ADOLESCENT SBIRT
IMPLEMENTATION checklist

mosaic
GROUP

the Adolescent SBIRT Checklist (ASC) is a tool designed to provide organizations with a set of critical steps that will help ensure that Screening, Brief Intervention and Referral to Treatment (SBIRT) becomes a sustainable, integrated part of routine care. This tool was developed by consultants at the Mosaic Group and is based on successful experience implementing and integrating SBIRT services into a variety of care settings. The steps contained in this checklist have been found to be essential in order to achieve optimal, sustainable SBIRT implementation. The ASC provides organizations with an implementation structure that allows for customization of a protocol that is unique to a variety of practice settings and clinical and staffing models.

The typical SBIRT implementation process occurs over a twelve-month period consisting of three planning months and nine months of prac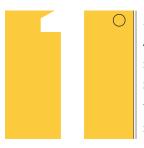tice implementation. Based on Mosaic Group's experience, it is evident that certain steps build and develop on each other and are subsequently critical to complete in chronological order.

THE STEPS CONTAINED IN THIS CHECKLIST HAVE BEEN FOUND TO BE ESSENTIAL IN ORDER TO ACHIEVE OPTIMAL, SUSTAINABLE SBIRT IMPLEMENTATION.

If these steps are completed out of order, the ASC will not support the most effective SBIRT implementation and integration. Additional steps in the ASC may be completed as appropriate depending on the specific care setting or organizational needs. Steps with numbers in yellow boxes should be completed in order, and steps with numbers in green boxes may be completed as appropriate according to the organization's planning circumstances and unique considerations for SBIRT implementation. Importantly, steps with numbers in green boxes must still be completed and are critical for successful SBIRT implementation.

Accompanying each step in this tool is an SBIRT Checklist User Guide. The User Guide provides more information and guidance about each of the checklist steps; gives organizations and sites additional relevant information on how to put into action the steps, stemming from previous experiences, lessons learned and best practices; includes references to sponsoring organizations that may be providing materials and/or technical assistance to sites and organizations implementing SBIRT services; contains setting-specific considerations to help organizations tailor the implementation process to the needs of their care setting; and presents recommendations for school-based health centers, behavioral health providers, primary care settings, and community-based organizations.

GAIN COMMITMENT
from senior leadership

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○ *Secure a commitment from the organization's highest-level senior executive and senior clinical leader.* Ensure that the identified leaders are willing to dedicate the time and resources necessary for effective, sustainable SBIRT implementation. Identify the alignment of SBIRT services with the organization's mission and business plan. Work with the leaders to ensure that they are committed and willing to allocate the personnel and other support necessary for effective, sustainable SBIRT implementation into routine care.

Form a MULTIDISCIPLINARY
SBIRT planning/implementation team

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○ *Identify leadership from key organizational units that will play a role in SBIRT planning and implementation.* It is recommended that leaders from the following units should be engaged as part of the planning and implementation team: clinical leadership, practice management, IT, quality improvement, case management, behavioral health services.

○ *Convene the kick-off planning meeting of the SBIRT team.* The primary goal of this meeting is to introduce the team to the SBIRT planning process and familiarize team members with the steps of SBIRT implementation. Team members should also understand their role in the planning process. At this meeting it is useful to discuss the overall SBIRT model and how it is typically implemented in the setting and discuss opportunities and challenges that the team will need to consider moving forward in the work. Additionally, it is useful to identify the electronic health record vendor and the process to adapt the system to support SBIRT implementation. Experience has shown that it is critical that key organizational leadership (administrative and clinical) be present at this meeting to demonstrate support.

○ *Reconvene the planning team at key points during the SBIRT implementation process to continue to develop the protocol, discuss progress, challenges, data, and sustainability.*

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○ *Conduct a comprehensive walk-through of the practice/setting that will be the focus for SBIRT implementation.* The analysis will document the workflow, describing how patients/clients are processed within the setting from entry, through care services, and ultimate completion of the care visit. The analysis should document key roles, decisions, and processes that a patient and provider/staff member will encounter during a visit. If multiple locations of the same organization participate in SBIRT implementation, separate workflow analyses are only necessary if there are specific identified differences across sites.

○ *Produce flow charts of the practice. Charts should accurately and comprehensively reflect the workflow analysis above and focus on the reality of the care setting, not an operations manual.*

○ *Review flow charts with the SBIRT planning team and modify as needed to ensure accuracy and acceptance.*

Develop SBIRT protocol

○ *Identify within the organization the target population of youth and young adults that will be receiving SBIRT services.* Organizations may have multiple services offered to adolescents (e.g., primary care, dental, behavioral health) and the organization should decide up-front which youth will be screened and, based on results, will receive subsequent SBIRT services.

○ *Select a standardized screening instrument for the target youth population.* Evaluate different validated screening instruments appropriate to the population of youth and young adults to be screened. For example, screening instruments for youth under 21, such as the six-question screening tool CRAFFT, may be most appropriate; however, organizations should also evaluate screening instruments for adults that may be more appropriate with older youth. Importantly, select one most appropriate instrument to be used with the entire youth population to be served.

○ *Identify the substance use screening frequency. Organizations provide services to youth at varying levels of intensity, which will help to inform decisions regarding screening frequency.* For example, organizations must decide whether to universally screen every patient/client at every encounter, or will there be a different interval (e.g., all new patients, a specific intervention or visit).

○ *Analyze the work flow to identify how best to integrate SBIRT services.* Experience has shown that this step is critical to identify the roles and staff that will support each step of the SBIRT process; this will serve as the foundation for developing the protocol as a step-wise procedure from every operational perspective.

