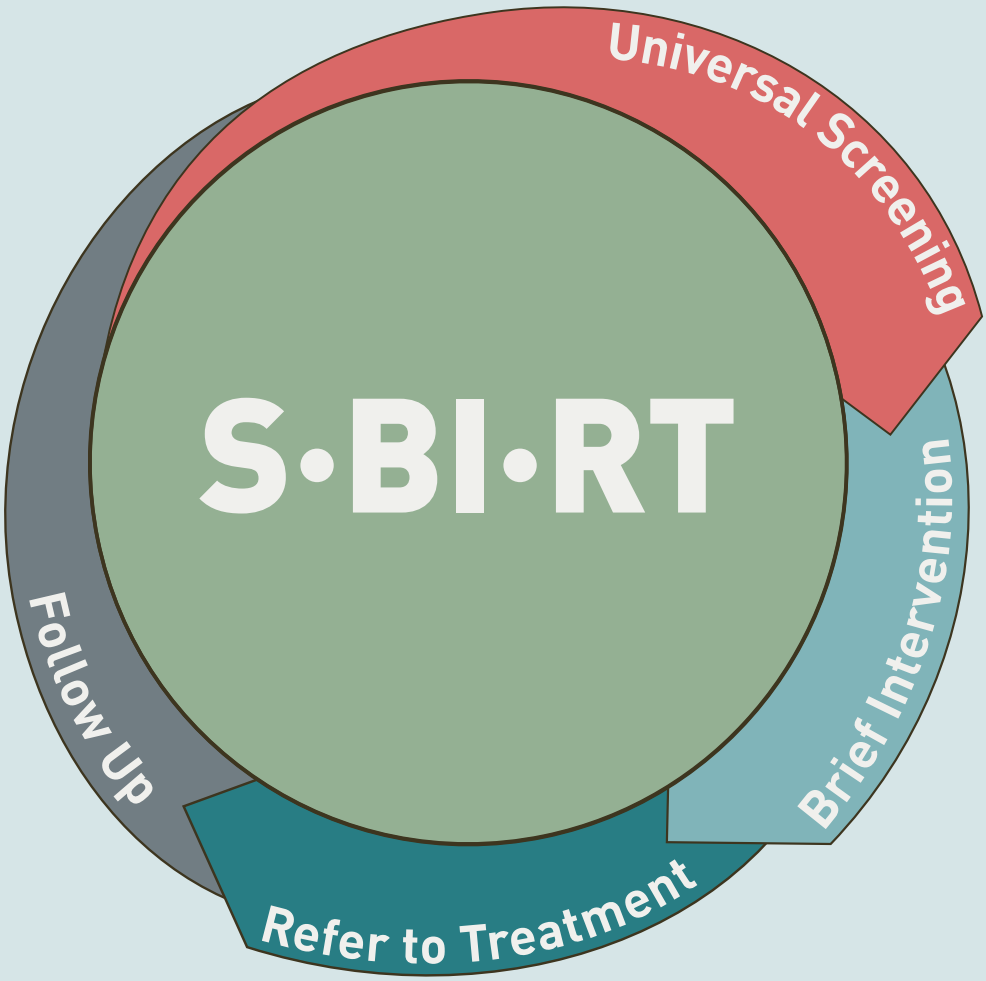
PLAYBOOK

SCREEN AND INTERVENE:
NH Youth S·BI·RT Initiative

Playbook
October 2015



NEW HAMPSHIRE
CHARITABLE FOUNDATION

SCREEN & INTERVENE
NH Youth SBIRT Initiative

Prepared for:

The New Hampshire Youth SBIRT Initiative of the ***New Hampshire Charitable Foundation*** in partnership with the ***Conrad N. Hilton Foundation***

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The New Hampshire Center for Excellence provides technical assistance, disseminates data and information, and promotes knowledge transfer to support the effectiveness of communities, practitioners, policymakers, and other stakeholders working to reduce alcohol and other drug misuse and related consequences in New Hampshire.

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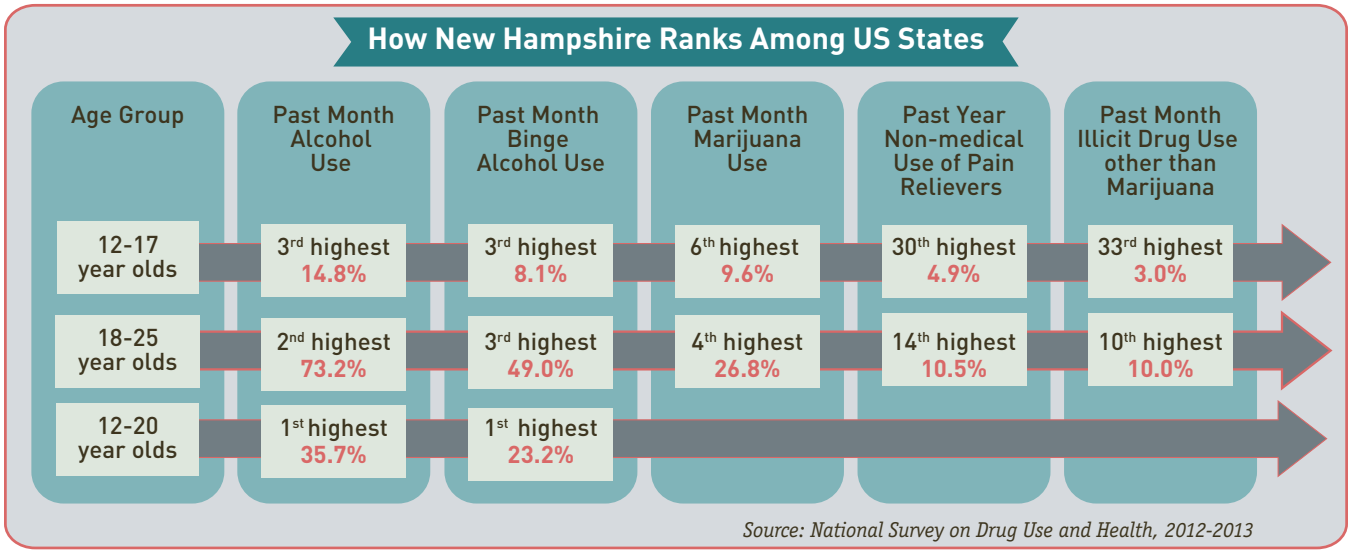
INTRODUCTION AND OVERVIEW

Introduction

The health care sector has a key role to play in supporting a culture change to address alcohol and drug misuse. Through universal screening and follow up, S · BI · RT enables practitioners to address various levels of alcohol and drug use – whether to affirm a young person's decision not to use, to engage a patient in a brief motivational conversation about reducing his or her drug or alcohol use, or to refer an individual to counseling or other treatment services if needed.

New Hampshire has the dubious distinction of being the state with the highest rate of reported regular illicit drug use, other than marijuana, among 18 to 25 year olds, at 10 percent.[1] Heroin-related deaths are rising, and according to the NH Medical Examiner's Office, heroin-related emergency department visits have multiplied exponentially in the last two years. Half of New Hampshire's 18 to 25 year olds report binge drinking in the past 30 days, the third highest rate in the country.[2] Alcohol and drug misuse cost the state more than $1.84 billion annually in lost productivity and earnings, increased expenditures for healthcare, and public safety costs.[3] The human health and economic toll of these trends is alarming.



Definition: Screening, Brief Intervention and Referral to Treatment

The acronym S · BI · RT – Screening, Brief Intervention and Referral to Treatment – denotes an approach to systematic universal screening for problematic alcohol and drug use and the routine steps taken to address the screening results. Through S · BI · RT, healthcare providers can identify problematic alcohol and drug use, provide early intervention, and coordinate effective care.

S · BI · RT represents a set of processes that include discrete components: S (screening), BI (brief intervention), and RT (referral to treatment). Beginning with screening, each component builds on the previous process. S · BI · RT is endorsed by the American Medical Association, American Academy of Family Physicians, American Academy of Pediatrics, and many other associations of medical professionals.[4]

[1, 2] *SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012-2013.*
[3] *Polecon Research. (2014). The corrosive effects of alcohol and drug misuse on NH's workforce and economy: Summary Report. Available at: http://www.new-futures.org/sites/default/files/Summary%20Report_0.pdf*
[4] *American College of Physicians, American Psychiatric Association, American College of Emergency Physicians, American College of Surgeons Committee on Trauma, American College of Obstetricians and Gynecologists, American Society of Addiction Medicine, and the World Health Organization*

The health insurance industry and the federal government also recognize S · BI · RT through established health provider reimbursement for S · BI · RT practices.[5]

As a set of processes, S · BI · RT acknowledges the impact of alcohol and other drug use on patients' health, and integrates care for problematic use into business as usual. In primary care, the process may be more accurately described as one of screening, brief advice, and follow up. Follow up may include brief intervention, brief treatment, return visit to provider, care manager calls and/or an external referral to specialized substance use disorder assessment and treatment. We refer to this process as S · BI · RT throughout this Playbook.

The New Hampshire Youth S·BI·RT Initiative

The New Hampshire Youth S · BI · RT Initiative of the New Hampshire Charitable Foundation is supported in partnership with the Conrad N. Hilton Foundation. This vanguard Initiative is a timely response to the changing healthcare environment and offers a mechanism for aligning healthcare and public health systems throughout the state. The NH Center for Excellence[6] (the Center) is the primary training and technical assistance provider for this Initiative and New Futures[7] is providing policy and advocacy support.

The New Hampshire Youth S·BI·RT Initiative Goal

Addiction is a pediatric disease. Early onset use of alcohol or drugs is a major predictor of the subsequent development of alcohol or drug dependence. The significance of S · BI · RT is that it focuses on stopping substance misuse before it starts, and/or catching early use before it escalates into addiction.

The goal of the NH Youth S · BI · RT Initiative is the universal screening of youth and young adults across NH pediatric primary care practices as a strategy for reinforcing healthy behaviors, identifying problematic drug and alcohol use early, reducing substance misuse, and referring to treatment those who need it. This three-year initiative's goal is the adoption of Screening, Brief Intervention and Referral to Treatment as a sustainable practice in NH by expanding youth S · BI · RT in primary medical care settings - including hospitals and community health centers – and addressing policy and financing barriers. The specific aim of this work is to screen at least 10,000 youth (ages 12-22) by 2017.

The NH Youth S·BI·RT Initiative Playbook

The NH Youth S · BI · RT Initiative Playbook (Playbook) is a compendium of actions and/or strategies that will help your organization in its implementation of S · BI · RT. The actions/considerations are called "Plays" as they are meant to be put into action at the right time, in the right place, and in the right sequence of S · BI · RT implementation based on the unique context and culture of your organization and site. The Plays were developed based on review of other 'how to' S · BI · RT guides and the recommendations and experience of NH implementation team members across diverse sites. Implementing a new process requires a quality management approach that includes quality planning to systematically design a process that will be able to work, monitoring alignment of the process with identified goals and aims, and using data-driven actions to make processes better through quality improvement. The Playbook provides an organizing framework for this quality management approach.

[5] *Appendix T – NH SBIRT Billing & Coding*
[6] *www.nhcenterforexcellence.org*
[7] *www.new-futures.org*

The Playbook is organized in sections: Introduction and Overview, Section One: The Work Before the Work (Plays 1-3), Section Two: S•BI•RT Preparation (Plays 4-10), Section Three: Success and Sustainability (Plays 11-15) and Section Four: Appendices. Although the Playbook, layout suggests that Plays are implemented in a linear fashion, as in a football game, they are intricately intertwined and should be implemented in the order that best fits your organizational structure, team experience, and culture. For example, Play 1 focuses on team development; however, your organization may already have a team in place, in which case you might start your process by looking at change models (Play 2).

Throughout this Playbook, Plays are described using the following outline: a) Descriptions of the Play including an Overview and a table that summarizes Play Purpose, Definitions, Team Members, and Measure(s); b) Recommended Approach, and c) key factors to Keep in Mind as you implement the Play. An example is included in the identified Appendix along with further information and resources about that Play.

Implementation Checklist

Play	Activities	Complete? (Y/N/NA)	Staff trained/ informed? (Y/N/NA)	Written Procedures?
Play 1 - Forming a Team	Structure the team			
	Who will be on the team?			
	How will the team make decisions?			
	What is the timeframe for project development and implementation?			
	What are the responsibilities of each team member?			
Play 2 - Use a Change Model	Identify change model			
Play 3 - Developing a Plan: Goals and Strategies	Create a team plan			
	Develop a work plan			
	Identify project goal(s)			
Play 4 - Confidentiality	Develop written protocol			
	Explore confidentiality considerations			
Play 5 - Screening Tool(s)	Identify Target population(s)			
	Identify evidence-based screening tool			
	Ensure screening process protects confidentiality			
	Screening documentation process determined			
Play 6 - Brief Intervention (BI)	Type of BI identified			
	BI staffing determined			
	Initial BI training completed			
	BI booster training scheduled			

Implementation Checklist

Play	Activities	Complete? (Y/N/NA)	Staff trained/ informed? (Y/N/NA)	Written Procedures?
Play 7 - Referral to Treatment	Internal referral mechanisms in place (if appropriate)			
	Community provider partnership(s) in place			
	Protocol for organizing how referrals will occur and to whom			
Play 8 - Follow Up	Protocol for identifying patients requiring follow up, method of follow up, and frequency of follow up			
Play 9 - Flow	Determine the physical who, what, when, and where aspects of the S•BI•RT components			
	Develop document outlining the flow			
Play 10 - Electronic Health Record (EHR) Modification	Consider capabilities & limitations of organization's EHR capacity regarding:			
	Screening			
	Brief Intervention			
	Referral to Treatment			
	Follow up			
	Confidentiality			
	Flow			
	Quality Planning and Data			
	Training			
Play 11 - Quality Improvement (QI) and Data Collection	Data Reporting Tool			
	Plan-Do-Study-Act mechanism			
	Data shared with staff			
Play 12 - Billing/ Reimbursement	Coding identified			
	Outreach to Health Plans			
	Billing			
Play 13 - Communications	Develop a communication plan			
	Promote dissemination of lessons learned			
Play 14 - Training	Develop a plan for initial and on-going training of existing and new staff			
Play 15 - Reflection and Celebration	Promote dissemination of lessons learned			
	Acknowledge successful implementation			

BEGINNING PRACTICE CHANGE

The Work Before The Work

Plays 1-3

Play 1 - Forming a Team

Play 2 - Using a Change Model

Play 3 - Developing a Plan: Goals and Strategies

Play 1: Forming a Team

Overview

The change team at your site will drive successful practice change. Team members should represent the various disciplines in your practice setting (e.g., MD and/or ARPN, PA, RN, MA, behavioral health, practice manager, IT, administrative staff). Each discipline will have a role, not only in implementing S•BI•RT, but also in creating a sensible, streamlined process that will become a sustainable component of care.

Purpose of Play 1

Structure the team by answering questions like the following: (a) Who will be on the team? (b) How will the team make decisions? (c) What is the timeframe for project development and implementation? (d) What are the responsibilities of each team member? Your team will *adopt and adapt* the S•BI•RT process for your setting and population..

Definitions

The team represents the various disciplines in your practice setting. Team members bring different yet critical skill sets and perspectives of the direct care environment to the work. All team members are equally important and accountable for the work.

Team members

Team members should represent the various disciplines in your practice setting (e.g., MD and/or APRN, RN, MA, behavioral health, billing, practice manager, IT, administrative staff).

Measure(s)

The team understands its roles, responsibilities and leadership.

Recommended Approach

In your first team meeting determine how the team will be structured:

- If a team already meets regularly, expanding the scope of that team's purpose to include S · BI · RT implementation and QI can facilitate sustained quality implementation.
- Discuss team membership. Who might be involved or affected by any process change? Are the right members included? Is anyone missing? Will some members be ad hoc?
- Develop and use meeting rules if this is not already common practice at your site. Find a standard meeting time/place – we recommend bi-weekly, at a minimum, to start.
- Review the change model to be used by your team for change implementation. Orient all team members to S•BI•RT (you can review this Playbook as a framework).
- Set the agenda for the next meeting – include as an agenda item report outs on any deliverables/action steps.

Keep in Mind

- DO NOT SKIP STRUCTURING YOUR TEAM. Early decisions on team structure will save potential misunderstandings later.
- Team members involved in any aspects of workflow will lend crucial insight into the decisions made regarding successful and sustainable implementation. Prioritize communication, engagement, and participation for all stakeholders involved with or affected by the required changes.
- The team leader does not need to be the provider or practice manager. In fact, roles may get confused when a team leader is also the organizational leader. If you are the organizational leader you will need to be careful about directing the work of the team unless you are also the team leader.
- When someone other than the formal leader of the organization assumes leadership of the team, more creative/out-of-the-box assessment and problem solving ideas may arise and be fostered. Quality planning and quality improvement are team activities that focus on implementing a new system and changing/improving a system, not about changing any individual person.
- Include key players on the team, but also tap other expertise as needs arise.
- Initiative grantees with Substance Misuse Prevention (SMP) Regional Network Coordinators on their teams have a stronger awareness of their population and better connections with community resources.
- The Team Plan is a proven systems change and implementation tool that ensures that everyone on the team understands the purpose and their role from the start.
- Reviewing, updating and adding to the checklist (page 3-4) as a standing agenda item at each meeting facilitates progress toward implementation.

"Having upper management involved helped to change the conversation about SBIRT from one person's idea to an agency-wide commitment."

Corresponding Appendix Section(s)

Tools for Team

Appendix A - SBIRT Team Examples

Appendix B - Team SBIRT Plan

Appendix C - Meeting Agenda

Change Model

Appendix D - Site Plan-Do-Study-Act (PDSA) Example

Appendix E - Clinical Microsystems: A Model for Improvement

Play 2: Using a Change Model

Overview

Implementing S•BI•RT requires complex practice change in most systems. It is a layered process, touching the system at multiple points. It is critical to your S•BI•RT implementation success and sustainability that your team addresses planning and implementation issues together systematically, and that your team is in agreement about decisions. Using a change model as a framework for implementation will help your team reach its goals and measure success faster and more effectively.

Purpose of Play 2 Identify and agree on the change model the team will use to implement S•BI•RT. The change model defines the processes you will use to adopt and adapt S•BI•RT, that is, bring the clinical material of S•BI•RT into your practice and make it fit your unique setting.

Definitions A change model is a road map that will help you and your team visualize how you will reach your goal. The change model proposed in this Playbook has been developed by a team of experts and tested in many settings.

Team members See Play 1.

Measure(s) The team has agreed to, understands, and will utilize the change model.

Recommended Approach

- If the team has already identified a change model for improving practice, adopt it and agree to use it.
- S•BI•RT provides a baseline understanding for the process the team will follow to get to goal.
- If the team does not currently utilize an evidence-based model for practice change, we suggest that the team adopt the Clinical Microsystems Model and seek training and support for utilizing the Model from the Center.

Keep in Mind

- A model is a blueprint for action, providing guidelines for how to effect change.
- Adoption of a model of practice change that can be applied to other system issues is an additional benefit of S·BI·RT implementation for your practice site.
- Regardless of the change model used, the process of improvement builds on an understanding of the "current state". Thus, improvement work for S·BI·RT must start with an assessment of your organization's specific processes related to youth screening: Why do you do it? Who does it? What does your patient population look like? What is the current flow of the work process and screening process and tools? What data are you using to measure screening and substance use screening?

