PREVENTING YOUTH SUBSTANCE MISUSE THROUGH INTEGRATED PRIMARY CARE:

Strategies for S·BI·RT Implementation

June 2018

SCREEN & INTERVENE

NH Youth SBIRT Initiative

Prepared for:

New Hampshire S·BI·RT Initiative of the New Hampshire Charitable Foundation and the Conrad N. Hilton Foundation

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NH Youth SBIRT Initiative

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JSI

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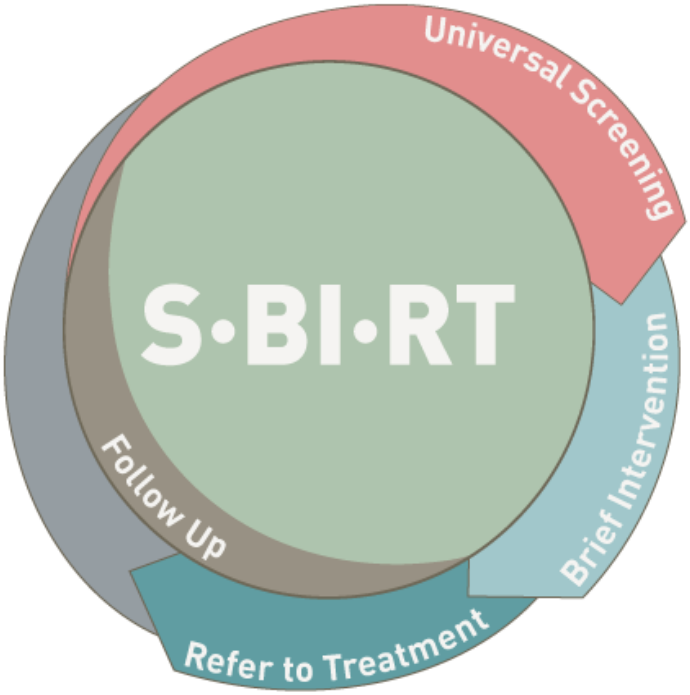
Table of Contents

Acronyms Used **5**
Introduction **7**
Project Goals and Duration 7
Project Summary 7
Context: New Hampshire, the Charitable Foundation, JSI, New Futures, and the Implementing Practice Sites **9**
Substance Use in New Hampshire 9
New Hampshire Charitable Foundation 9
Center for Excellence at JSI 9
New Futures 9
Implementing Practice Sites 10
Facilitation: Structure and Strategies **11**
Project Structure 11
Technical Assistance and Training 11
Technical Assistance 11
Training 13
Open-Source Resources 13
Website 14
Playbook 14
Annual NH S-BI-RT Summits 14
Communication 15
NH Youth S-BI-RT Initiative Communication Strategies 15
Project Outcomes Data **18**
Project Aggregate Data 18
Discussion of Aggregate Data: Interpretation and Implications 19
Implementation Process and Progress 24
Lessons Learned and Recommendations **25**
Implementation Strategies 25
Lessons Learned 25
Clinical Champion 25
Clinical Work-flow for Screening, BI, and Referral to Treatment 28
Cultural Competence 30
The Role of the Electronic Medical Record and Information Technology in Supporting S-BI-RT in Clinical Practices 31
Lessons Learned 31
Getting the Screening Template into the EMR 32
Entering Patients' Responses into the Screening Template 34
e-Tablets, Paper, and Work-flow 32
Documenting BI, Need for Referral, Referral Made and Follow-up 33
Data Retrieval and Reporting 34
Site Specific Policy Considerations Related to S-BI-RT Implementation 34
Lessons Learned 35
Other Reflections 38
Coding and Billing 35
Confidentiality 36
Sustainability **39**
Conclusion **40**
References **43**

Figures & Tables

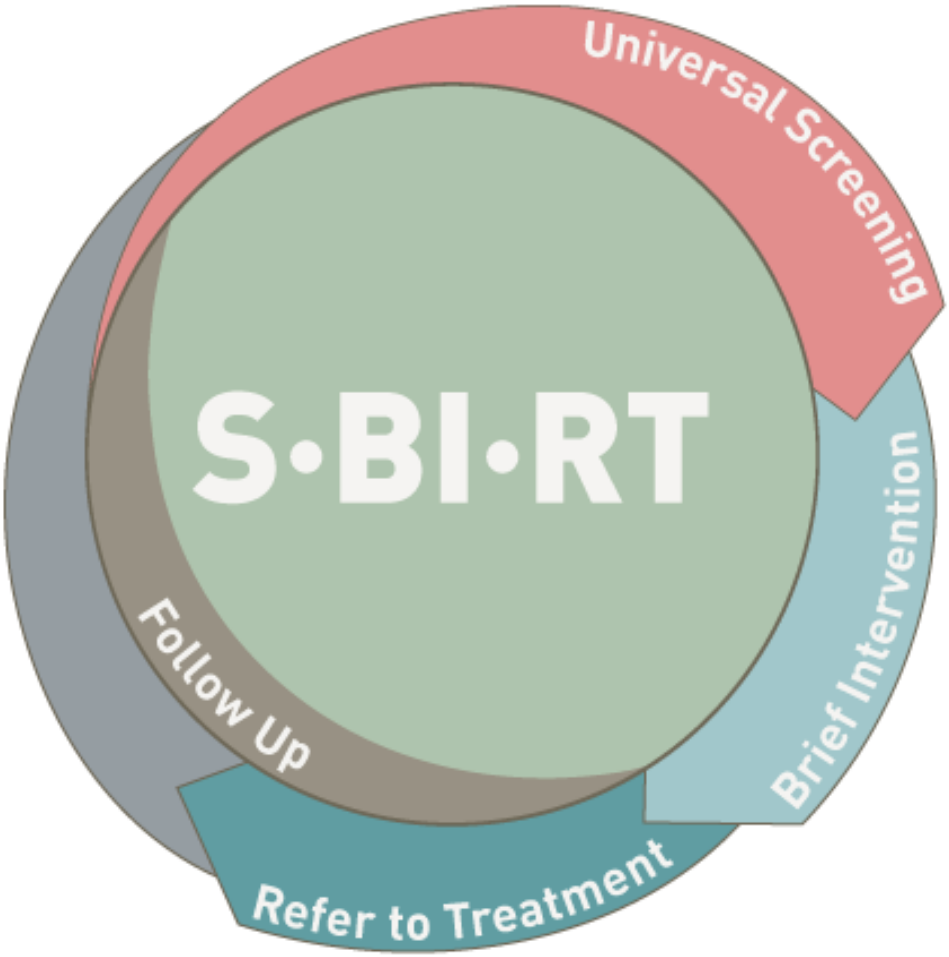
Figure 1: S·BI·RT Communication Strategy 15
Figure 2: NH Youth S·BI·RT Initiative Process Model 16
Figure 3: Percent of Youth Not Screened, Screened Not at Risk, and Screened at Risk 19
Figure 4: Screening Tools Used by Practice Sites 20
Figure 5: Activities or Mechanisms That Support Referral to Treatment (or Further Assessment) 23
Figure 6: Sample Screening Template 33
Figure 7: Sample Best Practice Advisory Alert Embedded in EMR 35
Figure 8: Primary Care Practices Implementing S·BI·RT in NH 40

Table 1: Significant Differences in Percent of Youth Substance Use Between NH, the Northeast (NE) Region, and the US 9
Table 2: Screening Format, Screening Tool, EMR, Number of Practice Sites and Number of Target Population Served 10
Table 3: Measures, Definitions and Aggregate Data 18
Table 4: Implementation Stages 24



Acronyms Used

AAP	American Academy of Pediatrics
ASAP	Boston Children's Hospital Adolescent Substance Abuse Program
BH	Behavioral Health
BI	Brief Intervention
BPA	Best Practice Advisory
Bureau	New Hampshire Bureau of Drug and Alcohol Services
Center	Center for Excellence at JSI Research and Training Institute, Inc.
Charitable Foundation	New Hampshire Charitable Foundation
CHC	Community Health Center
CME	Continuing Medical Education Credits
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
DHHS	New Hampshire Department of Health and Human Services
DSRIP	New Hampshire's Transformation Delivery System Reform Incentive Program
EMR	Electronic Medical Record
FQHC	Federally Qualified Health Center
Governor's Commission	New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery
Hilton	Conrad N. Hilton Foundation
HIPAA	Health Insurance Portability and Accountability Act
IDN	Integrated Delivery Networks
Initiative	NH Youth SBIRT Initiative
IT	Information Technology
JSI	JSI Research and Training Institute, Inc.
MA	Medical Assistant
MI	Motivational Interviewing
NH	New Hampshire
PCP	Primary Care Provider
QI	Quality Improvement
RFP	Request for Proposal
S·BI·RT	Screening, Brief Intervention and Referral to Treatment
SUD	Substance Use Disorder
TA	Technical Assistance


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

Introduction

Thanks to the extraordinary opportunity afforded by a three-year partnership between the Conrad N. Hilton Foundation (Hilton) and the New Hampshire Charitable Foundation (Charitable Foundation), the NH Youth S·BI·RT Initiative (Initiative) exceeded the goals of screening youth and embedding S·BI·RT as universal practice in primary care practices. The Initiative has enormously appreciated the focus of this project on learning, and recognize that this affords an opportunity to share evaluation findings and recommendations to others who aim to integrate S·BI·RT into clinical practice settings that serve youth. This report represents the culmination of our learning and insights over the duration of the project, from April 2014 through June 2017.

> *"SBIRT has opened doors to meaningful conversations with adolescents, giving them safe space to talk with their provider because we have demonstrated that we are ready to listen. Although the majority of the screenings we've done provide an opportunity for positive reinforcement of healthy choices, when risks are identified we've found that adolescents are hungry for an open ear and an opportunity to feel empowered to make positive changes. We never anticipated the gravity of such a simple screening tool, and now view it as an essential part of our clinical practice."*
>
> -Implementing Practice Site

Project Goals and Duration

The goals of the NH Youth S·BI·RT Initiative were to support the adoption of S·BI·RT as a sustainable and universal practice in New Hampshire. Those goals were as follows:

I. Expand youth S·BI·RT in primary care settings;
II. Screen no less than 10,000 youth and young adults (ages 12-22) by 2017; and
III. Address policy and financial barriers that were identified during the project.

While the Initiative also included a policy component, this report focuses on the practice implementation aspects (Goals I and II), spearheaded by the Center for Excellence (Center) housed within JSI Research and Training Institute, Inc. (JSI).

Project Summary

The implementation of S·BI·RT in primary care practices with a focus on youth ages 12-22 came at a critical time in New Hampshire's opioid crisis. While the headlines have focused on misuse of opioids and rise in deaths due to overdoses, misuse of alcohol and other drugs among New Hampshire youth persists at among the highest rates in the country.[1] In 2015, the New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery (Governor's Commission) developed a statewide strategic plan,[2] prioritizing S·BI·RT implementation for the medical community, as a new strategy to prevent and treat alcohol and drug misuse and related disorders in primary healthcare settings. 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.[3]

The New Hampshire Charitable Foundation, New Hampshire's statewide community foundation and a Hilton grantee, enlisted the Center as the backbone organization for youth S·BI·RT implementation. The Center provides a range of services including training and technical assistance in support of the New Hampshire substance use disorder continuum of care: prevention, early identification, crisis, treatment and recovery supports. The Charitable Foundation issued a Request for Proposals (RFP) and ultimately funded three cohorts of practice sites over the three and a half year period (2014-2017) of this project representing 10 organizations (23 practice sites) collectively serving over 74,000 patients ages 12-22. The Charitable Foundation offered grant support for participating sites to cover S·BI·RT implementation expenses such as staff planning and training time, and modifications to electronic medical record systems. No funding was provided for actual patient screenings or other clinical services. The practice sites represented a range of rural and urban service delivery settings, including Federally Qualified Health Centers (FQHCs) and other community health centers (CHCs), a large academic healthcare system, a mid-sized healthcare system, and two critical access hospitals. Several of the practices were patient-centered medical homes.

The project was structured as an action learning collaborative, engaging teams from the different clinical practice sites in shared learning and supporting sustainable system-based methods of quality improvement (QI). Facilitation of S-BI-RT implementation included:

- Training of office, medical, and nursing staff in the screening tools and Brief Intervention (BI) techniques;
- Technical assistance (TA) regarding improvements in work-flow and in the integration of the electronic medical record (EMR) with documentation of screening and data collection;
- Open resources on the S-BI-RT NH website www.SBIRTnh.org;
- A Playbook to guide clinical grantees in the implementation of S-BI-RT;
- Annual New Hampshire S-BI-RT Summits; and
- Communication strategies.

> ***"Participation for the first two years in the Learning Collaborative provided significant supports and help for the work required to implement and sustain SBIRT successfully."***
>
> **-Implementing Practice Site**

We reached our goal to screen 10,000 youth by December 2016; by June 2017, the end of data collection, 15, 126 youth had been screened across the 10 participating organizations, and 569 providers and other ancillary staff had received S-BI-RT training. Seventy-seven percent of youth seen in primary care for routine visits were screened using one of the suggested validated screening tools (CRAFFT, CRAFFT 2.0 or S2BI). Of those screened, 15% were found to be at risk for a substance use disorder (SUD). Of youth found to be at risk, 41% received a BI and 28% were at sufficient risk to need a referral to behavioral health (BH) services for further assessment and treatment. In the aggregate, this means that 6% of all youth screened received a BI, and 5% of all youth screened needed a referral to BH services. While some implementing sites stabilized their work-flow for documentation of S-BI-RT and data collection to achieve screening rates above 80% over time, others continued to struggle with inconsistency. However, with a few exceptions, all clinical sites made good progress at implementing screening into their office work-flow.

A very valuable part of this project was the lessons learned by working closely with the implementing practice sites, which fall into three broad categories.

1. S-BI-RT implementation requires a meaningful investment of time, effort, and resources devoted to addressing technical operations as well as practice culture, and to sustaining clinical grantee engagement throughout the project. Keys to success include:
   - » Strong support from leadership;
   - » Having a medical provider champion to promote the Initiative among peer providers and set performance expectations;
   - » Time dedicated to meetings and QI related to work-flow and roles; and
   - » A robust information technology department that works with implementation and QI efforts.
2. The EMR plays a critical role in S-BI-RT to support and document clinical care. There are significant challenges related to embedding screening tools in the EMR, managing the interface between the EMR and each site's clinical work-flow, and collecting and using the data related to clinical performance measures, that is, numbers of youth who were screened and found at risk, and who received BI and were referred to BH services for further assessment and treatment. Finally, there were EMR-related challenges in following up with at risk patients.
3. There are broader implications for policy that include barriers related to billing and coding of screening as a reimbursable service, and confidentiality considerations related to patient care, as well as organizational compliance with federal and state regulations.