○ *Draft a written SBIRT protocol.* Document all of the policies, roles, and procedures into a formal, written SBIRT protocol. This document should be drafted in a format that can be incorporated into the organization's policy manual.

○ *Review SBIRT protocol with the full SBIRT team and gain approval.* Have the SBIRT team members sign off on the operational plans to signal their consensus. If team members suggest specific edits, modify the protocol as warranted to achieve consensus.

ELECTRONIC HEALTH RECORDS
(EHR) modifications

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○ *Understand the organization's EHR vendor/consortium status to identify feasibility and EHR workflow.* Organizations will have different vendors (e.g., Epic, NexGen) and processes surrounding EHR modifications. We believe it is critical to understand these factors within the context of SBIRT implementation in the particular care setting in order to make the correct modifications.

○ *Understand EHR capabilities for modifications and data reporting.* Different EHR vendors and interfaces will have varying requirements for modification. It is important to work with the organization's IT staff to understand what will need to be done in order to successfully integrate SBIRT into the EHR system.

○ *Modify EHR to incorporate and document SBIRT services into medical records.*

○ *Produce screenshots of SBIRT in the EHR to review outputs and modifications — run a sample patient through the record and produce a sample data report.* This is a critical step in order to test functionality and identify whether or not the modifications were successful.

BILL and CODE
for SBIRT services

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○ *Identify codes within the specific state and setting that will be used to code for SBIRT service delivery.*

○ *Work with IT and staff to modify EHR to support SBIRT services billing and reimbursement.* This step is critical in integrating SBIRT service codes into the existing EHR system. There must be a fluid process of designating when SBIRT services are completed and the subsequent billing designation.

○ *Continually monitor the billing process to ensure SBIRT service reimbursement is occurring.*

Provide STAFF TRAINING

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○ *Develop customized training for all staff impacted by SBIRT.*

○ *Develop protocols for on-the-job training for new employees once SBIRT is effectively institutionalized.*

○ *Have SBIRT team members review and sign off on training protocols to signal their consensus.*

○ *Conduct training for all staff to be impacted by SBIRT.*

○ *Distribute relevant educational materials and tools to providers.* Available materials such as the standard drink chart, readiness ruler, and the SBIRT provider checklist are valuable for successful SBIRT implementation. These tools help both the patient and provider remember important information relative to the SBIRT process.

○ *Conduct booster trainings approximately every two or three months to review and refresh staff on SBIRT.* Booster trainings also serve as a critical forum to address barriers/challenges to SBIRT implementation, as well as reinforce successes.

Establish the
REFERRAL TO TREATMENT (RT) process

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○ *Verify referral to treatment contact/staff responsible within the organization and/or site.*

○ *Profile available resources in the community to understand locations and services relative to the specific setting and needs.*

○ *Develop RT protocol for the organization and give to all care managers.*

○ *Hold "meet and greet" sessions to introduce the SBIRT site to treatment providers so that they can get to know specific key personnel, such as intake workers at the treatment locations.*

○ *Train all staff and providers on how the RT process will work and provide support/assistance as needed.*

TRACK AND ANALYZE DATA to practice
continual process improvement

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Define frequency, source, and methodologies for collecting data. Once a site/organization goes live with SBIRT, data should be reported monthly via the provided Data Reporting Template.

Provide feedback for the SBIRT planning team on a monthly basis. Monthly and quarterly data will be analyzed such as numbers of encounters or unique patients, screening percentages, the number of brief interventions conducted, and the number of patients/clients referred to treatment. All staff and team members should be engaged in a conversation about the implications of the data — what is working well, and where improvement is needed.

Continue monthly feedback for at least six months, until the practices are fully integrated into routine operations.

Monitor effectiveness of protocols and modify as necessary to improve performance.

Ensure SBIRT SUSTAINABILITY
as an integrated part of care

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Establish a standardized method for SBIRT performance evaluation and new hire training. If possible, SBIRT evaluation should be competency-based (observation of skills) and conducted annually.

Develop a SBIRT orientation tailored to the specific organization and/or setting. New staff should be thoroughly trained on the SBIRT process to ensure no gaps in administration.

Institutionalize the quality improvement process through focused monthly reviews with leadership and staff.

Assure financial support is sustained for grant-funded staff. Experience has shown that it is critical to secure sustained funding for staff members who may be funded through grant dollars that will eventually end.

user guide

Each of the sections below corresponds to the numbered segment in the Checklist. This guide is intended to provide additional information and support drawing from the Mosaic Group's experience in SBIRT implementation. Additional comments are included to provide organizations with considerations for specific care settings.

This first step is critical in the SBIRT implementation process. Experience in SBIRT implementation continues to show a direct correlation between senior leadership support and the success of SBIRT implementation across all settings. In preparation for this step, research should be done to understand the leadership setting within the context of SBIRT implementation. This will help to identify potential alignment between the SBIRT process and the missions, business plan, and goals of an organization; clear interests of senior leadership. This will create an effective case during the presentation of SBIRT as a valuable component of the organization. It is important to engage both management/administrative leadership and clinical leadership, as appropriate. For example, working with the CEO of an organization as well as the senior clinical leader will create a comprehensive support network that will ensure the greatest buy-in across the organization. The composition of senior leadership will vary across settings and it will be important to identify the correct personnel during the start of the SBIRT implementation process. It may also be applicable to engage policymakers to support the SBIRT process. For example, the state Medicaid Director may need to activate the SBIRT billing codes and intervene if there is difficulty securing reimbursement for SBIRT services. State or local elected officials may need to approve budget allocations or changes in statutes.