"Implementing SBIRT has not only helped our patients, but changed the way we practice: It has led to formalizing protocols and training and program evaluation agency-wide."

Corresponding Appendix Section(s)

Tools for Team

Appendix A – SBIRT Team Examples

Appendix B – Team SBIRT Plan

Appendix C - Meeting Agenda

Change Model

Appendix D - Site Plan-Do-Study-Act (PDSA) Example

Appendix E - Clinical Microsystems: A Model for Improvement

Play 3: Developing a Plan – Goals and Strategies

Overview

The goal of the NH Youth S•BI•RT initiative is to increase the number of New Hampshire youth screened in primary care settings and who receive clinical response and referral appropriate to their level of risk by 2017. Your clinical site supports the accomplishment of this goal by incorporating S•BI•RT into your clinical practice.

The first step in implementing a new process or program is quality planning. Quality planning allows quality to be designed into a process before the first task has begun.

Purpose of Play 3 To ensure everyone on your team and in your practice knows the goals, aims and measures of S•BI•RT implementation.

Definitions

- A goal is a broad statement of what you plan to accomplish.
- A strategy is the change you will make in your practice- what you will do to accomplish the goal.
- An aim statement states specifically what you want to accomplish, and how you will know it when you do. It is more specific than a goal and can be measured.
- Quality planning is a systematic process for implementing a new program or project that will be able to meet established goals under operating conditions.

Team members See Play 1.

Measure(s) A list of your aims and measures based on an assessment of your practice and the goals of S•BI•RT.

Recommended Approach

In one of your early meetings:

- Determine the goal of S•BI•RT implementation and reach consensus on its value. Get all of the potential biases regarding alcohol and drug use out on the table. Seek consultation from the Center to address concerns.
- Make a list of everything you are concerned about as you embark on this project, and review and resolve that list as you work. This may impact the order in which you prioritize your aims on your workplan and the order in which you begin to work through the Plays.
- Discuss your current practice for assessing substance use, even if assessment is inconsistent. Make a flowchart or map of how it works—or doesn't work—now. What are the issues? This may inform priority areas to address in S•BI•RT preparation.

Keep In Mind

- *Quality planning* is the first step in quality management that includes systematic *planning*, monitoring alignment of process with goals and aims for *quality assurance*, and *quality improvement*, data-driven actions to make the process better.
- Any quality planning/systems change process begins with an understanding of the current state.

"It is really exciting to work on something like this that is so needed in a community like ours."

Corresponding Appendix Section(s)

Tools for Team

Appendix A – SBIRT Team Examples

Appendix B – Team SBIRT Plan

Appendix C - Meeting Agenda

Change Model

Appendix D - Site Plan-Do-Study-Act (PDSA) Example

Appendix E - Clinical Microsystems: A Model for Improvement

S·BI·RT PREPARATION

Plays 4-10

Play 4 – Confidentiality

Play 5 – Screening Tool(s)

Play 6 – Brief Intervention

Play 7 – Referral to Treatment

Play 8 – Follow Up

Play 9 – Flow

Play 10 – Electronic Health Record Modification

Play 4: Confidentiality

Overview

Confidentiality is an issue that cuts across other Plays. Your practice will need to incorporate management of potentially confidential drug and alcohol use information into the design of every Play. Confidentiality considerations will impact flow, Electronic Health Record (EHR) integration, referral relationships, and other decision points throughout your preparation for implementation. There are state and federal laws and regulations that govern confidentiality of alcohol and other drug use information. Your site must be savvy about what does and does not apply to your identified population, and your specific organizational and staffing structure.

S·BI·RT for pediatric patients entails that routinely asking youth questions about substance use, and intervening as indicated, is a standard component of your clinical assessment. Screening that results in honest answers to these sensitive topics depends on trusting relationships between youth and provider, including trust that screening responses are confidential and not shared with parents. How do you explain this in advance to the minor as well as the parent so that the boundary is clear? How will you securely document screening results in the EHR or patient portal so that parents cannot access them? Will you follow up without indicating the specific nature of the concern? How will you protect the nature of the appointment? In some cases it will be necessary to share information with parents. How will your site determine when it is appropriate to break that confidentiality and disclose to the parent?

Purpose of Play 4

- To understand confidentiality rules, regulations, and laws regarding alcohol and other drug patient information.
- To explore confidentiality considerations by population.
- To be clear in the site/organization's policy regarding confidentiality of substance use information by population.
- To decide how to communicate these parameters and to whom.
- To decide if you will include a written confidentiality protocol in your policies and procedures.

Definitions

The confidentiality protocol (verbal or written) is your site's process for how to manage and protect the information about patients' substance use.

Team members

Practitioners can be particularly helpful in clarifying confidentiality responsibilities and protocols. Behavioral health and pediatric practitioner representatives can be key to this decision-making.

Measure(s)

- Decision regarding confidentiality policy and protocol.
- Protection of confidential information throughout the visit flow (including on post-visit print outs and throughout the electronic health record)
- All staff know the boundaries of confidentiality and their responsibility for managing and protecting this information.

Recommended Approach

- Review current policies and procedures about confidentiality involving minors' behavior now, e.g., regarding sexual behavior, sexualy transmitted diseaes, depression, self-harm, and so on.
- Review the information included in the Appendices regarding federal and state law and consult New Futures[8] to clarify questions.
- Participate in peer learning opportunities to understand the decisions and experiences of other sites/organizations.
- Develop a clear decision regarding confidentiality procedure/protocol. Consult legal counsel if concerned about liability pertaining to your team's decisions.
- Confidentiality decisions should be incorporated into training and communications planning.
- Decisions regarding confidentiality and informed consent policy for your organizations S•BI•RT process may not be finalized until the end of the planning process as they will influence and be influenced by other Play decisions.
- Finalize and disseminate confidentiality/privacy policy decision(s).

Keep In Mind

- Berg v. Berg is established legal precedent in New Hampshire regarding a parent's right to their child's clinical information. While the Berg decision did not pertain to S•BI•RT directly, it offers helpful guidance to physicians and substance use treatment providers, suggesting grounds for medical professionals to resist disclosure of children's records to parents if in the minors' best interests.
- Federal confidentiality law pertaining to alcohol and other drug treatment information, 42 CFR Part 2, probably does not apply to your medical facility. It may apply to a specific embedded alcohol and drug treatment provider or program. As a general medical facility, it is only the specialty treatment unit or specialty treatment personnel to which federal confidentiality is applicable, NOT the whole facility.

Corresponding Appendix Section(s)

Confidentiality

Appendix F – S•BI•RT: Federal Alcohol and Drug Confidentiality Overview

Appendix G – S•BI•RT: Health Centers and Confidentiality Overview

[8] *www.new-futures.org*

Play 5: Screening Tool(s)

Overview

Screening provides a means to identify the level of a patient's use behavior, from risky use or no/low risk patients. Screening responses provide an oportunity for a discussion about substance use as part of the healthcare visit (see Brief Intervention). Screening enables identification of patients who are likely to benefit from a brief intervention, and distinguishes them from patients who are more likely in need of a referral. **Conducting a screening is not making a diagnosis.** Screening should be standardized and universal for the chosen population using an evidence-based tool. There are many valid and reliable screening tools. The Center's recommendations for screening adult and/or pregnant populations are included in Bibliography Appendix.

Screening youth may reveal one of three possible results:

- Negative for use
- Infrequent use, unlikely substance use disorder
- Risky use, possible substance use disorder
- High-risk use, probable severe substance use disorder

The NH Youth S•BI•RT Initiative originally required the CRAFFT screening (Appendix I). However, shortly after the beginning of the initial grant period, the Screening to Brief Intervention (S2BI) evidence was published[9] and also approved for use by grantees. This Initiative recommends the S2BI as the initial screener, followed by the CRAFFT or, more simply, replacing Part 1 of the CRAFFT with the S2BI questions and utilizing both (Appendix H).

Purpose of Play 5	To identify the target population(s) and evidence-based screening tool(s) to be utilized in S•BI•RT implementation.
Definitions	Screening for potential health problems is standard in primary care. The addition of screening for alcohol and drug misuse and other potential behavioral health conditions strengthens the patient-centered approach to care.
Team members	Primary care practitioners and integrated behavioral health clinicians play crucial roles in determining the screening tool to be utilized.
Measure(s)	• Agreement as to which screening tool(s) is to be utilized. • A written policy/procedure. • Screening of 80% of all patients at least annually.

Recommended Approach

- Review recommended screening tools.
- Explore what tools may already be built/available for your EHR and potentially available at a reduced cost in a shorter timeframe.

[9] *Levy, S., Weiss, R., Sherritt, L., & et al. (2014). An electronic screen for triaging adolescent substance use by risk levels. JAMA Pediatrics, 168(9), 822-828. http://dx.doi.org/10.1001/jamapediatrics.2014.774 doi:10.1001/jamapediatrics.2014.774*

- Discuss potential pros/cons of suggested screening tool(s) such as length and information gathered.
- Screen electronically if flow and resources can accommodate (particularly appropriate for adolescent and young adult populations).
    - If not electronically, screen on paper. Be sure to account for staff time required to input information into EHR and maintain confidentiality with hard copies.
    - If deciding to screen verbally, ensure that the chosen tool has an evidence base for verbal administration and that the questions are asked exactly as written. Consider costs of staff provider time for administration and regular booster training to maintain efficacy.
- Training in screening administration is imperative to receive consistent quality results.
- This Play recommends implementing screens currently utilized in NH health systems to encourage consistency; however, any evidence-based screen is an appropriate tool. We strongly recommend screening for both alcohol and drug use.

Keep In Mind

- Consultation and training on tools is available through the Center.
- Tools are evidence-based by population.
- Screening can be verbal, written, or electronic.
- Screening tools have an evidence base that is valid and reliable for the specific population and method of administration.
- Confidentiality considerations must be incorporated into every step of the screening process. Where is the screening information saved in EHR? If screens are administered by paper, how will you dispose of the screen? How is the screen incorporated into the record?
- S•BI•RT is an approach used across populations, screening tools and information for adult and pregnant patients are available in the CDC's Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices.[10]
- Sites across NH are integrating alcohol and other drug screening into integrated screening tools with tobacco, depression, and anxiety.

Corresponding Appendix Section(s)

Confidentiality

Appendix H – S2BI Screening Tool

Appendix I – CRAFFT Screening Tool

Appendix J – Integrated Alcohol & Other Drug Screening Tool

[10] *http://www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf*

Play 6: Brief Intervention

Overview

Brief intervention is a patient-centered motivating response to a positive screen which activates reduction of harmful use, or facilitates access to further assessment and treatment. This is a conversation in which the healthcare provider understands level of risk (screening score), patient readiness to change, specific needs and life circumstances, and need for follow up to actively facilitate positive change.

The term brief intervention, in the context of S·BI·RT, encompasses a number of approaches ranging from positive reinforcement to brief treatment, from three minutes with a provider to five sessions with a trained therapist. For the purposes of the NH Youth S•BI•RT Initiative the term "Brief Intervention" encompasses positive reinforcement, brief advice and brief intervention as described below.

The brief intervention, ideally a conversation between the healthcare provider and patient, utilizes motivational interviewing techniques to:

- Educate regarding safe(r) levels of use.
- Increase awareness of the (potential) health consequences of current use.
- Motivate towards changing risky using behavior.

Purpose of Play 6 To understand Brief Intervention as part of the S·BI·RT process.

Definitions

Positive Reinforcement

When a youth screen is negative for use, positive reinforcement is a crucial opportunity. It can be as simple for younger adolescents as "I see that you report not using any alcohol or other drugs. Most people your age do not, and I'm really glad to see you are making this choice for your health and safety." For later adolescence, a provider may inquire, "Do you have friends that have used alcohol or other drugs? What do you say to them to let them know you do not want to?" This unique prevention opportunity is a key benefit of the S·BI·RT approach.

Brief Advice

When a person screens positive, a conversation with their healthcare provider is the next step. When the screen is positive but the patient's use is infrequent and without substance use disorder diagnosis, brief advice is warranted. This very quick follow up acknowledges the positive screen, explains the risks to the developing brain, advises against further use, and facilitates development of strategies to support abstinence.

Brief Intervention

When the screening indicates risky use, ***drinking or using other drugs once per month or more***, a brief intervention is indicated. Practitioners are trained to engage in a different kind of conversation using simple motivational interviewing techniques. When the use is not severe, the goal of the conversation is to increase awareness of problematic substance use, encourage reduction in use, and

changes to risk behavior. Severe substance use, characterized in adolescents as using weekly or more frequently, often necessitates a referral to further assessment and treatment. The brief intervention conversation is required to engage the patient in the decision to participate in further assessment and to actively facilitate a successful referral to treatment. This may take several follow-up interactions and often necessitates parental engagement – with the youth's permission when at all possible.

Team members

All team members need to understand what brief intervention encompasses. This is vital to later integration of documentation into the EHR and determination of flow.

Measure(s)

- Understanding the scope of brief intervention.
- A target measure is established by the team

Recommended Approach

- Review recommended brief intervention techniques and tools for the chosen population. Explore what tools may already be built/available as prompts and reports for your Electronic Health Record and potentially available at a reduced cost in a shorter timeframe.
- Discuss potential pros/cons of suggested brief intervention techniques and impact on flow. For example, how long is the screening process?, who is conducting the BI?, how is documentation done?, and how is follow up captured?
- Brief intervention by the medical practitioner is ideal - if flow and resources can accommodate.
- Training in brief intervention is imperative to receive consistent quality results.

Keep in Mind

- Consultation and training on brief intervention is available through the Center.
- Techniques are evidence-based and incorporate motivational interviewing techniques. MOTIVATIONAL INTERVIEWING EXPERTISE IS NOT REQUIRED.
- Confidentiality considerations must be incorporated into every step of the brief intervention process. Where is the BI information documented in EHR? How is follow-up appointment scheduling explained to the parent?

Corresponding Appendix Section(s)

Brief Intervention

Appendix K – Example Brief Intervention Dialogue

Appendix L – Brief Intervention Tools

Play 7: Referral to Treatment

Overview

In the context of S•BI•RT, referral to treatment is shorthand for a well-planned process through which a healthcare professional provides an active referral to internal behavioral health resources or external specialty treatment for patients who screen positive AND indicate a willingness/desire for such services during the brief intervention conversation. Whether the process includes internal behavioral health providers and/or external referral sources, an established relationship, referral protocol, and family involvement are key components to successful referral.

Purpose of Play 7

To identify how referrals will occur and to whom.
To determine how/how often you will follow up.

Definitions

Active Referrals

Managing the referral process and ensuring that the patient receives the necessary chronic disease management and follow-up support is critical to the recovery process.

Internal Behavioral Health Providers

Warm Handoff

Practices in which behavioral health practitioners are available on-site through co-located or integrated service provision can create a flow that incorporates a warm handoff. This approach includes a physical introduction provider-to-provider and increases the likelihood of participation in further assessment, motivational counseling, or brief treatment. In some cases, a treatment option that is not available on-site will be necessary, and the patient is then referred to a higher level of care. Depending on flow decisions, integrated behavioral health staff may also be responsible for such external referrals to specialty care.

External Substance Use Disorder Specialists

Established Relationships and Protocols

In order for the referral to external specialty care to be efficient and successful, primary care practices must initially establish and cultivate relationships with specialty providers for all levels of care. Release of information mechanisms should be established to confidentially share and receive pertinent patient information with the referral provider prior to the need to refer a patient.

Parent and Family Involvement

Youth with severe substance use problems often know that there is a problem and are willing to talk with parents and accept a referral to further assessment, diagnosis and treatment. Parents are often already concerned about the problematic drug or alcohol use and, therefore, youth are often open to involving their parents in the conversation without further motivational conversation on the part of the provider. Parent involvement is crucial as patients with family involvement have better treatment outcomes. Explaining to young people is often helpful in gaining their consent to break confidentiality.

Team members

- Dependent on flow decisions. Who determines the need for referral? Who is responsible for the actual connection to the referral source? Who ensures documentation? Who receives information back from the referral source?
- Staff who will be responsible for developing referral relationships and/or updating the referral and resources list.

Measure(s)

A plan is in place for how patients are identified for internal and/or external referral, identified referral sources and established relationships.

Recommended Approach

- Create opportunities for warm handoffs in the flow.
- Identify and develop referral source relationships to facilitate successful referrals for youth.
- Discussion/training as to how to present the need for referral to the youth and parent/family as appropriate.

Keep in Mind

- The NH Alcohol and Drug Treatment Locator website (*www.nhtreatment.org*) is updated weekly. It provides contact information for treatment providers many different criteria, including by location, level of care, type(s) of payment accepted, etc. The Treatment Locator is also searchable by those domains.
- In spring 2015, the NH Governor's Commission on Alcohol and other Drug Abuse Prevention, Treatment, and Recovery released core competency recommendations to behavioral health clinicians providing care for alcohol and other drug problems. The Commission urges all behavioral health practitioners to meet the identified competencies and thereby expand access to treatment for alcohol and other drug use disorders across the state.
- Information regarding community supports such as Alcoholics Anonymous and Narcotics Anonymous should be readily available at your site; however, if you are only serving pediatric patients, please keep in mind that youth meetings are not widely available in NH at this time and that these resources are often more appropriate for those over 18 years of age.
- Training and consultation is available to prepare your practice to identify which patients need referrals, identification of referral resources, and techniques for successful connection to referral sources.

Corresponding Appendix Section(s)

Referral Resources

Appendix M – Release of Information Example s

Appendix N – Substance Use Disorder Diagnosis Overview

Appendix O – Core Competencies Recommended For Masters-Level Licensed Behavioral Health Counselors Who Treat or Plan to Treat Clients with Substance Use Disorders or Co-occurring Substance Use and Mental Health Disorders

Appendix P – NH Alcohol and Drug Treatment Locator

Play 8: Follow Up

Overview

Following up on screening result, brief intervention conversation, or referral to further assessment and treatment is crucial to on-going, whole health management with each patient.

Purpose of Play 8 To determine which patients will be followed up, how, by whom and in what time frame.

Definitions Follow up in this context is closing the loop – a continuation of previous BI or RT conversations AND receiving updates regarding treatment progress for coordinated care management (recovery support).

Team members Include EHR/IT personnel.

Measure(s) A target measure for percentage of patients identified for follow up who receive follow up within an established timeframe.

Recommended Approach

- Discuss which patients need to be followed up, for what, and by whom.
- Discuss how you will know that the patient had a positive screen and that you want to follow up at your next encounter. How will it be indicated in the EHR – in a form or in notes? How will the follow up be facilitated by information from the brief intervention conversation or information received back from the referral source?
- Ensure that internal and external behavioral health referrals can be tracked in your system. How will you know that the referral has been successful?

Keep in Mind

- Follow up is essential to your relationship with your patient and your establishment of alcohol and drug use information as a meaningful part of your healthcare relationship.
- Confidentiality of your brief intervention conversation with young patients may make scheduling face-to-face follow up more complex – how will you code the reason for a follow-up visit and explain it to the parent of the youth?
- Follow up by telephone or text communication, with signed informed consent, by behavioral health or case management staff may be an option at your site.

Corresponding Appendix Section(s)

Electronic Health Record (EHR) Resources

Appendix R – Screen Shots of NH S•BI•RT Initiative EHRs

Play 9: Flow

Overview

This is the nuts and bolts of how S•BI•RT will actually happen at your specific site:

- How exactly will the screening occur? On paper? On a tablet? Face-to-face questions?
- Who does the screening? MA? RN? Provider?
- When and where is the screening done? During the visit in the exam room? Before the visit in the waiting room?
- How is the screening documented in the EHR?
- Who/How is screening scored? Reviewed?
- Who/How is next step determined? (Positive Reinforcement? BI? RT? Internal Behavioral Health? Referral to external BH provider?