This report is organized around a framework that describes successful implementation as the interaction between strong evidence supporting the implementation of a practice or protocol, the context or setting in which the proposed change is implemented, and the type of support and strategies needed to facilitate making the needed changes.[4] This document focuses on the context (structure, culture, and norms) of the implementing practice sites within the State of New Hampshire, and the infrastructure of the Initiative itself, which included the Charitable Foundation, the Center at JSI, and New Futures. This report is intended to describe the structure and strategies of the action learning collaborative undertaken by the Center to support practice sites in adopting and implementing S-BI-RT. Finally, the Center will share accomplishments, lessons learned, and recommendations for S-BI-RT implementation in primary care settings that we hope will be useful to the S-BI-RT implementation work of others.

Context: New Hampshire, the Charitable Foundation, JSI, New Futures, and Implementing Practice Sites

Substance Use in New Hampshire

New Hampshire (NH) is experiencing one of the most significant public health crises in its history. The striking escalation of opioid misuse and overdose deaths over the last five years impacts individuals, families, and communities throughout the state. As shown in Table 1, NH has significantly higher prevalence of substance use than average rates in the Northeast and the United States.[5]

Table 1: Significant Differences in Percent of Youth Substance Use between NH, the Northeast (NE) Region, and the US (2015)[6]

	NH	NE	US
Youth 12-17 years old using marijuana over the past 30 days	9.44**	7.73	7.2
Youth 12-17 years old using marijuana in the past year	16.41**	13.51	12.86
Youth 18-25 years old using marijuana past month	29.12*	22.64	19.70
Youth 18-25 years old using marijuana past year	41.98*	36.45	32.07
Youth 18-25 years old using cocaine past year	10.54*	6.06	4.98
Youth 18-25 years old using alcohol past month	68.92**	64.17	58.96
Youth 18-25 years old past month heroin use	1.9**	0.98	0.69
*Statistically significantly different than both the NE and US rates **Statistically significantly different than the US rates			

Drug overdose deaths in New Hampshire from 2013 to 2015 increased by 129% (193 to 438 people), and increased again by 9% in 2016 (476 people); seven of these were under 19 years old.[7] Alcohol and drug misuse cost the state more than $1.84 billion annually in lost productivity and earnings, and increased expenditures for healthcare, and public safety.[8] The health and economic toll of these trends is alarming. Reducing SUDs and related problems is critical to the physical and mental health, safety, and overall quality of life of New Hampshire residents, as well as the state's economy.

Charitable Foundation

The Charitable Foundation as a statewide funder was able to use its reputation and relationships to encourage participation of providers in the Initiative. The Charitable Foundation was well positioned to create an application process and to conduct grants management to foster accountability with each of the participating sites, as well as with the Center and New Futures. Additionally, the Charitable Foundation engaged its communications capacity to raise awareness of the Initiative and its accomplishments, including producing a video featuring NH S-BI-RT practitioners.

Center for Excellence at JSI

The Center provided both conceptual and logistical expertise during the planning and implementation stages of the Initiative. In conjunction with the Charitable Foundation, the Center, as the lead training and TA provider for the clinical sites, designed the Initiative's learning collaborative structure and framed the short- and long-term approach to the project. The Center participated in outreach and engagement, conducted an initial needs assessment with each new implementing site to establish the groundwork for site-specific implementation plans, and provided evaluation services to the grantees throughout the course of the Initiative. Acting as a convener, the Center brought implementing practice sites together for shared learning opportunities during the implementation process, and also engaged a broader New Hampshire audience by working with the Charitable Foundation to design and deliver an annual S-BI-RT Summit open to statewide stakeholders.

New Futures

New Futures is a nonpartisan, nonprofit organization that advocates, educates, and collaborates to improve the health and wellness of all New Hampshire residents through policy change. The Charitable Foundation funded New Futures as part of this project to provide advocacy expertise to address identified policy and regulatory barriers to S·BI·RT implementation and sustainability. New Futures provided expertise in the areas of insurance coverage for screening and brief intervention, Medicaid expansion, confidentiality, and parity issues. In collaboration with the University of New Hampshire, New Futures developed the Resource Guide for Addiction and Mental Health Care Consumers.[9]

> *"Our clinic has gone from zero formal screening for substance use to 100% screening of adolescents 12-22 who present for wellness or new patient exams in our pediatric program. "*
>
> -Implementing Practice Site

Implementing Practice Sites

The Charitable Foundation issued an RFP inviting interested 501(c)(3) provider organizations to apply for grants up to $50,000 for the first year. Funding could be utilized to prepare for and implement the S·BI·RT process, including costs associated with making modifications to the EMR, workflow improvements or enhancements, and coverage of staff time devoted to learning, business practice adjustments, and initial implementation. Funding criteria required practice sites to have an EMR in place and a relationship with a BH provider - either on-site internally, or in partnership with an external practice - and to implement the CRAFFT screening tool. At the time the Initiative began, the CRAFFT screening tool was recognized as the most researched, reliable and validated screening tool. Funded practices created an implementation team which included a Medical Champion, a Behavioral Health Specialist, an Information Systems Expert, and a member with authority to make decisions, such as a Medical Director or Administrator. Practice sites could apply for additional funding of up to $25,000 for the second year to continue active implementation work. Three cohorts of practice sites were funded over the three and a half year period (2014-2017) of this project. Ten organizations participated in the Initiative, serving collectively over 74,000 patients ages 12-22. The sites represented a range of rural and urban service delivery settings, including FQHCs and other CHCs, a large academic healthcare system, a mid-sized healthcare system, and two critical access hospitals. Several of the practices were patient-centered medical homes.

Funded clinical practice sites were also required to participate as part of an action learning collaborative, and to submit quarterly data and annual progress reports. Table 2 provides details about screening tools, numbers of adolescents and young adult patients 12-22 served, and EMR utilized across sites.

Table 2: Screening Format, Tool, EMR Used, Number of Practice Sites, and Number of Target Patients Served

Screening Format	Screening Tool	EMR	# of Practice Sites	Estimated # of Patients (12-22 years old)
Electronic	CRAFFT	EPIC	4	58,750
Electronic	AUDIT-C & NIDA Quick Screen into AUDIT-DAST	EPIC	1	*
Electronic	S2BI intro CRAFFT (ages 12-17) NIDA and AUDIT/ DAST (ages 18-22)	eClinicalWorks	4	1,367
Electronic	S2BI intro CRAFFT (ages 12-17) NIDA and AUDIT/ DAST (ages 18-22)	Centricity	8	4,611
Electronic	S2BI intro CRAFFT	eMDs	1	801
Electronic	S2BI intro CRAFFT (ages 12-17) NIDA and AUDIT/ DAST (ages 18-22)	eMDs	2	903
Paper	CRAFFT	eClinicalWorks	1	1,522
Paper	S2BI intro CRAFFT (ages 12-17) NIDA and AUDIT/ DAST (ages 18-22)	Centricity	1	5,730
Verbal to Electronic	CRAFFT 2.0	NextGen	1	654

**Target population includes both patients within this age group as well as outside it, so was not included.

Facilitation: Structure and Strategies

Project Structure

The project was structured as an action learning collaborative with the following objectives: 1) engage teams in shared learning about service integration, screening for youth substance use, EMR adaptation, and supporting a culture of improvement; 2) engage practice sites in team efforts for sustainable process improvements; 3) foster a systems approach to improve a standard of best practice in youth screening; and 4) provide opportunities for shared learning within teams and across practice sites. This structure was designed to promote shared learning and implementation experiences, intentionally blending practice sites at different stages of implementation.

The project team utilized in-person learning sessions, virtual meetings, individual site visits, trainings, and phone/email consultation to meet the needs of the implementing practice sites. In addition to annual Summits, the grant required that each practice site's implementation team participate in two day-long in-person sessions. In the spirit of QI, the structure of the project evolved over time as the project team discovered which format and activities were practical and valuable for the practice sites. Details regarding this learning are outlined in the following sections.

In addition to active participation in the Initiative activities, each grantee provided a quarterly report to document implementation progress. These data were used throughout the project to inform the development of TA at the individual practice level and more broadly through Initiative-wide trainings.

> *"The monthly meetings provided some insight on common issues and opened up discussions for resolution."*
>
> -Implementing Practice Site

Technical Assistance and Training

The initial TA and training plan developed within the action learning collaborative construct included monthly cohort calls, individual on-site consultation, phone and email consultation, informational webinars, tailored on-site trainings, and in-person learning collaborative meetings. Action learning collaborative in person events initially were held twice a year. Formal and informal feedback was encouraged and incorporated into our own processes to ensure that needs and expectations of participants were consistently met. As the Initiative progressed, participants and Center staff alike felt that such frequent in-person meetings were no longer necessary in conjunction with the monthly cohort calls.

Technical Assistance

The TA plan was informed by an initial readiness assessment[10] completed through in-person meetings with each implementing team. Center staff gathered information that captured organizational context, including whether an initial implementation plan for screening existed, availability of services to accommodate referrals, confidentiality protocols, EMR in place, current QI practices, and organizational communication practices.

> *"We initially encountered much resistance internally. We would like to sincerely thank the guidance provided by the staff at the NH Center for Excellence through the two-year grant period. Additionally, without the support of the 'collaborative', implementation of S·BI·RT in our health center would have been challenging."*
>
> -Implementing Practice Site

The first year was the most structured. Each practice site team was required to attend monthly virtual meetings with the other practice teams. The content of these meetings was determined by the learning needs of the group, and often included webinars or content expert guests. Webinars were recorded and are available on www.SBIRTnh.org, and as further outlined below, along with other S-BI-RT tools and training materials created as part of the Initiative.

Going live took longer for Cohort 1 than anticipated, and we all learned as we progressed. However, once they launched, three of the five Cohort 1 sites quickly reached the point of successful implementation. As Cohorts 2 and 3 joined the Initiative, they had the benefit of the learning from Cohort 1. Several practices in Cohort 2 and 3 had also already implemented S-BI-RT for adults, or were screening youth for other issues (e.g., depression, tobacco, suicidality, anxiety, etc.), and had some infrastructure in place that facilitated youth S-BI-RT implementation.

The tailored TA approach evolved to address emerging needs of each site through virtual meetings, site visits, trainings, and phone/email consultation. Frequency and focus of TA site visits varied by practice. Center staff attended some virtual and some on-site team meeting visits, and provided site-specific TA via email or phone consultation.

> ***"Since we began this venture over a year ago we have already addressed many of the issues that confronted us while we were in the development stage. We are now in a position where systems and processes have been established and are working well."***
>
> **-Implementing Practice Site**

The Center conducted an extensive Mid-course Assessment in December 2015, and a 2016 End of Year Assessment in January 2017 using electronic surveys, which provided data highlighting the implementation status and unique TA needs of each site. The Mid-course Assessment asked practices funded through the initial and second round of funding to indicate their status of implementation ("haven't started it", "working on it", "almost complete", and "complete") related to components of S-BI-RT (e.g., established confidentiality policy, able to document screening, BI and referral to treatment in the EMR, work-flow in place, data shared with staff for quality assurance/QI purposes, etc.). Through this assessment we learned that most of the sites had screening protocols in place that protected confidentiality. Most sites also were able to document the numbers of patients seen, screened, and at risk. Challenges in capturing the number of patients receiving BIs, referrals, or follow-up services were identified, although most sites reported making progress in these areas. The areas that scored as "haven't started" or "working on it" included using data for QI purposes and billing for services. As a result, individual TA was targeted to the specific needs of sites. Training targeted development of QI skills, and virtual meetings focused on sharing across teams related to QI efforts.

A 2016 End of Year Assessment, conducted by the Center in January 2017, used the same methods to collect data from practice sites. An electronic survey asked specific questions about implementation status, barriers, and patient/provider perspectives on the value of S-BI-RT. Findings about specific implementation components are described in the following sections. The greatest overall finding was that referral to treatment and follow-up were areas where a clear understanding of the practices or protocols utilized by sites was lacking. As a result, the Center conducted structured interviews with implementing sites. Over the next two virtual meetings, we featured a panel of community support services that accept referrals for patients with positive screens, and a presentation that outlined interview findings, including strategies for facilitating "follow up".

It was a continual challenge to get sites to allow the Center to attend their standing S-BI-RT team meetings. It may be that they did not want to expose issues that they faced, or possibly that they were not meeting regularly. Some sites did not understand the Center's keen interest, and may have thought that our efforts were intrusive. However, when issues were brought to light through the assessments or reports to the Charitable Foundation, it facilitated access to the implementation teams. For these teams, we set up individual monthly meetings. Most sites seemed to appreciate the opportunity, which made a difference in their implementation timelines, supporting the value of tailored, site specific TA. Individual TA sessions generated ideas for webinars, summit topics, and website development. Throughout, the Center facilitated connections between and among sites, specifically with regard to selection of screening tools and EMR modifications.

Training

S-BI-RT trainings through Q4 2015 were provided by Boston Children's Hospital Adolescent Substance Abuse Program (ASAP). The length, scope of content, and timing of these on-site trainings were customized through collaborative content development between ASAP trainers and grantees. This allowed for adaptation based on each practice's level of expertise and access to other resources. For example, providers at some organizations had already received motivational interviewing (MI) training prior to this Initiative; thus, the focus of training for these grantees was less on developing MI skills, and more tailored to emphasizing developmental issues related to the 12-22 year old population that should be taken into account.

We learned that training is not a one-time need, but rather an ongoing need. In addition, just as there are multiple layers to S-BI-RT, there are multiple layers to S-BI-RT training. Initially, the Center provided S-BI-RT and BI training prior to implementation, but found that many sites spent a few months establishing their screening protocols and work-flows before going live. By that time, any BI training that had been done was stale. In addition, at the outset some providers overestimated their comfort level with BI, and it wasn't until S-BI-RT was implemented and they were doing BI that they asked for and truly engaged in training.

As sites implemented, some realized a need for booster trainings and/or more in-depth training. We found that while some sites initially only asked for trainings for providers, they followed up over time to include other staff, particularly medical assistants (MAs). The Center developed a suite of training options that include quick (45-60 minute) "Lunch and Learn" – type training activities that introduce BI principles, skills, or tools, depending upon the identified need of the site, as well as more in-depth three-hour trainings that include opportunities for practicing skills. (Please see Appendix A: Learning Opportunities Card.) The need to build in opportunities for practice is an important element that has been consistently reinforced by practice sites.

Based on our experiences, we recommend the following approach:

1. An initial introductory training should focus on what the S-BI-RT process is, why it is important, and what the implementation will involve.
2. The initial BI training for providers should be conducted just as the screening goes live.
3. Booster training for BI and MI should occur again 2-3 months after the initial training, and/or as requested.

The Center provided documentation for contact hours at training sessions, and also offered continuing nursing education units. In some cases, we were able to provide continuing medical education (CME) units. Some practice sites recorded trainings so that they have training resources available for newly hired staff. Through the SBIRTnh.org website, the Center provides recommendations for a set of open-source training videos and other materials, including recorded webinars, and practice sites have utilized these materials as they orient newly hired staff to their S-BI-RT activities.

