The National Center on
Addiction and Substance Abuse
at Columbia University

COLUMBIA

An SBIRT Implementation and Process Change Manual for Practitioners

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In collaboration with:

OASAS
Improving Lives.

NEW YORK STATE
OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES
Addiction Services for Prevention, Treatment, Recovery

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About this Manual

We are fortunate to be able to draw upon the numerous years of research conducted on the use of Screening, Brief Intervention and Referral to Treatment (SBIRT) in primary care and emergency departments. While 20 years of research has accumulated on brief interventions in medical settings, many of the manuals created are designed to teach providers clinical procedures and methods to conduct SBIRT interventions. Our goal is to provide a comprehensive SBIRT toolkit that focuses on implementing SBIRT in your agency - while working within your resources - and most importantly sustaining SBIRT through process improvement strategies. This manual is for physicians, nurses, community health workers, physicians' assistants, mental health practitioners, and administrators interested in integrating SBIRT into their practice.

This manual is designed to be a resource for those interested in creating a sustainable SBIRT program in their agencies. We do want to highlight that there are a vast amount of high quality resources available on the web based on the many previous SBIRT research studies and statewide implementation efforts. Therefore, at the end of each chapter, you will find links to external resources (e.g., websites and videos) put together by knowledgeable SBIRT researchers and practitioners to supplement the information we provide in this manual. For successful implementation of SBIRT, the information and toolkit provided within this manual are best combined with in-person or online training for relevant staff on SBIRT and how to perform the SBIRT components. This is not a training manual. It is meant to be used as a guide and resource for those who want to integrate SBIRT into their practice. Asking someone to simply read this manual and then implement SBIRT is not appropriate.

This manual covers four main areas:
☐ The components of SBIRT
☐ Process improvement strategies (implement and sustain)
☐ Planning your SBIRT program to fit your agency using tailored implementation strategies
☐ Toolkit and worksheets to guide implementation of SBIRT

One of the core features of this manual is the introduction of process change/process improvement strategies for the integration of SBIRT into your agency. These strategies have been borrowed from the business world and have been used successfully in addressing other healthcare issues such as the adoption of depression and diabetes management in primary care settings. They are designed to help create a fluid process in which you can identify, test and modify components of your SBIRT program over time.

1 | OVERVIEW OF SBIRT

What is SBIRT?

SBIRT stands for Screening, Brief Intervention and Referral to Treatment. SBIRT is designed to screen and deliver early intervention services for risky substance users, including those at risk for addiction. For the purposes of this manual, "risky substance use" is defined as any of the following:

- **Alcohol**: according to the NIAAA, more than 14 standard alcoholic drinks per week or 4 drinks per day for men; for women more than 7 standard alcoholic drinks per week or 3 drinks per day poses risks
- **Drugs**: according to NIDA, any use of illegal drugs or prescription drug use for non-medical reasons poses risks
- **Smoking**: according to the US Department of Health and Human Services, any amount of smoking poses risks

While SBIRT includes several components, only a portion of patients you screen will receive a brief intervention and a smaller portion would receive a referral to treatment. SBIRT can be performed in nearly any setting but has typically been done most often in emergency departments (EDs), primary care facilities and college health centers. SBIRT is specifically designed to find and help individuals who are not seeking help for addiction and therefore is termed an "opportunistic intervention". SBIRT is both a public health approach as well as a preventative service. It is a public health approach in that it provides services to people who may never become addicted to substances but whose risky substance use, as defined above, puts their health and well-being at risk. On the other hand, SBIRT is a preventative service in that, by intervening early, it may reduce the likelihood that a risky substance user will go on to become addicted. While this makes SBIRT a very powerful tool to help those who may not have otherwise gotten services or may have only gotten services once they become addicted, it is also a kind of intervention very different from traditional addictions treatment. Analogous to routine blood work as a preventative screening measure, SBIRT is performed to identify risky substance use among your patients/clients and provide them with appropriate interventions.

As indicated by The Substance Abuse and Mental Health Services Administration (SAMHSA), the components of SBIRT include the following:

Screening: Screening is a way to identify patients with risky substance use patterns. It does not establish definitive information about diagnosis and possible treatment needs. The goal of SBIRT is to make screening for risky substance use a routine part of medical care to help identify those who may not seek help on their own.

Brief Intervention: Brief intervention is a single session or multiple sessions of motivational discussion focused on increasing the patient's insight and awareness regarding substance use

and his or her motivation toward behavioral change. Brief intervention can be tailored for variance in population or setting and can be used as a stand-alone intervention for risky substance users as well as a vehicle for engaging those in need of more extensive levels of care.

Referral to Treatment: Referral to specialized treatment is provided to those identified as needing more extensive treatment than offered by the SBIRT program. The effectiveness of the referral process to specialty addictions treatment is a strong measure of SBIRT success and involves a proactive and collaborative effort between SBIRT providers and those providing treatment to ensure access to the appropriate level of care.

Making the Case for SBIRT

What is the Research on SBIRT across Settings?

There is extensive research which highlights that brief opportunistic interventions can be very powerful in helping people change risky substance use even when they are not thinking about changing. There have been over 15 systematic reviews and meta-analyses of SBIRT in various settings, brief interventions compared to more intensive treatment, and computer-based SBIRT. Although there are some slight variations in effectiveness depending on the setting and population, SBIRT and brief intervention studies reveal the following:

1. Most people with substance use problems do not seek formal treatment.
2. While risky substance users are often reluctant to seek specialist addiction treatment about two-thirds do visit their general practitioner each year.
3. Substance use problems are overrepresented in populations seeking medical care but screening and brief interventions for substance use are rarely performed in primary care.
4. SBIRT – even a 5 minute intervention - reduces risky substance use.
5. SBIRT in medical settings reduces health related diseases and consequences related to risky substance use (e.g. emergency room visits).
6. Screening and brief interventions work across settings though the effects are more powerful in some than others (primary care has very good outcomes).
7. Screening and brief interventions work across populations (e.g. pregnant women, college students).
8. Simple feedback on risky substance use based on a brief screening is one of the most important factors in why people change.
9. SBIRT does not have to be performed by a physician: any professional trained in conducting SBIRT who is empathetic and dedicated to helping people change is just as effective.

10. SBIRT can be enhanced using technology such as computer-based screenings, feedback and referrals.
11. Developing linkages with local specialized addictions treatment providers is crucial to the success of referrals to care.
12. Screening and brief interventions can be cost-effective for society.
13. Screening and brief interventions can generate revenue for agencies through direct reimbursement and linkages to affiliated mental health and addiction treatment agencies and partners.
14. SBIRT can be tailored to the individual needs of agencies.
15. There can be obstacles to performing SBIRT at any site, but they can be overcome with proper training and implementation techniques.

How Important is SBIRT?

Among the US Preventative Services Task Force's 25 recommended services, tobacco and alcohol screening and intervention for adults ranked the third and fourth highest when compared to the other recommended services on their effectiveness and cost-effectiveness[1]. Notably, the impact of screening for tobacco and alcohol was ranked HIGHER than screening for high blood pressure, high cholesterol, breast, colon or cervical cancer, and osteoporosis. At this point, most research has been conducted on SBIRT for alcohol and smoking; therefore, there is not a sufficient evidence base yet for the Task Force to make a recommendation on screening and brief intervention for illegal and prescription drugs. However, the evidence of SBIRT's effectiveness for illegal and prescription drugs is growing, and at the very minimum it is not harmful to conduct SBIRT for these substances. In addition, Task Force screening and brief intervention recommendations are currently for adults only; there is not sufficient evidence for adolescents and children at this point. The following agencies have officially endorsed SBIRT: the American Medical Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Psychiatric Association, American College of Emergency Physicians, American College of Surgeons Committee on Trauma, American College of Obstetricians and Gynecologists, American Society of Addiction Medicine, and the World Health Organization, among others.

Is SBIRT Right for Your Agency?

SBIRT can be integrated into nearly any practice. In our detailed review of the literature, there seemed to be three central themes that determined whether an agency or practice would integrate SBIRT into their care:

1. Do you believe that SBIRT can help your patients and society as a whole?
2. Can SBIRT generate revenue or at least be cost neutral?
3. Is your agency equipped to handle integrating SBIRT?

If the answers to these questions are yes, then with this toolbox you should have few problems integrating SBIRT into your practice.

If you said no to any of these questions, we hope that reviewing this manual will help to clear up any misconceptions you may have about SBIRT. If you do not believe that SBIRT can help your patients, we recommend reading through the articles in the reference sections of this manual. As noted in these articles, adding SBIRT to your agency can improve patient outcomes, generate revenue and help you create a truly integrated system. Remember – SBIRT is not without its shortcomings or barriers. It is not a panacea, but the literature certainly supports the practice.

Creating a Culture that Embraces SBIRT

As noted above, alcohol and tobacco screening and intervention are ranked very high among the 25 services recommended by the US Preventive Services Task Force. Their ranks are similar to screening for hypertension. Most people acknowledge the benefits of screening for hypertension. The problem is that addictions treatment is seen as outside of medical care and typically has not been integrated into medical services. Like any change process, integrating SBIRT requires a normative shift in how people think about substance use and the benefits of intervening (and the confidence that you can successfully intervene). For a new procedure to be integrated into care, each department and group needs to see the benefit. If you are reading this you probably already see the benefit to your patients and society as a whole. But it is equally important that the financial people see a benefit.

Changing one aspect of care creates a disruption in the standard operating environment of an agency. Specifically, how does SBIRT change how each person does their job? The overwhelming majority of people do NOT welcome changes to current business practices – regardless of the benefits. The beauty of SBIRT is that it is nearly identical to the process of screening for problems where there is a behavioral solution. For example - it is quite easy and quick to measure blood pressure. If it is within the normal range, that's it: you are done.

The exact same thing happens with a risky substance use screening. In fact, the process of screening takes significantly less work than taking blood pressure. Like blood pressure, risky substance use and associated problems follow a continuum – the more severe the problem, the more of an intervention is needed. Like blood pressure, most people who screen positive will probably be in the low risk range, but others may be at greater risk. The level of care will always correspond to the level of risk. Moreover, the level of care will correspond to your level of reimbursement.