Considerations for specific care settings:

• SCHOOL-BASED HEALTH CENTERS (SBHCs): In SBHCs, it is important to have a firm understanding of the organizational structure. Some SBHCs are privately run or have private providers, and subsequently will require different parties to be present at the stakeholder table. For example, if an SBHC has an FQHC private healthcare provider, the CEO and clinical leaders of the overall sponsoring organization should be present at the initial meeting, as their support is critical. Similarly, if the county health department or school district runs the SBHC, research must be done to understand who the relevant senior leadership stakeholders are in relation to school health; successful implementation will likely require access to the high-level school

district staff. Once this level of leadership has been established, it is then necessary to engage with the school principals and other critical student support service team members to create the most comprehensive collection of key stakeholders.

- PRIMARY CARE SETTING: In a primary care setting, an assessment should be made of the organizational structure to understand the correct leadership members to engage. For example, an organization's CEO and senior clinical leaders should be actively engaged in order to create a comprehensive leadership network. The leadership hierarchy in a primary care setting will likely be straightforward, and successful SBIRT implementation will ensure that all of the key staff are present at the initial meeting to show full support.

- BEHAVIORAL HEALTH PROVIDERS: In a behavioral health provider setting, the CEO of the organization and high-level clinical services leaders, such as the director of clinical services, should be engaged to provide support for the SBIRT process. These leaders will have substantial influence on organizational processes and their support will ensure that SBIRT becomes a sustainable and integrated part of healthcare delivery.

- COMMUNITY-BASED ORGANIZATIONS: Community-based organizations require additional care and research in attempting to understand the key stakeholders to engage during SBIRT implementation; this is due to the varying organizational missions and structures. These organizations will typically have a diverse leadership team and it will be critical to identify and gain support across teams to successfully implement SBIRT. Additionally, larger community-based organization may have a national focus whereas others may be regionally focused, and fully understanding this organizational structure will be important to identify the most appropriate staff members to include in the leadership team.
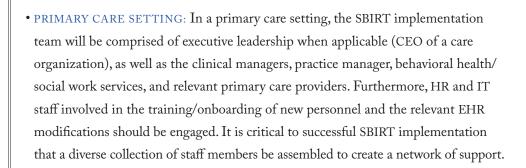
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Effective SBIRT implementation requires the buy-in and participation of many different levels of staff within the organization or care setting. Subsequently, it is critical to implementation that a multidisciplinary planning and implementation team is created. Experience in SBIRT implementation continues to show that in order to ensure successful implementation, buy-in must be achieved from the top-down and bottom-up of an organization; key leaders from organizational units need to be identified and engaged. In addition to service providers (e.g., counseling, clinical services, behavioral health services) and leadership (e.g., executive and clinical), the SBIRT implementation team should be comprised of staff including IT personnel or those who work with EHR, human resource staff, and training professionals, as appropriate. The senior leadership engaged previously should provide guidance on the organizational structure to identify the most critical staff members to be a part of the SBIRT team. Senior leadership should also provide insight into the staff members who most appropriately represent functional units at a management level; these staff members will be influential in the SBIRT implementation process, as they have developed relationships with the day-to-day functions. The exact composition of this team will vary across organizations and settings. After establishing the critical members, the SBIRT implementation team should have a kickoff meeting. The primary goal of this meeting is to introduce the team to the SBIRT implementation process and provide information on the SBIRT model and its relevance to the specific care setting. Basic information should be given to provide a groundwork level of understanding. Additional in-depth information may relate to the EHR; modifying electronic health records can often take time and delay the start of implementation, underscoring the importance of initiating the conversation early and having IT staff on the planning team. Furthermore, the SBIRT planning team should understand their responsibilities moving forward through implementation and be prepared to actively participate in the workflow analysis, protocol development, data review, and sustainability plan.

Considerations for specific care settings:

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- SCHOOL-BASED HEALTH CENTERS: Depending on the type of SBHC, the key leadership identified previously as well as all relevant clinical staff should be present; the composition of this clinical staff may vary. For example, a SBHC may have a director of nursing, nurse practitioners, and a school social worker all actively involved in the delivery of healthcare services. Subsequently, the SBIRT implementation team should include all of these staff members, as appropriate, as well as the associated IT staff; student support staff such as school psychologist, guidance counselor, or social worker; and the principals or vice principals.

- PRIMARY CARE SETTING: In a primary care setting, the SBIRT implementation team will be comprised of executive leadership when applicable (CEO of a care organization), as well as the clinical managers, practice manager, behavioral health/social work services, and relevant primary care providers. Furthermore, HR and IT staff involved in the training/onboarding of new personnel and the relevant EHR modifications should be engaged. It is critical to successful SBIRT implementation that a diverse collection of staff members be assembled to create a network of support.

- BEHAVIORAL HEALTH PROVIDERS: Similar to above, in a behavioral health provider setting, senior leadership must be included in the SBIRT implementation team. Additionally, the clinical director, IT staff responsible for EHR modification and maintenance, staff members involved in the referral to treatment process, and any relevant case manager should be included.

- COMMUNITY-BASED ORGANIZATIONS: Community-based organizations again pose significant considerations due to the varying organizational structures. Significant work and research should be done to identify key members, including leadership, IT and data staff, referral to treatment staff, and other management staff who have direct relationships with the youth. For example, in an organization that offers vocational training, the director of a specific area may be extremely influential and important to the SBIRT delivery process; this staff member should absolutely be included in the implementation process.