Not surprisingly, providers in practices that were already screening (whether screening adults for substance use, or screening youth for depression, anxiety, etc.) had more targeted questions during training sessions than did those without previous exposure to screening and follow-up for BH concerns. We learned that providers valued the opportunity to practice their BI skills, and designed training sessions to include time to practice skills. We also learned that providers benefit from periodic booster trainings, particularly after implementation when the process is less abstract, and they have context to bring to the training.

One of the challenges encountered in provider trainings was the variability of knowledge and expertise among attendees. For example, at one practice site, providers new to BI were anxious to practice new skills, while providers experienced in BI and applying MI skills and techniques were more interested in philosophical discussion about

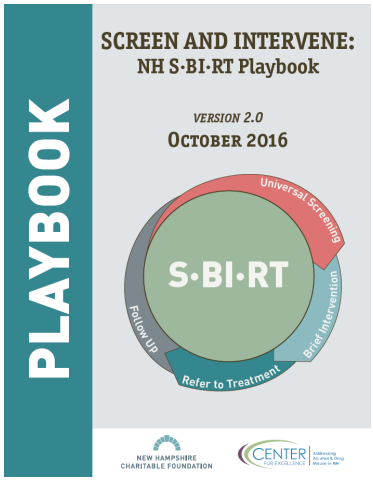
the benefits and drawbacks of these approaches and the providers' roles, especially in terms of the directive nature of BI. This required finesse and skill on the part of the trainer in re-directing the discussion to ensure skill-building for the providers who needed it.

Questions and comments raised by providers during BI trainings highlighted some interesting perspectives. One physician stated that he "wouldn't worry about a college student who was using, but would be concerned about the mental health and potential social isolation of a college student who was not using..." demonstrating a lack of SUD knowledge. Another issue, especially for providers who had been trained in MI, was a perceived mismatch between the BI training, which includes directive recommendations from the provider, and the open, non-judgmental "spirit of MI", indicating a lack of sophisticated understanding as to the nature of motivational interventions designed to move a patient toward healthier choices when they are not yet ready to move. Providers consistently requested more time to practice using MI tools and skills.

Open-Source Resources

Website

As part of this initiative, the Center built out the website www.sbirtnh.org. It contains resources to support S·BI·RT implementation, such as a series of webinars highlighting components of S·BI·RT including: Screening, BI, Referral to Treatment, Confidentiality, and Coding and Billing for S·BI·RT. Resources also include videos providing examples of BIs and warm hand-offs. Materials developed to support provider and staff capacity building, including guidelines to conducting BI conversations and strategies for cutting down, tip cards with readiness to change rulers, and educational materials illustrating pictures of standard sized alcoholic drinks that can facilitate conversations with patients, are posted as well. Although the Initiative focused on reducing youth substance use, providers were interested in information to support engaging parents in the discussion of adolescent substance use, especially around marijuana, so materials from the AAP, Teen Safe, and Drug Free NH (http://SBIRTnh.org/resources/#parentresource) were added.



Playbook

The Center created a Screen and Intervene: NH Youth S·BI·RT Initiative 2015 Playbook (Playbook), which was then updated in October 2016, and again in July 2017 to the *"Screen and Intervene: NH S·BI·RT Playbook Version 2.0."* 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 an organization's or practice site's unique context and culture. While the original Playbook was developed as a compendium of actions and/or strategies that facilitate S·BI·RT implementation, the most updated version was enhanced to address a broader range of S·BI·RT practices, not necessarily specific to youth, by including lessons learned from grantees over the course of the initiative and including the most current billing, reimbursement, and confidentiality information. An interactive digital version of the Playbook is available at http://SBIRTnh.org/playbook/; users also have the ability to request printed copies of the Playbook through this web page.

Annual NH S·BI·RT Summits

The Initiative included four Annual Summits. Although the focus for each Summit was youth S·BI·RT, objectives were broadened and adapted based on an evolving environmental context. The goals for Summit 2014 were to disseminate information and raise awareness of S·BI·RT among providers as an effective strategy for prevention and early intervention of substance misuse behaviors and disorders, and to activate Summit participants to implement youth S·BI·RT as a standard of practice. A year later, goals for Summit 2015 aimed to maintain the momentum of S·BI·RT activities occurring throughout the state, foster and support ongoing stakeholder engagement, and create new interest and engagement in S·BI·RT, with a focus on youth. In 2016, during an escalating opioid crisis and as the state began to launch a Medicaid 1115 waiver to strengthen primary care and BH integration, the focus was on showcasing S·BI·RT as a proven approach to successful integration of primary care and BH for adolescents and across the lifespan, sharing lessons learned and best practices related to clinical and business practice issues, and raising

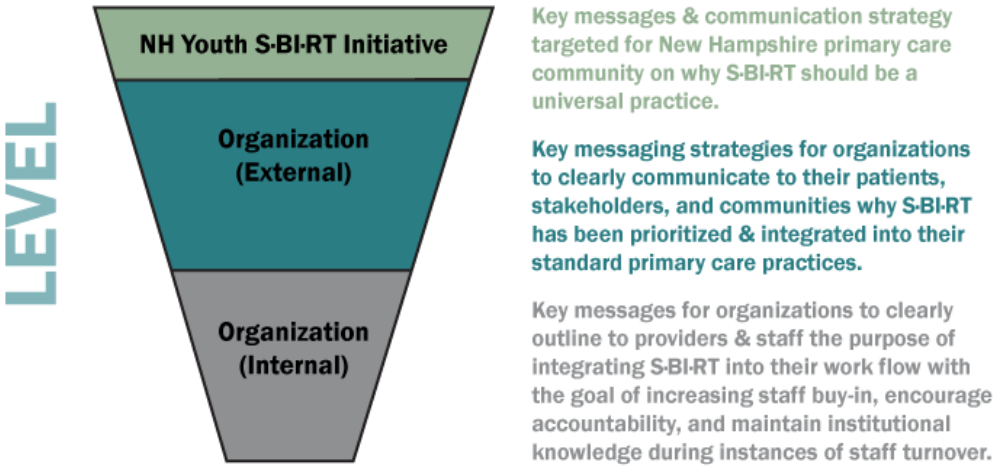
awareness of the urgency for substance misuse screening and intervention in primary care for people with other chronic conditions. Summit 2017 focused on sustainability of S·BI·RT, sharing workforce development opportunities related to policy, education, and practice transformation, with an emphasis on the use of data to improve service delivery throughout the S·BI·RT processes. Over the course of the Initiative, the Summits hosted 305 unduplicated attendees. On average, 91% of attendees indicated that knowledge gained at the summits would influence their future practices.

Communication

Communication is key for successful implementation; therefore, we developed a schema to represent three distinct, but interconnected, levels of communication relative to the NH Youth S·BI·RT Initiative. Figure 1 below outlines this strategy.

- At the highest level, communication was specific to the Initiative, including key messages targeting the primary care community regarding why youth S·BI·RT should be a universal practice.
- The middle section refers to organizational level communications which include key messaging from practices to their external stakeholders by implementing organizations to their external stakeholders (patients, families, communities, etc.) about why S·BI·RT implementation was prioritized as standard practice.
- The bottom level refers to communication within implementing organizations to providers and staff regarding the purpose of integrating S·BI·RT into their work-flow as a standard of care, promoting staff ownership of the process, fostering accountability, and developing and maintaining institutional knowledge despite staff turnover and other changes.

Figure 1: S·BI·RT Communication Strategy



NH Youth S·BI·RT Initiative Communication Strategies

The initiative aimed to communicate to a broad audience the value of youth S·BI·RT, and how it fits into larger efforts across the state addressing SUD and behavioral health integration. Our message was that S·BI·RT implementation creates a powerful bridge between medical and public health systems. Work in this area included the policy work led by New Futures related to parity, Medicaid expansion, and confidentiality; as well as partnering with the NH Bureau of Drug and Alcohol Services to take further advantage of youth S·BI·RT momentum to further engage FQHCs and rural health clinics in more uniform adult S·BI·RT, including for pregnant women.

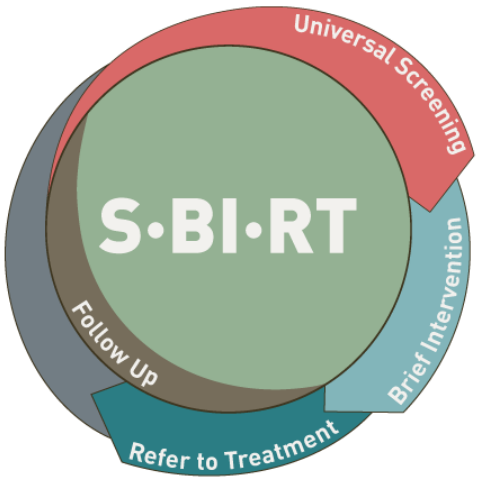
> ***"Community collaborations are beginning, as a result of the S·BI·RT implementation experience, and as part of the regional public health Community Health Improvement Plan (CHIP)... Community stakeholders recognize the importance of S·BI·RT in the development of a comprehensive community plan for addressing substance use and misuse, prevention, intervention, and treatment."***
>
> **-Implementing Practice Site**

During the course of the Initiative, New Hampshire implemented a Transformation Delivery System Reform Incentive Program (DSRIP) using a Medicaid 1115 waiver. DSRIP aims to transform BH and health care systems into an integrated system of care which will provide more efficient and accessible services including newly-eligible adults under the New Hampshire Health Protection Program (Medicaid Expansion). This transformation includes implementing S·BI·RT for all patients twelve years and older, and provides a rich opportunity for practices engaged in the NH Youth S·BI·RT Initiative to share their experiences and expertise.[11]

Promoting language that fosters shared understanding about S·BI·RT and the Initiative proved to be foundational. We learned early in the project that using the word "adolescent" when discussing the Initiative was confusing to practices and other stakeholders; since the Initiative targeted 12-22 year olds, "adolescents and young adults" or "youth" seemed more accurate. This is reflected even in the title upon which we settled: Screen and Intervene: NH Youth S·BI·RT Initiative. Notably, this language shift also changed the Bureau's initial perspective from the view that this Initiative was for "teens" and thus not in their purview, to an attitude of inclusion and partnership, since 18-22 year olds are a key demographic for their prevention work.

Over the course of the Initiative, we encountered broad references to "the S·BI·RT screen" or organizations that claim to "do SBIRT screening." The Center makes a conscious effort in communication strategies and information dissemination to instill an understanding that the continuum of Screening, BI, and Referral to Treatment is not a discrete activity, as the acronym "S·BI·RT" seems to suggest. Instead, it is a process that, when done correctly, should result in a closed loop of primary care within a patient's provider network. One way we tried to change the language used to describe S·BI·RT is by separating the well-known components of the acronym with a dot. The dot is meant to subtly highlight that the term "S·BI·RT" is not a single activity, but is the combination of the discrete components of a process, while still maintaining the familiar acronym.

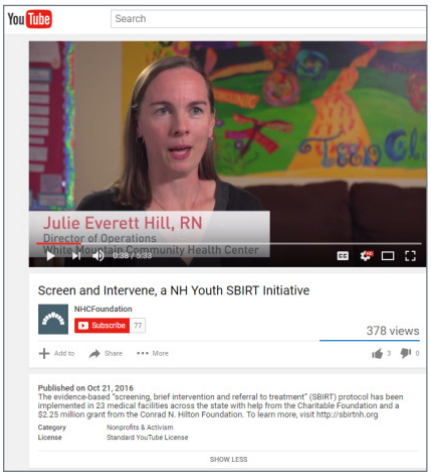
Figure 2: NH Youth S·BI·RT Initiative Process Model



The Initiative also modified our original S·BI·RT Process Model by incorporating an arrow that represents follow up. Follow up, though not explicitly included in the S·BI·RT acronym, functions as a critical step to ensure the closed-loop process has no end point. Instead, S·BI·RT should be a dynamic, ever-flowing process that ensures both providers and patients maintain important momentum from previous conversations that foster open communication between patients and their provider.

In the fall of 2016, the Charitable Foundation initiated a video production process to highlight the work of the Youth S·BI·RT Initiative. *"Can We Talk?"* five minute video was developed to share insights from three implementing practitioners and context from Charitable Foundation leadership and Dr. Sharon Levy of Boston

Children's Hospital. The overarching goals of the video were to explain to audiences how S·BI·RT is working in New Hampshire, how it helps young people and their doctors have conversations about substance use, and how S·BI·RT is keeping New Hampshire youth healthy. Feedback indicated that viewers found it very powerful.



The Center found that cultivating interest, enthusiasm, and ownership regarding S·BI·RT implementation was enhanced when providers delivered the message to their provider colleagues. For example, Dr. Sharon Levy, from Boston Children's Hospital was an effective and persuasive ambassador through grand rounds events. We optimized this effect by featuring respected New Hampshire practitioners in the *"Can We Talk?"* video, and have taken opportunities to share this video as part of an introduction to S·BI·RT at medical staff meetings, which has been well-received. Provider presentations at the Summits seemed to be an attraction to other providers.

Organizational Level Communication Strategies: External

Communication efforts by implementing organizations to educate patients, stakeholders, and communities about why S·BI·RT has been prioritized and integrated as a standard practice included developing and disseminating patient education documents. Some organizations developed their own materials for parents and families. Two separate organizations reported an increased awareness within their communities, when young patients share with their peers that they can expect to be asked about substance use when they see their provider. This kind of peer-to-peer communication helps to normalize these discussions.

As the network of available resources increased across New Hampshire, some practice sites reached out to newly established organizations to develop referral relationships. In fact, nearly 70% of practice sites have established new partnerships with organizations in their communities as a result of their youth S·BI·RT implementation work.[12] Several practice sites are represented on regional advisory groups, and their expertise is informing the behavioral health transformation work supported by the Medicaid 1115 waiver.

Organizational Level Communication Strategies: Internal

Internally, organizations need to ensure that staff have enough information to understand not only that S·BI·RT has been implemented, but also how their work fits into the process. The opioid epidemic has raised awareness among providers about the role they can play in prevention and early intervention. In one community with high prevalence of substance misuse, a teen suffered a fatal overdose of heroin, prompting the community health center to modify its screening policy from screening annually to screening at every opportunity. Other strategies included practices prioritizing S·BI·RT implementation and spread in their strategic plan, and including a diverse group of their staff in high level S·BI·RT trainings.

One practice site engaged all staff, including the facilities management crew, in MI training as "part of a push to assist everyone in understanding the language of MI, which is a huge part of the success of S·BI·RT implementation." Sharing aggregate data with staff to demonstrate their success or need for improvement, and sharing practitioner-level data with individual practitioners also communicates the importance of this work to the organization and the patients. Implementing teams have presented at staff meetings, and several have incorporated S·BI·RT into grand rounds. Continually training and re-training is recognized as critical to keeping staff aware, engaged and competent. Some organizations have adopted screening and/or BI rates into provider performance measures.