More importantly – SBIRT works! Some staff may become frustrated because they don't see immediate benefits. Change to business practices is a difficult process but worth it! Implementing SBIRT may seem overwhelming at first, but you will be working together as part of a team to get the job done; therefore, the process of integrating SBIRT requires a team effort. This manual will help you to see how the integration process can be achieved using team-based process

improvement strategies. As a member of the SBIRT team you will identify which strategies work and do not work for you and your clients. The next sections of this manual will review the components of SBIRT in more detail and discuss process improvement change strategies and provide you with an SBIRT Implementation Toolkit.

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[1]Solberg, L., Maciosek, M., & Edwards, N. (2008). Primary care intervention to reduce alcohol misuse: Ranking its health impact and cost effectiveness. *American Journal of Preventive Medicine*, *34*(2), 143-152.

SBIRT RESOURCE LINKS
CDC, SAMHSA, NIAAA, and NIDA Guides:
http://www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf
http://www.samhsa.gov/prevention/sbirt/
http://www.drugabuse.gov/publications/resource-guide
http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf
http://www.cdc.gov/InjuryResponse/alcohol-screening/pdf/SBI-Implementation-Guide-a.pdf

US Preventative Services Task Force Recommendations:

http://www.uspreventiveservicestaskforce.org/uspstf/uspstbac2.htm

http://www.uspreventiveservicestaskforce.org/3rduspstf/alcohol/alcomisrs.htm

http://www.uspreventiveservicestaskforce.org/uspstf08/druguse/drugrs.htm

SBIRT Wiki and Wisconsin SBIRT Website:

http://sbirtwiki.wikispaces.com/

http://www.wiphl.com/about/index.php?category_id=3197&subcategory_id=4259

SBIRT VIDEOS

SBIRT Testimonials and Recommendations from SBIRT COLORADO and WISCONSIN:

http://www.improvinghealthcolorado.org/files/flash/testimonial_320x240.swf

http://www.improvinghealthcolorado.org/files/flash/rosenbloom_320x240.swf

http://vimeo.com/9755670

http://vimeo.com/9729805

http://videos.med.wisc.edu/videos/13240

2 | SCREENING

Screening is the first step in SBIRT, and is completed by administering a brief questionnaire to your clients or patients. As a part of the planning and decision making process leading up to the implementation of your SBIRT program, your organization will benefit from carefully considering the population you serve, your clients' needs, your organization's capacity for managing SBIRT, as well as the time and resources available to conduct multiple or lengthy screenings. Below are some areas you will want to think through as well as a number of issues to consider as you weigh your screening options.

Issues to consider:
- What do you know about the population you are serving? Do you know that there is a high prevalence for use of a specific substance in your population?
- Who will be doing the screening? How much time is available for the screening and brief intervention?
- How **comprehensive** will the screening be? Again, time constraints may dictate the depth of the screening process, whether you screen for multiple substances (tobacco, alcohol, drugs) and whether you want to do a more comprehensive screening by including other health screenings (e.g., depression, obesity). Below are examples of screening tools that demonstrate a range of specificity for the substance use screening process. You will want to select the screening tool that best fits within your office culture and the time constraints you expect to encounter when incorporating this new tool into your practice.

There are a variety of well-validated screening tools to choose from. Your organization should choose the one that best meets your needs. One way to limit burden on clients and staff is to conduct an initial brief screening (e.g., the AUDIT-C or 1-item binge drinking question) and only conduct a full screening (e.g., full AUDIT) if the brief screen is positive. In addition, if you want to screen for multiple substances (e.g., drugs, alcohol and tobacco), some screening tools are designed to assist with this (see next page).

On the next page we have provided you with a list of some of the screening tools that are available. We have indicated the population that the tools are appropriate for, whether there is a Spanish version, if it is a drug, alcohol or tobacco screening tool (or some combination of those), as well as the number of items and how long it will take to administer. The "norms available" column indicates whether there statistics on how most other people of the same population score on the screening tool. These norms can help you to understand how your clients or patients compare to others who have been screened using the same tool. While this is not an exhaustive list of screening tools, it should provide you some good options to choose from. Links to screening tools are available at the end of this chapter under "Screening Resource Links".

	Age or target population	Norms Available	Spanish version	Drug (D) Alcohol (A) Tobacco (T)	Number of items	Administration time (minutes)
Binge Drinking Question	All	Yes	Yes	A	1	1
The Alcohol Use Disorders Identification Test (AUDIT)	Adults	Yes	Yes	A	10	2
AUDIT-C	Adults	Yes	Yes	A	3	1
NIAAA 3 Items	Adults	Yes	No	A	3	1
CAGE	Adults & adolescents (16+)	Yes	Yes (4M)	A	4	1
CRAFFT	Adolescents, young adults	N/A	Yes (CARLOS)	A	6	2
The Drug Abuse Screening Test (DAST-20)	Adolescents & adults	Yes	Yes	D	20	5
Single Item Drug Frequency	All	Yes	Yes	D	Based on the number of drugs	2-3
Short Michigan Alcoholism Screening Test (S-MAST)	Adults	N/A	No	A	13	3
Short Michigan Alcoholism Screening Test – Geriatric version (S-MAST-G)	Adults 65+	N/A	No	A	10	3
Alcohol Smoking Substance Involvement Screening Test (ASSIST)	Adults	Yes	Yes	D, A, T	8	5-10
Texas Christian University Drug Screen II	Adults	Yes	Yes	D, A	15	5-10
Single Item Tobacco; 5 A's	All	No	Yes	T	1	1

Choosing Your Screening Procedures

Once you have chosen your screening tool, a variety of factors will influence the strategy your organization will employ in administering this screening as well as brief intervention. The most significant factors include: costs, training, space, and time. Different methods have advantages and disadvantages, some being more costly others more time-intensive (which may also be costly). Three different options for conducting the screening are listed below—in-person, paper, and computer—along with some of the ways that each method will impact the most relevant factors of interest in the decision making process.

Staff In-Person Interviews

Staff in-person interviews are one way to screen patients or clients. In this mode of screening, staff ask the screening questions, document the answers on a paper or computerized version of the screening tool, and calculate a score. The screening can be administered in multiple ways using a variety of professionals. For example, a health educator may be designated to administer face-to-face screens as well as the associated brief intervention for those who screen positive during the interview. Another option is for a nurse to provide the screening during his/her interactions with patients (e.g., while taking vital signs and medical history) and then another staff member, such as a physician or health educator, could deliver the brief intervention for those who screen positive as a component of the office visit.

Your organization will have to think through the various advantages and disadvantages of different approaches and staff duties. A health-educator delivered screen will likely have the least amount of impact on other staff in the office (of course, changes in patient flow for office visits will take some getting used to). However, the health educator position will require that your office hire new staff to conduct the screening and brief intervention. You will need to carefully weigh the cost-benefit of this option. Staff time required to administer in-person screening interviews is much greater than patient self-administered screenings (discussed below).

Costs – Little or no costs involved (depending on the staff chosen to administer SBIRT).

Training – Moderate training; primarily training is related to the content of the screening, scoring, and brief intervention; may need to learn new technology if entering scores into a computer.

Space – Depending on the method employed, there may be little or no additional demand for space. However a confidential, private area will be needed.

Time – Time intensive; in-person staff time required for delivery of screening as well as intervention. However, a very brief screen (e.g., one-item) may be well-suited to in-person delivery, with longer screenings being administered only to those screening positive on the one-item.

Paper

An attractive screening alternative to in-person interviews is to provide a paper-based screening to all clients/patients. This strategy can reduce the amount of staff time required to deliver the screening questionnaire; after all, the patient is responsible for completing the form independently. This can be seamlessly added to a standard medical history form by either adapting the pre-existing form or adding a supplemental sheet to the medical history questionnaire. However, a staff member will need to be assigned to review the paper screening questions, to score it, and to deliver the brief intervention or make the referral, as needed. Your organization will need to weigh the pros and cons of selecting from among your staff to review the questions, deliver the brief intervention, and make referrals.

Costs – Minimal costs (basic supplies: paper and pens for completing screening instruments).
Training – Moderate training; primarily the training is focused on scoring the screening tool and content of the intervention; however, the staff will need to invest some additional time in learning the format of the screening form as well as scoring procedures.
Space – Little or no demand for additional space; the patients will likely be able to complete the form along with other paperwork for their office visit.
Time – Moderately time-intensive. Staff burden is reduced by having patients complete all screening questions independently; however, a staff member must manually review the questionnaire and score the measure to determine the level of risk, as well as to conduct the brief intervention.

Computer / Mobile

Advances in computing technology and the increased interest in modernizing the health care system make computer-delivered screenings an appealing option for many organizations. Electronic versions of SBIRT measures can be adapted from existing paper-based measures for use in a variety of health care settings and may work well for your needs.

Feedback
Computerized screening measures can be calibrated to automatically score client screening questionnaires, instantly identifying "positive" clients and saving valuable time. Screening results can be printed out for both the person performing the BI to review and incorporate into the conversation with the client AND for the client to take home and review individually. Alternatively, depending on the level of sophistication of your organization's IT system, the screening results and feedback guidance can be electronically delivered to the person completing the BI, making the process entirely paperless.

Depending on your organization's resources and available space, there are some useful options to consider for making use of computer-based screening tools.

Desktop computers

Some offices may find that a desktop-based screening tool is the best option. For example, your organization may already use desktop computers in the waiting area for completion of other information (e.g., medical history questionnaires) or for patient use (e.g., internet connectivity). When using a desktop-based system that is located in the waiting area, you may need to connect a printer to the computer so that feedback results can be printed out. Another option is to network the computer so that results may be printed in another location (e.g., behind the reception desk).

A desktop solution may also suit your needs well if your organization plans on having a space dedicated to the SBIRT process. This can either be a separate patient room (a location where both the screening is completed on the computer and the intervention is delivered by the health care provider) or it may be a shared space. Whatever the situation, this computer setup may benefit from having either a printer connected locally for feedback printouts or a networked connection that would allow the person performing the BI to collect the printed results from another location in the office. Alternatively, this can be a paperless option if the feedback is reviewed with the client directly from the computer screen.

Laptop computers

Laptop computers have become much more affordable in the past several years, and basic models can be procured for only a few hundred dollars. SBIRT-related screening programs and feedback results will generally require no advanced computing features (i.e., minimal RAM and processing speed should be sufficient), and as such a low-end model can be purchased at a minimal cost.