3

The workflow analysis process provides a structure and outline for the development of an SBIRT protocol and ultimately the entire SBIRT implementation process. An SBIRT workflow analysis begins with a comprehensive walk-through of the clinic, practice or setting where the SBIRT services will occur. The primary goal of the workflow analysis is to document how patients/clients are processed within the care setting. The analysis should begin with a documentation of the patient/client entry and initial form completion, the processing of those forms, the delivery of care services including any relevant time windows, and end with the ultimate completion of the visit with any associated documentation. All staff members and roles should be clearly highlighted in the workflow to provide a comprehensive understanding of the players involved in the delivery of SBIRT services. Importantly, within an organization there will be different staff members and/or professionals who support various components of the SBIRT process, and experience has shown it is critical to outline these roles in the workflow analysis. For example, often times the staff member responsible for SBIRT screening will not be the same person who provides the client with a brief intervention; this relationship should be documented within the workflow analysis to provide clarity and a comprehensive understanding. In addition to the staff members involved, all processes, decisions, and policies should be documented; these will significantly impact SBIRT implementation and must be noted at the correct places along the workflow. It is important that all of these items come together to effectively tell a story about what the patient/client will encounter throughout the entire delivery of services so that SBIRT may be optimally implemented within the specific care setting. It is very important to understand the dynamic within the visit between the parent and provider; meaning, when is the parent present during the visit, and will SBIRT services be delivered during this time. Experience in SBIRT implementation has shown that the presence of a parent may influence the responses of adolescents, and subsequently this should be considered

during implementation. Once the full workflow has been documented, flow charts of the practice/care setting should be created to visualize this workflow. This visualization needs to accurately reflect the reality of the care setting, including the EHR process, and not a procedure or operation manual. It is important that this workflow analysis is conducted thoroughly and realistically in order to ensure successful SBIRT implementation.

Considerations for specific care settings:

• SCHOOL-BASED HEALTH CENTERS: In an SBHC, the workflow analysis should mirror a walk-through from the time the student enters the health center to the time they leave, including all the personnel he/she interacts with. A successful workflow analysis will understand the relationships a student will develop with staff members and the associated dynamic. For example, what/how much information is shared, interactions with the classroom teacher, parental involvement, and additional student support services. A workflow of an SBHC should consider all potential resources and personnel that a student will encounter and may require research and conversation outside of the specific care setting walk-through.

• BEHAVIORAL HEALTH PROVIDERS: It is critical to understand the intake and assessment process and type/level of information collected in a behavioral health provider care setting. For example, a workflow analysis should identify what type, if any, of substance abuse assessment is currently being performed and by what staff members. This information will help guide the SBIRT implementation process and assure that there is no duplication or overlap of services and questions. A primary goal of early SBIRT implementation is to find a place during the healthcare workflow to have SBIRT become seamlessly integrated (ie., fill a current gap in services). Additionally, the workflow analysis should fully outline the process of an adolescent visit, including the stepwise intake process and frequency of clinical interactions.

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- PRIMARY CARE SETTING: A primary care workflow analysis should clearly document a walk-through from the time a patient enters the practice to the time the patient leaves. For example, an effective workflow analysis will document how a practice triages patients, the specific sets of a screening tools currently being used, when screening occurs, the key staff members involved, and the presence of any current referral to treatment processes. Furthermore, this analysis should outline additional relevant staff members such as a health educator, case manager, or social worker that will be actively in contact with a patient during a primary care visit.

- COMMUNITY-BASED ORGANIZATIONS: Workflow analysis in a community-based organization should thoroughly document the different levels/frequencies of interaction, intake, and assessment an adolescent may encounter. Careful consideration should be made as to what evaluations are currently being done and at what points during client encounters. A community-based organization may have specific criteria or protocols established for substance abuse testing that can significantly impact the SBIRT process. For example, an adolescent in a community-based organization may have to perform routine urine toxicology tests, and if positive, be discharged or sent for treatment. This outcome may be in conflict with the SBIRT process associated with reducing use over time, and the workflow analysis should highlight this conflict so that the SBIRT planning team can discuss the most appropriate method of integrating SBIRT as a part of care delivery.

ADOLESCENT'S HABITS CHANGE FREQUENTLY AND IT IS
CRITICAL TO REPEAT THE SCREENING PROCESS TO CAPTURE
THESE CHANGES AND NORMALIZE THE CONVERSATION.

4

Protocol development serves as the foundation for systems-level change, which is necessary to integrate SBIRT as a routine part of care and ensure sustainability past the end of the grant period. This step directly stems from the previous workflow analysis and SBIRT planning/implementation team meetings. Before designing and drafting the SBIRT protocol, it is critical to clearly understand the target population and appropriate screening tool. For example, research should be conducted to identify any potential subsets within the adolescent clients that will particularly benefit from SBIRT services. For example, in an SBHC, many healthcare visits may be for routine services such as over-the-counter medication administration; a decision must be made as to whether or not these youth will receive SBIRT screening at that visit, or only as appropriate. Additionally, the screening tools and methods of screening will vary across sites and settings. For example, some organizations and/or sites may screen on the computer or tablet, in contrast to a paper and manual data entry method. These variations should be clearly documented in the SBIRT protocol with corresponding considerations such as patient privacy/confidentiality and data entry timelines in order to most effectively support the overall SBIRT screening process. Although the CRAFFT is the most common screening tool for adolescents, other screening tools may be more appropriate for other sites and settings (eg., Simple Screening Instrument [SSI]). Importantly, only one screening instrument should ideally be used to evaluate adolescents; this ensures the best chance for standardization and comparability of results. Lastly, the screening frequency also needs to be identified. Meaning, different organizations will interact with youth at different levels of intensity, which will be relevant and influence the SBIRT implementation process. Examples of screening frequencies include every patient encounter, only unique patients, unique patients quarterly, or only new patients annually. The goal of selecting the correct screening frequency is to screen adolescents as frequently as possible without overburdening them with questions. Adolescent's habits change frequently and it is critical to repeat the screening process to capture these changes and normalize the conversation. Experience in SBIRT implementation has shown that

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over time, youth will develop a level of trust with providers and begin to open up and be more honest about their substance use practices. Another important consideration for protocol development is parental involvement. Successful SBIRT implementation requires a thorough understanding of when and where parents are present during an adolescent visit. Experience in SBIRT implementation has shown that parental presence can directly impact the percentages of positive screens, as youth are less likely to admit use in the presence of a parent. If possible, opportunities to screen without the presence of parents should be identified.