> ***"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 misuse, then our staff needs to have this same viewpoint."***
>
> **-Implementing Practice Site**

Project Outcomes Data

This section begins with a presentation of aggregate level project outcomes data and related findings regarding screening, brief intervention, referral to treatment, and follow up. This is followed by a discussion of lessons learned and recommendations for consideration with regard to S·BI·RT implementation.

Project Aggregate Data

The goal was to screen 10,000 youth by the completion of the project in June 2017. This number was reached by the end of the 2016 calendar year. In fact, by June 2017 practice sites had screened 15,126 youth, 150+% of the target goal. Table 3 lists the measures and their definitions, and the aggregate data for each of 11 quarters of data collection.

Table 3: Measures, Definitions and Aggregate Data

Measure	Definition	Aggregate
Number of Youth Visits	Total number of youth aged 12-22 seen in the office/clinic for wellness checkup or similar annual exam or visit	19,521
Number Youth Screened	Total Number of Youth Visits who completed a screening tool during wellness checkup or similar annual exam or visit	15,126
Number Youth at Risk	Total Number of Youth Screened who were identified as being "at risk" through the screening process	2,242
Number BI	Total Number of Youth at Risk who received BI/Brief Advice	929
Number Youth at Risk who Need Referrals	Total Number of Youth at Risk who need referral for treatment as indicated by the screening process	687
Number of Referrals	Total Number of Youth at Risk who need referral for treatment and for whom a referral was made	196
Number Follow-ups	Total Number of Youth at Risk who received follow-up care or contact from their primary care provider	146

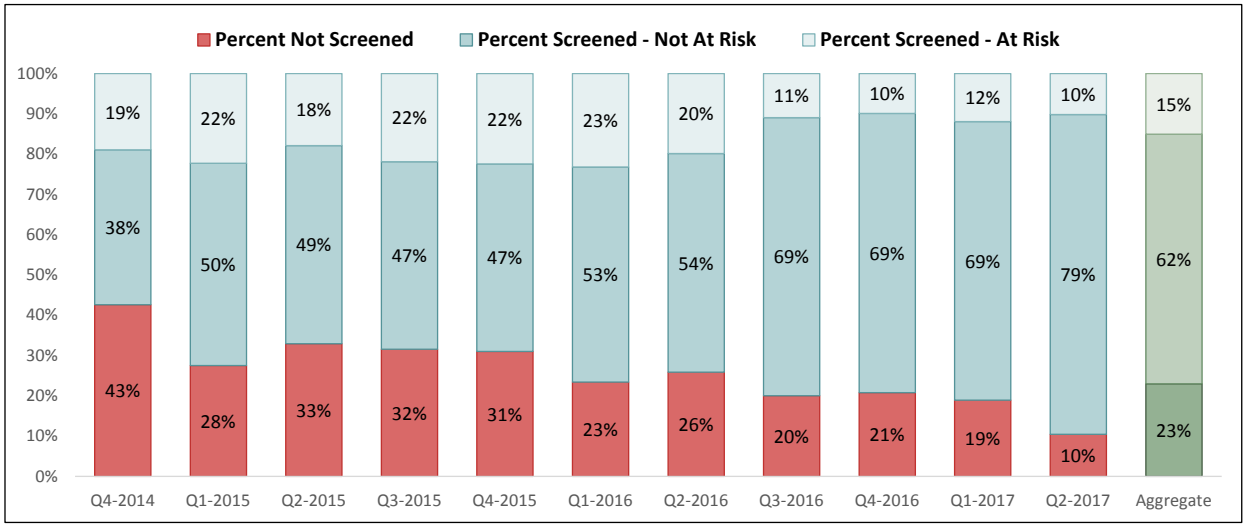
Table 4 indicates the numerators and denominators used to calculate the percent of the measures for each quarter, and the aggregate percent for each.

Table 4: Numerators and Denominators Used to Calculate Metrics and Aggregate Percents

Measure	Formula		Percent in the Aggregate
	Numerator	Denominator	
Percent of Youth Screened	Number of Youth Screened	Number of Youth Visits	77%
Percent Youth at Risk	Number Youth at Risk	Number of Youth Screened	15%
Percent BI	Number BI	Number of Youth Screened	6%
Percent Youth at Risk who Need Referral	Number at Risk who Need Referral	Number of Youth Screened	5%
Percent Referrals Made	Number Referrals Made	Number of Youth Screened	1%

Figure 3 shows the percentage of Youth Not Screened, Screened Not At Risk, and Screened at Risk by quarter. Screening rates improved over time. The results in aggregate for each measure are discussed in the following sections.

Figure 3: Percent of Youth Not Screened, Screened Not at Risk, and Screened at Risk



Discussion of Aggregate Data: Interpretation and Implications

It is critically important to note that the data reported in Figure 3, and in the discussion that follows, are the data that were documented, collected, and then reported by the practice sites to the Center. The documentation of screening, BI, and referrals in the EMR, and then the retrieval of that information for reporting purposes, were significant challenges for several sites throughout this Initiative. At times, some sites submitted corrected data for one quarter with the data for the next quarter. The Center made decisions about correcting data retrospectively on a case by case basis, especially when organizations were first reporting. But not all data could or should have been corrected. Problems with data collection are part of the data story. Detailed examples of challenges related to data collection and reporting are described in the following sections.

Percent Screened

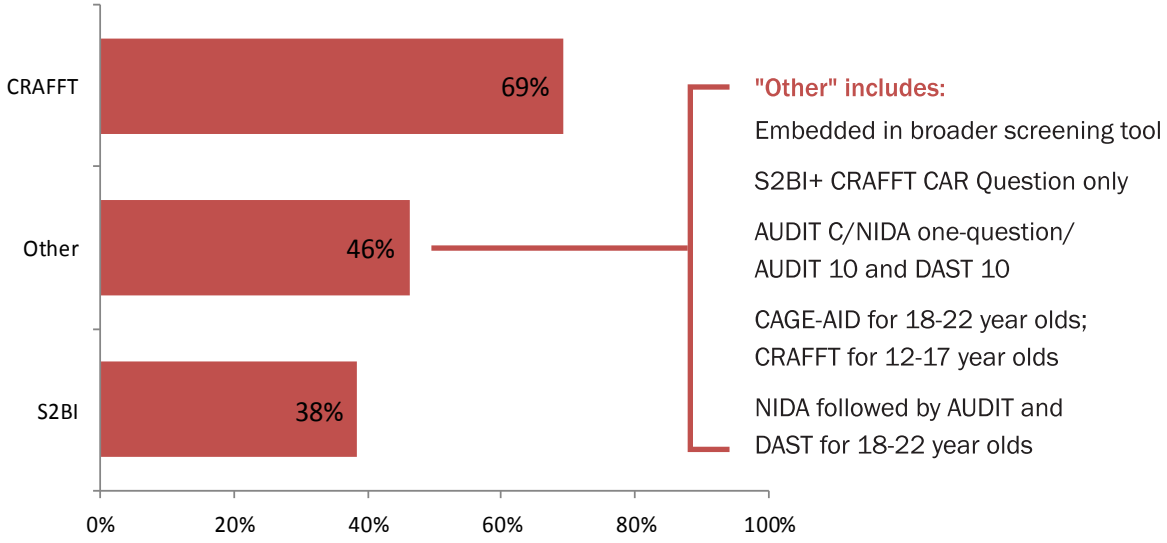
In the aggregate, 77% of *Youth Visits* to a primary care provider (PCP) were screened for risk of alcohol and drug misuse. [The aggregate percent is the total number of *Youth Screened* to date divided by the total number of *Youth Visits* to date, which is 15,126 ÷ 19,521.] It is important to note that these are not unique patients. Because it is recommended that screening occur at least once each year, it is possible that over the course of the project period some youth were screened twice. As of July 2017, aggregate data from all Hilton Initiative grantees (86 clinical sites) indicated that 73% of youth visits (n=31,684) had documented screenings.[13]

Since April of 2015, when the first cohort had had a few months of experience in screening and data collection, the mean percent screened was 74%, with a range from 57% to 90%. [The mean percent is the mean of all of the percentages in each reporting quarter over time, and so will be slightly different from the aggregate percent.] As different sites began reporting data at different times, the aggregate data could be expected to reflect the lack of experience of each new cohort with the screening process. That is, as more experienced sites began to improve their screening rate, new sites with no experience began to report data, which brought down the overall percent for that quarter. Even so, there was considerable variability across sites regarding achieving consistency in the screening process.

Screening modalities across sites ranged from high tech (embedded in an EMR as part of a more comprehensive screen) to very fundamental (use of an eraser-board). More than half (54%) screened electronically, 23% used paper screeners, and 23% reported using a combination of the paper and electronic screens. One site, in the early stages of implementation, used a dry-erase board for screening, but has since transitioned to electronic tablets (e-tablets).

> ***We learned that we got more honest responses to screening questionnaires when youth were able to use a tablet touch-screen for recording self-reported questions responses, rather than by responding to questions asked verbally from a Medical Assistant."***
>
> **-Implementing Practice Site**

Figure 4: Screening Tools Used by Practice Sites (n=13)



As noted in Figure 4, in addition to CRAFFT and S2BI, some practices also used other screening tools, depending upon the patient's age. For example, recognizing that a tool that is appropriate for a 14 year old may not be the best fit developmentally for someone who is 21, one site stratified the tool that was utilized, as well as the clinical decision support based on the patient's age. Most (77%) practices sites also screen adults.[14]

> ***"...Having other screening in place, such as depression screening, was a facilitator in implementing SBIRT."***
>
> **-Implementing Practice Site**

Percent at Risk

In the aggregate, 15% of *Youth Screened* were found to be at risk, with a range from 10%-23% over the course of the reporting period. This constitutes 2,242 of the 15,126 *Youth Screened.* [The data do not distinguish between low risk and high risk, although the data for *Youth at Risk who Need Referral,* discussed below, provide insight, as 687 (31%) of *Youth at Risk* needed a referral.] How these figures compare to national data depends on the survey used, the ages covered by the survey, and the definition of "at risk". Getting accurate comparison estimates of the prevalence of substance use and misuse among youth is difficult. For example, national studies like the Youth Risk Behavior Survey (YRBS) examine only high school students, whereas the NH Youth S·BI·RT Initiative targeted youth 12 through 21. As a result, existing prevalence data likely is underestimated.[15]

Percent BI

The Initiative characterized BI as a short (3-7 minute) motivating conversation in response to screening results that utilizes MI techniques. In the aggregate, 41% of *Youth at Risk* received a BI, as would be best practice, from the provider they saw for their visit, which is 6% of *Youth Screened.* However, BI rates for patients with a positive screen were more challenging to capture in the EMR than screening. While all sites reported incorporating BI best practices that included providing education about the health consequences of substance use, providing feedback on screening results, discussing pros and cons of changing behavior, and helping to identify actions to reduce harm from substance use, they also noted that BI is unique to the patient and the situation, and all BI activities may not be used by each provider for each BI, taking clinical assessment and judgment into account. As of July 2017, aggregate data from all Hilton Initiative grantees indicated that 4% of youth screened (n=1399) received a BI.[16]

For example, the practice site with the largest population in this Initiative did not consistently provide data about the numbers of *Youth at Risk* who received BI because they did not record this activity in patients' EMR. When asked, they said that all youth, whether at risk or not, had a conversation with their providers about substance use as part of routine practice. When this site is removed from the equation, 51% of Youth at Risk across all other sites received a BI. Other sites also reported difficulties with documenting BIs or retrieving the data.

It is apparent that implementing consistency in screening is easier than implementing consistency in providing and documenting BI. While some of this may be attributed to documentation in the EMR, other factors could include differences among providers in their style of interaction with youth and/or their level of comfort with discussing alcohol and drug use with this population.

Percent Youth at Risk who Need Referral

In the aggregate, 31% of the 2,242 *Youth at Risk* were at sufficiently high risk to warrant a referral for further assessment and treatment. This constituted 5% of *Youth Screened,* or 687 of the 15,126 *Youth Screened.* This finding that only a small percentage of patients screened rose to the level of needing a referral was not surprising for a number of reasons. As a prevention strategy, S·BI·RT reaches patients who are more connected to primary care, whose families are engaged in their health care, and who may be making more informed decisions about their health, in general. This finding may reinforce the value of S·BI·RT as a prevention strategy.

"Referral to Treatment" may be a misleading descriptor of this component of S·BI·RT, and one that accounted for some of the initial hesitation among providers to implement universal screening. Several providers expressed concern about using screening tools to identify patients who need treatment. In primary care settings, "referral" usually means "referral for further assessment" by a specialist who then makes a diagnosis and determines the need for treatment. For example, a PCP would refer a patient with a suspected cardiac problem to a cardiologist for further assessment, diagnosis and treatment. It would be important to help PCPs understand that "referral to treatment" as part of S·BI·RT means "referral to a behavioral health specialist for further assessment, diagnosis, and treatment."