The portability of laptop screening allows for flexibility and adaptability as far as location of the screening and even timing of the completion of the items. For example, clients may complete the screening in the waiting area or in another location (e.g., while the patient is in the examination room waiting for the physician to arrive).

Mobile Applications/PDA

A Mobile Application or PDA-administered screening may best be suited for offices with limited space and minimal electronic infrastructure. The application can be utilized by staff to access the screening items, deliver them orally to the client, and instantly score the results. This approach might best be described as a technology-assisted version of an in-person delivery of the screening session; after all, the application primarily serves as a tool to prompt for the screening questions and to automatically score the responses. Much like a strictly in-person screening, this approach is time-intensive.

Costs – Varied, depending on the method (e.g., desktop, laptop, etc.) employed and the amount of technological infrastructure already in place at your organization. This can be the most time-efficient method and may save costs in terms of staff time spent delivering SBIRT services; however, if your organization does not have a computerized system in place and/or you do not

have access to computer programmers to program the screening tool and scoring into your current IT system, this could be very expensive to put into place.

There are some free online screening resources that may assist organizations who have computers, but don't have computer programmers readily available. For example NIDA has an online clinician's screening tool for drug use in general medical settings which can be used to administer the ASSIST. This website also automatically provides a score and guidance on intervention based on the score level; see the Resources section at the end of this chapter under "Links to Online Screening Resources".

Training – Moderate; Staff must be trained on the screening software, technical logistics (e.g., where feedback is printed and how to interpret the feedback), and some minor trouble-shooting.
Space – Least intensive. Can use in waiting room.
Time – Least demanding. Screening questions are completed independently by the client and automatically scored by the computer, saving valuable staff time.

Choosing your Screening Population (Subgroups or Whole Population)

Selecting the population or group of clients that your organization will target with SBIRT is another important issue to consider before beginning implementation, although you can always revisit your decision. To begin, you may consider delivering SBIRT to your entire client population, i.e., every patient who comes through your clinic's/venue's doors. This approach is neither excessive nor inconsistent with the underlying objectives of SBIRT. In fact, SBIRT is ideal for broadly screening many clients and then narrowing down the population to those identified as "at risk" and in need of additional intervention or services. To be sure, not every organization can realistically implement SBIRT for the entire population serviced by the organization. There may be limited resources which restrict the expansiveness of the program, or there might be a specific need to target a subpopulation as a priority. Larger organizations (such as major networks of hospitals and clinics) may choose to implement SBIRT in only one area of their system (e.g., ED only, clinics only, etc.) or perhaps target sites that have some unique needs or features that work best for SBIRT. Others may choose to pilot SBIRT at one or more sites, tweaking the program before rolling it out to other sites in the network.

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SCREENING RESOURCE LINKS

Substance Use Measurement Collection from the Addiction Research Institute:
http://www.utexas.edu/research/cswr/nida/instrumentListing.html

Links to Screening Tools:
http://medicine.yale.edu/sbirt/curriculum/screening/100692_Audit.pdf
http://medicine.yale.edu/sbirt/curriculum/screening/100691_ASSIST.pdf
http://medicine.yale.edu/sbirt/curriculum/screening/100693_CAGE_Questions.pdf
http://medicine.yale.edu/sbirt/curriculum/screening/100694_CRAFFT.pdf
http://medicine.yale.edu/sbirt/curriculum/screening/100696_NIAAA3quest.pdf
http://medicine.yale.edu/sbirt/curriculum/screening/108876_AlcoholYouthGuideNIAAA.pdf
http://www.drugabuse.gov/nmassist/
http://medicine.yale.edu/sbirt/curriculum/screening/100697_nmassist.pdf
http://www.ahrq.gov/clinic/tobacco/tobaqrg.pdf
Links to Online Screening Resources:
http://www.drugabuse.gov/nmassist/?question=1
http://www.alcoholscreening.org/Home.aspx
http://www.drugscreening.org/
Screening and Brief Intervention Script from Project ED Health (NIAAA):
http://medicine.yale.edu/sbirt/curriculum/screening/100698_sbirt_script_7jul09.pdf
SBIRT Oregon Screening Tool Examples and Reference Sheet:
http://www.sbirtoregon.org/resources/SBIRT-reference-sheet.pdf
http://www.sbirtoregon.org/resources/SBIRT%20-%20Annual%20Screen.pdf
http://www.sbirtoregon.org/resources/SBIRT%20-%20AUDIT.pdf
http://www.sbirtoregon.org/resources/SBIRT%20-%20DAST.pdf

VIDEO LINKS

Screening and Brief Intervention Examples from SBIRT CO:
In Person Screen: http://www.improvinghealthcolorado.org/files/flash/process_320x240.swf
Self-Administered Screen: http://www.sbirtoregon.org/get-vid.php?vid=method
Training Videos for Emergency Practitioners from Yale School of Medicine:
http://medicine.yale.edu/sbirt/curriculum/video/index.aspx

3 | BRIEF INTERVENTION

There is a vast amount of literature, as well as many manuals and training videos on performing brief interventions (BI) with risky substance users. This chapter will offer some information on BI and throughout this manual we highlight the external resources available to learn more about conducting BI.

How the brief intervention is carried out is typically guided by two main factors.
1. Severity of substance use
2. Resources (time/space for the intervention)

These factors must be addressed simultaneously because the combination will determine how/who/where/when the BI will be done.

Severity of substance use is the primary factor that should guide the BI. Similar to any other health concerns, your intervention approach should be a hierarchy based on the threat of harm to the patient. Severe and frequent substance use is a serious mental and physical health concern.

While availability of time and space is a factor, having a system in place of who will review positive screens and perform the intervention at the outset of the program will help you determine what you can achieve. Assuming you have adequate staffing to perform the BI, time can vary. At the end of this chapter, we give an example of how a BI can be handled if you only have a few minutes.

Screening Results will Guide the Intervention

Your screening measure will give you an idea of how to proceed with the individual. For example, according to SAMHSA, when screening for alcohol, only about 4-5% of individuals who are screened will fall in the alcohol-dependent range and need a referral to treatment. About 25% will be in the risky alcohol use category and should receive a brief intervention, and the remaining 70% will be abstainers or low-risk alcohol users only requiring positive reinforcement.

Guidelines on patient risk levels and recommended courses of action are available with some screening tools. For example, if using the NIDA-Modified ASSIST screening tool, the guidelines are below (see resources section at the end of this chapter for a link to NIDA's website on screening and brief intervention):

Risk level based on assessment	Therapeutic Strategy
Lower Risk	Provide feedback, education, reinforce abstinence and offer positive reinforcement and support
Moderate Risk	Brief intervention including: feedback, advice, assessment of readiness to change, assistance in changing
High Risk	Brief Intervention AND referral to specialty treatment.

Be aware that not only dependent substance users are in need of specialized addictions treatment. It is possible that risky substance users who are only in the moderate risk range might be appropriate candidates, especially if they have a prior history of substance dependence or major substance use-related health problems (e.g., liver damage) and have failed to achieve their goals despite extended brief intervention.

In the next section we discuss the elements of a brief intervention in more detail. For those who are low risk and just need education, you may offer positive reinforcement (e.g. "your drinking pattern tells me you care about your health") and education. For example, if you are giving educational materials to low-risk drinkers, offering a tangible copy of something is helpful; you may also give web links through email (see resources at the end of this section for example brochures from NIDA).

BASIC ELEMENTS OF A BRIEF INTERVENTION

Below is a brief how-to guide for doing a brief intervention. Reviewing this section should be supplemented by additional training in brief interventions; please see the external resources provided at the end of this chapter for training information and videos.

The duration of a brief intervention can range from a few minutes to 30+ minutes, or even to several short sessions. Here is one example of how to conduct a brief intervention:

Open the Conversation

- As you review results from the screening tool, explain to the patient that you are screening all patients for risky substance use as a part of their routine care.
- Elicit the client's view of their own substance use.
- Example:
  - "Hello, I am _____. I'm a behavioral health counselor here in the office. As a part of the routine medical care we provide to our patients, we are now screening all patients for substance use, which is why you filled out the questionnaire about tobacco, alcohol, and drug use while in the waiting room. I'd like to know what you think about your own substance use. Have you ever thought about it? Do you have any concerns?"

Share Feedback

- Show the patient/client how much substance use they reported and describe their patterns of usage.
- Explain the level of health risk indicated by the patient's/client's responses and how his/her substance use compares to others.
- Example:
  - "I'd now like to show you a summary of the substance use that you reported on the questionnaire. This is how your use compares to the rest of the population. What do you think of these numbers?"

Importance of Feedback: Research has highlighted that one of the primary mechanisms of brief interventions is normative feedback[1]. Therefore one needs to have a way to administer questions that allows for creation of useful feedback for the patient which can include frequency norms, binge/consumption norms, risk factors, negative consequences, and dependence symptoms. The feedback will guide and determine how you proceed and increase motivation.

Share Concerns

You may only have a few minutes to be with the client. After reviewing the feedback and hearing the client's concerns, you can simply share your concerns by highlighting the consequences of substance use and your genuine concern for the patient. This can be very powerful – especially when you have limited time. If you have more time you can do a more formal motivational interviewing session using some of the elements below[2,3].

Increase Motivation using Motivational Interviewing Techniques

- Elicit the client's view of the problem.
- Recognize that patients/clients will vary in their receptivity to thinking about their substance use as a problem.
- Communicate that change is up to the client/patient, they will not be forced into any decision or action that they did not choose.
- Provide information and advice.
- Elicit from the client what (s)he perceives to be…
  - the possible benefits of action and the likely negative consequences of inaction?
  - the pros and cons of use?
- Elicit self-motivational statements by having the client voice personal concerns and intentions.
- Get the patient/client to speak about the why and how of making changes in behavior.
- Listen with empathy and reflect what the patient/client said.
- Compliment the patient/client on their strengths, motivation, intentions and progress.
- Adjust to, rather than oppose, patient/client resistance. Avoid argument and direct confrontation.
- Develop discrepancy between patients' goals/values and their current behavior. This helps patients to recognize where they are and where they hope to be.
- Summarize the patient/client's concerns.

Set a Goal

- Use readiness ruler (see link in resources section) to determine the patient's "readiness to change". Establish a goal for changing substance use. Provide advice on reaching the goal (e.g., self-monitoring, coping skills, etc.) and whether goal is feasible. Summarize the client's view, key discussion issues, and the agreed upon goal(s).
- Understanding abstinence vs. moderation.
- Identify barriers and tools/solutions
- Develop a change plan
  - What strategies has the client used in the past to make successful changes? That's a good starting point.
  - Have the client list some things to change AND come up with some expected/potential challenges/barriers to making those changes.