Once the aforementioned information has been gathered, the workflow analysis should be used as the basis to develop the SBIRT protocol. All relevant staff members and roles should be thoroughly documented throughout the SBIRT process to ensure clarity. This protocol will serve as a reference to the organization as a whole, as well as individual staff members, and subsequently should be as clear, thorough, and comprehensive as possible. The protocol truly is a step-by-step outline of the SBIRT process at a specific organization. Once the workflow has been integrated, the written protocol should be finalized with all relevant policies and procedures and presented to the SBIRT planning/implementation team. All members of the planning and implementation team should provide their written approval of the document to validate accuracy and ensure compliance.

Considerations for specific care settings:

- SCHOOL-BASED HEALTH CENTERS: In SBHCs, substantial thought should be given to the ways in which youth interact with the healthcare staff. As mentioned above, many visits to the school nurse may be completely routine, and screening adolescents at each visit may result in overburdening. Decisions should be made by the SBIRT implementation staff as to the best location and methodology of integrating SBIRT services into the delivery of care. Regarding the appropriate screening

instrument, the type of school in which the SBHC is located will impact the most appropriate screening tool. An alternative school that services older youth may need to consider an alternative to the CRAFFT. Furthermore, there are often staff limitations in SBHCs (e.g., part-time nurses or primary care providers), and considerations should be made as to whether or not it is appropriate to screen adolescents without the direct presence of a clinical provider. The SBIRT implementation team should discuss the dissemination of the protocol with other staff members to ensure all relevant parties are informed and knowledgeable about the SBIRT process and how it relates to the delivery of healthcare services within the SBHC. Furthermore, the method in which parents are informed about SBIRT results should be included in the decision-making process and protocol development.

4

- BEHAVIORAL HEALTH PROVIDERS: Specific considerations for behavioral health providers include thinking through the current set of questions administered to adolescents during a clinic visit; at what point is the SBIRT screen most appropriate to be administered. As compared to an SBHC, youth are being screened at a significantly more structured and scheduled basis, so careful thought should be given to the most effective integration of SBIRT as it relates to the overall visit. Additionally, the protocol should consider and highlight whether the behavioral health clinicians themselves or another staff member are performing the BI and RT. Additionally, some behavioral health clinicians are capable of providing treatment services as part of their interventions. Identifying when a brief intervention turns into a more structured behavioral health treatment/intervention should be completed; truly understanding these relationships will allow for effective SBIRT integration though the identification of co-occurring capabilities that provide seamless transitions across the stages of SBIRT services.

4

- PRIMARY CARE SETTING: A primary care SBIRT protocol should accurately reflect the developed workflow and include all relevant leadership and staff members. The protocol should accurately reflect the patient process from triage/intake to discharge and highlight the specific roles and responsibilities. As there will likely be preexisting screening processes, it is critical to clearly describe how SBIRT services will become integrated into the visit flow. The protocol should be signed off on and approved by staff members including any health educator or case manager actively involved in patient/client visits.

- COMMUNITY-BASED ORGANIZATIONS: In community-based organizations, it is critical that in the development of an SBIRT protocol, the correct staff members involved in the delivery of SBIRT services are identified and highlighted. For example, coaches or vocational counselors, in addition to case managers or counselors, may be actively involved in the screening, assessment, or intervention processes and these relationships should be understood and the roles clearly specified in the SBIRT protocol. The protocol should identify at what point within a visit that an adolescent receives substance abuse screening and all associated intake/treatment processes. The goal of a successful SBIRT protocol is to outline the entire care network and describe the responsibilities within: how is the screening being done, what is the role of the resource team, and who is delivering the brief intervention. Furthermore, work within the RT process should be done to note in the protocol whether or not there is an on-site treatment location, and if not, the method in which adolescents are referred to treatment.

5

The modification of EHR systems to incorporate SBIRT services has become increasingly important to the SBIRT implementation process. Years of experience in SBIRT implementation have shown that up-front, thorough work to create the appropriate EHR modifications is critical. The first step in SBIRT EHR modifications is to identify the vendor or consortium used at the organization and work with IT staff to identify the necessary process to modify electronic records. For example, Epic may have a different modification process than a vendor such as NexGen or Athena, resulting in adjustments to the modification process. It is important to understand the EHR capabilities and interfaces that will be encountered throughout the modification process. Importantly, the EHR modifications should accurately reflect and support the flow of the care visit to result in the most effective integration. Accordingly, it is critical to not just modify the EHR to incorporate the screening instrument, but also allow for areas for providers to appropriately document SBIRT services and notes. All of these modifications should be done within the context of the ultimate data report; meaning, how will the data be pulled and within what format. Discussions with the organization's IT staff should underscore the importance of data and the need for clear and concise data reporting. This process highlights the importance of establishing an early relationship with the organization's IT staff through the multidisciplinary SBIRT planning/implementation team. Gaining IT support and communication through that relationship will ultimately make the EHR modification process significantly easier. After the necessary modifications have been outlined, the IT staff should modify the EHR to incorporate and document SBIRT services into patient or client medical records. After the modifications have been completed, it is absolutely critical that the IT staff produces screen shots of SBIRT successfully integrated into the medical records; this includes running a sample patient report. Experience in SBIRT implementation has continued to highlight the importance of producing screen shots and reports as validation that the SBIRT process has been successfully integrated into the EHR. Without this validation, SBIRT may go live without the necessary EHR modifications and can cause substantial complications or delays.