Percent Referrals Made

Few referrals were documented, as compared to screening results, which surprised everyone. While only 5% of *Youth Screened* were identified as needing a referral (31% of patients identified as *Youth at Risk),* in the aggregate, only 9% of *Youth at Risk who Need Referral* had referrals made for them. This is 1% of all *Youth Screened,* or 146 of all of the *Youth Screened.* While we expected the number of youth who needed a referral to be low, we were surprised at the low rate of referral among the youth who were identified as needing one. When asked about the relatively low rate of making referrals for *Youth at Risk who Need Referral,* sites provided insight into the complexities of the day-to-day work of clinical practice in family primary care or pediatric care. This referral rate aligns with referral rate for all health care setting Hilton Grantees during the same period (n=235 or 1% of youth screened).[17]

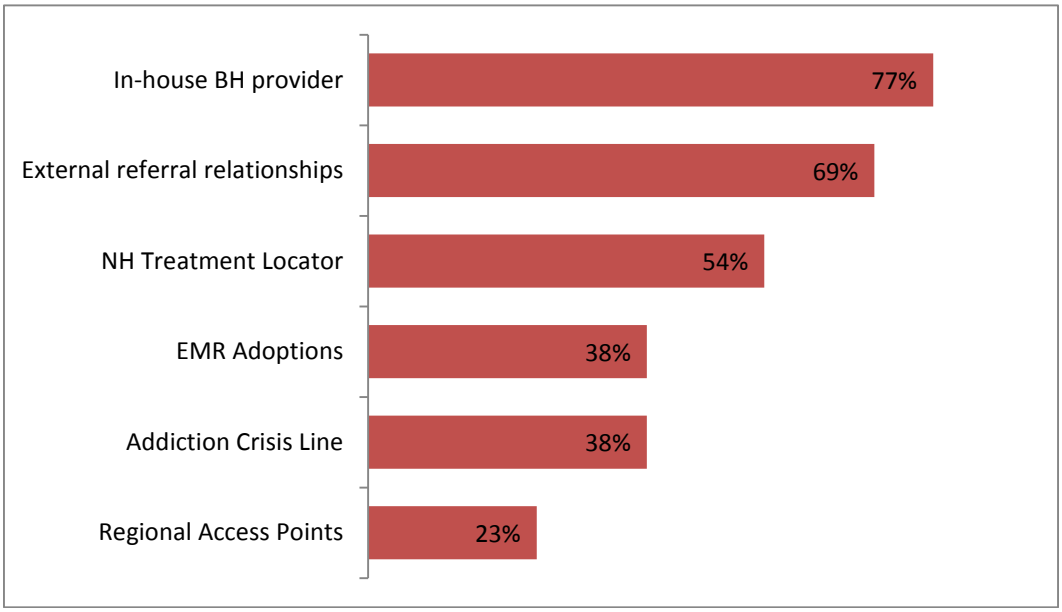
> ***"...Few positive screens resulted in an actual referral, as many of the positive scores that would result in an internal referral involved patients who were already being followed or treated, either at [our practice] or by an external provider, for drug/alcohol use."***
>
> **-Implementing Practice Site**

Some noted that these youth may already have been in treatment, most likely for associated mental health issues such as depression. In other cases, either the young patient or parent/guardian may have refused treatment, or failed to follow-up for various reasons, such as cost, driving distance to BH appointments, considering the problem to be a private family matter, or disagreeing that there was a problem at all. Providers said that multiple visits and conversations are sometimes needed before a patient agrees to a referral for substance use and mental health assessment and treatment. While some providers remained uncomfortable talking with patients about referral and treatment, none raised a lack of substance use and mental health treatment options as a major concern per se. **This is worth noting, especially given that perceived lack of access to treatment was a barrier that hindered some organizations' decisions to participate in this Initiative, and remained a perceived barrier by some who did engage.** Over the course of this Initiative, substance use disorder services increased somewhat throughout the state, though further progress is needed.

Most implementing sites (77%) referred patients needing further assessment to in-house BH providers.[18] Smaller agencies without on-site BH services made referrals to outside resources, such as a local mental health center with which the organization had a relationship. However, appointments were not always readily available, and some BH providers may lack experience with youth substance misuse. Although the State of New Hampshire has prioritized developing resources to support treatment and recovery services, a shortage of local adolescent treatment providers, especially in the more rural areas, continues to concern providers. The Center, as part of its suite of services, runs the NH Alcohol and Drug Treatment Locator, nhtreatment.org, which provides a valuable tool for finding agencies or individuals offering SUD services by location, service type, population served, and payment types accepted. As a standard of practice, we encouraged providers to be sure that they were included in the locator, to ensure that their information was correct, to update as necessary, and to share the information with their colleagues.

As shown in Figure 5, in addition to in-house BH providers supporting referral to treatment, we were thrilled to learn that nearly 70% of practice sites had, as a result of this S-BI-RT Initiative, developed new relationships or partnerships with other organizations, including treatment centers, BH providers, school-based Student Assistance Program counselors, and other PCP offices.[18] Mechanisms supporting referral to treatment include EMR adaptations, and other state-supported resources such as Regional Access Points[19], nhtreatment.org, and the Addiction Crisis Line at 1-844-711-HELP (4357).[20]

Figure 5: Activities or Mechanisms That Support Referral to Treatment (or Further Assessment) (n=13)



Follow-up

Following up on screening results, BI conversations, or referrals for further assessment and treatment is crucial to ongoing, whole health management with each young patient, and is essential to a meaningful healthcare relationship between provider and patient. This component of the process presented the greatest challenge to participating practices. Of the 2,242 *Youth at Risk,* only 146 received documented follow-up care or contact from their PCP, which is 7% of *Youth at Risk.*

The initiative defined "follow-up" broadly to include any action on the part of the PCP and/or office staff to proactively check in with a patient who has been identified as *Youth at Risk*. In the case of referral, it may mean checking in with the patient, or communicating with the individual provider or organization to which the patient was referred for further assessment and treatment. It may mean a phone call (e.g., "Were you able to make the appointment with XXX?"), or some more action (e.g., scheduling a follow-up appointment). Follow-up may be done by the provider, a care coordinator, educator, or other staff, depending upon the staffing and work-flow of a specific practice site.

To better understand the challenges with follow-up care, Center staff interviewed providers and/or staff at all of the sites regarding how they manage follow-up care for any patient considered to be at risk for a health condition or for patients who received referrals for specialty care, as well as for youth with substance use or mental health problems.

To summarize, considerable variability existed in how follow-up was provided for any patient referred to a specialist. All sites acknowledged that it was difficult to report the exact numbers for follow-up because there was no easy way to integrate this information into the EMR, in part because it was not always clear what constituted a follow-up. It could be a phone call, which is not reimbursed, or an appointment, in which case the billing code for the appointment might not reflect that it was follow-up care. It was often easier for FQHCs and other CHCs to provide follow-up care than the larger private organizations because FQHCs and CHCs either had BH services integrated into their clinic on-site or had standing relationships with local mental health centers to which they routinely referred patients. Community health centers and FQHCs also had staff assigned to follow-up with patients who had been referred to BH.

Stabilization of Screening Processes

The Center monitored the progress of implementation across a continuum which included activating the protocol, increasing capacity through training and testing, and active engagement in QI processes (Table 4).

Table 4: Implementation Stages

Implementation Stage	Description
Stage 1: Activating the Protocol	Activities: plan work-flow for S·BI·RT protocol, modify EMR for the adoption of the screening tools, develop policy to ensure confidentiality, establish baseline data, and develop a plan for training providers and staff.
Stage 2: Increasing Capacity Through Training and Testing	Activities: train staff in BI techniques, conduct pilot launch of S·BI·RT protocol, and review pilot prior to the full system launch.
Stage 3: Completed Implementation and Engaged in Active QI	Activities: fully implement S·BI·RT protocols into service delivery, conduct comprehensive and booster BI trainings, and engage in ongoing QI activities by reviewing data and identifying potential gaps in the current system.

One question we asked at the conclusion of our Initiative was how consistent sites have been in screening youth visits? That is, have they mastered the work-flow and EMR challenges sufficiently to achieve an optimal level of screening performance? To investigate this, we entered monthly data reports for each site into control percentage charts (P-charts) for analysis.[21] Few practices had stabilized their screening process at an optimal level of performance as of the formal conclusion of our project which marked the end of data collection. This can be attributed to the difficulty of systems change in complex organizations, and not the lack of commitment on the part of grantees in making these changes.

Lessons Learned and Recommendations

We noted findings in three broad categories: the strategies associated with operationalizing S·BI·RT; the role of the EMR; and policy issues including confidentiality considerations related to patient care as well as organizational compliance with federal and state regulations. Each of these is discussed in detail below.

Implementation Strategies

Through the varied experiences of practice sites we learned about key factors to successfully operationalize S·BI·RT in the primary practice setting.

Lessons Learned

Implementation is a complex endeavor that requires much more than just training staff and providers how to screen and conduct BI. Having a champion in place is crucial, as is engagement of a range of stakeholders, including leadership, at all points in the process. Continuity of leadership and staffing is also important. Institutionalizing all components of S·BI·RT into standard work-flow in a way that minimizes opportunities for errors and promotes consistency is essential. Finally, ensuring that the care provided is culturally and linguistically appropriate is critical, although this area is still lacking in evidence-based tools or practices beyond simple translation of screening tools.

Clinical Champion

Practice sites with engaged medical providers or clinical leaders as champions provided a perspective that balanced health benefits of implementing S·BI·RT with the administrative challenges that are inevitable as part of effective change management. Unsurprisingly, engagement at the outset of all staff who will be involved in the process strengthens the likelihood of success. It fosters ownership of the process and the outcome, and allows for more staff participation in decision-making, including allowing staff to identify their concerns and participate in developing strategies to address these concerns.

The critical importance of having a provider champion was evident at each implementing practice site. At one of the larger organizations there were two champions: one with an IT background and a data-driven approach to systems change, and another who supported S·BI·RT in practice, but felt it was already being done and didn't see the need for a system level initiative. After implementing standardized screening, this provider was surprised to find that adolescents whom he had known since birth but not previously identified as using substances were now talking with him about alcohol and drug use. The pre-visit screening identified issues that freed up time during the patient visit, and enabled time during the visit to have a real conversation about the issues identified through screening. This provider came to embrace the value of S·BI·RT processes and the impact they can have when done correctly. The partnering of a data driven technology-oriented practitioner with a provider who was excited about the potential impact of these processes created an extraordinary team to lead a large systems-wide initiative and communicate the significance of S·BI·RT statewide. Both of these champions have served as S·BI·RT ambassadors even beyond New Hampshire, presenting their team's work to national audiences, such as the American Academy of Pediatrics and the Substance Abuse and Mental Health Services Administration. A large system has resources that can promote and support leadership, especially in an academic setting.

Recommendations for Operationalizing S•BI•RT Implementation

Identify a Champion

Ensure that a champion with a clinical background or role, passion for prevention, and appreciation for the value of data in facilitating systems change is in place.

In the case of a smaller practice within a mid-sized health system, the incorporation of a new champion really turned S·BI·RT processes on its end, for the better. This site began implementation at the beginning of the Initiative, but never quite found its footing until the third year; the loss of the initial champion delayed the launch of the project. This site experienced a lack of continuity in the staff on the S·BI·RT implementation team when the S·BI·RT Champion left her position in early on in the project.

Over a roughly two year period, there were four different project leads. However, the two pediatricians who supported S·BI·RT at the start continued to provide a measure of stability in the process even though no specific person was stewarding the project or focusing on improvements. A new physician champion emerged during the final year of the project, providing a fresh perspective and renewed enthusiasm. Through his leadership, staff received training, screening rates increased in a stable pattern, and a comprehensive EMR template modification, which is embedded and available to all other practices in the health system, enables documentation of all S·BI·RT components, and ensures ease of process stability moving forward. He is a strong advocate for expanding system-wide S·BI·RT implementation beyond the Initiative.

> *"Our Medical Director was surprised by how many of his existing patients answered the paper S·BI·RT screener questions differently than he expected. This started new conversations between him and his patients about substance misuse and mental health concerns. This recognition by our providers of the new information provided by a universal screening tool has changed some long held assumptions and has not only improved our work re: substance misuse and mental health concerns but has also encouraged staff to support universal screening tools more generally."*
>
> -Implementing Practice Site

Two practice sites were led by QI Nurses as their champions, allowing S·BI·RT practices at these organizations to thrive. A QI perspective was invaluable in understanding S·BI·RT as a set of processes that required system-wide engagement and cooperation. This perspective fostered the establishment of a strong implementation team at the onset, and practice-wide engagement of staff in varied roles during process development and throughout the implementation process. These champions also facilitated a comprehensive approach to organization-wide staff training on S·BI·RT processes, implementation and QI. Their leadership is recognized in their communities; they have been invited to share their experiences with S·BI·RT implementation with other community providers.

A champion is essential to successful implementation. In each of the examples above, the champion had a clinical background that offered credibility and respect among other providers, was passionate about the power of prevention, and had an understanding and appreciation for the value of data for driving systems change.

Engagement

When practice sites reflected on factors contributing to successful implementation, engagement was a consistent theme. Engagement at every dimension was critical: engagement of leaders, providers,

Recommendations for Operationalizing S•BI•RT Implementation

Engage Your Team

Take the time needed to establish a team that reflects diverse perspectives, and includes people involved in any aspects of work-flow to lend 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.

practice staff, community partners, patients and parents. In some cases, engagement of medical students was also identified as a factor contributing to successful implementation.

At the beginning of the NH Youth S·BI·RT Initiative, practices expressed concern regarding anticipated resistance from patients, and more specifically from parents, due to the fact that questions about personal substance use would be asked of a younger population. However, patients and parents alike adjusted quickly to screening as a universal practice. Instead it was practice-level engagement that was a larger challenge for sites.

> *"It is important to have an implementation team with someone from every department in the practice. Pilot with one sector of the practice (one provider) to work out kinks before you do it practice wide. Even though it seems like an overwhelming add, most patients won't need a BI and RT, so they'll likely just need brief advice or reinforcement. It seems daunting but it's going to inform their care moving forward and it's got great value."*
>
> -Implementing Practice Site

Unfortunately, the importance of engagement is most sharply noted when barriers to successful implementation arise in its absence. Staff turnover is a reality in the clinical workplace. The loss of leadership presented a considerable disruption to the implementation process for several sites. At one site, after the leader who was an avid champion of S·BI·RT left, it came to light that other key decision-makers had not been strongly on board with implementing youth S·BI·RT. Because S·BI·RT was not an organizational priority, re-staffing the lead role was also not prioritized. In turn, several staff cycled through assigned responsibility as lead for the Initiative, but none had clinical backgrounds, relevant professional experience, or sufficient seniority or credibility with their colleagues to drive practice change.

The loss of staff and providers also disrupts the implementation process by changing team dynamics, and impacting the quality of screening and BI practices when new staff comes on board that have not been trained and may not yet embrace S·BI·RT protocols. For sites that served as clinical training sites, the rotation of residents presented a challenge due to the need for ongoing education, although also an opportunity for embedding S·BI·RT into the training of an emerging cohort of new providers.

At times, engagement can be lacking in an organization even in the absence of staffing disruptions. A practice transformation initiative requires engagement from all levels at the onset, which some sites lacked. It was interesting to note that lack of initial engagement generally did not rectify itself throughout the course of the process; years later, that initial gap affected organizational success. While leadership is necessary, it may not be sufficient; when a "top down" decision is made without getting other staff buy-in, this, too, can set up practices for larger challenges in seeking to achieve systems change.

> *"Staff buy-in and effective workflow are important infrastructures for the S·BI·RT process; include all staff from the front desk, call center, behavioral health providers, case management, medical providers, medical assistants and managers."*
>
> -Implementing Practice Site

Several sites underscored the importance of having a core implementation team in place right from the start, one that included PCPs and MAs. Several practice sites identified gaining physician buy-in as the greatest challenge in implementing S·BI·RT, specific to their time constraints for participating in training.

Clinical Work-flow for Screening, BI, and Referral to Treatment

Each component of the S·BI·RT process provided lessons that emerged from our close collaborations with clinical site grantees.