Referral or Follow-up Plan

- For those who need specialty treatment, provide a referral – make sure you speak to a live person when available and set up a follow-up appointment.
- For those who either will not attend specialty treatment or do not need it but are at risk, scheduling a follow-up session is an important means to help people meet their goals.

- Explain self-monitoring as a means to assessing substance use over time
- See referral section

What Are the Most Important Mechanisms and What Do I Do if I Only Have a Few Minutes?

If you have limited time, the most important pieces that can be accomplished in 5 minutes are:

1. Review results and offer feedback compared to norms.
2. Assess the client's view of their substance use
3. Ask client about goals and if nothing is suggested offer suggestions and options on goals based on severity and problem recognition.
4. Provide educational materials or links to web-based tools
5. Set up follow-up appointment

While this may seem like too much to do in 5 minutes, it is entirely possible especially considering that steps 4-5 take no time at all. Aside from a non-judgmental approach it is important to remember that you CAN make suggestions on goals if the client is resistant or unsure as long as it is empathetically delivered. If you only have two minutes, simply take out step 2 (client's view), offer medical advice based on the screening results, and give the client the self-help tools (s)he needs.

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BRIEF INTERVENTION LINKS

Readiness ruler:

http://www.sbirtoregon.org/resources/Readiness%20ruler.pdf

NIDA Brief Intervention Guide and Patient Handouts:

www.drugabuse.gov/nidamed/nmassist-screening-tobacco-alcohol-other-drug-use

Training resources from NY OASAS Website:

http://www.oasas.ny.gov/training/providers.cfm?providerType=SBIRT4&sbirt=4

http://www.oasas.ny.gov//AdMed/sbirt/index.cfm#training

Training Resources from Yale School of Medicine:

http://medicine.yale.edu/sbirt/curriculum/index.aspx

Training Resources for Primary Care from Oregon SBIRT:

http://www.sbirtoregon.org/training.php

BRIEF INTERVENTION VIDEOS

Screening and BI videos from SBIRT Colorado:
http://www.improvinghealthcolorado.org/healthcare_videosandwebcasts.php

SBIRT Videos from Boston University School of Public Health:
http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/

4 | REFERRAL TO TREATMENT

Clients will be referred to treatment if their screening score indicates this more intense course of action is appropriate in addition to or instead of a brief intervention. The goal of a referral should be to assure that the patient/client contacts a specialist for treatment, as the screening indicates that their substance issues may be too severe to be managed with only brief intervention and/or that they need additional assessments to determine the severity of the problem.

Providing the patient/client with a specialist's contact information is usually not enough to ensure that (s)he will make the decisive step to seek treatment. Many factors may come into play in the patient's decision for or against contacting a treatment provider. While most people are aware of their risky substance use, many are resistant to taking immediate action to change. It is therefore important to diminish patients'/clients' uncertainty with regard to what is involved in addictions treatment.

After presenting information about available treatment service options, describing the treatment agency patients will contact, the mental health workers they will meet and the treatment they will receive, patients/clients are likely to be more receptive to making a decision to enter treatment. Financial aspects can create a major barrier to treatment. Much attention should be focused on collaboratively evaluating which treatment options are available through the patient's/client's health plan and/or out-of-pocket. Also, if a patient has been in treatment in the past, inquiring what the client/patient did and did not like about his previous treatment experience may prove helpful in identifying a suitable treatment option that the patient will accept.

By the time you recommend a referral, some of the ambivalence should be resolved. If the client/patient consents, a first appointment with the treatment agency can be arranged on the spot. When calling the treatment agency, make sure to speak to a live person and to answer any questions that the patient may have.

If a client/patient is resistant, a referral is unlikely to be kept. At minimum you can suggest that there is no harm in contacting the treatment provider and they can always leave, if they decide to go. Moreover, simply highlighting that as their healthcare provider, you think this is one of the best things they can do to improve their health can be very powerful.

If a client/patient is unwilling to attend treatment or does not fulfill the clinical criteria but is at risk, a follow-up session should be scheduled to monitor his/her substance use over time. Follow-up sessions can easily be conducted over the phone. In order to make the telephonic follow-up most efficient, the client/patient should indicate at what hours he/she can best be reached during the week.

Establishing a Referral System

The effectiveness of the referral process is not only dependent upon the degree to which clients/patients can resolve their resistance, but relies mostly on the ability of your agency to establish solid linkages with treatment agencies.

This requires sound preparation on the part of your agency before a referral can go into effect. According to the World Health Organization and the Centers for Disease Control and Prevention, there are several steps to consider when creating a referral system[1]:

- Use the SAMHSA treatment finder (http://findtreatment.samhsa.gov/) to find treatment providers that are easy for your patients/clients to reach either by foot or public transport.

- Obtain information about costs and which health plans cover addictions treatment services (e.g., Medicaid, Medicare, state assistance, and public programs).

- Identify the types of services offered by each provider (e.g., Cognitive Behavioral, 12-Step, Motivational Enhancement Therapy), modalities (e.g., in-patient, out-patient), and language options (e.g., Spanish).

- Find out whom to contact to refer a client/patient and familiarize yourself with the necessary procedures for enrollment. Instead of just compiling phone numbers, develop a working relationship with the treatment agency and invite providers to describe their services to the rest of the team.

- Prepare short descriptions of the available treatment options so patients can understand the differences among alternative approaches.

- Compile a training manual for staff on how to make a referral to local addictions treatment providers, addiction physician specialists (e.g., addiction medicine specialists and addiction psychiatrists), and on mutual-help groups in the community (e.g., Alcoholics Anonymous). Include this information in the orientation and in ongoing training for future employees.

- Coordinate with the treatment provider to schedule follow-up upon completion of treatment. Following treatment, patients should be monitored in the same way a primary care provider might monitor patients with cardiovascular disorders. Periodic monitoring and support may help the patient resist relapse or control its course if relapse occurs.

Follow-up Appointments after a BI

Similar to any medical test, if someone screens positive for risky substance use, and a referral is made, follow-up is essential. Setting up a follow-up appointment at the end of a session will help the client increase their motivation to reach their goal. An addition to this is simply asking the patient to monitor their use for the next appointment.

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REFERRAL VIDEO
See Screening and Brief Intervention Sections for Referral Video Examples

5 | CONTINUOUS QUALITY IMPROVEMENT

He who ceases to try and do better ceases to do well. – Oliver Cromwell

SBIRT has been found to be effective in reducing substance use and creating healthcare cost savings. However, despite sounding simple, it can be difficult to implement and sustain over time. One thing we have learned is that SBIRT needs to be adapted so it can fit into the work flow of each setting. To build a sustainable SBIRT program, staff need to have tools for adapting SBIRT to their specific situation. These tools are called change process strategies. There are several change process strategies that have received empirical support in healthcare settings, one of which is Continuous Quality Improvement (CQI)[1,2] discussed in this section and the other is Tailored Implementation Strategies (TIS)[3], discussed in the next section.

We would like to emphasize that organizations should work in small iterative steps, slowly adapting SBIRT components into their workflow using the techniques described below, rather than launch one big project. It is important to make small, progressive changes to determine what works and what does not, before launching a large project that has been poorly integrated into the workflow of your settings. For example, you may start screening clients on one or two days of the week with a limited number of staff and see how that goes before implementing screening every day with all staff.

The secret to a good SBIRT program start and continued high-quality performance is appropriate quality improvement. This means that once staff are trained properly in SBIRT and are ready to begin providing SBIRT services, you must measure performance regularly and compare your results with a standard of excellence. Communicating the importance of effective and efficient services and providing measures of performance is a way to maintain adherence to the program. If performance results do not come close to goals, you may have loopholes in your plan and need to revise them.

Because you are newly integrating SBIRT into your practice, you are incorporating a new system into an existing system. Using a process improvement/continuous quality improvement design will effectively help you maintain your SBIRT program based on YOUR needs.

What is Continuous Quality Improvement (CQI)?

CQI is an approach to quality management that emphasizes the role that organizational and systems components play in influencing outcomes and performance. CQI places the focus of correction and change (i.e., quality improvement) on the "process" as opposed to the "individuals" involved in operations. Another principle feature of CQI is that it requires the utilization of data to bring about and monitor improvement. This is sometimes referred to as a data-driven approach to

change. There is also an emphasis on using project champions and forming process change teams to bring about system changes. Finally, inherent in the CQI methodology is the notion that improvement is always possible; there is no such thing as a perfect process or system. Continuous learning is therefore paramount. CQI recognizes that changes can always be made to improve work flow (increase efficiency) and/or outcomes (improve quality). In summary, the key features of CQI are: 1) Emphasis on system over individuals; 2) Project champions and process change teams; 3) Data-driven approach: use of measurement/metrics; 4) Empirical testing: rapid cycle change/experimentation.

1. Emphasis on the System over Individuals: There are No "Bad Apples"

CQI does not seek to blame people for shortcomings in performance. Rather, there is an underlying assumption that the <u>system</u> is the source of error and must be modified or improved to most effectively make use of human resources and optimize performance. Rather than look for individual employees that are "letting the team down," or "slowing down the process," a CQI approach assumes that system errors or workflow barriers are to blame for breakdowns in performance. CQI is therefore supportive of employees and values them as active contributors to the improvement process.

2. Project Champions and Process Change Teams

A Project Champion is someone who leads the change effort and promotes the benefits of SBIRT. This individual should be knowledgeable about the site where SBIRT is being implemented, energetic, and influential. The Process Change Team is a group of individuals with knowledge of the system needing improvement. This team should include a broad spectrum of employees, from the front line staff working on the actual process (e.g., the health educators doing an SBIRT screening) to the CEO (or other executive) that can remove barriers and provide top-level buy-in for any changes being implemented. Diverse perspectives and levels of education/expertise will enrich the problem-solving process involved in carrying out CQI tasks. Change Team participants should be "team players" and should approach problem-solving with open-mindeness and some creative flair. We have provided you with a worksheet (Worksheet #1) to facilitate forming process change teams in Chapter 8 of this manual.