Purpose of Play 9 To determine the physical who, what, when, where and how of all S•BI•RT components.

Definitions The flow is the logistics of the encounter and the entire S•BI•RT process. It identifies the roles and responsibilities of each staff person, in addition to the logistics of how and when screening, brief intervention, and/or referral to treatment is done and documented.

Team members The entire team at each site needs to discuss and analyze flow, test the proposed flow with "walk-throughs," and modify as necessary.

Measure(s) Incorporation of new flow into daily practice. Depending on your practice setting, this may become part of your policies and procedures.

Recommended Approach

- Map current flow for annual visits (or other visits at which screenings occur).
- Discuss what works and what doesn't. How will your incorporation of S•BI•RT processes capitalize on what works well and become an opportunity for quality improvement?
- On another piece of paper, map out potential S•BI•RT flow – who can do what, when, where and how, and who can be responsible for what parts?
- Walk through as a mock patient to test the potential S•BI•RT flow as the initial Plan-Do-Study-Act (PDSA) cycle.
- Then pilot with a subset – perhaps one provider team - do PDSA cycles, that is, trial how this will work and revise until it works as you need it to. Then set target implementation date.
- Capitalize on multiple opportunities to educate all staff (Play: Training) on the new flow until it is part of daily practice.

Keep in Mind

- The research base for the impact of Brief Intervention is that it is most effective when it is delivered by the healthcare practitioner.
- Embedding all S·BI·RT components into the EHR is optimal.
- Working from existing flow patterns and protocols as much as possible aids sustainability.

"Without including SBIRT planning in our Patient-Centered Medical Home meetings, with all the staff involved in the flow present, implementation would not have been as smooth as it was."

Corresponding Appendix Section(s)

Brief Intervention

Appendix K – Example Brief Intervention Dialogue

Appendix L – Brief Intervention Tools

Flow

Appendix Q – Flow Chart Examples

Play 10: Electronic Health Record Modification

Overview

Your electronic health record (EHR) is the critical tool for implementing, sustaining, and improving S•BI•RT. NH Youth S•BI•RT sites have worked to modify a variety of EHRs including Epic, Centricity (CHAN), eMDs, and others.

Purpose of Play 10 To support consideration of uses for the EHR throughout the S•BI•RT process.

Definitions This play is not a "how to". It is included to ensure consideration of the myriad ways that your EHR might be helpful to your site in ensuring that all components of the S•BI•RT process are completed and documented.

Team members Including the person who will be creating and/or communicating the required changes in your EHR from the beginning is ideal.

Measure(s) Success may include things such as no additional staff time for screening or data entry, prompts which practitioners utilize and find helpful, automatically updated local referral list from nhtreatment.org website included in EHR, automatic prompts to follow up on positive screens/brief interventions at subsequent appointments, etc.

Recommended Approach

Consider the following given the capacity of your EHR to automate, remind, encourage, and report:

- Screening – Incorporating the screening tool is the lowest level of utilization of the EHR. Can it then score and recommend next steps based on that score?
- Brief Intervention – Can you create practitioner supports (best practice guidelines or clinical decision supports) within your EHR that not only recommend next steps based on screening results but also capture required data for reporting?
- Referral to Treatment – Can your EHR receive information regarding patient progress from the referral site? If information is not received within an identified number of days, can it automatically generate a reminder?
- Follow up – How can you use your EHR to document the outcome of brief intervention and set reminders at the next visit?
- Confidentiality – How will you maintain the confidentiality of your young patients' drug and alcohol information from parents in the portal? From record requests? Do you effectively use the confidential capacity of your EHR? Should you use it for drug and alcohol use information? For screening results positive or negative? For follow ups to brief intervention?
- Flow – How can your EHR facilitate streamlining flow and not adding to staff time? Can you incorporate tablets that will automatically populate your chart?

- Quality Planning and Data – How will you pull data for reporting? Are there other data that your team wants to track for quality improvement (QI)? How will you receive feedback from flow staff as to the utility of the EHR screens after initial rollout? How will you decide to update or improve?
- Training – How will you incorporate the "S·BI·RT screens" in your EHR into "booster" and new staff training?

Keep in Mind

- Other NH sites already implementing S·BI·RT may utilize the same EHR. The Center can connect you to other users, provide screen shots, and help your team maximize the use of your EHR.

Corresponding Appendix Sections

Electronic Health Record (EHR) Resources

Appendix R – Screen Shots of NH S•BI•RT Initiative EHRs

SUCCESS AND SUSTAINABILITY

Plays 11-15

Play 11 – Quality Improvement and Data Collection

Play 12 – Billing/Reimbursement

Play 13 – Communications

Play 14 – Training

Play 15 – Reflection and Celebration

Play 11: Quality Improvement and Data Collection

Overview

Aims of the NH Youth S•BI•RT Initiative include clinical as well as process outcomes. For example, a specific aim related to clinical outcomes for the Initiative is to screen at least 10,000 youth by 2017. A process-related aim is to build capacity for S·BI·RT in primary practice settings through training and technical assistance.

The Initiative requires that you report on specific measures, which provide a good picture of what is happening related to S·BI·RT in your practice. In the initial stages of implementation, success will be based on meeting your planning goals. Once you implement S·BI·RT, and have baseline measures for each component of S·BI·RT, you can use it to establish clear aim statements that will enable you to measure improvement in your practice using the Change Model that your practice has adopted. As an Initiative participant, your practice will be asked to submit quarterly data reports. We suggest that your team include data collection and reporting in your workplan. All Initiative sites will collect and submit data and progress reports in the same way.

Purpose of Play 11 To make clear expectations for data collection and reporting from each Initiative site and to recommend key data points for ongoing quality improvement.

Definitions Data collection encompasses determining what data to collect and submit, how, when, by whom, to whom, and in what format.

QI is following the change model your team adopted.

Team members Select team members or staff members who will be responsible for data collection/submission, reporting and ongoing QI. All team members should review the data and reports at regular intervals.

Measure(s) Timely submission of Youth S•BI•RT data reports.
Data are used for ongoing quality improvement of the S•BI•RT process.

Recommended Approach

Consider the following given the capacity of your EHR to automate, remind, encourage, and report:

- Review the information in the related Appendix regarding expectations about data collection/submission and reporting. Quarterly data reports for NH Youth S•BI•RT grantees are due on the 15th of the month following the close of each quarter (in a calendar year).
- For QI, review and utilize the systems change model adopted in the Change Model Play. This is when your team tests new change ideas for improvement using Plan-Do-Study-Act (PDSA) cycles.
- Each site will decide the roles and responsibilities of those charged with fulfilling these expectations.

Keep in Mind

- QI is an iterative process. Your team will be making frequent corrections along the way as your team learns from experience with each step and identifying other actions to add to your team's strategy. Be prepared to refocus your aim.
- Small-scale changes are easier to manage, and allow your team to refine the new processes, demonstrate their impact on practices and outcomes, and build increased support by stakeholders.
- Use of data separates what is thought to be happening from what is really happening.
- Any learning is forward progress- even if it is only learning about what does not work!
- NH Youth S•BI•RT grantee data submission is part of a larger reporting process. A tight turn-around time between your data submission deadline and submission of aggregated data by the New Hampshire Charitable Foundation to the Conrad N. Hilton Foundation makes the due dates fairly inflexible.

Corresponding Appendix Section(s)

Change Model

Appendix D – Site Plan-Do-Study-Act (PDSA) Examples

Appendix E – Clinical Microsystems: A Model for Improvement Quality Management and Data Collection

Appendix S – NH Youth S•BI•RT Initiative Evaluation Measures

Play 12: Billing/Reimbursement

Overview

Reimbursement is critical to sustainability. As such, exploring billing and reimbursement opportunities for S•BI•RT components is crucial to long-term implementation and sustainability. Billing and coding should be considered throughout the process of determining flow and EHR documentation. Further, sites with integrated behavioral health will find that reimbursement may allow them the option to integrate on-site Brief Treatment from those providers.

Purpose of Play 12	To develop billing and reimbursement for S•BI•RT (components parts) in support of long-term sustainability.
Definitions	Reimbursement from private insurers and NH Health Protection Program is available for S•BI•RT in NH. Optimized billing will differ from site to site with negotiated contracts, federally qualified health center (FQHC) status, and other reimbursement factors.
Team members	Include financial, billing and coding staff.
Measure(s)	Reimbursement for S•BI•RT components in the first six months of implementation contributing to the sustainability of the process.

Recommended Approach

Consider the following given the capacity of your EHR to automate, remind, encourage, and report:

- Review current knowledge and included materials about billing and reimbursement for S•BI•RT components and related activities (behavioral health counseling).
- Review the coding guidance Appendix and seek consultation as necessary.
- Determine what codes, for which service, provided by whom, for what time period is reimbursed by which insurer.
- Finalize site-specific billing plan.

Keep in Mind

- The NH landscape for billing and reimbursement for substance misuse has changed over the last year and continues to move in a positive direction.
- The NH State budget signed in September 2015 by Governor Hassan includes substance use disorder services for the existing and expanded Medicaid beneficiaries in NH. The "existing" Medicaid beneficiaries include youth and will have substance use disorder coverage in 2016.
- The NH Health Protection Program beneficiaries are moving to Marketplace insurance plans as of January 1, 2016 and accessing care through private insurance plans. These plans have been benchmarked to include substance use disorder services including S•BI•RT.

- Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) for beneficiaries applies to substance use disorder diagnosis and treatment from a positive evidence-based screen.
- Advocates across the state have worked for years to increase access to substance use disorders through increasing access to reimbursement.
- ANY ON-GOING DIFFICULTIES WITH BILLING AND REIMBURSEMENT SHOULD BE SHARED WITH THE CENTER, NEW FUTURES, AND/OR NH DHHS BUREAU OF DRUG AND ALCOHOL SERVICES so that systemic problems can be identified and ameliorated as soon as possible.

Corresponding Appendix Section(s)

Flow

Appendix Q – Flow Chart Examples

Electronic Health Record (EHR) Resources

Appendix R – Screen Shots of NH S•BI•RT Initiative EHRs

Billing and Coding in New Hampshire

Appendix T – NH S•BI•RT Billing & Coding

Appendix U – New Futures EPSDT Overview

Play 13: Communications

Overview

There are many stakeholders in S•BI•RT implementation for your site, and each requires a consistent message from you and your team about S•BI•RT and what it means for them. The success of this project depends a great deal on your relationships with internal as well as external stakeholders. A communication plan lists your stakeholders, your message to them, who will reach out to them, how, and when. Your team may also want to anticipate questions, and be prepared to respond with consistent answers.

Key stakeholders may include your own staff in your practice, patients ages 12-22, the parents/families of those patients, services to which you may refer youth/families, and your community – regional prevention network, local coalitions, schools, etc.

Purpose of Play 13	To identify stakeholders, your message to them, and how and when you will deliver this message.
Definitions	A communication plan lists your stakeholders, your message to them, who will reach out to them, how, and when. Your message is what your team wants your stakeholders to know so that they can repeat it to others.
Team members	Training and/or communications staff should be included.
Measure(s)	Consistent positive messaging regarding S•BI•RT implementation.

Recommended Approach

- Determine who your team wants to know what and by when.
- Discuss and evaluate the potential pros and cons of public messaging.
- Determine your audiences.
- Develop a communications plan and/or calendar.

Keep in Mind

- Diversify the messenger to the extent it is possible (do not have one person be the only one that talks to folks about S•BI•RT)
- The Center is available to support communications planning and support development of messaging and/or materials.

"One of the things that we have built into our communications plan is the notion that nobody is perfect and that mistakes are opportunities for learning and changing, not opportunities for staff-bashing. If we expect our youth to respond to this same notion as they navigate their own behavior changes related to substance mis-use, then our staff needs to have this same viewpoint."

Play 14: Training

Overview

Initial training for S·BI·RT implementation is available through the Center at no cost to NH Youth S·BI·RT Initiative grantees and may be available to other organizations upon request. Sustaining effective implementation, however, requires incorporating training into new staff orientation and regularly offering boosters to existing staff beyond initial training and beyond the life of the Initiative.

Purpose of Play 14 Create a plan for initial and ongoing training.

Definitions S·BI·RT training includes training in specific components, training in your site's policy and procedure decisions, flow, and EHR modifications.

Team members Training staff should be included.

Measure(s) All staff and practitioners understand the S·BI·RT process as it is to be implemented at your site and are trained in and implementing their components of the S·BI·RT process.

Recommended Approach

- List potential training topics/needs such as S·BI·RT Overview, Brief Intervention techniques, Site flow/EHR changes, etc.
- Determine which can be done with internal staff and which requires outside resources. Can the training be done on site? Should the training be done in concert with other S·BI·RT implementers?
- Determine where S·BI·RT training will be incorporated into new staff orientation and training.
- Offer/require at least annual "booster" trainings for key staff.

Keep in Mind

- The Center is available to provide or contract for external trainers for your site.
- Training through the Center can be modified to suit your individual site's/practitioners' needs.

Numerous on-line S · BI · RT trainings are available with CEUs/CMEs and can be a low-cost/no-cost means of ongoing training. Our recommendations are available at *http://sbirtnh.org/resources/*.

"One thing we have learned is that you have to be careful with not getting paralyzed by all the "what ifs". It is easy to get caught up in trying to problem-solve all the "what if" scenarios, and having that stall your forward momentum. At some point we realized that we couldn't plan for every eventuality and needed to simply go forward, realizing that some things cannot be prepared for and not every workflow will handle every situation. Sometimes you have to trust the capabilities and judgment of your staff in dealing with things that might come up that do not have a script."

Play 15: Reflection and Celebration

Overview

Quality improvement (QI) is challenging work. Periodic reflection in a safe environment provides an opportunity to evaluate what happened and why it happened, and to use that knowledge to sustain strengths and improve upon weaknesses. Sharing and celebrating success represents opportunities for professional development on a personal level, opportunities to highlight the work of the entire team and your organization, and to spread what works to other settings, promoting better care for everyone. Sharing across Initiative grantees facilitates achievement of the Initiative's goals and is an expectation of funding.

Purpose of Play 15 Document enablers and barriers to the work and acknowledge successes.

Definitions Reflection is mental concentration, careful consideration, a thought or an opinion resulting from such consideration.

Celebration is an essential component of performance improvement. A celebration acknowledges that something positive occurred.

Team members All staff should be included.

Measure(s) Timeline documenting key milestones of the work.

Recommended Approach

- After the project's end, periodically communicate the fact that the outcomes are continuing.
- Display ongoing progress of outcomes of work to acknowledge sustainability, encourage further work, and foster pride.
- Engage in cross-team sharing during virtual and face-to-face meetings.

Keep in Mind

- When progress is incremental, as it often is with QI, a team may feel it is accomplishing little. Celebrating even small successes helps to overcome that feeling.
- Accomplishments are easier to remember when marked with celebrations.
- Taking the time to commemorate a team's achievements also makes it easier to recollect them when it is time to list those accomplishments, such as in a grant or proposal.
- Never underestimate the human factor and that having people's support for sustaining changes can make or break success.
- Professional conferences provide a venue for sharing and recognizing your team's work and success.

APPENDIX: TOOLS FOR TEAMS

Appendix A – S•BI•RT Team Examples

Appendix B – Team S•BI•RT Plan

Appendix C - Meeting Agenda

S•BI•RT Team Structure Examples

Recommended Team Membership	Discipline/Role	Site A	Site B	Site C	Site D	Site E
Medical Champion	Medical or pediatric provider	x	x	x	x	
Behavioral Health Specialist	Behavioral Health	x	x	x	x	x
Administrator	Quality Improvement	x			x	x
	Practice Manager	x	x	x		x
EMR/IT Expert	EMR/IT Expert	x	x	x	x	x
Other	Medical Assistant	x	x		x	
	SMP Regional Network Coordinator	x		x		x
	Youth Representative		x			
Meeting Frequency		Weekly	Weekly	Every other week	Weekly	Every other week

Team S•BI•RT Plan

S•BI•RT Implementation Team Plan
[site name]

Team leader: [name, contact info]
Team members: [names]
Date of team formation: [date]
Anticipated length of time the team will focus on S•BI•RT Implementation: [dates]

The problem...
{According to the 2012 National Survey on Drug Use and Health, New Hampshire's rates of alcohol and other drug misuse, particularly among youths, are some of the very highest in the country. Recent research indicates that 90% of adults addicted to alcohol, tobacco or other drugs began using these substances before the age of 18. This suggests that professional screening in primary care settings provides great possibilities for changing the paradigm, reducing stigma, and significantly reducing the threat that substance misuse poses to individual and population health and well-being.}

The Goal of S•BI•RT Implementation is...
{To increase the number of New Hampshire youth screened in primary care settings and who receive clinical response and referral appropriate to their level of risk by 2017.}

The Global Aim of the [site name] S•BI•RT team is...
{To universally screen for alcohol and drug use in our practice and provide appropriate clinical response including brief intervention, referral, and follow up appropriate to their level of risk by [date], by incorporating S•BI•RT into our practice.}

The S•BI•RT process begins...
{When a designated staff person initiates the screening of a patient.}

The S•BI•RT process ends...
{When the screening results have received identified response including documentation of brief intervention, results of referral, and follow up visits. }

Out of scope...
{Providing [on-going] treatment for patients with substance use disorders.}

In scope...
{Providing brief treatment and supported referrals with existing behavioral health clinicians.}

Appendix B

Team structure

1. Identify the leader for S•BI•RT at your practice site:

2. List the leader's responsibilities:

3. List the responsibilities of the team members:

4. Decide how often your team will meet, where, and for how long:

5. Decide how decisions will be made (Consensus? Vote? Only during meetings? Via email?).

6. Develop a plan for communicating among team members between meetings.

Example Team Deliverables

Play 3: Developing a Plan - Goals and Strategies

- Determine the goal of S•BI•RT implementation and reach consensus on its value. Get all of the potential biases regarding alcohol and drug use out on the table.
- Make a list of concerns regarding the project. Review and resolve that list during implementation.
- Discuss current practice for assessing substance use, even if assessment is inconsistent.
- Make a flowchart or map of how it works—or doesn't work—now. Identify issues to inform priority areas to address in S•BI•RT preparation.

Measure(s): A list of your aims and measures based on an assessment of your practice and the goals of S•BI•RT.

Meeting Agenda

The agenda does not have to be printed and distributed. It can be written on a white board or easel paper. Just make sure it has these elements:

Leader: Wilma
Timekeeper: Barney
Recorder: Fred
Facilitator (optional): Betty

Time*	Topic	Person	Decision/Product
10:00-10:05	Review agenda (Clearly state what needs to be accomplished by end of meeting)	Wilma	
10:05-10:30	Review team charter and work through unanswered components	Betty	Will meet weekly Fridays at 8am. Finalized goals. Barney will revise and bring to next meeting.
10:30-10:45	Identify 1st Play (may or may not be in the order they are presented in the Playbook) for team to work through	Wilma	Team discussed SCREENING. S2BI and CRAFFT will be utilized in blended screener. EHR modifications to be explored this week and discussed at next meeting. Invite BamBam (EHR/IT guru).
10:45-10:55	Review workplan, revise as necessary to be useful going forward and insert work outcomes of today's meeting; document assignments/deliverables for next meeting.	Fred	Updated workplan; FLOW and TRAINING to be discussed at next week's meeting. Invite ad hoc members.
10:55-11:00	Wrap up: Review decisions, assigned work; set agenda for next meeting; set roles for next meeting; evaluate meeting – determine if changes necessary. (in future meetings can update workplan in wrap up)	Wilma	Agenda for Friday October 32nd Leader: Fred Timekeeper: Wilma Recorder: Betty Facilitator: Barney

* Use actual time to facilitate keeping the meeting on schedule, otherwise a 10-minute block can be stretched because you aren't sure when the 10 minutes started whereas it is clearer when it is 3:10 pm.