> *"Consistent screening over time as an expected part of the patient visit has decreased the stigma of the questions being asked, and initial negative responses to screening questions sometimes eventually give way to more accurate responses by youth."*
>
> -Implementing Practice Site

Screening

- Although the initial RFP required that funded practices implement the CRAFFT, a widely used reliable and validated screening tool, the emergent research on the S2BI presented another option. The S2BI is a shorter validated and reliable tool.[22] Several practices adopted a process using the S2BI for initial screening, and utilizing the CRAFFT as a framework for further conversation and an initial focus for BI.
- Practices using other screens with their adolescent patients, such as for tobacco, depression, anxiety, suicidality, and intimate partner violence more readily embraced S·BI·RT, and found it easier to implement, as they already had work- flow processes in place. One site starts their screening process by asking the young patient what they are most proud of.
- Some sites thought that they were effectively implementing other screens, but identified through this S·BI·RT implementation process that they were not conducting screening in the most effective way.
- Some providers who were initially hesitant to embrace the S·BI·RT implementation process, because they deemed substance misuse to be highly sensitive, reconsidered when taking into context that alcohol and drug use could and should be addressed along with depression, suicidality, bike safety, etc. Some were also hesitant to document substance use-related issues in the EMR due to misplaced concerns that documented details of illegal drug use in the EMR might follow the young person into adulthood and negatively impact opportunities for future employment, academic, or other goals.

Brief Intervention

- It was easier to implement screening than to take the next step and provide a BI. While many primary care practices are accustomed to screening patients for a number of health risks, providing a BI constituted a behavior change for providers, who have inherent differences in styles of relationships with patients; and it is much more difficult to change behavior than to embed a screening tool in the EMR. Many providers were not yet skilled at having conversations to increase motivation to reduce harm.

Referral to Treatment

- As noted earlier, Referral to Treatment (the RT in S·BI·RT) may be a misleading descriptor of this component of S·BI·RT. In primary care settings, “referral” usually means “referral for further assessment” by a specialist, who then makes a diagnosis and determines the need for treatment.
- If the EMR is not structured to capture referrals, this information is often documented in field text or narrative notes, making it difficult to track and provide follow-up care. Another barrier to good patient follow-up is the lack of mechanisms to note whether the patient is already in treatment, or whether they declined referral.

Follow-up

- We found that the S·BI·RT mnemonic lacked an important component to the process, which is “follow–up”, that is, any contact with a youth at risk that closes the loop with the primary care practice, regardless of whether that patient receives a BI or is referred to specialty services/treatment. Follow- up refers to proactive outreach rather than waiting to receive a formal report. The nature of follow-up depends upon the patient’s needs, the capacity of the patient and his or her family, and provider preferences, and may vary by provider within the same organization. Barriers to follow-up occurred at the three levels: practice level, patient and family, and specialists or partners.

- Practice –related barriers included workforce shortages, increasing patient acuity that requires providers to take more time with patients who are sicker or have more complex needs, the time that it takes to track and reschedule patients who do not show up for appointments, and the lack of standing follow-up protocols.
- Patient and/or family-related barriers included a lack of readiness to accept referral or adherence in following through when a referral was made. Sometimes communication was a barrier; patients may not understand to whom they are being referred, or why, or may not understand their role in following through with a referral. Communication may be a barrier when patients or families move, change phone numbers or have phone service disconnected, and for those patients around the age of 18 because these adolescents are often leaving home for work or college. Additionally, lack of insurance coverage or the cost of treatment services may be a barrier for some families.
- Specialist-related barriers included a shortage of resources for high-intensity therapy. Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Title 42, Code of Federal Regulations; Part 2 (42 CFR Part 2) pose challenges with regard to balancing privacy protection and promoting continuity of care. Some specialists have very small practices without support staff or an EMR, making communication around follow-up difficult. Some specialists may close the loop on an initial referral visit, but fail to continue to communicate with the PCP if the specialist-patient relationship is ongoing. The burden is often on the PCP to close the loop on referrals. Finally, far too often there is still the perception that mental and/or BH are separate and different from the medical system. For example, at one of the grantee practice sites, a staff person told us: "You never know what mental health is up to with patients like you do with cardiology...."

- Practice sites identified four interrelated categories of approaches to encourage follow-up: EMR-related strategies, staffing strategies, having protocols in place, and the existence of strong standing relationships.
  - EMR-related approaches included having a shared EMR, which occurs in an integrated practice where all clinicians can access a patient's record. In some cases, external providers may also share an EMR with a PCP. When all clinicians are documenting in the same EMR, follow-up is more likely to occur and the outcome of the

Recommendations for Operationalizing S•BI•RT Implementation

S·BI·RT Clinical Work-flow

Use the S2BI followed by the CRAFFT.

Screen electronically if flow and resources can accommodate it.

Administer the screening while the patient is waiting to see the provider to allow the most provider time during the appointment to address important issues identified through the screening.

Institutionalize S·BI·RT training, including as part of orientation for new staff, to achieve consistent quality results. Retraining is important, especially to strengthen skills after initial implementation.

Augment face to face training sessions with online tools such as simulated training or videos which may be easier for staff to access on demand.

Where staffing permits, distribute the responsibilities for patient care activities to afford PCPs the time needed to listen, engage, and develop relationships with patients.

Integrate substance use screening into depression screens and other screening protocols.

Utilize tracking mechanisms that enable effective follow up, such as EMRs with the capability of generating automatic provider reminders and/or patient reminders.

Establish relationships with partners who serve as resources for referrals so that they are in place when they are needed.

Counsel providers that "Referral for Treatment" means referral for further assessment, diagnosis, and treatment.

Work with leadership and clinical champions to set performance expectations about screening and documenting S·BI·RT.

referral is more likely to be communicated to the PCP. Additionally, it is more easily identified if the follow-up does not happen. Some tracking mechanisms that enable effective follow-up include EMRs with the capability of generating automated provider reminders that are delivered to the provider after a prescribed period of time; for one site, this was two to three months after the visit. Another mechanism was sending automatically generated patient reminders.

> *There is no doubt that New Hampshire has been hit hard by the opioid crisis. What was surprising was the brutally honest and candid remarks made by the adolescents. They felt comfortable enough speaking with their Clinician and admitting their use. More importantly, they took the Clinician's advice and guidance towards changing their behavior. Having Behavior Health Clinicians in-house for warm hand-offs helped ease their trepidations towards a new healthcare provider to speak with."*
>
> **-Implementing Practice Site**

- Staffing-related approaches included providing team-based care that maximizes the roles and scope of practice for each staff member, removing some of the burden from the providers whose time with the patient is already compressed. Team-based care recognizes that all team members have an integral role in providing patient care. Redistributing the responsibilities for patient care activities among a greater number of people in a practice affords PCPs the time needed to listen, engage, and develop relationships with patients. Some sites established a PCP/MA dyad working structure; some used care coordinators, who may be nurses; one recommended the "Velcro approach" of linking a BH provider and a PCP. Some practice sites utilized community health workers. School-based clinicians were also mentioned as resources for providing follow-up services.
- Protocol-related approaches included making a "warm hand-off" to a BH provider at the same visit, having BH providers reach out directly to patients after two weeks. Each of these protocols requires an integrated – or at least co-located – practice. In other cases, the BH provider receives an electronic message, and all documentation (consultant report, quality report, outstanding referrals) are exchanged electronically. Some practices call patients with a reminder prior to the follow-up appointment. This requires that the patient has a telephone, and that the practice has current contact information. Another approach is to check with patients at the end of the primary care visit to determine whether they would like the provider's office to make that call for an appointment.
- Relationship-related approaches included having strong standing relationships with a patient, and with partner organizations to which PCPs can refer patients for effective follow-up. Having a longstanding relationship engenders trust between patient and provider, making it more likely that a patient will make and/or attend a recommended follow-up appointment. Having standing relationships with community-based partner organizations increases provider awareness of available resources, and an existing connection between professionals facilitates access to those resources when they are needed.

Cultural Competence

While promoting youth S-BI-RT practices, the initiative identified that communication and screening processes had not been adequately considered and adapted for non-English speaking patients, and/or patients from other countries. This is not a problem unique to New Hampshire.

Cultural competence extends much deeper than simply using a validated screening tool translated in the patient's first language; it requires culturally adaptive screening and MI. As relevant to the patient's background, this may, for example, involve strategies that "include an enhanced focus on family dynamics, social support, the social context of immigration, employment challenges,

and experiences of discrimination and health literacy."[23] It may also require a specific focus on the cultural and social aspects of substance use, including isolation, acculturation-related stressors, and marginalization among many newcomer groups.

Effective S·BI·RT depends, of course, upon the use of validated screening tools and MI techniques during a BI. It appears that current validated substance use screening and intervention practices do not adequately address this need for populations other than non-Hispanic white patients. Some tools have been validated in a cultural context, and some have been translated into languages other than English; however, the literature lacks evidence of tools that address both a culturally and linguistically competent approach to S·BI·RT. Additionally, although many screening tools have been translated into a variety of languages, we have not found any that have been tested for validity and reliability.

Recommendations for Operationalizing S•BI•RT Implementation

Cultural Competence

Strive for linguistic and cultural competence in providing S·BI·RT services, as part of patient-centered healthcare. Collectively devote research and attention to addressing existing gaps in tools and knowledge to develop valid and effective S·BI·RT protocols for non-English speakers and patients with varied cultural and ethnic backgrounds.

Despite a lack of validated tools, health systems can bolster their ability to deliver culturally competent S·BI·RT processes by seeking to ensure that interpreters utilized in the system are also able to serve as cultural brokers for patients. Beyond providing interpreter services, the Georgetown Health Policy Institute provides some additional strategies[24] for delivering culturally competent healthcare that have relevance for youth S·BI·RT. These include: 1) recruit and retain staff that are reflective of the ethnicities of the communities served; 2) provide training to increase cultural awareness, knowledge, and skills; 3) coordinate with traditional healers; 4) use community health workers; 5) incorporate culture-specific attitudes and values into health promotion tools; and 6) include family and community members in healthcare decision making. As S·BI·RT becomes more embedded in healthcare, educational, and social service organizations, there will be an increased need to accommodate the diverse cultural needs of New Hampshire populations.

The Role of the Electronic Medical Record and Information Technology in Supporting S·BI·RT in Clinical Practices

Lessons Learned

A key area of learning that emerged from the Youth S·BI·RT Initiative was the challenges presented by EMRs. As noted, significant challenges were identified related to 1) embedding screening tools in the EMR, 2) managing the interface between the EMR and each site's clinical work-flow, 3) relying on EMRs to document follow-up with at risk patients, and 4) extracting and using EMR data related to clinical performance measures. The professional literature is replete with studies that find that documentation in the EMR takes more time than writing in a paper chart, and that the design of EMRs often does not meet the needs of end-users, e.g., the clinical and administrative staff. Our experiences bore this out, with practices encountering multiple EMR-related challenges, from getting the screening template into the EMR, to getting reliable data out.

Major issues may be summarized as follows:

- EMRs were designed primarily to capture codes for billing for services provided, and have not yet been adapted for population level data collection and analysis.
- Embedding S·BI·RT screening tools into the EMR varied by clinical site and by EMR vendor, based on the Information Technology (IT) resources available and unique aspects of the work- flow and personnel at each clinical site. It is not enough to embed screening tools; structured fields need to be created to document that a BI was provided, referrals made, and follow-up completed.

Careful coordination between IT, the staff providing and documenting patient care, and the staff retrieving and reporting the data is needed from the outset to ensure reliable and valid data management.

Getting the Screening Template into the EMR

- While some organizations had in-house IT departments that could build the screening templates into the EMR, others needed to ask their EMR vendor to do so. Either way, an unexpected obstacle was the wait time for IT availability for development of the screening template, as IT staff usually have multiple competing requests for EMR customization.
- One vendor that served several organizations customized the EMR for the first implementing organization but expected other implementing organizations to use the same screening template, even though it did not fit their work-flow.
- The CRAFFT2.0 and S2BI each have two sections, and a patient is considered "At Risk" with an answer of yes to any question on the first section, while the second section helps to determine whether the risk is sufficient to call for a referral. A two-tiered template can be more difficult to build and to score in an EMR, and so scores were not generated in some of the EMRs.

Entering Patients' Responses into the Screening Template: e-Tablets, Paper, and Work-flow

- There were concerns at some sites that e-tablets would be stolen from waiting rooms.
- Some sites had to order e-tablets through their IT department, which caused additional delays in implementation. As a result, staff created workarounds in which S-BI-RT screening was accomplished using their own laptops, a work-flow that, while inefficient, became familiar and preferred to using e-tablets.
- Unless the screening process used an e-tablet inter-operable with the EMR, that is, automatically populating a patient's responses into his/her EMR, an MA had to manually enter the responses into the EMR. Thus documentation of screening rates reflected the MA's reliability and consistency in entering the responses, as well as the efforts of the front desk staff in handing a young patient the screening materials.

Recommendations for Optimizing the EMR

1. Early on, determine what EMR vendors are used by clinical sites, how changes to the EMR are done, and how long it will take for those changes to be made. IT departments at individual sites and EMR vendors may both face multiple competing requests to customize the EMR, and some vendors may be resistant to customizing EMRs for multiple sites.
2. Also early on, engage the IT department and staff responsible for quality indicators as well as clinicians, and make clear the following infrastructure requirements for implementing and sustaining S-BI-RT:
    a. Embed an evidence-based screening tool into the EMR that fits the clinical work-flow in the setting.
    b. Create a Best Practice Advisory, to support providers' decisions for clinical care during the visit based on responses to the screening tool.
    c. Use the evidence-based recommendations of the screening tools' developers to set the trigger for the BPA.
    d. Create structured fields to capture documentation of care provided, that is, BI, referrals made, and follow-up.
    e. Trial the work-flow for entering screening data and documenting care with at least five members of the clinical team in a temporary mock-up. Look for ease of use and clarity of purpose.
    f. Run reports on a monthly basis on the following:
        i. Number of youth visits related to routine care, such as annual appointments;
        ii. Number of youth screened;
        iii. Number of youth who received BI;
        iv. Number of youth for whom a referral was made; and
        v. Number of youth with whom the practice followed-up.
3. If using e-tablets that automatically populate the EMR, test trial them prior to going live in order to ensure reliability.
4. If using paper or other e-tablets for screening, trial the process for manually entering data and train staff as needed. If possible, run reports on incomplete data entry for screening tools.
5. Use all data reports for Continuous Quality Improvement.