3. A Data-driven Approach

A core element of CQI is the heavy reliance on data. Any change should have a targeted objective which is *measurable*. It is important that the objective is clear and that there is an agreed-upon metric for measuring change. The change/metric can be very basic. For example, it might be the number of patients who complete a written alcohol screening questionnaire while waiting to see the doctor. All changes should involve the collection of data associated with those changes as well as a clear measure of how the team will know that a "change" has occurred. We discuss ongoing performance monitoring in more detail in Chapter 7 of this manual.

4. Empirical Testing

CQI uses rapid-cycle change strategies to achieve improvements in quality. This process is essentially a rudimentary version of the scientific method and is often referred to as Plan Do Study Act (PDSA). The changes are "rapid" in the sense that they are mini-experiments that can be conducted quickly and over a short period of time (e.g., one week). We will discuss PDSA cycles in more detail in Chapter 7 of this manual, and also provide you with PDSA cycle worksheets (Worksheets 5a, 5b, and 5c) in Chapter 8.

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CQI LINKS

Institute for Healthcare Improvement (IHI):

http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/testingchanges.htm

NIATx:

http://www.niatx.net/Home/Home.aspx?CategorySelected=HOME

Improving Chronic Illness Care:

http://www.improvingchroniccare.org/index.php?p=Care_Coordination&s=326

6 | Barriers to Change and Tailored Implementation Strategies

Barriers to implementing SBIRT are complex and may be at different levels of the system, ranging from the state and organization level to the staff and patient level. Sites where SBIRT is being implemented are likely to be busy and may not have a great deal of resources to dedicate to a complex substance use intervention. However, in addition to using CQI techniques, a second empirically-based change strategy called Tailored Implementation Strategies (TIS[4]) can help in successfully implementing SBIRT. The core message of TIS is that, in order to succeed, SBIRT needs to be tailored to your local setting. For example, if 5 minutes worth of brief advice on substance use is all that your staff can perform, then this should be incorporated into the SBIRT model for your setting. If you have the staff and resources for more elaborate (e.g., 15+ minutes or multi-session) brief interventions, then the SBIRT model for your specific setting can reflect this.

Using TIS, you will identify barriers and facilitators specific to your site in order to inform the implementation process and assist in tailoring SBIRT to your local circumstances. The idea here is that each site where SBIRT will be implemented will have unique aspects that help or hinder incorporation of SBIRT. As a general statement, if SBIRT can be performed in the busiest emergency rooms in the country, it can be performed anywhere!

What are Common Barriers and Facilitators to Implementing SBIRT?

Common barriers and facilitators include: 1) provider attitudes and competence; 2) workflow and resources; 3) SBIRT adaptability; 4) organizational support; and 5) patient/client attitude and background.

1. Provider Attitudes and Competence

Lack of provider knowledge and skill, and low confidence in their capacity to deliver SBIRT have been identified as major barriers to SBIRT implementation. Further, staff may believe that SBIRT is not part of their role. Providers may also be extremely busy and face many competing demands when seeing clients/patients. Studies suggest that general training has only modest effects on SBIRT providers, and that greater training intensity (including on-site coaching) leads to better results[1]. Changing provider skill and attitude may require intensive and long-term efforts and it should be recognized that didactic training alone is typically insufficient[2]. For example, studies have shown that training sessions work best when there is follow-up coaching and/or ongoing assessment with constructive feedback.

2. Workflow and Resources

Competing demands, financial constraints, and limited resources affect implementation of SBIRT. In busy settings, providers have limited time, or may be faced with demands from other initiatives. Settings may not have the financial resources to hire additional staff to deliver SBIRT and may need to utilize current staff to deliver it. In some statewide SBIRT programs, dedicated counselors delivered SBIRT; however, program leaders concluded that while this model worked well in a specially funded demonstration project, it was not sustainable due to staffing costs[3].

3. SBIRT Adaptability

Each setting where SBIRT is implemented is different. Therefore, adapting SBIRT to local settings is important. Tension between the need to achieve full and standardized implementation while providing flexibility to address local concerns requires careful consideration.

4. Organizational Support

Gaining leadership support and buy-in at each organizational level is an indispensable element in any implementation effort. Organizational leaders must be willing to provide resources for successful implementation. For example, time for SBIRT training, coaching, and supervision must be released. The use of electronic medical records and automated clinical decision tools facilitates SBIRT. Having a strong network for referrals to specialty care as well as availability of expert consultation and, if needed, co-management of cases also facilitates SBIRT.

5. Patient/Client Characteristics and Background

Some patients/clients may be reluctant to answer questions about their substance use. This may vary depending on the individual's cultural background, the relationship with the provider and the way in which SBIRT questions are introduced.

What are Tailored Implementation Strategies (TIS)?

In TIS, barriers to implementation in specific settings are prospectively assessed using formal evaluation methods, and a plan is developed to address identified barriers. The plan is then implemented and evaluated in a process improvement cycle (e.g., PDSA). Research suggests that this strategy is promising in sustainably introducing changes to work routines in healthcare settings[4].

Customizing SBIRT to your agency is crucial. There are so many unique features of practices that it is naïve to expect that having a one size-fits-all approach would work for all agencies. Customizing SBIRT to your agency requires ongoing process improvement strategies which consist of trial-and-error implementation and ongoing modification of the program. However, there are some universals including creating a client-centered program and having strong referral linkages in place

for positive–screen clients interested in obtaining more help. The easiest methods to understanding your specific setting with all its benefits and challenges are: 1) Initial Barriers and Facilitators Assessment; 2) Identification of the Workflow of your Setting.

1. Initial Barriers and Facilitators Assessment

One way to determine what will be a barrier or facilitator to implementing SBIRT is to conduct an assessment. This process will highlight some of the most common factors that should be addressed when integrating SBIRT into your agency and will help you think about how each single issue may best be resolved given your particular program. We have provided you with a barriers and facilitators assessment tool to help with this process; see Worksheet #2 in Chapter 8 of this manual.

2. Assessing the Workflow of your Setting

Process Mapping. One of the most important features of integrating SBIRT into your agency is process mapping. Process mapping creates a work flow chart that describes the experience of a client from their first contact or appointment at the agency to when they leave. Process mapping will help you visualize the areas where you can integrate SBIRT with least disruption of care as well as areas where there may be barriers or inefficiencies in your system. Process mapping helps you make decisions based on your unique needs.

Shadowing, Observation, and Walk-throughs. Additional techniques to get to know your SBIRT setting are to shadow a key staff member at the site, or to observe the site and document workflow patterns. Another option is to pretend to be a patient/client by making an appointment and going through the system from start to finish as a patient/client ("walk-through"). Each of these techniques allow for a more in-depth understanding of how clients/patients and staff operate together within the system.

We suggest using process mapping along with one of the other techniques discussed; the choice should be based on implementation practicality, given your specific setting. Once these activities are completed, you can use a process improvement cycle (e.g., PDSA) to begin implementing SBIRT customized to the specific needs of your setting. We have provided you with an example of a process map and a worksheet (Worksheet #3) to help you create a process map in Chapter 8 of this manual.

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7 | SBIRT Implementation Toolkit

In the previous sections we have reviewed the basics of SBIRT as well as the background on CQI and TIS. We will now provide a step-by-step guide to employ these strategies using five basic tools:

- Tool 1: Identify a Champion and Form a Change Team
- Tool 2: Assessment of Barriers and Facilitators
- Tool 3: Process Mapping and Getting to Know the Venue
- Tool 4: PDSA (Plan, Do, Study, Act) Cycles
- Tool 5: Ongoing Performance Monitoring

In **Chapter 8** of this manual, we have also provided worksheets that can be used to help guide the process.

Tool 1: Identify a Champion and Form a Change Team

The Project Champion leads the Change Team and should be someone who is a team player, knowledgeable about the system, enthusiastic, and well-respected. This person will essentially begin to change the norms of the venue to favor SBIRT. In addition to the Project Champion, the Change Team will consist of the 2-3 additional members who are involved in the system in which SBIRT will be implemented. **Worksheet 1** provides further information on how to successfully form a Change Team, assign roles, and structure meetings.

Tool 2: Assess Barriers and Facilitators

A first step in understanding your setting's needs is to conduct a barriers and facilitators assessment. **Worksheet 2** provides examples of a wide variety of barriers and facilitators known to affect SBIRT. The Change Team should use this worksheet to identify the relevant barriers/facilitators at your site and discuss potential solutions.

Tool 3: Process Mapping and Getting to Know the Venue

Process mapping. Developing a process map will allow you to visualize the workflow of your site. First, conduct a process map of the "status quo" of your worksite, i.e. without SBIRT services incorporated. This will help you to visualize the current workflow at your site and can foster discussion regarding where in the process SBIRT components may be incorporated. You may then wish to create additional process maps which incorporate SBIRT components. **Worksheet 3** takes you step-by-step through process mapping, and provides an example of a process map that has incorporated SBIRT components into the workflow.

Depending on your situation and your site, you may need to make some preliminary decisions about how SBIRT will be conducted. For example, how will screening be completed? Will you use a paper-and-pencil form that clients/patients complete themselves or will you do an in-person interview? **Worksheet 4** will help you identify some of the decisions that need to be made and will prompt you to identify pros and cons involved with each option. This worksheet can be used in conjunction with process mapping (**Worksheet 3**) to help you make decisions along the way.

Getting to know the setting. At this point you should also conduct additional activities to get to know, in detail, the setting in which SBIRT is being implemented. This can be done by shadowing a key staff member at the site, observing the site, or conducting a walk-through. You may wish to do one or more of these activities. These activities can be done prior to process mapping, or after process mapping. Each has advantages: gaining an in-depth understanding before process mapping can make putting together a process map easier; doing it after process mapping can cue you into the accuracy of your process map.

Tool 4: PDSA (Plan, Do, Study, Act) Cycles

At this point, you should have identified a Project Champion and Change Team, assessed barriers and facilitators, and process mapped and gotten to know your venue (e.g., shadowing). Now you are ready to **P**lan/**D**o/**S**tudy/**A**ct (**PDSA**). The PDSA cycle is what the Change Team uses to test whether potential solutions and ideas generated during barriers assessments and process mapping are workable and indeed have the outcomes desired. As part of the PDSA cycle, the Change Team will need to brainstorm potential strategies for implementing SBIRT as well as the changes that ought to be made to accomplish this goal. Brainstorming is an important aspect to implementing a CQI strategy. It should be noted that it is common for different members of the group to understand the system "flow" differently. Some keys to *effective brainstorming are*:

- Provide a clear objective for the session beforehand
- All ideas are welcome
- Record ideas on a flip chart
- Encourage participation from all involved
- Creative thinking (e.g., pretending that money were no object, etc.)