Appendix C

Meeting Roles – Ideally rotate roles

Leader: Just leads the meeting - helps the group move through the agenda; not the same as the chair.

Timekeeper: Keeps group aware of use of time; e.g., if Charter discussion is to end at 10:30 Barney will remind the group at 10:25 that they need to wrap up or modify the agenda.

Recorder: Keeps meeting record, including placing names of group members alongside the next steps that they "own" [An owner makes sure that the work is getting done, and is probably a member of the subgroup doing the work. This gives the leader one person to contact about that action step between meetings.]

Facilitator: Not always necessary, best for a large group; monitors the group process as a back up to the leader to make sure everyone gets a chance to participate and one or two people do not monopolize the meeting.

APPENDIX: CHANGE MODEL

Appendix D – Site Plan-Do-Study-Act (PDSA) Example

Appendix E – Clinical Microsystems: A Model for Improvement

Appendix D

Site Plan-Do-Study-Act (PDSA) Example

Change, Test, Repeat: Using NIATx to implement SBIRT

By: Catherine Ulrich Milliken
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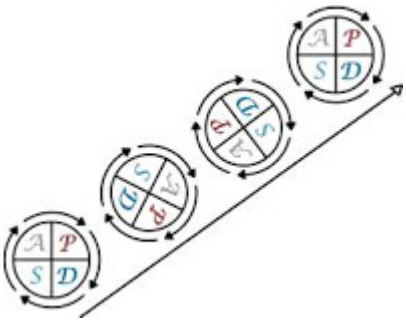
Introducing a new practice like SBIRT can be a challenge in any setting. In the Dartmouth Hitchcock Medical Center (DHMC) Perinatal Addiction Treatment Program (PATP) we faced the added challenge of implementing a new practice across three departments and two institutions.

That's where my previous experience with the NIATx model came into play. I was fortunate to be a part of a NIATx STAR-SI grant in Maine while working for Crossroads for Women (Crossroadsme.org). Over three years beginning in late 2006, the ten state-provider partnerships used the NIATx diffusion model to accomplish four goals: build state capacity to improve access and retention; build payer/provider partnerships that drive the improvement process; implement payer improvement strategies; and implement performance monitoring and feedback systems.



The incremental and iterative approach that NIATx teaches was key to the success in our SBIRT integration project. We used rapid-cycle testing or PDSA Cycles so our change teams could try out a change to make sure it was working and that it was an actual improvement.

Visit the NIATx website to learn How to conduct a PDSA Cycle.

As I wrote in my last blog post, Integrating Care and Improving Birth Outcomes with SBIRT, we launched the PATP in fall 2013. By September 30, 2014, SBIRT was fully implemented across all three OB/Gyn divisions at the Dartmouth Hitchcock Medical Center.

Here are some lessons that have emerged from the four Plan-Do-Study-Act (PDSA) cycles we ran to get SBIRT in place:

Cycle 1: Confidential screening in Maternal Fetal Medicine (MFM) Team
Perceived barrier: Patient reluctance to separate from family members for screening
Change tested: Nurses' perceptions that patients would not want to be seen alone

Data: Before: Patients were screened for drug/alcohol use with their family members present, unless they came alone. *After*: Only five of the first 386 patients declined to be seen alone (and therefore were not screened.)

Results or lessons learned: Sequestering patients is much easier than anticipated, and provided unexpected opportunities for disclosure of a number of important issues, both substance-related and not.

Cycle 2: SBIRT pilot in Maternal Fetal Medicine (MFM) Team
Perceived barrier: Fitting SBIRT into nursing workflow will be difficult and make visits longer.
Change tested: Nurse training in screening techniques and BI/Implementation
Data (Qualitative from nursing): Nurse workflow was not adversely affected and communication about prenatal substance use was enhanced, improving the care delivered.

Results or lessons learned: Nurses report "We are finally starting to deal with this issue in a practical way. SBIRT provides a framework for making this happen!"

Cycle 3: SBIRT implemented in Certified Nurse Midwife (CNM) Team
Perceived barrier: Provider discomfort with providing brief intervention (BI)
Change tested: Provider training in BI
Data: (Qualitative) CNMs are able to manage BI and referral process to PATP; and patients with SUD are no longer required to transfer care to the MFM team.

Results or lesson learned: Provider training can increase comfort level in caring for pregnant women with SUD.

Cycle 4: SBIRT implemented in General OB/GYN Division
Perceived barrier: Nurses' discomfort with process
Change tested: Nurse and provider training; followed by additional training session (Grand Rounds) six months after implementation
Data: Not available from all nurses or providers; APRN staff has adopted SBIRT as standard practice and feels comfortable with BI and referral process.

Results or lesson learned: Need to be able to collect department/division level data to assess whether program goal of evidence-based screening for SUD for all PN patients has been met.

What else did we learn from these change cycles? For one thing, developing a timeline and planning out cycles strategically is key. What we wish we'd known at the onset was how difficult it would be to access data to measure process and outcomes. Electronic implementation of screening (available soon, with the implementation of mobile tablets) should improve data capture.

Our next PDSA cycle will be used to implement electronic record-keeping. The OB departments have not had sufficient staffing to assess what proportion of new OB patients are actually getting screened. With the help from The New Hampshire Charitable Organization, the OB/GYN Department was able to purchase mobile tablets that will be used to make the switch from pen and paper screening to electronic screening. Once electronic screening is operationalized, we

will be able to compare the number of patients screened to the number of new OB visits scheduled. Electronic screening will allow for better data collection, outcomes tracking, and consistent billing practices. Adding an electronic best practice alert for positive screens will be included with the electronic roll-out, and this will prompt providers to enter the correct charges.

What has become clear to us is that this partnership of integrated care is benefiting all involved. As we continue to share our experience, new champions come forward, and our vision becomes clearer and more comprehensive, despite the perceived barriers.

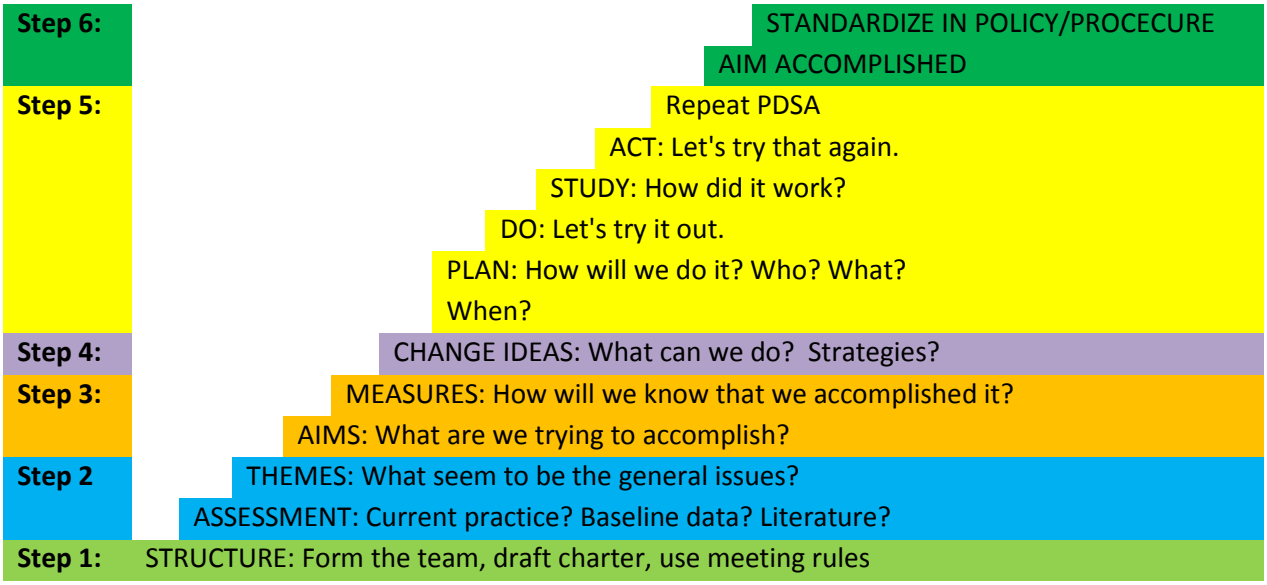
Catherine Ulrich Milliken, M.S.W., LICSW, MLADC, LCS, is the Program Director for The Dartmouth Hitchcock Medical Center Addiction Treatment Program and an instructor in Psychiatry at the Geisel School of Medicine at Dartmouth. Previous academic appointments included University of Southern Maine, University of New England, and University of New Hampshire. She has worked passionately to improve the care and treatment of women's mental health and substance issues for the last 15 years. Before working at Dartmouth, she was the Director of Outpatient Services at Crossroads for Women, which provides gender-specific and trauma-informed outpatient programs and services for substance abuse and mental health, as well as residential rehabilitation and halfway house services for substance abuse in Portland, Maine. During that time, she also saw clients in private practice, specializing in adult psychotherapy, substance use and women's issues and worked with clients struggling with HIV and AIDS diagnoses. She conducts training on the basics of chemical addiction, tools for leading groups, exploring the relationship between substance abuse and child maltreatment, and women's treatment concerns, among other areas.

- See more at: http://attcniatx.blogspot.com/2015/08/change-test-repeat-using-niatx-to.html#sthash.8Yt2JFjz.dpuf

Appendix E

Clinical Microsystems: A Model for Improvement

The Clinical Microsystems model for improvement looks like a ramp. The version below is an adaptation of the original model.



Step 1: TEAM: In your first meeting:

a) Identify who the core team will be that will implement this change in practice. In your first meeting, do not talk about SBIRT, talk about how you will work together.
b) Review and use the meeting rules.

Step 2: ASSESSMENT: In your early meetings:

a) Discuss your current practice for assessing substance use in youths, even if it is inconsistent. Try to make a flowchart or map of how it works—or doesn't work—now. What seem to be the issues?
b) Review the new practice and reach consensus on its value. Make a list of everything you are concerned about, and make sure that you address these concerns as you work.
c) Review the Playbook.

Step 3: AIMS AND MEASURES

a. Aims should be measurable. There should be a numerator and denominator if applicable. There should be a time frame. If your aim is to screen youths, how will you know that you screened youths? You could say "we screened 50 youths," but if you have 300 in your practice, that is only 16.6% of your population. And is 300 your best denominator? A good aim:
"Screen 80% of unique youths who have an office visit between January and June of 2015."
"Unique" means you don't count a youth more than once in that time period. And do you want it to be any office visit? Would physicals for sports count?
b. Revise the workplan to reflect your aims and measures.

Appendix E

Step 4: CHANGE IDEAS

a) Your overall goal is to increase the number of youths screened for substance use. SBIRT is your overall strategy.
b) If your specific aim is "Screen 80% of unique youths who have an office visit between January and June of 2015" what strategies/change ideas do you need? Changes in workflow? Changes in policies and protocol? Communication plans? These are examples of strategies and the workplan should help you map out the details over time.

Step 5: PDSA

a) Plan the details of how you would change workflow, as an example: Map it out. Who does what when where and how?
b) Do it. Try out the new workflow.
c) Study: How did it work out? What worked? What did not work?
d) Act on what you learned: What can you do differently?

Step 6: STANDARDIZE

a) Once your plan for your change idea works, sustain it. Codify it in policy, procedures.
b) Train staff.

The Clinical Microsystems framework captures the structure, processes and outcomes of a service delivery system. It was developed by The Dartmouth Institute for Healthcare Policy and Clinical Practice, and has been used worldwide as a model for improving practice. A clinical microsystem is defined as "a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, and a shared information environment, and it produces performance outcomes."[1] A clinical microsystem can be a clinic, an office practice, an ambulatory care surgery center, or a patient care unit in a hospital. The microsystem is where direct patient care happens. It is at the center of an organization, and is surrounded by larger systems, such as administration in the organization and the community it serves.

In a clinical microsystem, all team members are considered of equal importance, and each team member brings a different yet critical skill set to the direct care environment. Everyone who is part of the microsystem shares accountability for the care that is provided to patients. Patients are also members of the clinical microsystem. As partners in their own care, patients contribute to developing their goals for treatment, and are informed of their progress at each encounter.

Members of the microsystem make the decisions about how to improve their own work. **In other words, trust the people who do the work to know how to do the work better.**

[1] Nelson, E.C., Batalden, P.B., & Godfrey, M.M. (2007). *Quality by design: A clinical microsystems approach (p.7)*. San Francisco: Jossey-Bass.

APPENDIX: CONFIDENTIALITY

Appendix F – S•BI•RT: Federal Alcohol and Drug Confidentiality Overview

Appendix G – SBIRT: Health Centers and Confidentiality Overview

S•BI•RT: Federal Alcohol and Drug Confidentiality Overview

Key Points

42 C.F.R. Part 2 Valid Written Patient Consent Form Must Include:

1. Name/general designation of program making disclosure
2. Name of individual/entity receiving disclosure
3. Name of patient who is subject of disclosure
4. Purpose/need for disclosure
5. Description of how much and what type of information will be disclosed
6. Patient's right to revoke consent, and any exceptions
7. Date/event/condition on which consent expires
8. Patient's signature
9. Date signed

Integration and Confidentiality: How can Integrated Health Centers Comply with Alcohol and other Drug Confidentiality Regulations?[1]

Sharing Information with Co-located/Integrated Behavioral Health Providers

A program can share information with co-located/integrated providers utilizing these four exceptions:

Exception One: Written patient consent

Patient can sign a written consent form, with all elements required by 42 C.F.R. Part 2, authorizing her alcohol/drug treatment providers (program) to communicate with her primary care (and/or other) providers. The program must provide the Notice Prohibiting Re-disclosure when it discloses patient's protected alcohol/drug information pursuant to consent.

Valid consent form

Most disclosures are allowed if a patient signed a valid consent form (called "authorization" under HIPAA) that has not expired or been revoked. The consent must adhere to proper format; otherwise, it is NOT sufficient. The proper format for consent to release information includes the following documentation: 1. Name/general designation of program making disclosure; 2. Name of individual/entity receiving disclosure; 3. Name of patient who is subject of disclosure; 4. Purpose/need for disclosure; 5. Description of how much and what type of information will be disclosed; 6. Patient's right to revoke consent and any exceptions; 7. Date/event/condition on which consent expires; 8. Patient's signature; 9. Date signed; and further, 10. HIPAA: program's ability to condition treatment, payment, enrollment, or eligibility on the consent.

[1] 42 C.F.R. confidentiality information included in this Appendix is the synthesis of the Legal Action Center's presentation and slides available on their website and used with their permission.

Minors and Consent

Both HIPAA and 42 C.F.R. Part 2 leave the issue of who is a minor and whether a minor can obtain health care or alcohol/drug treatment without parental consent entirely to State law. However, under 42 C.F.R. Part 2, the program must always obtain a minor's consent for disclosure, and must also obtain parental consent for disclosure ***only*** if State law requires parental consent to treatment. ***In NH, youth aged 12 and older can seek treatment for substance use disorders without parental consent.***

Prohibition on Re-disclosure

Any disclosure made pursuant to written patient consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the recipient may not disclose it further unless permitted by the regulations. This is true even for verbal disclosures. This language is dictated by regulations:

> *"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." (42 CFR § 2.32)*

Exception Two: Internal Communications

Programs covered by 42 C.F.R. Part 2 may disclose information without patient consent to an entity with administrative control over the program, to the extent the recipient needs the information in connection with providing alcohol/drug services. The "entity with administrative control" could include, for example, a records or billing department of a general medical facility. Information may also be disclosed to other program staff but only to the extent the recipient needs information in connection with provision of drug/alcohol services (purpose and amount).

Exception Three: Medical Emergency

Disclosure may be made to medical personnel to the extent necessary to meet a bona fide medical emergency of the patient or any other individual. A medical emergency meets two criteria: 1) it is an immediate threat to the health of the individual, AND 2) it requires immediate medical attention. The determination of a medical emergency can be made by personnel based on professional judgment.

Documentation of Medical Emergency

A disclosure made in connection with a medical emergency must include the following documentation in the patient's record: name and affiliation of recipient of information; name of person making disclosure; date and time of disclosure; and nature of emergency.

Exception Four: Qualified Service Organizations/Business Associates (QSO/BA) Agreement

Disclosure without patient consent to certain outside organizations that provide services to the program or its patients may be made with a QSO Agreement. These outside organizations are referred to as Qualified Service Organizations (QSOs) in 42 C.F.R. Part 2, and as Business Associates (BAs) by HIPAA. QSOs may provide services such as medical services, data processing, dosage prep, lab analyses, vocational counseling, patient transport, legal or accounting services, electronic storage of patient records, etc.

Requirements of a QSO/BA Agreement

The program must enter into written agreement with the QSO, agreeing that the QSO:

- is fully bound by 42 C.F.R. Part 2; and
- will resist an effort to obtain access to patient information except as permitted by 42 C.F.R. Part 2

An organization serving as QSO that is also covered by HIPAA must also meet BA agreement requirements.

Incorporating alcohol/drug treatment records into EHR systems

Regardless of the EHR system in place, providers must be mindful of the requirements of 42 C.F.R. Part 2 when including alcohol/drug patient records. Records protected by 42 C.F.R. Part 2 can be integrated into EHR sys-tems with providers not covered by 42 C.F.R. Part 2 in the same ways that a program can share information with co-located/integrated providers:

1. Written patient consent

The system must be able to implement patients' consent choices. For alcohol/drug records, the EHR system must be able to ensure records are disclosed only: 1) pursuant to proper written consent (Consent Form Must Be 42 C.F.R. Part 2 Compliant), 2) with the amount/type of information listed on the consent form, and 3) for the purpose listed on the consent form. The systems must be able to ensure information ceases to flow when consent expiration is reached, including providing notice prohibiting re-disclosure with information disclosed. The consent form must comply with 42 C.F.R. Part 2 requirements, and the system must be able to comply with medical emergency requirements, and be capable of implementing QSO/BA agreement limitations.

2. Internal communications exception

Programs covered by 42 C.F.R. Part 2 may disclose information without patient consent to an entity with administrative control over the program, to the extent the recipient needs the information in connection with providing alcohol/drug services.

3. Medical Emergency Exception

When information protected by 42 C.F.R. Part 2 is disclosed in connection with medical emergency, the program must document certain information and the EHR system must be able to:

- Notify the program when its patients' records are disclosed in medical emergency;
- Capture the information that the program is required to document in its records; and
- Include the information with the notification.

4. QSO/BA Agreement

A QSO/BA agreement is a two-party agreement between the program and the QSO/BA; the QSO/BA cannot re-disclose the information. When alcohol/drug patient information is included in an EHR system pursuant to a QSO/BA agreement, the EHR system must have the capability to ensure the information is not re-disclosed without proper patient consent.