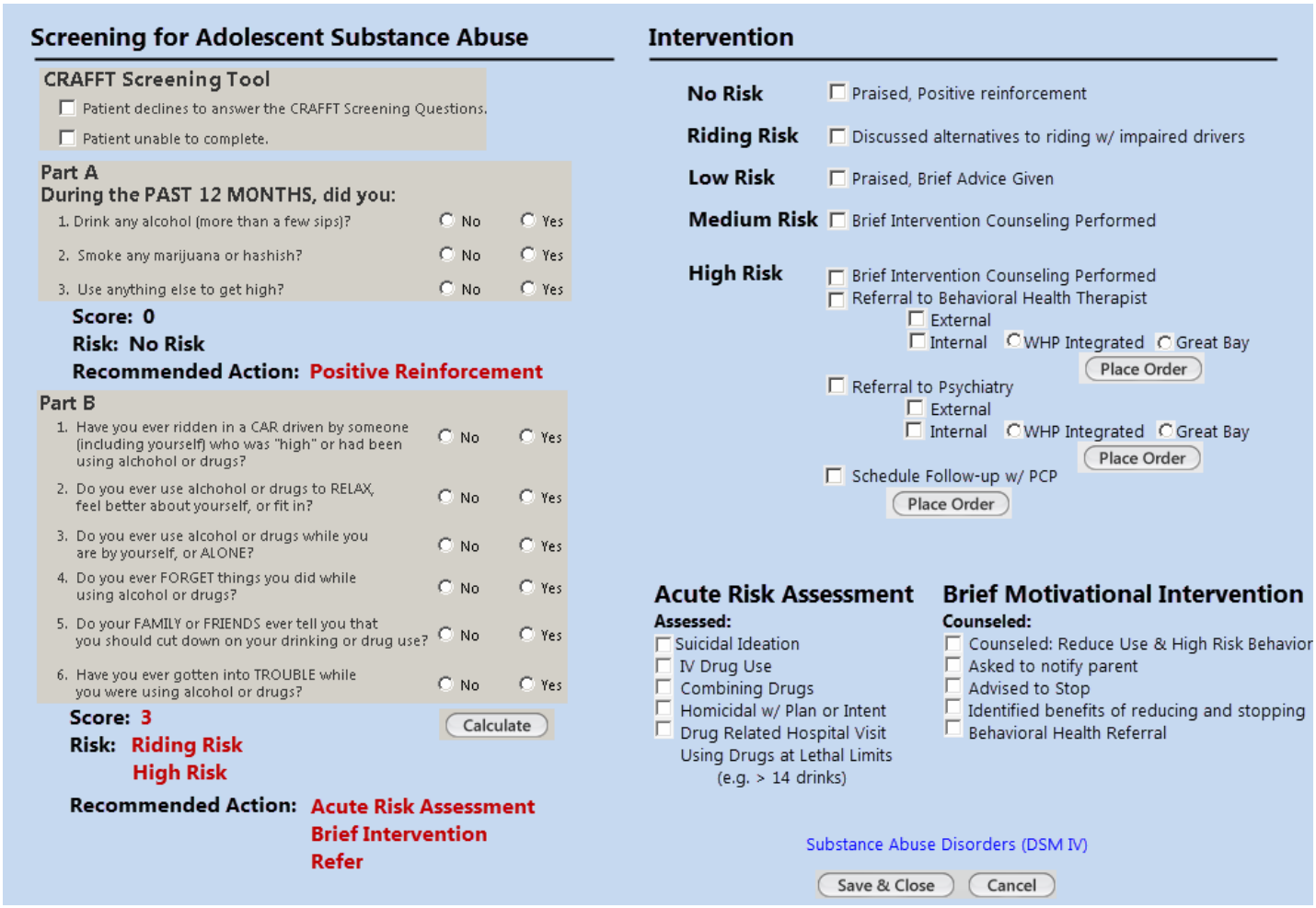
- Even after patients' responses on the screening tools were entered into the EMR manually, finding these responses often required searching through the notes and charts in order to find the results, often switching screens (referred to as "clicks" on the mouse), which was inefficient.

Documenting BI, Need for Referral, Referral Made and Follow-up.

- The screening templates did not include documentation fields for the provider for *BI, Need for Referral, Referral Made and Follow-up,* and so additional structured fields had to be built to capture what was done in the appointment related to S·BI·RT by an electronic query. Again, this required switching screens to find the appropriate place to document, and documentation needed to be done in structured fields in order for data to be retrieved.

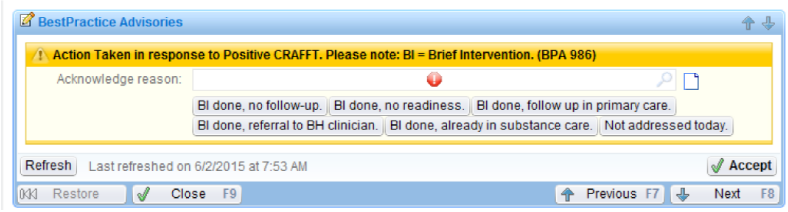
- Sites reported that documenting correctly the care provided in the appointment so that it could be clearly demonstrated and then data-mined was a frequent problem. "Templating" of the documentation process in the EMR can have a domino effect of problems, if the "clicks" are not thought out thoroughly and planned at the beginning. Staff experienced numerous instances where they had to "back up and start again," or at least modify, documentation pathways in terms of the EMR "clicks." A sample template is shown in Figure 6.

Figure 6: Sample Screening Template[25]



- Ideally a Best Practice Advisory (BPA) would prompt providers to do a BI for patients at risk (see example in Figure 7), and then they would document in the EMR that it had occurred. But not every EMR had a BPA, or it was not turned on. The BPA fields should capture the data needed for reporting and engaging in quality improvement efforts.
- Documentation of a referral and follow-up was a multi-layered challenge in many practices.

Figure 7: Sample Best Practice Advisory Alert Embedded in EMR



You will get the above alert at the close of your encounter with a patient who has a positive CRAFFT screen. You must choose one in order to close the encounter. Here is a more detailed description of the above options.

Data Retrieval and Reporting

- Structured fields for documenting care provided, such as BI, were not always built at the same time as the screening templates, nor were they designed to capture the data requested for this initiative, such as "how many youth screened received BI."
- Data retrieval by query was done by either the IT department or the vendor, which meant that sites experienced delays in getting their data.
- Some sites had to retrieve their data manually, which was very labor intensive, and resulted in incorrect entries into Excel spreadsheets.
- Sites were not always sure that their data was accurate, either because it may not have been entered or retrieved appropriately.

The EMR was never designed to capture population health data, although there are increasing demands that this be done in primary care. The sites in this S·BI·RT Initiative worked very hard and usually successfully to capture the care being provided to youth at risk for substance misuse, but the challenges were not inconsequential and always frustrating. While it is appealing to think that simply standardizing the EMR nationally for S·BI·RT might help resolve the challenges that the EMR presents, standardization of clinical terminology involves working with a suite of designated standards set by the U.S. federal government for the electronic exchange of clinical health information that includes interoperability specifications of the U.S. Healthcare Information Technology Standards Panel. Their work is ongoing and complex, involving several health coding languages.

Site Specific Policy Considerations Related to S·BI·RT Implementation

While there are a host of policy issues related to laying a strong footing for successful S·BI·RT practice, there are a couple that so directly impacted providers in their day to day efforts that they are specifically addressed here. These include coding and billing for screening and BI as reimbursable services, and confidentiality considerations related to patient care as well as organizational compliance with federal and state regulations. In essence, while both these issues added some level of perceived complexity, in the end neither presented a significant barrier to implementation.

Lessons Learned

Coding and billing can be a confusing area for practices; guidelines can vary by state and by insurer. While billing issues were initially perceived as a potential barrier to implementation, and there was some provider confusion, most coding and billing reimbursement issues were able to be resolved. We found that practice sites recognized the value of screening even when they could not be reimbursed for it. In addition, insurers recognized the value of prevention and/or early intervention for youth substance misuse and were open to providing payment in appropriate cases for S·BI·RT activities. Ultimately, confidentiality was not the substantial barrier to implementation that it was originally perceived to be; by the completion of the Initiative, no sites identified confidentiality as an ongoing barrier.

Coding and Billing

Coding and billing for S·BI·RT was identified early as an issue, as we understood from the start that ability to receive payment for S·BI·RT services would potentially be an important component of sustaining the practice. There were conflicting perspectives between payors and practice sites. Payors reported that codes were in place, but that providers were not using them. Practice sites reported that although mechanisms for coding and billing were in place, complexities presented persistent challenges to successful billing:

> *"...One of [our providers] does not bill for [S·BI·RT], as she feels it is part of the conversation they already bill for in the physical. Another says he only bills for it if he is going to follow up with a BI or referral – and it warrants further documentation otherwise he does not... he bills for it but he bills for an extended or an acute physical, not specifically billing for the S·BI·RT screener. They would bill for the physical or a complicated physical if the screener was positive and needed a BI. So because they are doing it this way they are not running into any issues in getting paid."*
>
> -Implementing Practice Site

- Guidelines and related allowable charges may vary by payor, professional providing the service, or length of time required to deliver the service, as well as the state in which the services are provided;
- Some codes are specific to services conducted by BH providers only, and thus could not be used for services provided by PCPs;
- New Hampshire traditional Medicaid S·BI·RT specific codes include time parameters (with the shortest time requirement being 15-30 minutes), which led many providers not to bill for simple administration of the S·BI·RT screen and brief intervention;[26]
- Some billing parameters pertain only to patients in specific age ranges (e.g., Early and Periodic Screening Diagnosis and Treatment [EPSDT] covers children under the age of 21 enrolled in Medicaid[27,28]); and
- In addition, for FQHCs, as well as FQHC look-a-likes and rural health clinics, screening and referral services are considered covered under the encounter rate, meaning that these practices could not bill separately for S·BI·RT unless patients required follow-up BH interventions.[29, 30]

Coding and billing may also be confounded by administrative changes that take place extraneous to the S·BI·RT implementation process. For example, in 2017, there was a disruption in payment of Current Procedural Terminology (CPT) codes[30] which resulted in some confusion when a site billed and received notice that the code was not valid and would not be paid.[31]

In the 2016 End–of-Year Assessment of practice sites' implementation status, the Center included questions about coding and billing. While five sites reported that they had billed using various codes, only one reported successful reimbursement from a private insurance provider. Barriers cited included getting codes and billing options approved by their organizations and building billing codes into EMRs, inconsistent billing practices by providers, and lack of coverage for screening in the FQHC setting.

In March 2017, the Center sent a request to all participating sites for more details regarding their billing challenges. We asked that they share any information about issues besides those that we knew were unresolvable, e.g., FQHCs billing for S·BI·RT services outside of the encounter rate; billing for S·BI·RT services delivered to Medicaid youth before July 1, 2017 (before the benefit existed for this population); and billing to self-funded plans which are outside New Hampshire regulatory authority (where benefits may not include S·BI·RT coverage). No sites responded with additional billing concerns.

Site Specific Policy Recommendations Related to S•BI•RT Implementation

Coding and Billing

Stay abreast of developments in a changing policy environment, and work with practice sites on this issue from the beginning.

Confidentiality

Early in the Initiative, the Center began working with New Futures and the Legal Action Center to clarify confidentiality issues under state and federal laws and regulations, and was able to provide TA to sites on this issue.

Confidentiality issues are critical throughout the S·BI·RT process; the considerations will impact work-flow, EMR modification, referral relationships, and other decision points. However, providing care that ensures confidentiality for patients under 18 presents additional complexities and considerations.

> *"It was very important to always keep patient confidentiality... Each patient has the right to keep their drug and alcohol use confidential. However, it is integral to have the parents involved if the adolescent is to be successful in changing their risky behavior. It was very beneficial, to both the parent and patient, to have the Clinician present to facilitate the conversation about drug and/or alcohol use. Action plans have to involve everyone if they are to be successful."*
>
> **-Implementing Practice Site**

Through the initial readiness assessment, all practices identified confidentiality as a concern. Specifically, concerns about confidentiality were generally related to: 1) sharing information across providers, pursuant to federal and state confidentiality regulations, with or without parental knowledge or consent, and 2) protecting the patient in completing screening tools independently when parents are present. In addition, concerns were expressed regarding sensitive substance use related information being discoverable in patient records in the context of future employment and higher education applications. Confidentiality was a concern both when protecting the organization and the patient. There was a general lack of understanding and confusion regarding confidentiality issues under state and federal laws and regulations, particularly the implications of 42 CFR Part 2.

New Hampshire law (RSA 318-B) provides assurance of confidentiality and allows children 12 and older to consent for drug treatment without obtaining parental consent, inserting an additional layer of complexity. This means that if a provider advises a parent regarding their child's drug use, or consults them without their child's consent, it is a breach of the law. Although this issue raised concern at the outset, we found that it did not, in fact, present a barrier to services. For most patients where it was an issue, the parents already knew that their child was using, and providers were able to obtain the patient's consent to bring the parent into the conversation. On the other hand, when parents were reluctant to allow their children to complete the screen privately, or have a private conversation with their provider, we found that providers were able to finesse these situations by explaining that they prefer to have some one-on-one time with their adolescent patients.

> ***"Concerns about patient and/or parental push-back on the screening questions and/or Brief Intervention were less of an issue than originally anticipated. Most patients and families do not question the process."***
>
> **-Implementing Practice Site**

Among pediatric patients, considerations frequently arise on the boundary of patient confidentiality and disclosure to parents. For example, because the screening results might generate a referral to BH services, some agencies were concerned about who had access to this information and when to disclose to a parent. To ease the process in the case that this may occur, some sites included confidentiality consent forms as a routine part of the process when patients enter care.

Site Specific Policy Recommendations Related to S•BI•RT Implementation

Ensure Confidentiality

Provide a private space for young patients to complete the screen that is separate from the parents, preferably using e-tablets, in the waiting room, in a kiosk, or in the exam room.

Include a confidentiality consent form in the initial process when enrolling a new patient. This will ensure that if or when a situation arises that a referral is needed, it will not present a barrier.

Confidentiality decisions should be incorporated into provider training and communications planning.

Practice sites established some creative approaches to ensure that patients have the privacy needed to comfortably complete the screening tools without their parents "standing over their shoulders." These included engaging reception staff in occupying parents with other intake documentation, asking parents to simultaneously complete questionnaires about their concerns about their child's health, using an eraser board for the screen, pulling up the screen on the MA's laptop and turning it toward the patient to complete by touch screen in the exam room, and setting up separate physical space for the patient to use. Some providers encouraged their patients to assume active responsibility for their care, and explained to parents that they would like time alone with the patient. They found that parents generally accept this approach, especially when it also accompanies an opportunity for the parent to "check in" with the provider in the hallway. Some providers continued to express concern about the potential impact for patients with documented details of illegal drug use in their EMR relative to future employment, academic, or other goals. Nevertheless, in general, concerns from providers, patients, and families were alleviated as the S·BI·RT process was fully integrated into a site's flow.

Overall, confidentiality was identified as an area of concern during implementation planning, and it created hesitation from providers. Ultimately, through TA, trainings, and guidance, practices were able to find practical solutions to confidentiality issues as they arose and work through difficulties and questions. Moreover, despite initial cautions, for most of the practice sites, which were medical facilities, 42 CFR Part 2 did not apply, except possibly to an embedded alcohol or drug treatment provider or program. Resources provided from New Futures, the Legal Action Center, and the Center provided implementing sites with a working knowledge of confidentiality regulations to navigate concerns of substance use information in parent disclosure, referral to treatment, and follow-up.