During PDSA cycles, you will be applying the scientific method to test and refine changes by planning, collecting and using data for facilitating effective decision making. A big idea behind the PDSA cycle is that the Change Team should conduct small, brief, relatively inexpensive experiments before deciding whether to devote a lot of resources to fully implement a new way of working. The small experiment can help determine whether a change can be done and whether the change is worthwhile (e.g., cost-effective). The PDSA experiment has the following steps:

1. *Plan* – Design an experiment that tests a particular question or idea. The plan should identify the who, what, where, when, and how of the small experiment.

2. *Do* – Conduct the experiment.
3. *Study* – Analyze the data and summarize the lessons learned.
4. *Act* – Decide whether the tested solution should be implemented or move on to another potential solution.

The Change Team works through multiple consecutive PDSA experiments as it strives toward achieving its SBIRT aims. This process is a cycle because the team typically starts a new PDSA soon after concluding a prior one, with the goal of making gradual changes that together progress toward achieving the team aims and mission. **Worksheet 5a** is a step-by-step guide to conducting a PDSA, **Worksheet 5b** is a PDSA checklist to keep you on track, and **Worksheet 5c** is an example of a PDSA cycle.

Tool 5: Ongoing Performance Monitoring

Once your PDSA cycles are completed and SBIRT is being implemented at your site, it is important to use data to monitor your progress. The Change Team should discuss exactly HOW they will define and measure success. *What metric will be used? Who will collect the data? Who will analyze the data?* Broad, general aims may be tracked and monitored over time and connected to the overall mission of the Change Team. Data will always drive decisions in a CQI approach to SBIRT implementation. Potential outcomes to collect information on are:

- Total eligible patients/clients
- Percent of patients/clients receiving screening
- Percent of patients/clients with a positive screen
- Percent of patients/clients receiving a brief intervention
- Percent of patients/clients receiving referral to treatment
- Percent of patients/clients receiving screening
- Percent of patients/clients receiving follow-up

Toolkit Essential Ideas

Using the five tools discussed in this chapter along with the worksheets provided in the next chapter, you will be well on your way to successfully implementing SBIRT in your setting. We have provided one final worksheet (**Worksheet 6**) with issues that should be considered when implementing SBIRT. These issues include, developing protocols for your settings, and informing all site staff about SBIRT. Some final key ideas to keep in mind through the SBIRT implementation process are to:

- ✓ **Be proactive:** don't think of quality management as monitoring things after they are done
- ✓ **Empower all employees:** quality improvement is everybody's responsibility
- ✓ **Think in measurable terms:** mission and aims should be stated in ways that can be quantified
- ✓ **Use small experiments:** think PDSA

- ✓ **Be creative:** be willing to depart from business as it has always been done
- ✓ **Use a team approach** – enlist people who are interested and will be affected by SBIRT implementation.
- ✓ **Have a dedicated project champion**. Give someone the responsibility even if multiple individuals are performing SBIRT. Like any project, one individual being the team leader will reduce diffusion of responsibility.
- ✓ **Highlight process improvement as the goal.** SBIRT is a flexible program and can be adapted to nearly any setting. The goal is to improve the health and wellbeing of our patients and clients while simplifying the work processes involved.

8 | Continuous Quality Improvement

Toolkit Worksheets

WORKSHEET 1 | Change Team Checklist

> The task of the **Change Team** at your venue is to successfully implement SBIRT practices while minimizing disruptions to care.

The Change Team will have regular on-site meetings to evaluate and optimize the implementation and effectiveness of SBIRT. The team will be self-directed and employ quality-improvement strategies that result in rapid cycle change. In other words, the team will foster innovation through small-scale experimentation using the so-called Plan-Do-Study-Act (PDSA) framework.

The success of the team will depend on the team's ability to work together. Team members should be creative and motivated to simplify the way work is organized.

3 STEPS TO A SUCCESFUL CHANGE TEAM

1. Choose the Team

The Change Team will consist of 2-3 members. Consider the following professionals as possible team members:
- Primary Care Physician
- Nurse Specialist
- Behavioral Health Specialist/Health Educator
- Administrative Staff
- Reception/Intake Staff
- Representative of Record Keeping/Billing/Data Management

Potential ad hoc members may also be invited.

2. Assign Roles

Delegating responsibilities within the team will help things move along in an efficient and effective manner. Roles will differ in scope and time investment, but every team member should have specific responsibilities. Specific project roles include:

Project Champion – This person will lead the team in implementing SBIRT at your agency.

Clinical Team – These individuals actually implement SBIRT in the clinic. It will include people who are involved in the process, from intake/reception to the clinician doing the intervention.

Once you have formed the Change Team and assigned team member roles, you can use **Table 1** for documentation.

3. Structure Meetings

Structuring team meetings based on the following outline will help your Change Team work together efficiently. Creating a routine meeting day and time that is compatible with the members' schedules can be very helpful.

- Clarify the objective of the meeting
- Review the agenda of the meeting
- Work through the agenda items
- Summarize the content of the meeting
- Develop an agenda for the next meeting
- Evaluate the meeting
- Distribute the meeting summary and agenda among Change Team members via email

Table 1 | Template for Change Team Members' Contact Information

VENUE NAME:	
VENUE DIRECTOR The venue director is someone who understands the objectives of the NYSBIRT program and is committed to leveraging resources to deliver SBIRT services to patients/clients within their clinic or site.	
Name & credentials Phone number E-mail address Office location(s)	
PROJECT CHAMPION The project champion is someone who is able to champion the project on-site. This person should have insight into the local work environment and be able to influence the successful implementation of SBIRT.	
Name & credentials Position/role at venue Phone number E-mail address Office location(s)	
OTHER CHANGE TEAM MEMBERS (Suggest having 1-2 members to represent various groups of staff)	
Name & credentials Position/role at venue Phone number Email address	

WORKSHEET 2 | Barriers and Facilitators Worksheet

Patient/Client	Comments/Possible Resolutions	Notes
Patient Age	Patient age should not influence whether you perform SBIRT but may determine *how* it is done and will likely alter your referrals to match the demographic (e.g., elderly patients vs. young adults).	
Patient Insurance	The type of insurance/reimbursement will likely guide much of your SBIRT program. There is variation among both public and private payers in terms of what they will reimburse and the appropriate codes.	
Patient Language	Screening instruments and feedback reports should be translated if needed. Make sure you have adequately trained bi/multi-lingual staff that matches your population.	
Patient Culture	If you have a significant portion of a specific culture obtaining your services it is important to tailor your presentation to that culture to ensure the best outcomes.	
Patient Cognitive Abilities	Patient cognitive abilities (e.g. elderly with memory problems) may determine HOW the feedback is offered. Those with even mild cognitive dysfunction may need more handouts and follow-up to ensure better outcomes.	
Patient Expectations (e.g. not expect SBIRT)	Patients may be surprised that you are asking about their substance use depending on your setting. You may wish to frame your questions to relate to the reason for their visit to your agency if applicable.	
Patient Resistance	Patient resistance to SBIRT is common and is the core of the clinical training for SBIRT. Using motivational interviewing to guide screening will help with resistance.	
Patient Time Limits	Patients may not have the additional time needed for a brief intervention. Ideally, SBIRT can be performed while patients are waiting, as part of their normal visit, or if they have any down time so this will not be an issue.	
Fear of Alienating Patients	This is a concern among practitioners that is not justified. There is no research to suggest that patients will be alienated (especially if SBIRT is done properly) and SBIRT should result in the opposite effect: "they care about me and took the time to ask about these problems"	

Staff/Practitioner		
Available Staff to Perform SBIRT	If you are not hiring new staff you will need to identify those within your agency that will be willing/want to perform SBIRT. This is also usually dependent on patient flow.	
Time to Perform Intervention	Probably the most frequent concern highlighted by staff (especially in busy settings) is the time needed to perform SBIRT and its impact on the practice as a whole. Identifying the best fit of SBIRT into the workflow will assist with this issue.	
Service Coordination / Referrals	This can be a time-intensive process. Setting up linkages in advance so the referral process is smoother and more efficient will assist.	
Doubts about SBIRT Efficacy	Providing proper background and training on SBIRT should reassure those with doubts about its efficacy.	
"This is not what we do!"	Providing background and training on SBIRT and having project champions on site to change the norms around negative reactions to SBIRT can resolve staff resistance.	
Interpersonal Skills	Staff should use an empathetic, non-judgmental style to connect with patients when conducting SBIRT. Some of these techniques can be learned via training.	
Knowledge about Addiction	You do not have to be an expert in addiction medicine to integrate SBIRT into your agency. Formal training and ongoing supervision will help with this learning experience.	
Do not Feel Qualified	Staff should have initial and ongoing training.	
Do not Feel Comfortable Discussing Substance Use	You may think that patients will be uncomfortable talking about their substance use. However, research has found that patients feel just as comfortable speaking about their drinking to their medical providers as smoking and diet and find it JUST as IMPORTANT, too! Training will teach you to best approach screening and BI.	
"What's wrong with having 4 drinks in one night? I do that sometimes!"	Sometimes it feels odd to perform an intervention if you perform the behavior you are targeting. While drinking within the safe guidelines, not using drugs and not smoking is recommended, your own substance use should not deter you from performing SBIRT.	
Project Champions	It is important for there to be project champions at each SBIRT site.	

Proper Back-up	There is some concern if only one person is trained there is not proper back-up if they are out or leave the practice. While we recommend training several people, this is not always possible; there may be gaps in service.	
Available Supervisors	The availability of trained supervisors or consultants can help to bounce tough cases off.	
Ongoing Training of Staff	Like in any other type of clinical training, ongoing training and supervision is warranted. There is a large and extensive video base on using SBIRT and can be used to perform ongoing training.	
Staff for Billing	Because SBIRT will generate revenue and will require billing, it will be an additional burden to the billing department. This should not require new staff as the workload should not significantly overwhelm staff.	
Outside vs. Staff Within Organization	Some agencies might also want to simply use outside staffers to perform the screening and interventions. This has obvious pros and cons depending on your program.	
Organization		
Buy-in from Administration	Administrative and financial staff have a job to make sure the agency is not wasting money. The goal is to think of SBIRT as similar to buying a new piece of equipment. The upfront costs - which may be minimal - should be covered by the revenue generated over the long term.	
Creating a Unified Team	A unified team includes staff from all areas of your agency. If there are groups who are opposed to integrating SBIRT into the agency it can affect the entire process. Having a site champion and providing information on SBIRT to staff in all areas can help create a unified team.	
Limited Confidential Space to Perform the Feedback/ Intervention	Intervention should be performed in a private room, but extra space is often not available. Some practices may have to use different rooms each day and/or brainstorm other solutions!	
Limited Start-up Funds for Staff and Training	This is an issue but needs to be seen through the larger long-term lens. You may have to spend money on training and supplies in the short-term to obtain the long-term gains.	