S•BI•RT: Health Centers and Confidentiality Overview

S•BI•RT and Confidentiality: When do Health Centers Need to Comply with Alcohol and other Drug Confidentiality Regulations? [1]

Introduction

"Screening, Brief Intervention and Referral to Treatment (SBIRT) is a cluster of activities designed to identify and intervene with people who engage in risky substance use or who might meet the criteria for a formal substance use disorder. Clinical findings indicate that the overwhelming majority of individuals screened in a general medical setting do not have a substance use disorder and do not need substance use disorder treatment.

The determination whether patient information acquired when conducting SBIRT services is subject to federal alcohol and drug confidentiality regulations **(42 C.F.R. Part 2)** depends on whether the entity conducting the SBIRT activities is a federally-assisted "program" as defined in the regulations. If the entity conducting SBIRT services is not a federally-assisted program, then SBIRT services and patient records generated by such services are not covered by this federal regulation, although HIPAA and state laws may apply. However, if the entity or unit within a general medical care facility conducting SBIRT services is a federally-assisted program (as defined in Part 2 and explained below), then SBIRT-related patient records are subject to Part 2 regulations.

42 C.F.R Part 2

42 C.F.R. Part 2 (Part 2) is the federal regulation implementing the federal drug and alcohol confidentiality law (42 U.S.C. § 290dd-2). It was enacted in the 1970's to combat the stigma of alcohol and other drug problems, and governs confidentiality of alcohol and drug treatment and prevention information. **Part 2** prohibits the disclosure of information that identifies a patient (directly or indirectly) as having a current or past drug or alcohol problem (or participating in a drug/alcohol program) unless the patient consents in writing or another exception applies. This is true even if the person seeking the information already has it, has other ways to get it, has some kind of official status, has obtained a subpoena or warrant, or is authorized by State law.

[1] 42 C.F.R. confidentiality information included in this Appendix is the synthesis of the Legal Action Center's presentation and slides available on their website and used with their permission.

42 C.F.R. Part 2 applies only if you, your program or your facility are both a drug and alcohol treatment and prevention *program* and are *federally assisted.*

Definitions: **What is a PROGRAM and what does FEDERALLY ASSISTED mean according to** 42 C.F.R. Part 2?

Program

There are three definitions of a drug and alcohol treatment and prevention program:

a. An individual or entity, other than general medical facility, that "holds itself out as providing", and does provide, drug/alcohol diagnosis, treatment, or referral for treatment is a program;

b. An identified unit within a general medical facility that holds itself out as providing, and does provide, drug/alcohol diagnosis, treatment, or referral for treatment is a program; or

Key Points

For a **general medical facility** it is only the specialty unit or personnel that is the *program* and NOT the whole facility.

c. Medical personnel or other staff, in a general medical care facility, whose primary function is the provision of drug/alcohol diagnosis, treatment, or referral for treatment, and who are identified as such is a program (even if it is only one person).

Although the law does not define "general medical facility," SAMHSA [2] provides some examples: hospitals, trauma centers, and Federally Qualified Health Centers. Likewise, the law does not define "holds itself out" but SAMHSA provides examples: State licensing procedures, advertising, or posting notices in office, certifications in addiction medicine, listings in registries, Internet statements, consultation activities for non-"programs," information given to patients and families, any activity that would reasonably lead one to conclude those services are provided.

Federally assisted

A program is federally assisted when it receives Federal funds in any form (even if not used for drug/alcohol services), or is authorized, licensed, certified, registered by the Federal government, such as assisted by IRS by grant of tax-exempt status, has Drug Enforcement Administration (DEA) registration to dispense controlled substances to treat drug/alcohol abuse, is authorized to provide methadone treatment, and/or is certified to receive Medicaid or Medicare reimbursement.

[2] http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs

Appendix G

42 C.F.R. Part 2 prohibits the disclosure of information that identifies a patient (directly or indirectly) as having a current or past drug or alcohol problem (or participating in a drug/alcohol program) unless the patient consents in writing or another exception applies.

Definitions: What is DISCLOSURE and what are the EXCEPTIONS according to 42 C.F.R. Part 2?

Disclosure

Disclosure of identifying information is communication (oral or written) of information that identifies someone as having a past or current drug/alcohol problem or being a past or current patient in a drug/alcohol program. This includes communications to people who already know the information.

Exceptions

There are ten exceptions to the general rule prohibiting disclosure:

1. Written consent;
2. Internal communications;
3. Medical emergency;
4. Qualified service organization agreement;
5. No patient-identifying information;
6. Crime on program premises/against program personnel;
7. Research;
8. Audit;
9. Court order; and
10. Reporting child abuse/neglect.

APPENDIX: SCREENING TOOLS

Appendix H – S2BI Screening Tool

Appendix I – CRAFFT Screening Tool

Appendix J – Integrated Alcohol & Other Drug Screening Tool

Screening to Brief Intervention (S2BI)

Developed at Boston Children's Hospital with support from the National Institute on Drug Abuse.

The following questions will ask about your use, if any, of alcohol, tobacco, and other drugs. Please answer every question by clicking on the box next to your choice.

In the past year, how many times have you used

Tobacco?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

Alcohol?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

Marijuana?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

STOP if answers to all previous questions are "never." Otherwise, **continue** with questions on the right.

In the past year, how many times have you used

Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

Illegal drugs (such as cocaine or Ecstasy)?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

Inhalants (such as nitrous oxide)?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

Herbs or synthetic drugs (such as salvia, "K2", or bath salts)?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly or more

For More Information: Levy, S., Weiss, R. D., Sherritt, L., Ziemnik, R., Spalding, A., Van Hook, S., & Shrier, L. A. (In Press). Screening to Brief Intervention (S2BI): An Electronic Screen for Triaging Adolescent Substance Use by Risk Levels. *JAMA Pediatrics.*

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Table 1. Prevalence, sensitivity, and specificity (95% CI) of frequency-only questions vs. CIDI-SAM DSM-5 diagnosis of substance use disorder.

S2BI frequency category[a]	CIDI-SAM diagnosis	Prevalence[b] N (%)	Sensitivity (95% CI)	Specificity (95% CI)
'Once or twice' or more for any substance	Any Substance Use	90 (42.3)	100 (n.a.)	84 (76, 89)
'Monthly' or more for any substance	Any Substance Use Disorder	41 (19.2)	90 (77, 96)	94 (89, 96)
'Weekly' or more for any substance	Severe Substance Use Disorder	19 (8.9)	100 (n.a.)	94 (90, 96)
'Once or twice' or more for alcohol	Alcohol Use	87 (40.1)	96 (89, 99)	92 (86, 95)
'Monthly' or more for alcohol	Alcohol Use Disorder	29 (13.6)	79 (61, 90)	96 (92, 98)
'Weekly' or more for alcohol	Severe Alcohol Use Disorder	6 (2.8)	100 (n.a.)	88 (83, 91)
'Once or twice' or more for cannabis	Cannabis Use	74 (34.7)	100 (n.a.)	96 (92, 99)
'Monthly' or more for cannabis	Cannabis Use Disorder	30 (14.1)	93 (77, 98)	93 (88, 96)
'Weekly' or more for cannabis	Severe Cannabis Use Disorder	16 (7.5)	100 (n.a.)	93 (89, 96)

a. See table 2 for screen interpretations
b. Prevalence rates from CIDI-SAM criterion standard measure

Table 2. Sensitivity and Specificity of screen for tobacco use and dependence

	CIDI-SAM Prevalence N (%)	Sensitivity (95% CI)	Specificity (95% CI)
Past-year Tobacco Use	34 (16.0)	94 (79, 99)	94 (89, 97)
Nicotine Dependence[a]	20 (9.4)	75 (52, 89)	98 (95, 100)

a. We are reporting rates of nicotine dependence (DSM-IV) based on CIDI-SAM interview because the CIDI SAM did not include a question on craving, which is one of the possible criteria for DSM-5 diagnosis of Nicotine Use Disorder.

Table 3. Risk Levels and Recommended Interventions

Frequency of using tobacco, alcohol, or marijuana	Risk level	Brief intervention
Never	No use	Positive Reinforcement
Once or Twice	No SUD	Brief Advice
Monthly	Mild/Moderate SUD	Further assessment, brief motivational intervention
Weekly or more	Severe SUD	Further assessment, brief motivational intervention, referral

This tool was validated with 213 participants, aged 12-17 presenting to primary care or to an outpatient substance abuse treatment program in a pediatric hospital in Boston, MA.

For More Information: Levy, S., Weiss, R. D., Sherritt, L., Ziemnik, R., Spalding, A., Van Hook, S., & Shrier, L. A. (In Press). Screening to Brief Intervention (S2BI): An Electronic Screen for Triaging Adolescent Substance Use by Risk Levels. *JAMA Pediatrics.*

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The CRAFFT Screening Questions

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high?	☐	☐

"anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"

If you answered NO to ALL (A1, A2, A3) answer **only B1** below, then STOP.

If you answered YES to ANY (A1 to A3), answer **B1 to B6** below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

CONFIDENTIALITY NOTICE:
The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

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Appendix J

Integrated Alcohol & Other Drug Screening Tool

Patient Name: **Dummy, Child** Date of Birth: **6/19/2004**

HEALTH HABITS QUESTIONNAIRE		
Please answer honestly; your answers will be kept strictly confidential.		
Over the past two weeks, have you been bothered by:		
Little interest or pleasure in doing things? ☐ Not at all ☐ Several Days ☐ More than ½ the days ☐ Nearly every day		
Feeling down, depressed, or hopeless? ☐ Not at all ☐ Several Days ☐ More than ½ the days ☐ Nearly every day		

During the past 12 months, did you:		
Drink any alcohol (more than a few sips)?	☐ Yes	☐ No
Smoke any marijuana or hashish?	☐ Yes	☐ No
Use anything else to get high? Anything else includes illegal, over the counter, and prescription drugs and things that you sniff or huff.	☐ Yes	☐ No
Please answer the following questions:		
Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐ Yes	☐ No
Do you ever use alcohol or drugs to RELAX, feel better about yourself, fit in?	☐ Yes	☐ No
Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐ Yes	☐ No
Do you ever FORGET things you did while using alcohol or drugs?	☐ Yes	☐ No
Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐ Yes	☐ No
Have you ever gotten in TROUBLE while you were using alcohol or drugs?	☐ Yes	☐ No
I decline answering these questions at this time.	☐	

APPENDIX: BRIEF INTERVENTION

Appendix K – Example Brief Intervention Dialogue

Appendix L – Brief Intervention Tools

Example Brief Intervention Dialogue

Build Rapport

I have reviewed your answers to the questions regarding alcohol and other drug use. Would you mind taking a few minutes to talk with me about your use of --? Before we start, can you tell me a little bit about a day in your life? Where does your --- use fit in?

Pros/Cons of Use

I don't think you would have continued using --- if there weren't some good things about it. Help me understand the good things about using ---. What are some of the not so good things? So I understand that your use of --- has some positives for you –summarize pros-- and on the other hand it is also –cons-.

Feedback

I have some information about --- and the health and safety impacts of using before age __ that I'd like to share with you, is that okay? (share) What do you think?

Readiness to Change

On a scale from 1 to 10, with 1 being not at all ready and 10 being completely ready, how ready are you to make changes in your --- use? Thank you. This is great; you are __% ready to make a change. Can you tell me why you choose __ and not a 1 or a 2? These are important reasons for making a change.
What are some steps you could take to move toward that change? What do you think you can do to stay health and safe? Do you have family or other adults that have helped you with challenges in the past? Friends? Could --- support you in making these changes?

Prescription for Change

So let's talk about the steps you are willing to take to change ---? So you agree to ---? Great, I'm going to write you a prescription for that change. It sounds like –family—and –friend—have been supportive of you making a change as well; other patients have found that sharing their prescription has been very helpful in making positive changes. You said your --mom—is one of your supports and she is here with you today. Can we talk with her about your prescription? I'd also like to talk to you again in –timeframe—to check in on how it's going.

This example is based on the Brief Negotiated Interview and Active Referral to Treatment Provider Training Algorithm from the BNI-ART, Boston University School of Public Health. It is meant to be an example only and not a script to follow for brief interventions. Provider training in brief interventions and motivational interviewing are key components to success.

Appendix L

READINESS RULER
Miller, William R., and Stephen Rollnick. Motivational Interviewing: Helping People Change. New York, NY: Guilford, 2013. Print.
CONFIDENCE
www.sbirtnh.org
How CONFIDENT are you about making this change?
SCREEN & INTERVENE
NH Youth SBIRT Initiative
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NOT
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READINESS RULER
Miller, William R., and Stephen Rollnick. Motivational Interviewing: Helping People Change. New York, NY: Guilford, 2013. Print.
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NH Youth SBIRT Initiative
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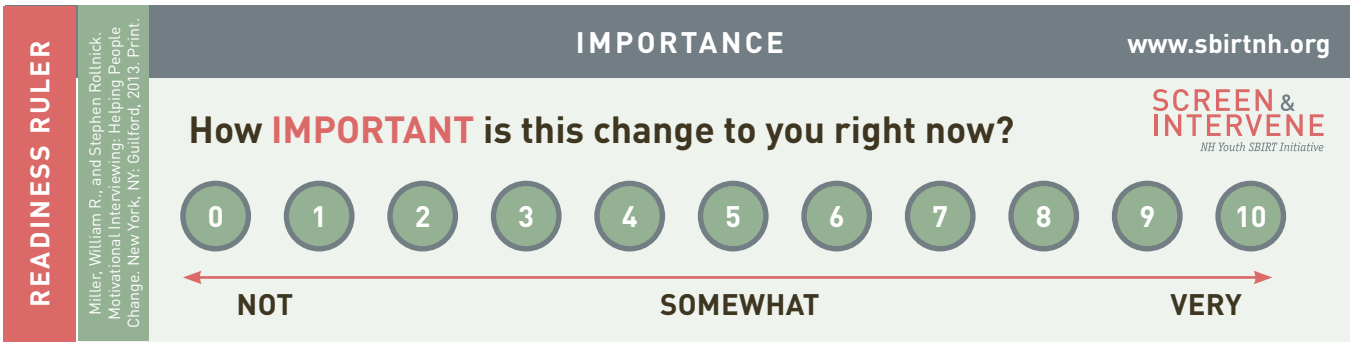
Appendix L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How IMPORTANT is this change to you right now?
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Brief Intervention Tools

Observation Sheet: Strategies for Evoking Change Talk:

These are specific Motivational Interviewing skills strategies that are likely to elicit and support change talk in patients. Place a check mark when you see the strategy used in the video.

Raise the Subject	
Ask Evocative Questions	• Asked open questions: the patient's answers should elicit change talk. • Explored Decisional Balance: Ask for the pros and cons of both changing and staying the same.
Provide Feedback	
Enhance Motivation	• Shared the patient's AUDI/DASH scores and zone. • Reviewed NIAA guidelines relevant to his/her gender and age group. • Explored possible connection to health, social, work issues and express concerns if relevant.
Enhance Motivation	
Good Things/Not SO Good Things	• Asked about the positives and the negatives of the target behavior. -"What do you like about drinking? What's good? -"What is not so good about drinking."
Ask for Elaboration and Examples	• Asked for more details when she heard change talk. -"In what ways…?" -"Tell me more…" -"What does that look like…?" -"When was the last time that happened…?"
Negotiate a Plan	
Come Alongside	• Explicitly sided with the negative or status quo side of the ambivalence. -"Perhaps having drinks (beer) with friends is so important to you that you won't give it up at this time." -"At this time you do not want to stop drinking despite the recommendation. You enjoy drinking with friends."
Motivation	
Look Back	• Asked about a time before s/he did not drink – how were things better or different?
Look Forward	• Ask what may happen if things continue as they are (status quo)? -"If you were 100% successful in making the changes you want, what would be different? -"How would you like your life to be in 5 years?"
Query Extremes	-"What are the worst things that might happen if you don't quit drinking?" -"What are the best things that might happen if you quit drinking?"
Use Change Rulers	• Used the Readiness Ruler (1) On a scale of 1 -10, how important is it to you to quit drinking? One is not important and 10 is extremely important. Follow up "And why are you a XX and not XX?" -"What might happen that could move you to a higher number?" (2) Ask: "How confident are you that you could make the change if you decided to quit?"

Verify Current Use: Determine Risk of Drinking

Verify Current Use: What's Standard Drink?

APPENDIX: REFERRAL RESOURCES

Appendix M – Release of Information Example

Appendix N – Substance Use Disorder Diagnosis Overview

Appendix O – Core Competencies For Behavioral Health Counselors

Appendix P – NH Alcohol and Drug Treatment Locator

newfutures

advocate • educate • collaborate
to reduce alcohol and other drug problems in New Hampshire

Summary of the Rule (Title 42 CFR Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records)

Generally, a program may disclose any information about a patient if the patient authorizes the disclosure by signing a valid consent form ('§ 2.31, 2.33). A consent form under the Federal regulations is much more detailed than a general medical release. It must contain all of the following nine elements. If the form is missing even one of these elements, it is not valid:

1. The name of the patient.

2. The name or general designation of the program making the disclosure.

3. The recipient of the information.

    - Although the recipient should not be as general as an entire agency or department, it need not be as specific as the name of an individual. Instead, the consent form may describe the recipient's job title and/or job functions

    - It is permissible to list more than one recipient on a single consent form and to authorize disclosures between and among all the parties listed. When doing such multiple-party consents, however, it is important that the "information" and "purpose" and all other elements of the form (see below) be the same for all of the authorized
    disclosures.

4. The purpose of the disclosure. The purpose should be narrowly described and should correspond with the information to be released. The purpose should never be as broad as "for all client care."

5. The information to be released. The information should be described as exactly and narrowly as possible in light of the purpose of the release. Releases for "any and all pertinent information" are not valid.

6. That the patient understands that he or she may revoke the consent at any time - orally or in writing- except to the extent that action has been taken in reliance on it.

    - A consent for a patient referred by the criminal justice system, however, may be made irrevocable for a period of time (§ 2.35). (But note that some State statutes and regulations provide for the automatic expiration of such consents after 60 or 90 days.)

    - When a patient revokes a consent form, the program is advised to note the date of the revocation clearly on the consent form and to draw an X through the form.

7. The date or condition upon which the consent expires, if it has not been revoked earlier. Although the Federal regulations do not provide for any time limit on the validity of a consent form, some State laws provide for the automatic expiration of consents after a certain period of time.

8. The date the consent form is signed.

Summary of the Rule (Title 42CFR Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records) Con't

9. The signature of the patient.

    - If the patient has died, the executor or administrator of the estate, or if there is none, the spouse or, if none, then any responsible member of the patient's family may sign (§ 2.15(b)(2))

    - No consent is needed to disclose information relating to the cause of death to such agencies which are empowered to collect vital statistics or inquire into causes of death (§ 2.15(b)(1)

    - If the patient is an adjudicated incompetent, a guardian or other person authorized by State law to act on the patient's behalf may sign (§ 2.15(a)(1))

    - If the patient is a minor, the patient generally must sign the consent form - even if the disclosure is to the minor's parent.

For example, if State law requires a program to obtain a parent's consent in order to treat a minor, the minor must sign a consent form authorizing the disclosure to the parent (§ 2.14(b)-(c)). The only exception is for minors who are applying for alcohol and other drug services and yet lack the capacity to make a rational decision about whether to sign a consent form authorizing a disclosure that the program director determines is necessary to reduce a threat to the life or physical well-being of the applicant or anyone else (§ 2.14(d)).