Other Reflections

Sites highlighted the unique challenges of caring for children of parents who misuse substances, which may include parents' lack of acknowledgment that an issue exists or hesitance to shine a light on the issue at all. In addition, young patients may choose not to divulge any issue with substance use in efforts to protect parents who are using. One provider noted that when he further questioned a patient who indicated that she had "ridden in a car driven by someone who was 'high' or had been using alcohol or drugs" he learned that it was the patient's parent who had been driving the car.

Primary care practices in general, and those that care for children and youth in particular, are incredibly busy given the demands of caring for patients with multiple medical and behavioral co-morbidities as well as socioeconomic challenges. In addition, there are increasing demands for compliance with multiple regulations and expectations set by insurers and state and national authorities. For example, there are many demands for additional screening and services, including for obesity and nutrition, exercise, bullying at school, and learning disorders. Unfortunately, primary care practices are under-resourced for the work that must be accomplished every day, as most continue to rely on reimbursement for services provided. Taking time for meetings, training programs, and so on during clinical time represents revenue lost. We have been duly impressed and even humbled by the efforts of the implementing practice sites in this Initiative to implement S·BI·RT notwithstanding these challenges and competing organizational imperatives. Site-specific planning and implementation were crucial to the Initiative's success, and was only possible through the Charitable Foundation grants made with the support of Hilton Foundation funds.

The Charitable Foundation's commitment to leaning into S·BI·RT implementation through leadership and resource development promoted systems change at the state level and as well as the practice level to impact the health of individuals.

Partnerships between the Charitable Foundation, the NH Department of Health and Human Services (DHHS), and the Center had profound impact on the success of this Initiative, and the expansion of S·BI·RT to other New Hampshire populations. Lessons learned through the NH Youth S·BI·RT Initiative informed the decision by the NH Maternal Child Health Bureau to require their contracting agencies to implement S·BI·RT.

The Center's capacity to provide training and TA related to S·BI·RT implementation was expanded through the process of supporting the Initiative, enabling a partnership of the Center and the New Hampshire Bureau of Drug and Alcohol Services to provide resources to those contracting agencies. In addition to elevating S·BI·RT with DHHS, the NH Youth S·BI·RT Initiative has increased attention to the need for youth treatment capacity at the level of the Governor's office and the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery.

> *"We learned that making screening a consistent part of the preventive visit 'normalized' the asking of these kinds of questions, and that asking the questions at every preventive visit may yield an at-risk 'yes' eventually, after initial 'no' responses to questions, as youth got used to, and even expected, being asked. We believe that the S·BI·RT process opened up conversations that may not have taken place in the past."*
>
> -Implementing Practice Site

Sustainability

The Center has developed deep expertise through its work with this Initiative. It has embedded S·BI·RT TA capacity as a core component of its ongoing work, including work funded by the Charitable Foundation and the New Hampshire Bureau of Drug and Alcohol Services. The Center's director is recognized at the national level as an expert, sharing our work and lessons learned.

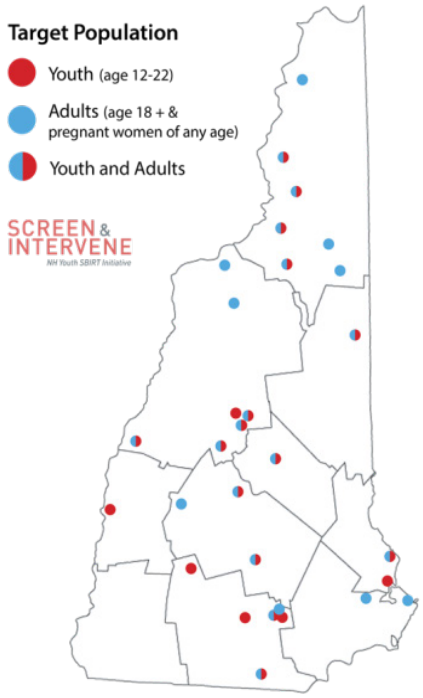
There is an increasing awareness of the importance of S·BI·RT throughout the state -- in part a reaction to the opioid crisis, but also in part due to an increased understanding that implementing S·BI·RT is doable, that peers have adopted it successfully, and that there is expertise available through the Center. Because it provides a broad base of support across the entire continuum from prevention to treatment to recovery at the state and regional levels, the Center is optimally positioned to provide TA to support expanded implementation and scale of S·BI·RT going forward.

The Initiative has raised awareness and understanding of S·BI·RT as a mechanism for integrating primary care and BH, and also as a prevention strategy in the face of the opioid epidemic. New Hampshire CHCs now provide S·BI·RT services for adults and pregnant women, in part due to capacity development supported by the Initiative. The intentional decision to open-source rather than charge for materials, such as the Playbook and on-line simulation training, removes cost-related implementation barriers.

S·BI·RT (for youth and/or adults) has been implemented in all regions of New Hampshire, and continues to grow (See Figure 8). The Center feels confident that S·BI·RT protocols, while not yet universal practice, have taken meaningful root all across the state, and thanks to this Initiative, will continue to build momentum. Practitioners in all regions of the state are now engaged in S·BI·RT implementation, for youth as well as adults, all of them benefiting from the TA capacity, tools, and learning afforded by this Initiative.

Thanks to this Initiative and related efforts, interest in S·BI·RT has also expanded beyond the primary care setting. The Center has provided TA or trainings to the Juvenile Justice Network, home visiting agencies, occupational therapists, and the New Hampshire Women, Infants and Children (WIC) Nutrition Program. As S·BI·RT becomes more embedded in healthcare, educational, and social service organizations, there will be an increased need to accommodate the diverse cultural needs of New Hampshire populations.

Figure 8: Primary Care Practices Implementing S·BI·RT in NH



New Hampshire's implementation of the Transformation Delivery System Reform Incentive Program (DSRIP), using a Medicaid 1115 waiver, is channeling funds into networks of providers to meet metrics demonstrating improved patient outcomes and who promote delivery system reform. Transformation is driven by regionally-based networks of medical and BH providers as well as community-based social service organizations addressing social determinants of health. Appropriate screening and intervention for SUD is included as a project outcome measure for the New Hampshire DSRIP. The metric is defined as "Percent of patients screened for alcohol or drug abuse in past 12 months using an age appropriate standardized alcohol and drug use screening tool AND if positive, a follow-up plan is documented on the date of the positive screen age 12+.[33] The regional networks are seeking support with S·BI·RT implementation for various populations in a range of settings, and the Center is supporting them with training and/or TA as their needs emerge.

In addition, the New Hampshire Bureau of Drug and Alcohol Services is supporting regional networks across the state to target prevention and early identification strategies to the young adult population. The Center is supporting several regions to implement S·BI·RT in youth serving organizations and local colleges.

As New Hampshire health systems move toward integration of primary care and BH, medical professionals equipped with screening and intervention best practice tools are well positioned to successfully improve patient outcomes and reduce healthcare costs. The experience of this Initiative, the learning, and the buy-in it has generated provide critically valuable momentum, insights, and practical solutions for practitioners in these networks to advance S·BI·RT as a linchpin of integrated care and the standard of patient care in New Hampshire.

Conclusion

The gains made through the NH Youth S·BI·RT Initiative have occurred in a dynamic context characterized by an environment experiencing significant changes in federal and state policy that impact the availability of services; the development of new regional systems and partnerships through BH transformation; organizational level mergers, closures and EMR system transitions; turnover of staff and leadership; the individual challenges that staff bring to their work each day; and the widespread availability of ever-changing addictive substances. We are confident that, thanks to this NH Youth S·BI·RT Initiative, a resilient infrastructure is in place that will continue to advance S·BI·RT protocols beyond the ending of this Initiative. This work positions New Hampshire to continue to embrace S·BI·RT as standard practice, and to continue a range of efforts to better integrate SUD and BH care in advancing both prevention and better access to services and treatment where needed, especially for New Hampshire's young people.

This project was specific to S·BI·RT; and as such, it separated and focused on substance use screening and intervention. However, true success in making S·BI·RT universal as part of routine medical care for youth will be achieved not when it is called out, distinguished unduly, or stigmatized, but rather when it is fully integrated as part of the many issues – from smoke detectors to family violence to depression and anxiety – about which patient-centered care calls for providers to engage their young patients.

"S·BI·RT has opened doors to meaningful conversations with adolescents, giving them safe space to talk with their provider because we have demonstrated that we are ready to listen. Although the majority of the screenings we've done provide an opportunity for positive reinforcement of healthy choices, when risks are identified we've found that adolescents are hungry for an open ear and an opportunity to feel empowered to make positive changes. We never anticipated the gravity of such a simple screening tool, and now view it as an essential part of our clinical practice."

-Implementing Practice Site

Appendix A

Screening, Brief Intervention, and Referral to Treatment (S•BI•RT)
LEARNING OPPORTUNITIES

S•BI•RT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for prevention and early intervention with individuals at greater risk before more severe consequences occur.

A variety of training opportunities are available that will increase your knowledge and skills to successfully implement S•BI•RT. Trainings can be tailored to your practice or program, and coordinated with regard to time, place, and length of training session. Each learning activity offers tips, tools and resources to efficiently and effectively train staff on their role with S•BI•RT and fully adopt all aspects of S•BI•RT.

S•BI•RT RESOURCES AVAILABLE THROUGH THE CENTER FOR EXCELLENCE

Workshops: Onsite tailored training to help overcome implementation barriers. Topics include:

- S•BI•RT 101: Overview of the components of why they are important
- Advanced S•BI•RT Implementation
- Screening for Medical Assistants
- Brief Intervention, Parts 1 and 2: Based on skill level and may include:
  - Basic concepts of providing a brief intervention in response to a positive screening
  - Strategies for engaging patients in conversations that motivate them to reduce their risky use of alcohol or drugs, and/or
  - Interactive skill building using role-play and case studies

Technical Assistance: In-person & web-based for implementing S•BI•RT

S•BI•RTNH.org: Searchable website with evidence-based resources & tools including:

Kognito: Free online 1-hour interactive role-play simulation to build skills in screening and brief intervention, with CEUs

Webinars: A full listing of recommended current and recorded Web-based learning opportunities

Screen and Intervene: NH S•BI•RT Playbook: A step-by-step S•BI•RT implementation guide

Visit SBIRTNH.org or for more information,
contact nhcenterforexcellence@jsi.com or 603.573.3348

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[4] This report is organized around the PARiHS implementation framework: Successful Implementation is a function of

Evidence, Context and Facilitation, or SI = f(E, C,F). Please see also:

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[19] Regional Access Points Services offer assistance for screening, case management, and active referral to treatment and recovery support services at no cost statewide. Skilled staff are accessible by phone or in person to help New Hampshire residents struggling with addiction to get the timely, supportive services they need, and to help both individuals and families navigate the complex systems of care

[20] "2016 End of Year Assessment of NH Youth S·BI·RT Initiative" Compiled by New Hampshire Center for Excellence, JSI Research and Training Institute, Inc. (March 2017).

[21] A P-chart is a type of statistical process control chart used in quality improvement initiatives to determine the stability of a process over time when that process is measured in percentages, and the numerator and denominator vary naturally.

That is, the number of Youth Visits and number of Youth Screened will vary each month. To be meaningful 20-24 data consecutive points are needed, and although some interpretation can be made with fewer data points, more than 24 data points is not helpful. Because P-charts capture a process over time, earlier data that represent start-up efforts can be eliminated and replaced as later data is entered that represents a maturing process.

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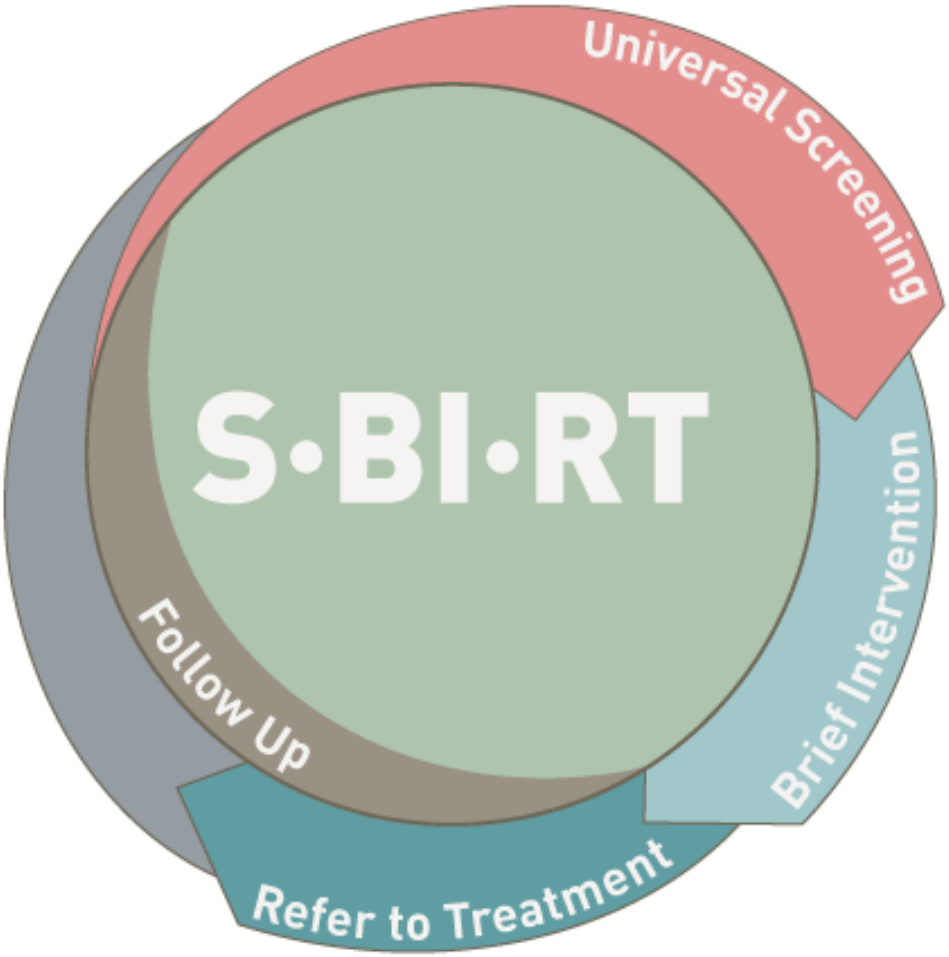
[30] Although the NH Department of Insurance requested from the Centers for Medicare and Medicaid Services (CMS) that S·BI·RT be reimbursed on top of the bundled rate, this request was denied.

[31] Standardized CPT codes, developed and maintained by the American Medical Association, are used by insurers to help determine the amount of reimbursement that a practitioner will receive for services provided.

[32] The change involved one common code that previously had been paid (99420, administration and interpretation of health risk assessment instrument), which was replaced with a new code (96160, Administration of patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument).

[33] New Hampshire Department of Health and Human Services "DSRIP Progress Year 1". Available at: https://www.dhhs. nh.gov/ombp/documents/dsrip-mcac-051517.pdf


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