Concerns about Sustaining Program	Sustaining SBIRT is a major concern– the activation of Medicaid and private insurance codes can make a dramatic difference in making SBIRT a self-sustaining program from a financial perspective. In addition, using CQI techniques can help in sustaining the program.	
Time for Training and Supervision	Initial training can take several hours to up to two days, and there may be a need for additional supervision. Using online trainings may assist in cutting down time commitments.	
Ongoing Training and CQI	Ongoing training is always an issue as new developments occur in SBIRT research. There are numerous online videos and continuing education classes that can be done continuously.	
Availability of Addiction Resources within Your Agency	All organizations should do a basic self-analysis to determine both formal addictions services available on-site as well as staff members who may have addiction intervention experience.	
Knowledge of Addiction Resources Available to Your Agency	Having formal linkages with formal specialty addiction programs is one of the most important features of SBIRT. Creating a strong network and meeting with any stakeholders may require upfront time but it will pay off for both you and the referral agency.	
Record Keeping/EMR/Data Confidentiality	Alcohol and drug information is covered under specific HIPAA rules. There needs to be a specific plan to whether screening information is kept separately or within the medical record. Specific procedures may also be needed for EMRs.	
Understanding of HIPAA for SUDs	http://www.hipaa.samhsa.gov/Part2ComparisonCleared.htm	
Ongoing Follow-up with Positive Screens	Your agency should set up a protocol for which staff will set aside time to do follow-up calls to those who had positive screens and required referrals. This will not only improve the outcomes for your patients but will highlight how much you care about them.	
Cost of Ongoing Follow-up	Like any medical procedure, you are likely not going to be reimbursed for calling and checking-in on patients. Simple phone calls can improve outcomes and help patients return to care.	
Dealing with Those who do not go to Their Referrals	Some of the best ways to deal with this is to have strong linkages created with referral sources and using a patient centered approach e.g. it seems like you are not ready to go to treatment	

	right now. If you think you might need assistance later I am here to help."…	
Screening: Computer vs. Paper	This will be specific to your agency. See screening section for guidance.	
Where to Perform Screening and BI?	Waiting room? Nurses' station? Patient room? See Screening and BI section for guidance.	
How/Who to Perform Screening and BI?	This is entirely agency dependent. It depends on what works best for your setting and workflow. See screening and BI section for guidance.	

WORKSHEET 3 | How to Create a Process Map

Process maps will make you gain an organizational focus on work processes at your agency.

1.   Why Process Mapping

Developing a process map will allow your site to visualize the SBIRT implementation process. Process maps can be used to describe new and/or existing processes and can help you identify bottlenecks and errors. A completed process map organizes your patient flows, SBIRT strategies and decision rules into a plan from which you can work out the details of what each screen, brief intervention, or referral to treatment will look like. A process map will allow you to identify key problems/bottlenecks within your system and determine where to test ideas to optimize impact (→ PDSAs, see **Worksheets 5a-c**).

Specifically, a process map should address and answer the following questions:
- What's the name of process?
- Where does the process begin, and where does it stop?
- Who does what?
- What does the process include/not include?

EXERCISE: Develop a process map of the steps that a typical client follows from initial contact (phone, walk-in, or referral) to a screening session (for an example, see **Figure 1**).
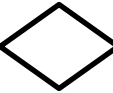
2.   Process Mapping in 5 Easy Steps

-   **Step 1:** Needed resources?
    - ✓ *A roll of brown paper/flipchart*
    - ✓ *One extra sheet of paper*
    - ✓ *Markers*

-   **Step 2:** Before getting started, the Change Team should…
    - ✓ *Define the objectives*
    - ✓ *Identify additional staff members who can provide input on the process map.*

-   **Step 3:** Draw process map, using symbols below (see **Table 2**)
    - ✓ *Define the process name, beginning, and end*
    - ✓ *Identify decision points*
   - ✓ *Identify bottlenecks*

- **Step 4:** On a separate sheet of paper, list any data collection forms that are used

  ✓ *Identify where along the process map the forms are used*

  ✓ *Record what is done with the data collection forms*

- **Step 5:** Gather suggestions for process improvements
  ✓ *Review suggested changes*
  ✓ *Evaluate ideas*
  ✓ *Discuss next steps: Test most promising ideas using PDSAs (→ **Worksheets 5a–c**)*

Table 2 | Process Mapping Symbols

process step		data symbol	
decision point (needs 2 lines leaving it)		terminator	
document symbol		connector	
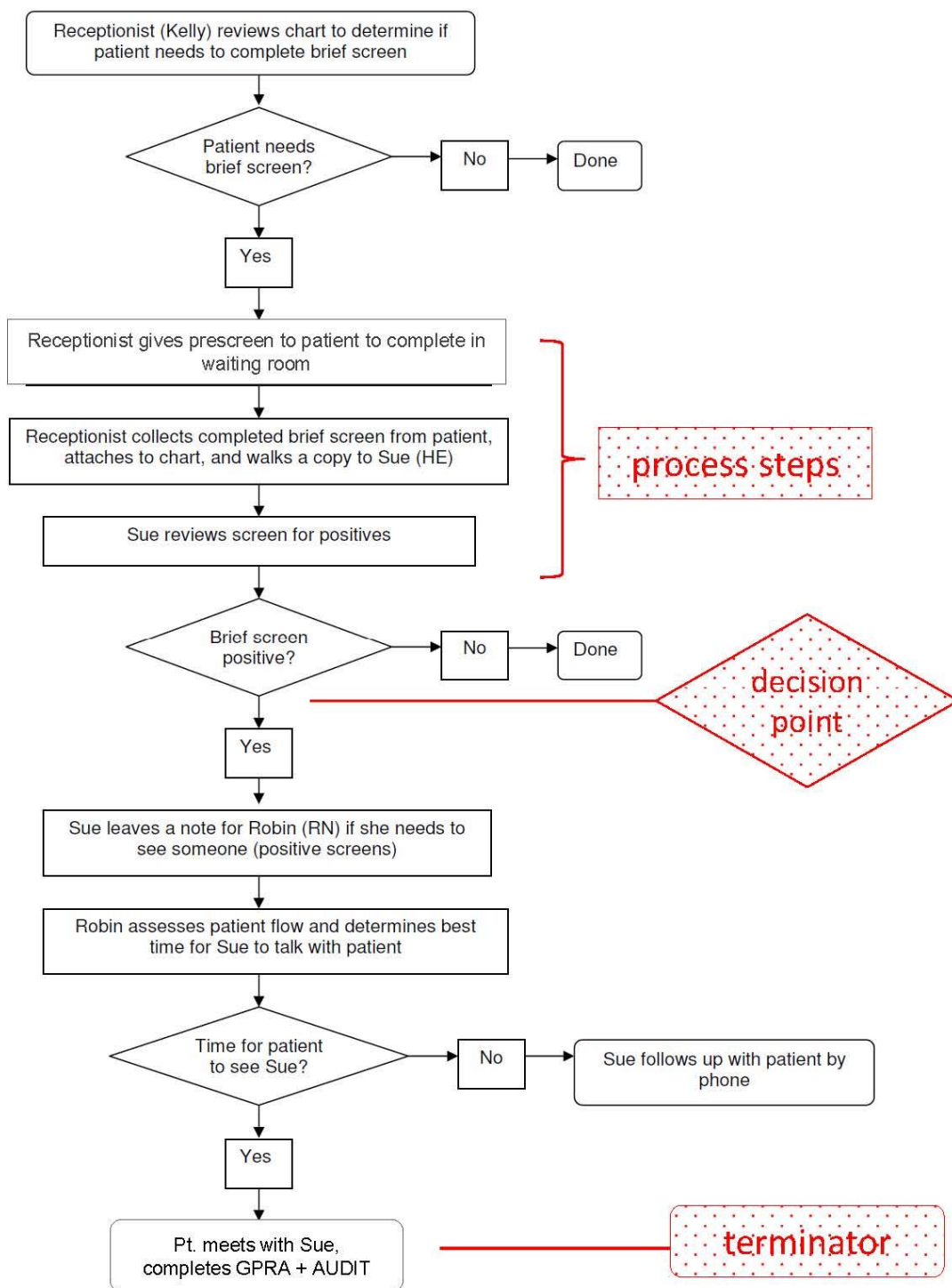
Figure 1 | Example of an SBIRT process map: From patient admission to screening.

WORKSHEET 4 | Preliminary Decisions about SBIRT

1.   Screening

Decision Tree rules for screening will depend on many factors. Below is a list of <u>general</u> Pros and Cons for the different scenarios of *when*, *how*, *what/how long*, *where*, and *who*.

Disclaimer: You may need to adjust this decision tree to your specific work environment.

When To Screen		
	PROS	**CONS**
Pre-Medical Care (Waiting Room) Pre-Medical Care (Exam Room) During Formal Medical Care Post- Medical Care (Waiting for Labs) Other		
How to Screen		
NOTE: The "how" will depend on privacy restrictions (HIPAA policy) and other important factors when collecting drug and alcohol information.		
	PROS	**CONS**
Brief Screening Questions (Intake Form) Paper and Pencil Screening Self-report. Computer Screening Self-report. Interview		
What/How Long		
	Whether to Integrate	**Barriers**
Pre & Full Screen Follow-up Screen GPRA Interview		
Where		
	PROS	**CONS**
General Waiting Room Exam Room Other		

Who		
	PROS	**CONS**
Physician		
Triage Nurse (Pre-screen)		
Other Nursing Staff		
Behavioral Health Staff		
Health Educator		
Substance Use Counselor		
Injury Prevention Staff		
Social Worker		
Other		

2.   Brief Intervention and Referral to Treatment

Decision Tree rules for the Brief Intervention piece will depend on many factors. Below is a list of underline general Pros and Cons for the different scenarios of *when*, *how*, *what/how long*, *where*, and *who*.