In addition to the minor's signature, the parent's or other legal guardian's signature is only required if State law requires parental authorization for treating a minor. If the State permits the minor to be treated without the legal guardian's authorization, the minor's signature alone may authorize a disclosure (§ 2.14(b)-(c)).

- A client should never sign or be requested to sign a consent form before all of the blanks have been filled in.

- If any changes are made to a consent form after a client signs it, the client should initial the changes when they are made to indicate that the patient understands and agrees to the changes.

Whenever a disclosure is made pursuant to a consent, it must be accompanied by a written notice prohibiting redisclosure (§ 2.32). The written statement, which can be in the form of a separate sheet of paper or a rubber stamp on the disclosed document, warns the recipient that the information disclosed is protected by Federal law and may not be redisclosed except with the patient's consent or under other authorization. The language in the warning must be identical to that set forth in § 2.32 of the regulations. The prohibition on redisclosure notice must be sent to the recipient even if the disclosure was made orally.

Copies of all consent forms should be kept in the patient's file.
Sample informed consent forms for the disclosure of program participant confidential information:

Sample consent forms #1 and #2 can be utilized as a guide for grantee programs to either request program participant confidential information from other sources (i.e., other treatment facilities) or release program participant confidential information to other sources.

Sample Form #1
PATIENT CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, Jane Doe, authorize
(NAME OF PATIENT)

ABC Treatment Program
(NAME OR GENERAL DESIGNATION OF PROGRAM MAKING DISCLOSURE)

to disclose to: Mary Roe or another TANIFF counselor
(NAME OF PERSON OR ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE)

the following information:
my attendance and compliance in substance abuse treatment
(NATURE OF THE INFORMATION, AS LIMITED AS POSSIBLE)

The purpose of the disclosure authorized herein is to:
Assist the Hill Co. Dept of Welfare to determine my eligibility for benefits and/or to evaluate my readiness/ability to participate in a training program.
(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

XX/XX/2003 or upon program discharge
(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

_____

(Date) (Print Name) (Signature of Participant)

_____

(Date) (Print Name) (Signature of Parent, Guardian or Authorized Rep. when required)

Sample Form #2
MULTIPARTY CONSENT FORM FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, Jane Doe, authorize
(NAME OF PATIENT)

ABC Treatment Program
(NAME OR GENERAL DESIGNATION OF PROGRAM MAKING DISCLOSURE)

to disclose to:

1.
2.
3. _____
(NAME OF PERSONS OR ORGANIZATIONS TO WHICH DISCLOSURE IS TO BE MADE)

the following information:
my attendance and compliance in substance abuse treatment
(NATURE OF THE INFORMATION, AS LIMITED AS POSSIBLE)

The purpose of the disclosure authorized herein is to:
Assist the Hill Co. Dept of Welfare to determine my eligibility for benefits and/or to evaluate my readiness/ability to participate in a training program
(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

XX/XX/2003 or upon program discharge
(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

_____
(Date) (Print Name) (Signature of Participant)

_____
(Date) (Print Name) (Signature of Parent, Guardian or Authorized Rep. when required)

Appendix M

Notice to accompany release of confidential information consent form. Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Appendix N

Substance Use Disorder Diagnosis Overview

Reference Sheet: DSM 5 Substance Use Disorder Criteria

The *Diagnostic and Statistical Manual of Mental Disorders* 5 (DSM-5), published in May 2013, replaces the two categories of substance abuse and substance dependence with a single category: *substance use disorder*. The disorder is diagnosed substance specific and with a severity qualifier. The number of criteria met generally measures severity. M*ild* (2–3 criteria); M*oderate* (4–5 criteria); or S*evere* (6 or more criteria). For example: *Alcohol Use Disorder, Mild* or *Marijuana Use Disorder, Severe*. The DSM-5 utilizes the same criteria regardless of the substance.

The 11 Criteria

1. Taking more or for longer than intended
2. Unsuccessful efforts to stop or cut down use
3. Spending a great deal of time obtaining, using, or recovering from use
4. Craving for substance
5. Failure to fulfill major obligations due to use
6. Continued use despite problems caused or exacerbated by use
7. Important activities given up or reduced because of substance use
8. Recurrent use in hazardous situations
9. Continued use despite physical or psychological problems that are caused or exacerbated by substance use
10. Tolerance to effects of the substance*
11. Withdrawal symptoms when not using or using less*

**People who are using medication as prescribed; for example opioids, may exhibit only these last two symptoms and not have an opioid use disorder.*

Appendix O

Core Competencies Recommended for Masters-Level Licensed Behavioral Health Counselors who Treat or Plan to Treat Clients with Substance Use Disorders or Co-occurring Substance Use and Mental Health Disorders

March 2015

Introduction

The following competencies and criteria are recommended for all master's-level licensed behavioral health/mental health counselors who include or seek to include the treatment of substance use disorders (SUDs) and/or co-occurring SUD and mental health disorders (CODs) in their scope of practice. These recommendations have been developed by a multi-partner work group comprised of representatives from the NH Department of Health and Human Services Bureau of Drug and Alcohol Services, the NH Alcohol and Other Drug Service Providers Association, the NH Training Institute on Addictive Disorders, and the NH Alcohol and Drug Abuse Counselors Association. The recommendations have been endorsed by the NH Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment and its Treatment Task Force as well as by the New Hampshire Alcohol and Drug Abuse Counselors Association.

Purpose

The purpose of these recommendations is to increase the capacity of the existing behavioral health profession to treat SUDs and CODs effectively within practitioners' scope of practice.

This capacity expansion is critically needed to deliver services to the growing number of New Hampshire residents who are experiencing problems with substance use disorders. This capacity expansion is also critically needed to deliver SUD and COD treatment to New Hampshire residents who are newly covered under the NH Health Protection Program (Medicaid expansion) that provides a robust SUD benefit at a higher reimbursement rate than traditional Medicaid's psychotherapy benefit.

Recommendations

Recommendations for knowledge and skill areas are provided on the following page. Training, coursework, or other means for knowledge and skill acquisition and development within each of these categories to achieve and/or sustain competency are strongly encouraged.

Please note that the multiple categories and topics on the following page are not intended to imply that full courses or all-day trainings are needed for each. It is anticipated that many trainings and courses are likely to cover several of the categories and topic areas. These recommendations, therefore, do not stipulate a number of hours of education for each area; rather they outline knowledge and skills needed. The recommendations also articulate the importance of clinical support through supervision, professional mentoring and/or peer collaboration networks to help practitioners apply newly acquired SUD and COD-specific knowledge and skills in clinical practice.

Categories of Competence[1]	Recommended Topics for Knowledge and Skill Development
Data Collection & Diagnosis of SUDs*	✓ Assessment & differential diagnosis of SUDs and CODs
Initiating Treatment*	✓ ASAM[2] criteria to determine appropriate level of care ✓ Treatment planning for SUDs/CODs
Crisis Response*	✓ Crisis intervention relative to SUDs/CODs (e.g., severe withdrawal, overdose, alcohol poisoning)
Counseling*	✓ Application of best practices to SUDs/CODs, including differential application of treatment modalities to patients with SUDs/CODs, including medication assisted treatment
Regulatory Issues*	✓ 42 CFR, Part 2 (federal law relative to patient privacy protection and confidentiality specific to SUD treatment that is more stringent than HIPAA) ✓ Ethical considerations specific to SUDs/CODs
Community Utilization*	✓ Awareness of community resources and recovery supports specific to SUDs/ CODs, including peer support meetings and common barriers to attending meetings and accessing supports
Alcohol and Drugs*	✓ Basic knowledge of alcohol, drugs, interactions, and medication assisted treatment
Sociological Factors* **Physiological/Medical Factors*** **Psychological/Psychiatric Factors***	✓ Biopsychosocial factors in SUDs/CODs and the inter-relationship of biology, social environments, personality traits, life experiences, and other psychological factors
Treatment*	✓ Basic understanding and application of the continuum of care for SUDs/CODs ✓ Progression of SUDs, CODs and recovery ✓ Medication Assisted Treatment (e.g. buprenorphine, methadone, naltrexone or other medications)
Integrated Care	✓ Knowledge and skill development relative to integrated treatment of substance use disorders and mental health disorders.
Clinical Support	✓ Regular, on-going collegial mentoring, either through clinical supervision provided by a clinician with extensive experience treating individuals with SUDs/CODs, a professional mentor with such experience, peer collaboration groups supporting effective SUD and COD treatment, or similar means.

[1] The categories of competence noted here were established for licensure as a Master's Level Alcohol and Drug Counselor (MLADC) in New Hampshire, based on the International Credentialing and Reciprocity Consortium (IC&RC accessible at internationalcredentialing.org).
*Indicates an MLADC Core Competency area
[2] American Society of Addiction Medicine

Opportunities & Resources

There are many resources available to mental health counselors who are interested in expanding their scope of practice to include the treatment of SUDs/CODs. Biannual continuing education requirements may provide an opportunity to gain training and coursework to build competency in SUD/COD treatment.

Training	Continuing Education Coursework	Clinical Support
NH Training Institute on Addiction Disorders	*University of New Hampshire School of Social Work*	*Clinical Supervision*
Trainings specific to licensure and certification for SUD and COD prevention, treatment and recovery support services www.nhadaca.org/NHTIAD.html	12-16 credit course certification track for SUD/COD treatment	Regular on-going clinical supervision provided by a Master's level clinician with extensive experience treating individuals with SUDs or CODs
NH Alcohol and Drug Abuse Counselors Association	*Plymouth State University*	*Peer Collaboration Groups*
Training and practitioner support in effective service delivery www.nhadaca.org	12-16 credit course and internship for certificate track congruent with core competencies recommended by NHADACA	Practitioners meet regularly to discuss and problem-solve challenges to effective treatment of SUDs/CODs**
NH Health Protection Program behavioral health care management organizations	*Other institutions of higher education*	*Professional Mentors*
Additional training and phone consultation for treatment practitioners Cenpatico clinicaltraining@cenpatico.com Beacon Health Strategies Nicholas.pfeifer@beaconhs.com	Provide referral information on higher education institutions that offer coursework in SUD/COD treatment www.nhadaca.org/Resources.html	Provide regular opportunities for clinicians to troubleshoot challenges in clinical practice relative to treating SUDs/CODs one-on-one with an experienced mentor

** *Please note:* The NH Alcohol and Drug Abuse Counselors Association (NHADACA) has regional clinicians who may assist with finding peer collaboration groups or mentors. See contact info below.

For more information about opportunities to gain knowledge and skills, including very low-cost training opportunities, and for opportunities for clinical support through professional mentors or peer collaboration groups, please contact NHADACA at 603-225-7060, traininginstitute@nhadaca.org, or www.nhadaca.org.

NH Alcohol and Drug TREATMENT LOCATOR

The ***NH Alcohol and Drug Treatment Locator***, www.nhtreatment.org, is a new website directory now available for locating alcohol and drug treatment service providers in New Hampshire who offer assessments, withdrawal management, outpatient counseling, residential treatment, recovery supports and other services.

The on-line locator allows providers and the general public to identify services and narrow search results by location, service type, population/specialties served, and/or payer.

Search results may be printed to include provider contact information for referral organizations to share. Additionally, current listings may be updated and new listings can be added to the directory.

Promotional materials are also available to share with colleagues, patients and in waiting rooms including flyers, business cards and magnets. Please consider using this resource to help your patients get the help they may need.

How Do I Search for Treatment Options?

- ✓ Type your address or zip code in the *Address* field. You may also indicate a range within 10 to 250 miles.
- ✓ Filter by clicking on the *Service Types*, *Populations/Specialties Served*, and/or *Payer* radio buttons.
- ✓ Click on the points on the map within the location of interest to obtain provider contact information.
- ✓ Scroll down the page for a full list of providers specific to the service type(s) selected.

How Do I Update A Listing Or Add A New Listing?

- ✓ Click on the *Submit Edits* tab at the top of the home page and complete form as indicated. Edits/new listings will be updated within two weeks of a submitted request.

How Can I Obtain Promotional Materials?

- ✓ Click on the *Promotional Materials* tab located at the top of the home page to access all available materials.

Who Can I Contact for Help Navigating the Site and for More Information?

Rekha Sreedhara, NH Center for Excellence	603-573-3342	rsreedhara@jsi.com
Lisa Mure, NH Center for Excellence	603-573-3311	lmure@jsi.com

Are you looking for alcohol or drug treatment?

A variety of services are available including...

- Withdrawal Management (detoxification)
- Counseling Sessions
- Medications
- Residential Programs
- Recovery Support Services

Treatment is available.

Contact a provider in your area today.

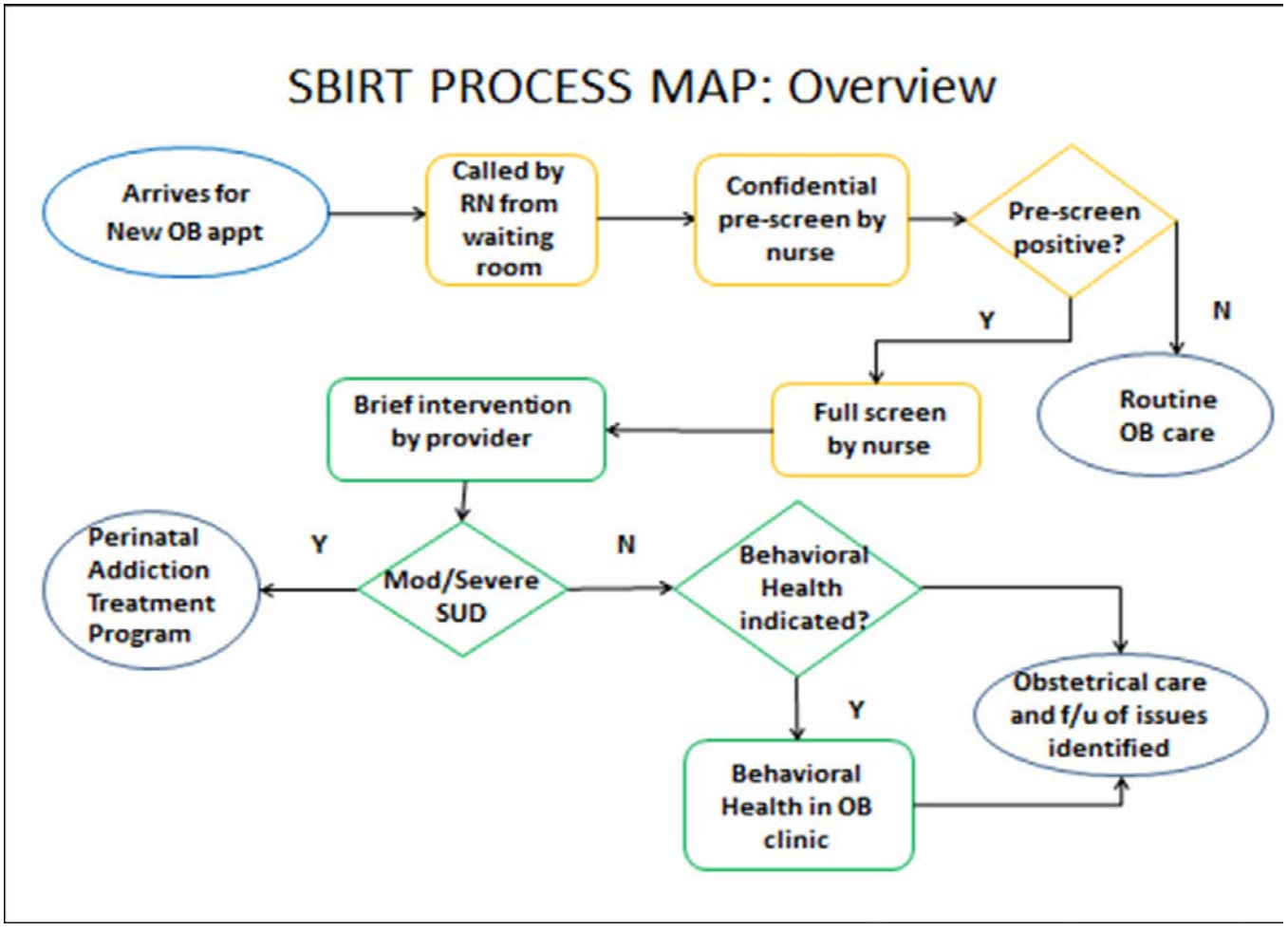
To find treatment services visit:

NH's Alcohol and Drug
TREATMENT LOCATOR

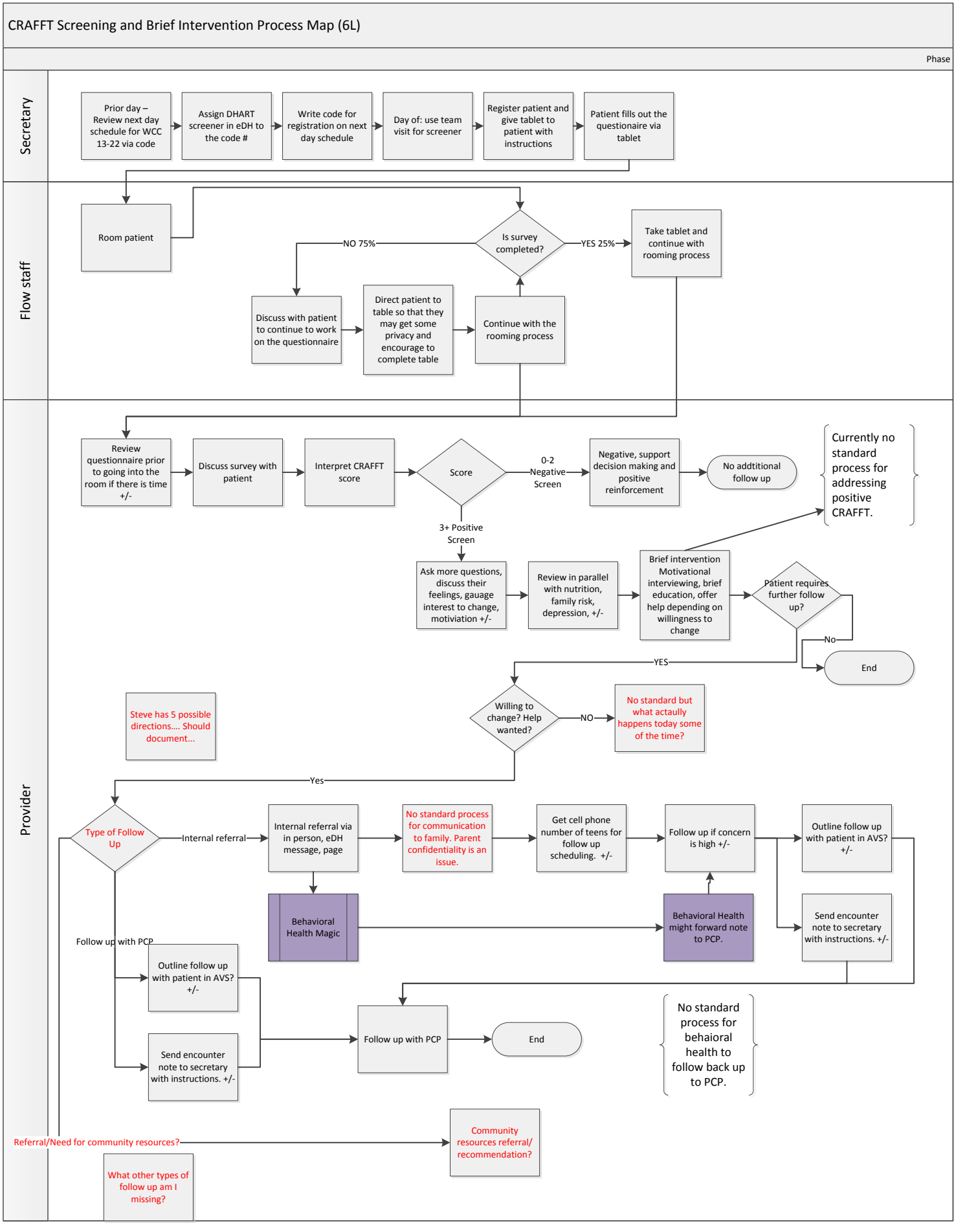
www.nhalcoholanddrugtreatment.org

Appendix Q – Flow Chart Examples

Site Flow Chart Example 1



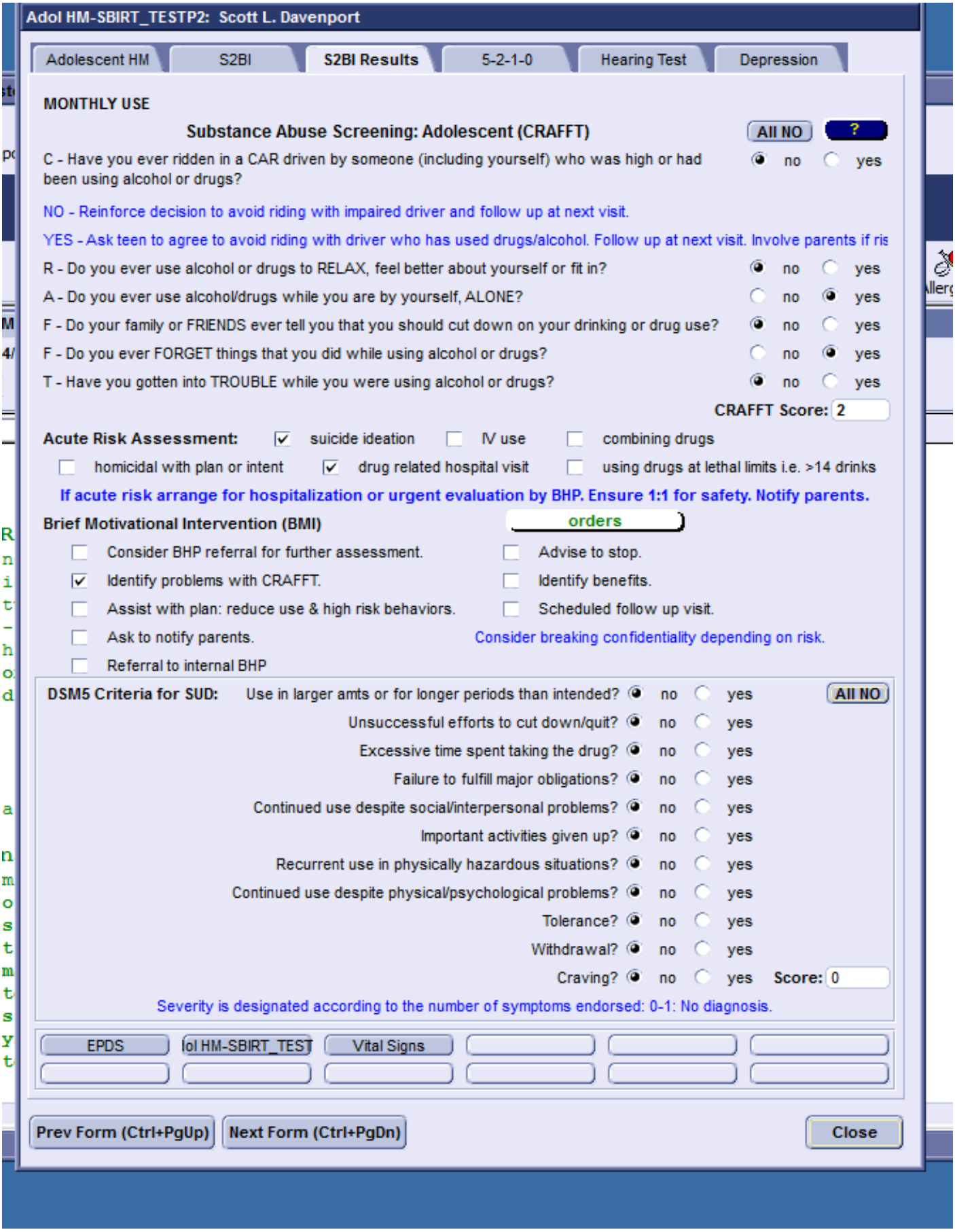
Site Flow Chart Example 2



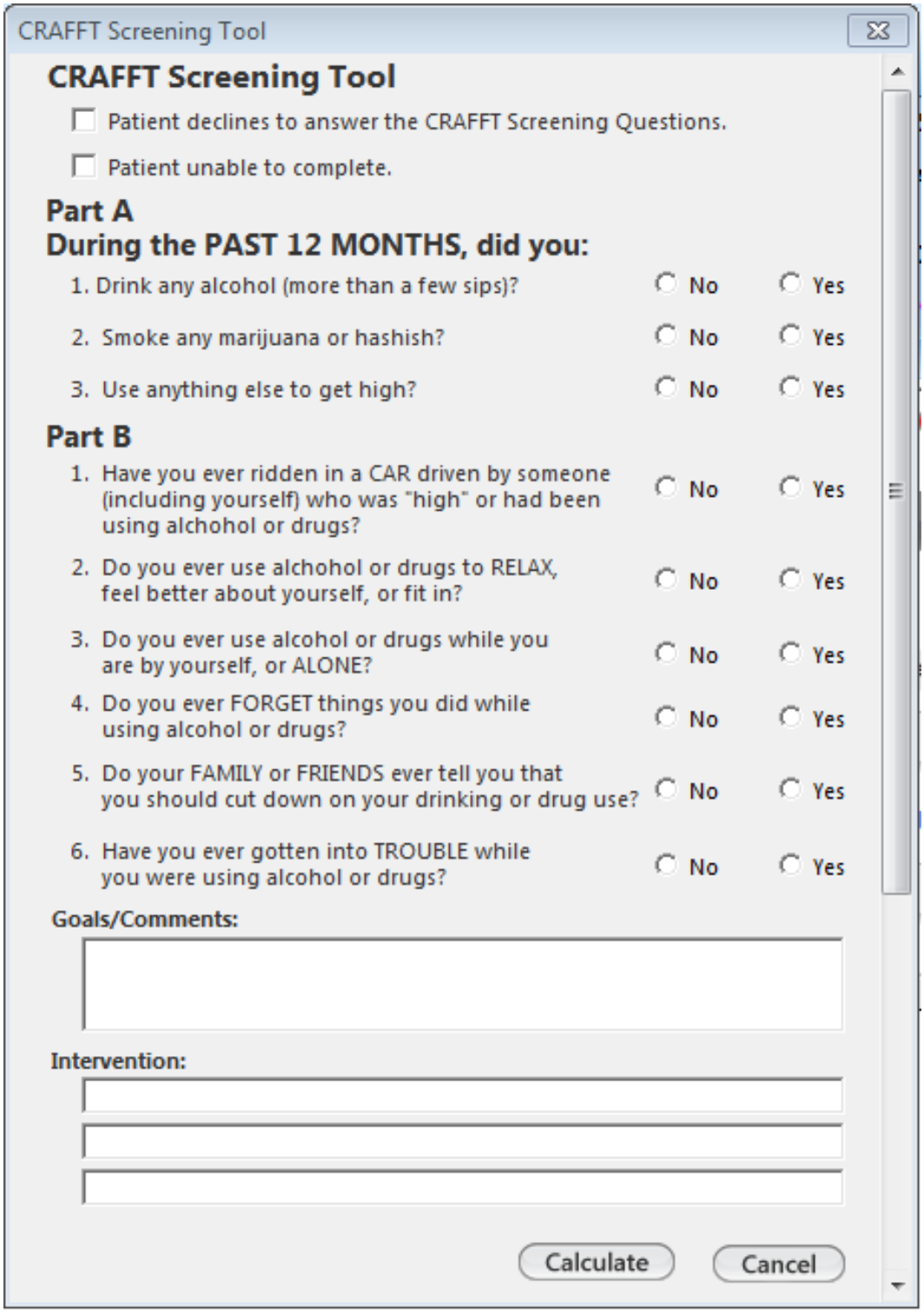
APPENDIX: ELECTRONIC HEALTH RECORD (EHR) RESOURCES

Appendix R – Screen Shots of NH S·BI·RT Initiative EHRs

Site EHR Example 1



Site EHR Example 2



APPENDIX: QUALITY MANAGEMENT AND DATA COLLECTION

Appendix S – NH Youth S·BI·RT Initiative Measurements

Appendix S

NH Youth SBIRT Initiative Evaluation Measures

Measure	Numerator	Denominator
% of youth who screened as no current use	total # youth who completed screen during wellness check-up (or similar annual exam or visit)	total # of youth aged 12-22 seen for wellness check-up (or similar annual exam or visit)
% of youth who screened as no current use **• on CRAFFT, "no" to all questions on Part A** **• on S2BI, "never" to first three questions**	# youth screened no current use	# youth screened
% of youth screened as being at risk **• on CRAFFT, any "yes" answer on part A** **• on S2BI, any answer greater than "never" on first three questions**	# youth identified at risk through the screening process	# youth screened
% at risk youth who received BI/BA	# at risk youth who received BI/BA	# youth identified as being at risk
% at risk who need referral **• CRAFFT score ≥ 2 on part B** **• S2BI, weekly use of any substance**	# at risk youth who need referral for treatment	# youth identified as being at risk (line 11)
For organizations with internal behavioral health services: **% who need a referral who received a referral**	# at risk youth who received a referral for treatment to internal behavioral health services	# at risk youth who need referral for treatment (line 17)
For organizations with internal behavioral health services: **% at risk who received a referral to external behavioral health services**	# at risk youth who received a referral to external behavioral health services	# at risk who need a referral to treatment
For organizations WITHOUT internal behavioral health services: **% at risk who received a referral to external behavioral health services**	# at risk youth who received a referral for treatment to external behavioral health services	# at risk youth who need referral for treatment (line 17)
At risk youth who received BI/BA were followed up by PCP		
At risk youth referred for treatment who were followed up by PCP		

Appendix S

Training

and role of staff trained in SBIRT

Patient Satisfaction Survey

surveys completed

1. Were you asked questions about alcohol and other drug use as part of your visit today? Y/N

2. If so, did your provider talk with you about your answers? Y/N

3. Did you feel that you were able to ask questions or talk about any concerns? *1-4 (absolutely to not at all)*

4. How likely are you to talk with this healthcare provider about any concerns about alcohol and other drug use in the future? *1-4 (absolutely to not at all)*

5. If you or your provider thought that you needed to make a change today, did you make a plan for that change? *Y/N/Did not think we needed to make a change*

APPENDIX: BILLING AND CODING IN NEW HAMPSHIRE

Appendix T – NH S•BI•RT Billing & Coding

Appendix U – New Futures EPSDT Overview

Appendix V – Annotated Bibliography

NH SBIRT Billing & Coding

NH MEDICAID: Health Behavior Assessment and Intervention (HBAI) Codes

Billing for services performed by licensed non-physician qualified Behavioral/Mental Health Provider must include a medical ICD-9-CM Code (e.g. Diabetes; Asthma). HBAI Codes reflect brief, time limited behavioral health consultation with patients in medical settings to help patients and their providers better manage primary medical conditions such as diabetes, obesity, heart disease, and cancer.

Description	Code
Assessment for biopsychosocial factors affecting a patient's primary medical condition	96150 - 96151
Services provided to patient, a group of patients, or patient's family to improve patient's health or well-being using cognitive, behavioral, social and/or psychological interventions.	96152 - 96155

NH Health Protection Program Substance Use Disorder Service Benefit (only for NH HPP beneficiaries NOT traditional Medicaid)[1]

Description	Code	Charge
Screening		
Screening by Behavioral Health practitioners[2]	H0049	$65.01
S•BI•RT 15-30 minutes	99408	$37.33
S•BI•RT >30 minutes	99409	$71.64
Individual Counseling	H0004	
30 minutes	U1	$65.01
45 minutes	U2	$86.18
60 minutes	U3	$112.96
Family Counseling		
Without patient present	H0047-HS	$104.58
With patient present	H0047-HR	$107.79
Group Counseling		
	H0005	$26.59[3]

[1]More information available at www.dhhs.nh.gov/ombp/nhhpp
[2]Using an evidence-based screening tool (e.g., DAST, AUDIT,
[3]Per person per session

August 2014
*CODES WILL BE UPDATED TO REFLECT ICD-10

Related services included in the array covered by the NH HPP:

- Assessment
- Crisis intervention
- Acute hospital care – medically-managed withdrawal
- Pre-natal care at-risk enhanced service coordination
- Opioid treatment program
- Office-based, medication-assisted treatment with primary care provider
- Intensive Outpatient Services
- Partial Hospitalization Services
- Rehabilitative Services (residential, low/medium intensity) – adolescent and adult Rehabilitative Services (residential, high intensity – adult and pregnant & parenting)

Medically-monitored withdrawal management (Outpatient detoxification and non-hospital residential); Peer and non-peer recovery support services, individual and group; and Continuous Recovery Monitoring (CRM) case management.

Reference Sheet: Private Insurance Billing and Code Sheet

Type of Visit	CPT Codes	Patient Status	Additional Notes
Preventive	*99401 – 99404* and *99420*		
Evaluation and Management (E & M)	*99201 – 99205*	New Patients	CPT Up Coding: Providers who devote more than half of a visit counseling a patient about their alcohol or drug use may use the E & M codes for office and other outpatient services (99210-99215), with appropriate documentation of services provided in the clinical record.[4]
	99211 – 99215	Established Patients	

Codes recommended by the National Association of Community Health Centers (NACHC)[4]

Health Behavior Assessment and Intervention (HBAI) codes are used for services identifying psychological, behavioral and social (rather than mental health or substance use) factors important to prevention, treatment or management of physical health problems.

[4]http://www.integration.samhsa.gov/sbirt/reimbursement_for_sbirt.pdf
[5]Billed at 15 minute units

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Service	Criteria	Code	Duration of Visit	Charge[6]
Alcohol and/or substance abuse (other than tobacco) structured screening and brief intervention services	•Use of validated screening tool (e.g., AUDIT, DAST, CRAFFT, S2BI) •Requires documentation of rationale, assessment outcome, goals, and duration.	99408	15 - 30 minutes	$33.41
		99408	> 30 minutes	$65.51

The following codes may be used in conjunction with E & M codes with -25 modifier:

Service	Description	Code(s)	Charges	
Screening - No Intervention Required	Health & behavior assessment	96150	Varies by Provider	
	Screening and Brief Intervention	96150–96155	Varies by Provider	
	Administer and Interpret Health Risk Assessment	*99420*	Varies by Provider	
	Annual alcohol misuse screening (includes pregnant women)	G0442	15 minutes	$17.36[7]
	Brief face-to-face behavioral counseling for alcohol misuse (includes pregnant women) [8 9]	G0443	15 minutes	$25.191[1]
Screening plus Intervention[10]	Alcohol and/or substance abuse structured screening and brief intervention services	G0396	15 - 30 minutes	$29.42
		G0397	>30 minutes	$57.69

[6] http://www.samhsa.gov/sbirt/coding-reimbursement
[7] Average national fee schedules
[8] Will be denied unless G0442 is used in the past 12 months
[9] Limit of 4 times in 12 months
[10] http://www.samhsa.gov/sbirt/coding-reimbursement

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Additional Notes:

- Code G0442 is an annual benefit so at least 11 months must pass between services.
- Both screening and counseling services have time elements of 15 minutes, so documentation should include duration of visit as well as screening or counseling notes.
- Counseling for alcohol misuse must be based on the Five As (Assess, Advise, Agree, Assist, and Arrange), so be sure your documentation reflects this.
- The alcohol screening and counseling services are payable with another visit on the same day (e.g., office visit for other problems), except for the Initial Preventive Physical Exam ("Welcome to Medicare" physical).
- Medicare allows payment for both G0442 and G0443 on the same date (except in rural health clinics and FQHCs), but will not pay for more than one G0443 service on the same date.
- These services are not subject to deductible or co-insurance.

New Futures EPSDT Overview

newfutures advocate • educate • collaborate
to reduce alcohol and other drug problems in New Hampshire

What is EPSDT?

"EPSDT" is the common abbreviation for Federal Medicaid's Early and Periodic Screening Diagnosis and Treatment benefit. [1] Under federal Medicaid law, States must provide comprehensive and preventive health care services to youth under the age of 21 who are enrolled in Medicaid.[2] The EPSDT provisions of the federal Medicaid Act, mandate States seeking federal match for Medicaid expenditures to cover all "necessary health care, diagnostic services, treatment and other measures described in [42 U.S.C. § 1396(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, *whether or not such services are covered under the State [Medicaid] plan*."[3] While the scope of EPSDT services is broad, States have considerable discretion in how they choose to administer the program.

How EPSDT functions in NH

As New Hampshire's single state Medicaid agency, the Department of Health and Human Services (DHHS) is responsible for establishing, maintaining, implementing and coordinating NH's EPSDT benefit.[4] DHHS is guided in its execution of federal Medicaid law by state statute and administrative rules. In the context of EPSDT, New Hampshire's Medicaid Office is guided by He-W 546. [5]

He-W 546 provides direction for billing purposes and outlines which services can be administered under EPSDT without an independent review of medical necessity from DHHS.[6] If a physician performs an EPSDT screen or service outside of those listed in He-W 546, and has not gained prior approval, DHHS may refuse the physician reimbursement for those services.

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[1] *See* U.S.C. § 1396a(a)(1); 42 U.S.C. § 1396d(1)(4)(B); and He-W 546
[2] *Id. see also* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html
[3] 42 U.S.C. § 1396(r)(5)
[4] *See* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf
[5] N.H. CODE ADMIN. R. ANN He-W 546 (1992) *available at* http://www.gencourt.state.nh.us/rules/state_agencies/he-w500.html
[6] N.H. CODE ADMIN. R. ANN He-W 546.05 (1992).

Why recent changes to He-W 546 are significant

Until very recently, the screening services listed under He-W 546 were keyed to an outdated March 2000 "Recommendations for Preventative Pediatric Health Care" document from the American Academy of Pediatrics. This fifteen-year-old document contained stale periodicity schedules and an incomplete list of currently recommended youth medical screenings.

This flaw in He-W 546 required providers administering substance misuse and SBIRT screens to apply for EPSDT coverage via an independent review by DHHS for each patient and screen administered. The administrative burden of this requirement led some physicians to forgo performing youth SBIRT altogether.

Fortunately, DHHS recognized this problem within the rule and worked with advocates on a rule change to He-W 546. The final rule change updated the list of approved screenings and services to coincide with the most recent recommendations of the American Academy of Pediatrics; reflecting current recommendations to screen youth for behavioral health and substance use disorders.[7] On May 15, 2015, New Hampshire's Joint Legislative Committee for Administrative Rules accepted the proposed changes to He-W 546, eliminating previous barriers to universal SBIRT screening of Medicaid youth in NH.