Experience in SBIRT implementation continues to underscore the importance of up-front EHR modifications. Subsequently, the above strategies are applicable across all identified care settings.

Bill and code
for SBIRT services

6 The first step in the SBIRT billing and coding implementation process is to identify which codes will be used for SBIRT services. It is necessary to begin by researching and understanding whether or not the codes related to SBIRT services are turned on for billing in the specific state/setting. Meaning, different states and care settings may use various codes for SBIRT services and it is important to begin by identifying these codes in order to successfully bill for services. If the codes are not turned on, work will need to be done to identify another mechanism for billing, if possible. Provided the SBIRT codes are turned on and available, the next step is to work with IT and staff members to modify the EHR to support SBIRT services billing and reimbursement. It is critical to ensure that the documentation of screening, brief interventions, and referrals to treatment in the EHR system interfaces with the billing process so that the appropriate codes may be assigned to the SBIRT services. If this is not possible, work must be done with the organization and IT staff to identify an alternative way to bill for SBIRT services that remains consistent with other provided healthcare services. Similar to the above step of EHR modifications, developing an up-front relationship with an organization's IT staff is critical to result in the easiest billing and coding process. After the coding, billing, and reimbursement have been successfully integrated, it is important that the staff and IT members monitor the billing process to ensure that service reimbursement is occurring correctly. This billing process should be embedded in the SBIRT protocol.

Across all care settings, successful SBIRT implementation will require the understanding and identification of the specific billing requirements and availability of codes.

Ideally staff training should not occur until all of the above steps have been worked out. Specifically, the protocol has been clearly approved and the EHR modifications have been made and tested. The reason for this is that effective SBIRT implementation needs the context and information to support the training process rather than just general information. Staff training and orientation on the SBIRT process is one of the most important steps in the SBIRT implementation process. The first step in SBIRT training is to develop a customized training for the organization and practice, providing information for all staff impacted and involved with SBIRT services. It's important to build a case for why SBIRT is important in the setting and organization — provide relevant data (local if possible) to support the need for their adolescent patients/clients. This training process includes an overview of the SBIRT process — highlighting the necessity and importance of the roles of staff members and providers, and providing helpful tips and instructions, screen shots of the EHR to clearly outline how to document SBIRT services, and ample time for questions to be asked. The initial training should be comprehensive and detailed to provide as much information as necessary; staff members new to the brief intervention process should receive all of the necessary information including motivational interviewing skills, how to connect the conversation to the current clinical model, and the relevance of substance abuse to the child's health. Experience has shown the importance of different training techniques, both in the initial training session and beyond. For example, a standard lecture may be required to convey up-front information, but skills-based trainings such as demonstrations, role plays, and case studies are extremely valuable additional teaching methods. Also, the necessary allotted time for training sessions will differ by organization and setting, dependent on time constraints, attendance, and internal capacity; however, our experience in SBIRT implementation has shown that a minimum of 90 minutes should be allotted for the initial training. Additionally, the timing of training is critical for successful implementation. Experience in SBIRT implementation has shown that the initial training should be conducted as close to the go-live date as possible to ensure that

the information and skills are utilized soon after learning. It is imperative that all staff members who will be working on SBIRT in any way are in attendance at the training to ensure that there are no gaps in knowledge. Experience in SBIRT implementation has shown that gaps in training and knowledge can have significant impact on SBIRT outcomes.

Educational materials should be distributed to providers at the initial training session. For example, standard drink charts (indicating what is considered to be one drink), readiness rulers, and handouts on the effects of excessive alcohol use (in English and Spanish) have been shown to be very effective tools during SBIRT services. Experience in SBIRT implementation continues to show that these tools are very beneficial and educational for patients/clients and serve as positive reinforcement.

Lastly, booster trainings should be conducted every two or three months to review and refresh staff and providers on the SBIRT process. These training sessions are absolutely critical in identifying challenges and barriers to SBIRT implementation, as well as celebrating successes. All relevant outcomes data should be shown to the attendees and highlight any achievements and areas for improvement. Experience has shown that these booster trainings frequently reveal challenges, such as documentation or EHR mistakes that negatively impact SBIRT outcomes. Booster trainings represent a critical time for staff/provider feedback and troubleshooting. Experience in SBIRT implementation has shown that these booster trainings can uncover simple mistakes (e.g., documentation) that can be substantially impacting SBIRT implementation and performance. For example, a simple issue of not clicking the correct box in an EHR can suggest poor performance, when providers are actually providing more services than those being documented. Booster trainings are also used for skill building in screening and brief intervention practices; once providers have experience to speak about and relate to, booster trainings serve as forums to discuss real-life cases and help to enhance and develop SBIRT skills.

Considerations for specific care settings:

- SCHOOL-BASED HEALTH CENTERS: Considerations for training in SBHCs primarily include a firm understanding of how SBIRT relates to the dynamic of health services in the school setting. Ensuring that the appropriate staff members are present will result in the most effective training outcomes.

- BEHAVIORAL HEALTH PROVIDERS: In a behavioral health setting, it is important to consider the varying skill levels of providers present at the trainings. Experience in SBIRT implementation has shown that tailoring trainings to the specific audiences is most effective. For example, if the trainer understands that most staff present at a training are skilled healthcare professionals with substantial experience in delivering brief interventions, it may be redundant to repeat all of the basics.