Disclaimer: You may need to adjust this decision tree to your specific work environment.

When to Conduct BI		
	PROS	**CONS**
Pre-Medical Care (Exam Room)		
During Formal Medical Care		
Post- Medical Care (Waiting for Labs)		
Bedside		
Other		
What/How Long		
	Whether to Integrate	**Barriers**
Brief Feedback		
Brief Intervention		
Follow-up		
Referral		
Referral Follow-up		

Where		
	PROS	**CONS**
General Waiting Room Exam Room Other		

Who		
	PROS	**CONS**
Physician Other Nursing Staff Behavioral Health Staff Health Educator Substance Use Counselor Injury Prevention Staff Social Worker Other		

WORKSHEET 5a| PDSA Cycle Guidelines

Rationale for Using PDSA Cycles

The PDSA (**P**lan – **D**o – **S**tudy - **A**ct) cycle, developed by W. Edwards Deming, and based on statistician Walter Shewart's work during the 1920s, is designed to ease the identification of problems and potential solutions. It is a tool used to actively manage a process while continuously improving it. The SBIRT PDSA Cycle Worksheet serves to document critical points in the decision-making process, as well as information about "mini-experiments" that the Change Team will be conducting over time. This PDSA documentation will help you to better understand the trends represented by the quantitative data collected. PDSA enables you to identify approaches that appear to be working, as well as approaches that are not working or are unlikely to produce the desired outcomes and need to be revisited and revised. The PDSA cycle is discussed in detail in "The Improvement Guide" by Langley and colleagues[1].

Cycle and Date Fields

The Change Team should keep track of all PDSA cycles. At the top of the PDSA Cycle Worksheet, provide the cycle number and date. This information will allow you to establish an organized, historical record of your cycles, and the work involved in each. Most importantly, these worksheets will serve as a systematic record of the Change Team's progress over time.

Objective Field

This field should capture the overall aim of the PDSA cycle. Here is where you answer the question: "What are we trying to accomplish?" For example, your objective might be: "To increase the rate of ED patients screened for unhealthy substance use from 70 to 90 percent."

Objective of a Cycle: Examples

- To decide if a proposed change will lead to the desired improvement.
- To evaluate how much improvement can be expected if a change is made.
- To decide whether a proposed change will work in the actual environment of interest.
- To evaluate which combinations of changes will have the desired effects on the relevant quality measures.
- To evaluate the costs, social impact, and/or side effects of a proposed change.
- To appease those skeptical of the efficacy of a change. Your cycle may simply be a way to collect "evidence" for certain people.

You can include a description of how the objective fits in with your mission, e.g., "This PDSA cycle is meant to make progress toward the part of our mission that aims to identify and prevent risky substance use and addiction in clients."

Step 1 | PLAN the Test

This is where you make specific plans for your test. You will think about the details of how you will accomplish your objective. It is broken down into the four sub-sections listed below:

Questions

What questions are you trying to answer through data collection and analysis? Answering these questions is the purpose of conducting a cycle. In this phase, the team should agree on specific questions to address and explore via the cycle procedure. It is important to limit the number of questions addressed within a single cycle; as a rule of thumb, stronger conclusions can be drawn from cycles that address fewer questions.

Predictions

What do you think will happen? What obstacles do you expect you might encounter? Be sure to answer the question "why?" for your prediction and provide a theoretical basis for your prediction. Having a theoretical basis and formulating sound hypotheses will allow you to understand why a PDSA was (or was not) successful, and will lead to data-informed decision-making.

Plan for Change or Test

Who will be responsible for running the test? Who must be involved to carry out the tasks? What specifically needs to happen to run the test? Who does those tasks? When will the test begin? End? Where will the test take place?

Plan for Collection of Data

Who will be responsible for collecting the data? Compiling the data? What data need to be collected? When will the data collection and aggregation take place? Where will the data be collected?

Step 2 | DO the Test

Carry out the change or test. Collect data and begin analysis. In addition, this is where you will document problems and unexpected observations, including problems with the collection of data itself. Those collecting the data should keep track of all problems that occur during data capture.

Step 3 | STUDY the Results

Complete the analysis of the data. Summarize what was learned. Remember, the purpose of the PDSA cycle is to build new knowledge. This is where you examine the results. Compare the results to baseline data and your predicted results. Has the change resulted in an improvement? Why or why not? What worked well about the cycle or idea? The knowledge gained from the cycle helps you predict if the change will be useful in the future. Using charts and graphs to visualize the collected data will facilitate the later evaluation of the PDSA cycle.

Step 4 | ACT on the New Knowledge

Are we ready to make the change? Should the change be tested under different conditions? Should it be adopted? Dismissed? Adapted? Should we plan a follow-up cycle, to investigate the change more specifically? Do members of the team need more evidence of the efficacy of the change?

Repeat the Test

Consider what barriers you faced, what you would do differently in the future, and what went well and should be repeated. Begin a new cycle, adapting the change as needed, in order to make it a real improvement.

Document Success

Once you have an empirically efficacious innovation, document the innovation and its effects by updating your data charts. At this point, the team should meet to discuss implementing the innovation, even if only for a trial period.

REFERENCE

Langley, G.J., Nolan, K.M., Nolan, T.W., Norman, C.L., & Provost, L.P. (1996). *The Improvement Guide*. San Francisco: Jossey-Bass Publishers.

WORKSHEET 5b| PDSA Checklist

1. Plan

- ✓ What are the specific aims of this cycle?
- ✓ What is the current process?
- ✓ What are the barriers to attaining the goal?
- ✓ What are the key leverage points?
- ✓ What are the key steps to attaining the goal?
- ✓ What will the PDSA test be?
- ✓ What outcomes to assess?
- ✓ Who will carry out the single steps of PDSA test? When?

2. Do

- ✓ Implement the chosen action(s)
- ✓ Collect the quantitative data
- ✓ Get qualitative feedback from staff and patients

3. Study

- ✓ Analyze the collected data
- ✓ Compare the results to predictions
- ✓ Summarize what was learned

4. Act

- ✓ Need to rework it/modify/revise the action?
- ✓ Is the improvement big enough?
- ✓ What to target next?
- ✓ How to make further improvements?
- ✓ How to sustain the gains over time?

Adapted from Langley, G.J., Nolan, K.M., Nolan, T.W., Norman, C.L., & Provost, L.P. (1996). *The Improvement Guide*. San Francisco: Jossey-Bass Publishers.

WORKSHEET 5c | PDSA Example

Cycle: _____   Date: _____

Objective: *Identify ways to increase the number of ED patients screened for unhealthy substance use from 70 percent to 90 percent.*

Plan:

Questions: At ED intake, staff does not always find the time to administer a full 15-item screening instrument to patients. The current screening rate at the ED is 70%. Can we increase the percentage of ED patients screened by introducing a 3-item pre-screen?

Predictions: The percentage of ED patients screened will increase significantly with the introduction of a 3-item pre-screen.

Plan the test (who, what, when, where): Alice, the receptionist, will administer the 3-item prescreen as part of the general intake form. When a patient gives a positive reply to any item, Alice will notify Health Educator Sam who will conduct the full 15-item screening. Alice will keep record of the number of patients admitted, the number of patients screened, and the number of positive screens. Sam will calculate the screening rates.

Plan for collection of data (who, what, when, where): Alice will provide Sam with the number of admissions and screens, and Sam will prepare a chart of screening rates.

_Do_: *Carry out the change or test. Collect data and begin analysis.* Alice will introduce prescreens on Monday. Sam will calculate screening rates on daily basis. Repeat through Friday.

Study: *Complete analysis of data. Summarize what was learned (see below).*

Act: *Are we ready to make a change?* If the analysis demonstrates a significant increase in screening rates as a result of the introduction of the pre-screen, incorporate the pre-screen into the intake assessment protocol.

Day	*Admissions*	*Pre-screens (Total + %)*	*Positive Screens (Total + %)*
Monday *Tuesday* *Wednesday* *Thursday* *Friday*			

Adapted from Langley, G.J., Nolan, K.M., Nolan, T.W., Norman, C.L., & Provost, L.P. (1996). *The Improvement Guide*. San Francisco: Jossey-Bass Publishers.

WORKSHEET 6 | SBIRT Implementation Checklist

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

		Person in Charge	**Due Date**
Develop CQI initiatives.	- Form a Change Team - Process Map and Walk Through - Identify Barriers - Plan-Do-Study Act - Performance Monitoring		
Define your target population.	Which patients will you screen? - All patients? - Certain department within your facility? - Certain subgroups of patients? - Adults/Adolescents? Which patients will you exclude from screening?		
Document a screening protocol.	Who will conduct screening? - Nurse - Medical Assistant - Receptionist - Behavioral health staff - Health Educator - Substance use counselor - Injury prevention staff - Social worker - Other		
	When and where will screening be conducted? - Triage - Quiet room - Waiting room - Exam Room - Bedside/During care - Post-appointment/discharge		

Document a brief intervention and referral protocol.	Who will conduct the brief intervention and RT? - Screening staff, MSW, MD, Psychologist, RN, CASAC? - If the screener is not the same person that conducts the intervention, what alert process needs to be created? - If a referral is needed, who will do this? If not the same person that does the BI, what alert process needs to be created? - What linkages and contacts need to be made for a smooth referral process?		
	Which BI support materials will be used?		
	Which patient handouts will be used?		
	When and where will brief intervention be conducted? - Triage - Quiet room - Bedside/During care - Pre-discharge		
	When selecting BI providers take the following into account: - Time availability. - Knowledge and experience. - Interpersonal skills. - Willingness to take on responsibility. - Flexibility in work schedule.		
Develop a charting and billing protocol.	Where will chart note be kept? - Main medical record. - Locked files. - Separate from the medical record.		
	What information will be included related to the screen and/or brief intervention?		
	What information will not be included?		
	Determine the flow of information, paperwork, and data.		

Inform all staff of the SBIRT initiative and set a date for the full initiative to begin.	How will you inform all staff? - General staff meeting - Memo - Other		
Train all relevant staff.	Who needs to be trained? How will staff be trained? - Group training - Individual training - Online training		