Why EPSDT is important for youth with Substance Use Disorders in NH

As mentioned above, the EPSDT provisions of the federal Medicaid Act mandate States to cover all "necessary health care, diagnostic services, treatment and other measures described in [42 U.S.C. § 1396(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] plan" for enrolled beneficiaries under the age of 21.[8] The New Hampshire State Medicaid plan does not include a Substance Use Disorder benefit for traditional Medicaid populations; so, for Medicaid youth with Substance Use Disorders, the EPSDT mandate fills an important gap in health coverage.

If a Substance Use Disorder is detected in a Medicaid youth through an EPSDT SBIRT screen, DHHS is required to arrange for (whether directly or through referral to appropriate agencies, organizations [MCOs] or individuals) any "necessary" treatment.[9] While States are not required to pay for services that are not "medically necessary," they cannot arbitrarily deny or reduce the amount, duration, or scope of services based on the diagnosis, type of illness or condition.[10] The standards used by DHHS to determine the "medical necessity" of services, must be also keyed to accepted clinical criteria.[11] For

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[7] *See* http://www.dhhs.state.nh.us/oos/aru/documents/hew546ip.pdf
[8] 42 U.S.C. § 1396(r)(5)
[9] 42 U.S.C. § 1396a(a)(43)(C); *See also* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html
[10] 42 C.F.R. §440.230(c)(1)
[11] 42 U.S.C. § 1396(a)(17); N.H. CODE ADMIN. R. ANN He-W 546.01(e) (1992).

Medicaid youth with Substance Use Disorders, accessing services through EPSDT can help to ensure proper and timely treatment.

How to access coverage for Substance Use Disorder Treatment when medically necessary for a Medicaid youth

To access Substance Use Disorder Treatment under EPSDT, families and providers must first request prior authorization from the appropriate state contractor, Managed Care Organization (MCO) or MCO contractor. Because Substance Use Disorder Treatment is not currently included in New Hampshire's State Medicaid Plan, the request for prior authorization must be submitted according to the EPSDT provisions and detail the medical necessity of the treatment for the particular child.

As previously explained, New Hampshire defines "medically necessary" as "reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service."[12] The EPSDT request for prior authorization should be as specific as possible (e.g. X hours of Intensive Outpatient Treatment per week) and reference EPSDT and the standard for coverage described above. Additionally, the request should include any applicable diagnostic evaluations, a letter of medical necessity from the child's treating physician or therapist, and any other documentation supporting the medical necessity of the requested service at the requested level.[13]

If the child has Fee-for-Service Medicaid (i.e. the child's Medicaid is administered by the New Hampshire Department of Health and Human Services), the EPSDT request for prior authorization must be submitted through KEPRO[14], the State's contractor for Medicaid utilization management. A different process must be followed for EPSDT requests for prior authorization when the child has Medicaid through one of the State's two MCOs, Well Sense or New Hampshire Healthy Families. Well Sense contracts with Beacon Health Strategies[15], LLC and New Hampshire Healthy Families contracts with Cenpatico to manage behavioral health services. The EPSDT request for prior authorization based on medical necessity for coverage of Substance Use Disorder Treatment must be submitted through the appropriate MCO contractor, either Beacon or Cenpatico.

How to appeal a denial or limited authorization of Substance Use Disorder Treatment

Medicaid recipients and their providers have a right to appeal any denials, limited authorizations, or termination of treatment that they believe is medically necessary.

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[12] *See* N.H. CODE *supra* note 5 *at* He-W 546.01(e).
[13] For detailed instructions about what must be included in an EPSDT request for prior authorization based on medical necessity, please review He-W 546.06. (*See attached)*
[14] *See* https://nhmedicaid.kepro.com/
[15] *See* http://beaconhealthstrategies.com/ and http://www.cenpatico.com/

Appeals may be filed with the New Hampshire Department of Health and Human Services' Administrative Appeals Unit (AAU).[16]

If the service coverage dispute is with a MCO or MCO contractor, the MCO's appeal process must first be exhausted before further appeal to the AAU is permitted. To ensure treatment services continue pending appeal, the appeal and a request for continuation of benefits must be made no later than 10 days from the receipt of the MCO's written notice. After receiving notice of appeal, an MCO has 30 days to issue a decision. If waiting 30+ days for a resolution would seriously jeopardize the life or health of the Medicaid beneficiary, an expedited appeal may be requested. An MCO must issue a decision on an expedited appeal within 3 calendar days. If the result of the MCO appeal is unfavorable, a request a fair hearing before an impartial hearing officer at the AAU may be filed as mentioned above.[17]

For more information on the new EPSDT rules or accessing EPSDT coverage in NH, please contact New Futures at 603-225-9540 x109 or visit http://www.new-futures.org/.

For more information on appeals to the AAU or MCO appeals, please contact the Disabilities Rights Center- NH at 800-834-1721 or visit http://drcnh.org/.

[16] For more information on appeals to the AAU see "Fair Hearing Rights Under Medicaid," http://www.drcnh.org/medicaidhearings.html

[17] For more information on MCO appeals, see "Know Your Rights: New Hampshire Medicaid Managed Care Health Plans - Your Right to Appeal or File a Grievance," available at www.drcnh.org/MMCappealsgrievances.html

Appendix

He-W 546.06 Prior Authorization for Coverage Based on Medical Necessity.

(a) Prior authorization shall be required for services described in He-W 546.05(c) and (e).

(b) Requests for prior authorization shall include the following:

(1) The recipient's name, address, and Medicaid identification number;

(2) The recipient's diagnosis and prognosis, including an indication of whether the diagnosis is a pre-existing condition or a presenting condition;

(3) An estimation of the effect on the recipient if the requested service is not provided;

(4) The medical justification for the services or equipment being requested;

(5) The recommended timetable of the prescribed treatment;

(6) A discussion of why the service is medically necessary as relates to He-W 546.01(e);

(7) The expected outcome of providing the requested service;

(8) The recommended timeframe to achieve the expected outcome;

(9) A summary of any previous treatment plans, including outcomes, which were used to treat the diagnosed condition for which the requested service is being recommended;

(10) Listings of individuals or agencies to whom the recipient is being referred; and

(11) Assurance that the requested service is the least restrictive, most cost-effective service available to meet the recipient's needs.

(c) Requests for prior authorization shall include a statement signed by at least one of the following indicating that they concur with the request:

(1) Treating physician or primary care provider;

(2) Treating advanced practice registered nurse; or

(3) Primary treating psychotherapist.

(d) Prior authorizations for coverage of services requested in accordance with He-W 546.06 shall be approved by the department if the department determines that the information provided in (b) above demonstrates medical necessity.

(e) Confirmation of department approvals shall be sent to the treating physician in writing.

(f) Providers shall be responsible for determining that the recipient is Medicaid eligible on the date of service.

(g) If the requested service is denied, or denied in part, by the department, the department shall forward a notice of denial to the recipient and the treating provider with the following information:

(1) The reason for, and the legal basis of, the denial; and

(2) Instructions that a fair hearing on the denial may be requested by the recipient within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.

(h) Decisions made by the department in accordance with (d) and (g) above shall not be superseded by the treating or consultative health care professional's prescription, orders, or recommendations

Annotated Bibliography

American Academy of Pediatrics, Committee on Substance Abuse. (2011). Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians. Pediatrics, 128(5), e1330-e1340. doi: 10.1542/peds.2011-1754

As a component of comprehensive pediatric care, adolescents should receive appropriate guidance regarding substance use during routine clinical care. This statement addresses practitioner challenges posed by the spectrum of pediatric substance use and presents an algorithm-based approach to augment the pediatrician's confidence and abilities related to substance use screening, brief intervention, and referral to treatment in the primary care setting. Adolescents with addictions should be managed collaboratively (or co-managed) with child and adolescent mental health or addiction specialists. This statement reviews recommended referral guidelines that are based on established patient-treatment–matching criteria and the risk level for substance abuse.

Available at: http://pediatrics.aappublications.org/content/early/2011/10/26/peds.2011-1754.abstract?rss=1

American Board of Addiction Medicine Foundation. (2015). Identifying and Responding to Substance Use among Adolescents and Young Adults: A Compendium of Resources for Medical Practice.

Prepared by The National Center for Physician Training in Addiction Medicine, this compendium is a comprehensive toolkit with resources for practitioners treating adolescents and young adults. Available resources begin with Screening tools and follow through Referral to Treatment guidance, and also include resources for other important components of care.

Available at: **http://www.abam.net/wp-content/uploads/2015/07/ABAMF-Compendium-Final.pdf**

An SBIRT Implementation and Process Change Manual for Practitioners (2012)
National Center on Addiction and Substance Abuse
Columbia University: New York

This manual provides a resource for creating a sustainable SBIRT program. It is meant to be used as a guide and resource for those who want to integrate SBIRT into their practice, and covers four main areas: 1) The components of SBIRT, 2) Process improvement strategies, 3) planning your SBIRT program to fit your agency using tailored implementation strategies, and 4) Toolkit and worksheets to guide SBIRT implementation.

Available at: http://www.casacolumbia.org/sites/default/files/files/An-SBIRT-implementation-and-process-change-manual-for-practitioners.pdf

Appendix V

Bohman, T., Kulkarni, S., Waters, V., Spence, RT., Murphy-Smith, M., McQueen, K. (2008). Assessing Health Care Organizations' Ability to Implement Screening, Brief Intervention, and Referral to Treatment. Journal on Addiction Medicine 2: 151-157.

The article summarizes a study of a new measure of Medical Organizational Readiness for Change (MORC). The MORC measures organizational readiness among a range of dimensions, including Need for External Guidance, Pressure to Change, Organizational Readiness to Change, Workgroup Functioning, Work Environment and Autonomy Support, and found that when change agents used the MORC data to inform their implementation process the results were positive, thus concluding that MORC scales can help planners and change agents at organizations to understand thier organization's readiness to integrate SBIRT.

Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities. Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices. Atlanta, Georgia, 2014.

This guide is designed to help an individual or small planning team adapt alcohol SBI to the unique operational realities of their primary care practice. It takes them through each of the steps required to plan, implement, and continually improve this preventive service as a routine element of standard practice. Rather than prescribing what the alcohol SBI services should look like, the Guide will help you and your colleagues create the best plan for your unique situation.

Available at:
http://www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf

IRETA Institute for Research, Education and Training in Addictions SBIRT Toolkit

This toolkit is designed for practitioners and organization s who are using (or considering using) Screening, Brief Intervention and Referral to Treatment in a variety of settings. It includes educational resources for clients, and a range of materials for practitioners. Examples include general information about SBIRT, adolescent-specific materials, and examples and guidelines for screening tools, brief intervention techniques, and referral to treatment guidance.

Available at: http://ireta.org/improve-practice/toolkitforsbirt/

Levy S, Weiss R, Sherritt L, et al. An Electronic Screen for Triaging Adolescent Substance Use by Risk Levels. *JAMA Pediatr.* 2014;168(9):822-828. doi:10.1001/jamapediatrics.2014.774.

This study describes the psychometric properties of an electronic screen and brief assessment tool (S2BI) that triages adolescents into 4 actionable categories regarding their experience with nontobacco substance use: (1) no past-year alcohol or drug use, (2) past-year alcohol or drug use without a SUD, (3) mild or moderate SUD, and (4) severe SUD. The tool has 3

additional categories for tobacco use: (1) no tobacco use, (2) tobacco use, and (3) nicotine dependence. A single screening question assessing past-year frequency use for 8 commonly misused categories of substances appears to be a valid method for discriminating among clinically relevant risk categories of adolescent substance use.

Available at: **http://archpedi.jamanetwork.com/article.aspx?articleid=1889047**

National Institute of Alcohol Abuse and Alcoholism. (n.d.). **Alcohol Screening and Brief Intervention for Youth | A Practitioner's Guide.** NIH Publication No. 11-7805

With this Guide, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) introduces a simple, quick, empirically derived tool for identifying youth at risk for alcohol-related problems. It was produced in collaboration with the American Academy of Pediatrics, clinical researchers, and health practitioners.

Available at:
http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf

Rahm, A. K., Boggs, J. M., Martin, C., Price, D. W., Beck, A., Backer, T. E., & Dearing, J. W. (2014). Facilitators and Barriers to Implementing SBIRT in Primary Care in Integrated Health Care Settings. *Substance Abuse*, 00-00. doi: 10.1080/08897077.2014.951140

This formative evaluation explored implementation of the Substance Abuse and Mental Health Services Administration (SAMHSA) Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach at Kaiser Permanente. Key clinical stakeholders, including patients, provided feedback through key informant interviews and focus groups. All clinical stakeholders promoted clinic-based psychologists to conduct brief intervention and determine referral to treatment as the optimal implementation program. Organizationally, systems exist to facilitate drug and alcohol use screening, intervention, and referral to treatment. However, physician time, alignment with other priorities, and lack of consistent communication were noted potential barriers to SBIRT implementation. Clinicians expressed concerns about competing priorities and the need for organizational leadership involvement for successful SBIRT implementation. A unique suggestion for successful implementation is to utilize existing primary care clinic-based psychologists to conduct brief intervention and facilitate referral to treatment. Patient stakeholders supported universal screening but cultural differences in opinions and current experience were noted.

SBIRT Oregon

This website presents information and tools designed to counter barriers to SBIRT implementation. It emphasizes a team-based approach. Resources address SBIRT workflow, screening forms, clinic tools, training materials, and information about billing and documentation.

Available at: http://www.sbirtoregon.org/

Appendix V

SBIRT: Screening, Brief Intervention, and Referral to Treatment.
SAMHSA-HRSA Center for Integrated Health Solutions.

This website includes resources for training for each component of SBIRT, as well as resources and examples for workflow, screening tools, and financing. It includes webinars, fact sheets and resources for implementing SBIRT across a range of populations and settings.

Available at: **http://www.integration.samhsa.gov/clinical-practice/SBIRT**

Sterling, S., Valkanoff, T., Hinman, A., & Weisner, C. (2012). Integrating Substance Use Treatment Into Adolescent Health Care. *Current Psychiatry Reports, 14*(5), 453-461. doi: 10.1007/s11920-012-0304-9

This article examines the literature on the integration of substance use treatment with adolescent health care with a focus on emergency department settings and school- and college-based health centers.

Available at: http://www.ncbi.nlm.nih.gov/pubmed/22872492

Substance Abuse and Mental Health Services Administration. Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment. Technical Assistance Publication (TAP) Series 33. HHS Publication No. (SMA) 13-4741. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

This comprehensive document describes core elements of screening, brief intervention and referral to treatment programs for people with or at risk for substance use disorders. It describes SBIRT services implementation, covering challenges, barriers, cost, and sustainability.

Available at: http://www.integration.samhsa.gov/sbirt/tap33.pdf

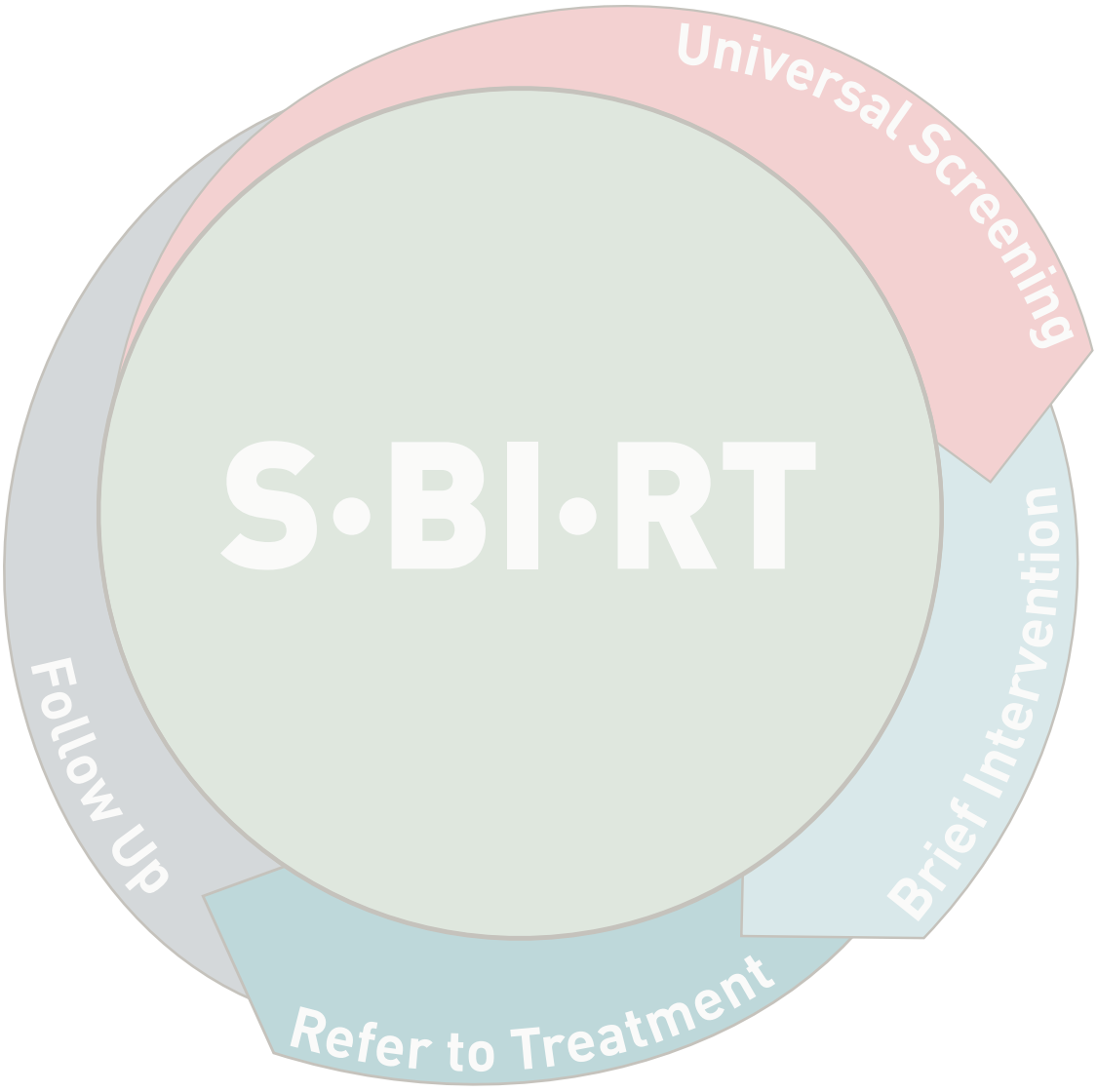
The SBIRT App for Screening, Brief Intervention and Referral to Treatment for substance use provides users with detailed steps to complete and SBIRT interventions with patients or clients. The app is designed for use by physicians, other health workers, and mental health professionals, and can be used with patients and clients 12 years and older.

Available at: https://itunes.apple.com/us/app/sbirt/id877624835?mt=8

Levy, S., & Schrier, L. (2015). Adolescent SBIRT Toolkit for Providers Boston, MA: Adolescent Substance Abuse Program, Boston Children's Hospital.

This toolkit is designed to provide up-to-date guidance on research-informed practices to address substance use, including providing anticipatory guidance, accurate brief medical

advice, brief motivational interventions, and successful referrals. The toolkit includes an overview of the problem of adolescent alcohol and drug use, role of primary care providers, anticipatory guidance, screening tools, brief intervention, referral to treatment, and billing. It provides resources related to confidentiality issues, and practice case studies and vignettes.


Universal Screening
S·BI·RT
Brief Intervention
Refer to Treatment
Follow Up