- PRIMARY CARE SETTING: Special considerations for staff training in a primary care setting are similar to the above behavioral health setting; it is important to understand the audience and tailor the training sessions accordingly. For example, a training session may consist of experienced clinicians, but also a health educator without an understanding of substance abuse and SBIRT services. Therefore, the trainer must spend time understanding the most effective methods and relevant information to include in the specific training.

- COMMUNITY-BASED ORGANIZATIONS: As mentioned above, understanding the audience's skill level and knowledge of SBIRT is critical to successful trainings. In a community-based organization, many staff members or providers may not be knowledgeable in brief interventions or motivational interviewing, and subsequently, trainers should really stress the basics and create a solid foundation of information from which to build upon. SBIRT implementation could represent a big change in organizational operations, and a trainer should be sensitive of this change and include all of the relevant information to empower and motivate the staff members.

Establish the
REFERRAL TO TREATMENT
(RT) process

8

Experience in SBIRT implementation has shown that establishing a clear referral to treatment process is important to ensure that patients/clients are successfully referred and linked to treatment. The first step is to verify the referral to treatment contact within the organization. This staff member or provider will be the primary initial contact, and should be actively engaged throughout the SBIRT implementation process. Additionally, available treatment resources in the surrounding area should be understood and profiled. This profile of nearby resources is critical in understanding available insurance, treatment facility hours, contact information, and continuum of services (e.g., residential, detox). Additionally, the RT process should focus on matching the client's need with the most appropriate service and incorporate all relevant factors such as barriers to treatment — transportation, other obligations, and parental involvement. This information will provide the referral to treatment contact and other providers with the tools necessary to refer patients/clients to the locations best suited to provide healthcare for the specific needs. Importantly, the SBIRT referral to treatment process provides up-front information necessary to direct the patient to the treatment center or treatment setting that fits the needs of the client; this center will then provide a formalized assessment to understand the appropriate treatment services. Experience has shown that this point is particularly relevant in the youth SBIRT process, as many youth frequently don't require traditional substance abuse treatment and it may be most appropriate to refer adolescents to treatment centers providing additional services. Experience in SBIRT implementation has shown that a successful means of establishing the RT process is to conduct a meet and greet for involved staff members to build and develop relationships. As in previous steps, an RT protocol should be established and given to all care managers that outlines the referral process and provides contact information. Similarly, all staff and providers should be trained on the RT process to create a support network. The goal is to have a warm handoff in BI to RT, so that the adolescent is linked to treatment successfully and comfortably.
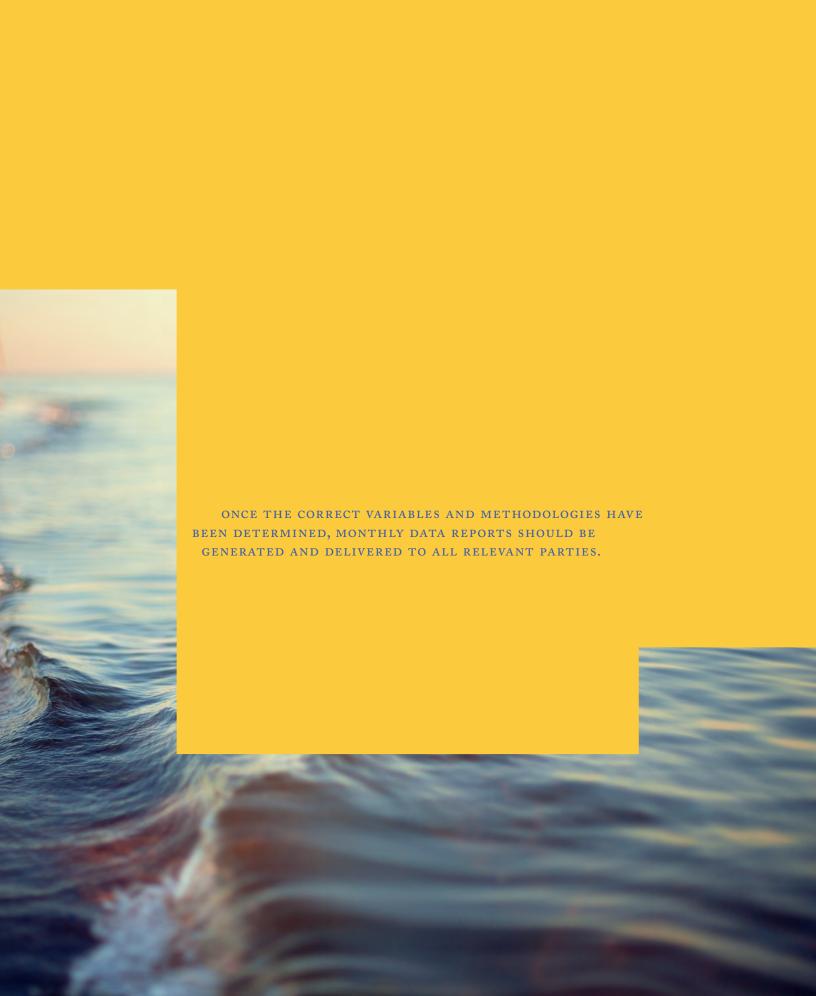
Considerations for specific care settings:

- SCHOOL-BASED HEALTH CENTERS: In an SBHC, it is critical to understand the availability and capacity of the RT process within the school setting. For example, establishing whether or not there is a mental health provider on-site and if he/she is able to see patients that need this level of care. Furthermore, if an SBHC refers to treatment at an outside location, the involvement of the youth's parents becomes critical and requires careful consideration.

- BEHAVIORAL HEALTH PROVIDERS: Special considerations for behavioral health providers include the development of an understanding as to which services, if any, are co-capable within the protocol and what is considered treatment within an organization's own clinical action.

