TTS grade. So adding another billing code doesn’t benefit the organization as far as reimbursement goes.”
–Quality Manager

“The billing codes? We don't bill for it. I think patients would get upset, honestly, if they saw that on their EOB.”
–Office Manager

Factors Relevant to Maintenance of SBIRT

Given delays experienced by Site C, only Sites A and Sites B were followed for a “maintenance” period of 3 months (Figure 5), where we continued to monitor screening rates but did not offer technical assistance or conduct check-in calls. Site A maintained high screening rates, which increased further by month 15. Site B screening rates returned to month 1 level.

Figure 5. Cross-Site Comparison of SBIRT Monthly Screening Rates During the Data-Only Maintenance Period.



All three sites indicated their intentions to continue to provide SBIRT services to patients. Continued training and monitoring delivery of not just screening, but also brief interventions, were mentioned as important to sustaining SBIRT.

“It’s another vital sign to me now.”
–Medical Assistant

“I think documentation of interventions – that’s still clunky. That’s the piece that needs more work if we’re going to continue to monitor how successful we are. But I think the bigger thing is having it be part of every new employee’s training.”

–Medical Director

“I think simply monitoring and providing data is often in itself just a good way to remind people and bring it to the forefront that yeah, we are still doing it, we still want you to do it, we are still looking at it.”

–Quality Manager

RECOMMENDATIONS: WHAT DO WE RECOMMEND FOR SPREADING SBIRT

(1) Practice leaders, provider and staff champions, state public health, and health professional associations, should clearly state the reasons for adopting universal alcohol screening and brief advice, education or intervention, within primary care settings—i.e., to prevent negative consequences of risky drinking as a part of routine health promotion.

“We're not able to do adequate substance abuse counseling as a primary care clinic, and we're not trained for it, either. I'm not a substance abuse counselor. And there are really limited options of where people can go.”

–Physician

“If it's not part of the Alaska Primary Care Association's MA training, it should be.”

–Medical Director

(2) States and communities interested in spreading SBIRT should create opportunities that encourage mentoring and collaboration among practices.

“You know what was probably the most helpful and gave us sort of a push, because we weren't excited to do this, I have to tell you, was we went up to [Clinic A], and they opened their doors and they showed us what they did. Now, they had a completely different EMR, but just showing us how they did it so we could actually take what you gave us on paper, and we could see how they put it into practice.”

–Office Manager

(3) Practices need financial and technical support to retrofit or purchase EHR systems that include the AUDIT screener with scoring algorithm, decision support based on screening results, the ability to document, communicate, and bill for SBIRT services provided, and the ability to produce summary reports to monitor quality and manage population health.

“I felt like it was pretty cumbersome, in that I think because our EMR – you know, we're taking a process, you're asking us, and we have to kinda like mold it into this thing, and I'm sure you guys have had challenges. I know I did. And I'm not sure our tool is as effective as it could be, but it's the best we could do. So I thought it was pretty hard.”

–Office Manager

“Our SBIRT was in a whole different part of the chart so unless an MA specifically said their SBIRT was off the scale, you may or may not realize it until you go in there and looked for it.”

–Nurse Practitioner

[We] added SBIRT to the clinic care guidelines, which “informs the MA and provider of which guidelines are scheduled for review at the time of the patient visit.”

–Quality Manager

(4) Providers and staff need training and opportunities to practice their skills; booster training, patient education materials, and updated information with community and online resources are welcome.

“From an implementation standpoint - training and then reinforcement of tools – brief learning on how to do motivational interviewing and teaching staff those. I would say we probably have spent four to five full days with full clinical teams, which are many people, on training over the course of a couple of years.”

–Medical Director

Having visual aids that depicted the drinking containers commonly used by patients seen at these sites, was helpful for screening and educating patients about alcohol quantity. Pre-printed “wallet” cards with updated local information and resources was valued by providers.

“I made copies of the questions and the size of drinks and put them in every single room, so they’re all available. And we also have, in every room we have, on our bulletin board we have the trifold [patient education handout]. And people do read them a lot. And we have stacks of them in the room for them to just take and read if they choose to.”

–Medical Assistant

“The diagrams with the red Solo cup [16oz plastic cup]. That is actually very helpful.”

–Medical Assistant

“If I had to find something that was somewhat useful from before SBIRT versus after, having that little card [with local and national resources] that had information on it was useful.”

–Physician

(5) Use SBIRT as a model for improving coordination and integration of co-located behavioral health.

“In a perfect world, we would have a person in office waiting and if the number is high it’s like, oh, we stop right here and get this person to further do counselling. We’re just not set up for that. We don’t have the staff. I think it’s something we’re working towards...”

–Nurse Practitioner

“At our facility we have behavior health specialists that can then be, if we have a positive SBIRT, I’ll often involve them in the visit. ‘Hey, I’m going to have you meet one more of my team members and they’ll come over and chat with you a little bit too.’”

–Physician Assistant

Having behavioral health fully integrated into SBIRT procedures may also alleviate a few key barriers to SBIRT adoption, with regard to perceived lack of treatment services, and constraints related to having sufficient time, skills and confidence to provide an effective intervention. Indeed, the site that integrated a “warm hand-off” to an in-house behavioral health professional as part of their SBIRT procedures, perceived SBIRT as not only effective for identifying problematic drinking, but also for preventing and reducing problematic drinking.

(6) Identify and connect to area programs and places for referral prior to implementation.

“Really make an effort to connect with other resources within the community. I think that’s something we could have done better, to try to identify referrals, places to refer to quickly.”

–Quality Manager

SBIRT RESOURCES

For materials and worksheets on how to implement alcohol screening and brief intervention using a 10-step process, we recommend the CDC Planning and Implementation guide, available at: <https://www.cdc.gov/ncbddd/fasd/documents/AlcoholSBImplementationGuide.pdf>

Training and resources for preventing alcohol exposed pregnancies, FASDs, and implementing universal screening and brief intervention, can also be found at: <https://nccd.cdc.gov/FASD/Search.aspx?category=Collaborative%20for%20Alcohol-Free%20Pregnancy%20Courses>

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