- PRIMARY CARE SETTING: The referral to treatment process in the primary care setting will benefit from the understanding of available treatment resources outlined above. It will be critical to establish the staff members within the primary care setting who will be involved with and responsible for the referral to treatment process.

- COMMUNITY-BASED ORGANIZATIONS: Community-based organizations will have varying organizational structures, resulting in different RT processes. It is important that the SBIRT protocol highlights the network of support to ensure that youth are not disengaged in the event of substance abuse. The SBIRT model is built upon the BI and RT process; thus if there is no opportunity to deliver these services, the outcomes will not be successful.

Track and
ANALYZE DATA TO PRACTICE
continual process improvement

[9] The collection, analysis and dissemination of SBIRT data is critical in any SBIRT care setting to ensure smooth implementation into organizational operations as a routine part of care. The staff member who will be running the data reports should be a part of the SBIRT implementation and planning team. Prior to going live, the staff involved with data collection and reporting should identify the frequency, source and methodologies for collecting and reporting SBIRT data. These processes vary substantially across organizations and settings, so it is critical that up-front work is done to outline the data collection and reporting process. Sample reports should be run and reviewed to ensure that correct variables are being retrieved through the EHR and data report generation. Experience in SBIRT implementation continues to underscore the importance of sample reports; the variation in organizational data reporting processes often creates confusion. It is recommended that, at minimum, sites and organizations report the number of patients seen (relative to the screening frequency), number of screens completed, number of positive screens, number of brief interventions, and number of referrals to treatment. Once the correct variables and methodologies have been determined, monthly data reports should be generated and delivered to all relevant parties. It is important that the relevant parties include the clinical champion and/or executive leader; those staff members who will be actively and influentially engaged in the necessary responses to address challenges. This data collection and reporting process is absolutely fundamental to successful SBIRT implementation, as it serves as a marker of current progress and reveals areas for improvement. The data should be used to provide feedback to staff and providers at monthly meetings or calls. From experience, reviewing the data with staff has been extremely helpful to identify challenges and improve outcomes; staff often do not realize areas in need of improvement until the data has been reviewed with them. In addition to the monthly data reports, implementation should offer a range of TA methods, including but not limited to: individual calls, group calls, and on-site visits. Careful consideration must be made as to which methods of TA are appropriate to different levels of staff and the findings from this process will directly inform the future training structure. Monthly

ONCE THE CORRECT VARIABLES AND METHODOLOGIES HAVE BEEN DETERMINED, MONTHLY DATA REPORTS SHOULD BE GENERATED AND DELIVERED TO ALL RELEVANT PARTIES.

[9]

data reviews and feedback should be continued for at least six months, even if the outcomes are exceeding performance targets. Experience in SBIRT implementation has shown that it is important to ensure that at the nine-month mark of the implementation period that the relevant performance targets are being met; without data validation of the performance targets, it will be unclear as to whether or not SBIRT has been successfully integrated into the care setting. This consistent reinforcement will help to support successful SBIRT implementation and integration.

Importantly, data reporting and evaluation should be relatively uniform across care settings to provide as much comparability of results as possible. Subsequently, the above strategies are applicable across all identified care settings.

Ensure SBIRT SUSTAINABILITY
as an integrated
part of care

It is important to ensure SBIRT sustainability as a routine part of care beyond the one-year implementation period. In order to do this, institutionalized methods for performance evaluation and training should be established. The system for SBIRT orientation and onboarding of staff should be identified and SBIRT training should be fully integrated and fully cemented into the organization's existing process to provide a seamless transition; this process can be tailored to the specific organization or care setting. Ideally, all new staff members should go through the same SBIRT orientation process to ensure that there are no gaps in knowledge or services. Experience in SBIRT implementation has highlighted the importance of institutionalizing the practices, policies, and procedures to result in a sustainable practice. Additionally, research and planning should be conducted to understand the organization's performance evaluation process. Existing performance evaluation methods, including competency-based evaluation if applicable, should be modified or updated to include all relevant SBIRT processes. For example, in a primary care setting, if a PCP is not performing BIs when necessary, this gap should be able to be identified and addressed through the organization's performance evaluation system. Similarly, quality improvement methods should also fully incorporate SBIRT. For example, across the nine-month SBIRT implementation period, the SBIRT data should be evaluated with the goal of fully integrating these data indicators and measures into the organization's routine data review or quality improvement plan. This integration will provide consistent reinforcement and reminders to the staff members about the importance of SBIRT.

Sustainability is critical to any SBIRT implementation and strategies will be largely applicable across care settings.

adolescent SBIRT implementation

The timeline outlines the approximate intervals in which the steps from the ASC will be completed throughout the twelve-month implementation period. As mentioned in the discussion, certain steps must be completed in chronological order, while others may be completed as appropriate within the specific organization and care setting.

MONTH

1

- Gain commitment from senior leadership

- Form SBIRT planning team and kick-off meeting

- Conduct workflow analysis

MONTH

2

- Kick-off planning team meeting

- Develop SBIRT protocol

- Conduct EHR modifications

MONTH

3

- Staff SBIRT training

- Referral to treatment process

- SBIRT billing and coding

- GO LIVE

MONTH

4

- Begin monthly data collection and analysis

- Monthly TA

MONTH

6

- SBIRT booster training

- Monthly data collection and analysis

MONTH

9

- SBIRT booster training

- Monthly data collection and analysis

MONTH

12

- SBIRT sustainability meeting

- SBIRT booster training and close out meeting

- Monthly data collection and analysis

CONRAD N.

Hilton

FOUNDATION

mosaic
GROUP