Adolescent SBIRT Implementation in an Urban Federally Qualified Health Center: The First Year

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The authors report no conflicts of interest
Study Design

- Multi-site cluster randomized trial
  - 7 adolescent primary care clinics in Baltimore City
    - 3 randomized to Specialist Condition
    - 4 randomized to Generalist Condition
  - serving 3,600 patients ages 12-17 years

Implementation Strategies for delivery of BI

- Generalist
  - Primary Care Providers (PCPs) conduct BI

- Specialist
  - PCP does “warm handoff” to Behavioral Heath Specialists (BHSs)
Study Design* (cont.)

**Evidence-based Intervention Strategy**

SBIRT

**Implementation Strategies**

- Systems Environment
- Organizational
- Group/Learning
- Supervision
- Providers/Consumers

**Outcomes**

(implementation, service, patient)

- Penetration of BI and referral
- Cost; Cost-effectiveness
- Acceptability
- Timeliness
- Fidelity/Adherence
- Patient Satisfaction
- Sustainability

SBIRT Training

- All clinical staff received training by site on:
  - SBIRT principles
  - Screening process for adolescent alcohol, drug, and tobacco use, and associated HIV sexual risk behaviors

- PCPs and BHSs received additional BI training based on motivational interviewing
Supportive Elements

- Bi-monthly feedback on screening rates, intervention processes and model adherence
  - Email feedback through clinic managers
  - Hard-copy feedback delivered to providers

- Quarterly booster trainings
  - In-person 30 minute refresher trainings
  - Walk through numbers and trouble-shoot process
Baseline Surveys: Provider Views of SBIRT

$N = 92$

- 9 Nurses
- 14 (Primary Care Providers) PCPs
- 39 Medical Assistants (MAs)
- 19 BHSs
- *11 Administrators

* 1 Physician Administrator not included with PCPs; and
* 1 Behavioral Health Administrator not included with BHSs
<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine screening and intervening won’t really make a difference in</td>
<td>36%</td>
<td>45%</td>
<td>4%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>adolescent substance use.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAs</td>
<td>28%</td>
<td>41%</td>
<td>3%</td>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td>PCPs</td>
<td>47%</td>
<td>40%</td>
<td>0%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>BHSs</td>
<td>40%</td>
<td>40%</td>
<td>15%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>Routine screening and intervening for adolescent substance use takes</td>
<td>41%</td>
<td>41%</td>
<td>8%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>time away from more important services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAs</td>
<td>41%</td>
<td>36%</td>
<td>5%</td>
<td>5%</td>
<td>13%</td>
</tr>
<tr>
<td>PCPs</td>
<td>27%</td>
<td>53%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>BHSs</td>
<td>25%</td>
<td>55%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>THC believes that screening, brief intervention, and referral to</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>33%</td>
<td>56%</td>
</tr>
<tr>
<td>treatment (SBIRT) should be a routine part of care for all adolescent</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THC is committed to providing effective SBIRT services to our adolescent</td>
<td>3%</td>
<td>2%</td>
<td>8%</td>
<td>36%</td>
<td>51%</td>
</tr>
<tr>
<td>patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAs</td>
<td>0%</td>
<td>5%</td>
<td>3%</td>
<td>41%</td>
<td>51%</td>
</tr>
<tr>
<td>PCPs</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>BHSs</td>
<td>15%</td>
<td>0%</td>
<td>30%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Reason</td>
<td>Yes</td>
<td>No</td>
<td>MAs</td>
<td>PCPs</td>
<td>BHSs</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>-----</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Time constraints.</td>
<td>47%</td>
<td>53%</td>
<td>23%</td>
<td>69%</td>
<td>68%</td>
</tr>
<tr>
<td>Uncertainty regarding the effectiveness of available treatments.</td>
<td>18%</td>
<td>82%</td>
<td>12%</td>
<td>19%</td>
<td>26%</td>
</tr>
<tr>
<td>Patients often do not tell the truth about their substance use.</td>
<td>41%</td>
<td>59%</td>
<td>49%</td>
<td>44%</td>
<td>17%</td>
</tr>
<tr>
<td>Doing so may question your patients’ integrity.</td>
<td>12%</td>
<td>88%</td>
<td>18%</td>
<td>0%</td>
<td>17%</td>
</tr>
<tr>
<td>You do not want to upset your patients.</td>
<td>10%</td>
<td>90%</td>
<td>11%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>You are concerned about the reaction of parents.</td>
<td>19%</td>
<td>81%</td>
<td>31%</td>
<td>13%</td>
<td>0%</td>
</tr>
<tr>
<td>You’re uncomfortable talking about substance use with adolescent patients.</td>
<td>9%</td>
<td>91%</td>
<td>11%</td>
<td>13%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Please tell me if any of the following are reasons why you **MIGHT NOT ALWAYS TALK TO OR COUNSEL** your adolescent patients about tobacco, alcohol, or drug use:

<table>
<thead>
<tr>
<th>Reason</th>
<th>PCPs</th>
<th>BHSs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time constraints.</td>
<td>69%</td>
<td>31%</td>
</tr>
<tr>
<td>Uncertainty regarding the effectiveness of available treatments.</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>Patients often do not tell the truth about their substance use.</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>Doing so may question your patients’ integrity.</td>
<td>6%</td>
<td>94%</td>
</tr>
<tr>
<td>You do not want to upset your patients.</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td>You are concerned about the reaction of parents.</td>
<td>3%</td>
<td>97%</td>
</tr>
<tr>
<td>You’re uncomfortable talking about substance use with adolescent patients.</td>
<td>6%</td>
<td>96%</td>
</tr>
</tbody>
</table>
Implementation Trends: The First Year
Patient Visits that Completed All Parts of the aSBIRT Screening
May 2013 - April 2014
Number of Patient visits which scored 2+ on CRAFFT
May 2013 - April 2014
Percentage of Patient Visits Appropriately Counseled to Stop/Reduce Alcohol and/or Illicit Drug Use
May 2013 - April 2014
Conclusions

- Perceived need and acceptability of providing aSBIRT
  - BHSs less familiar with model at baseline than medical staff

- Identified screening barriers:
  - Time, honesty, and parents

- Identified BI barriers:
  - Time, honesty, comfort discussing substance use/abuse

- Screening rates increased substantially and have been well maintained
Provider feedback for positive SBIRT screens is very erratic and was greatly impacted by EMR change last October.

- Counseling to stop or reduce use has not returned to levels prior to EMR change.

BI delivery varied by Implementation strategy:

- Rates of Provider-delivered BIs varied by site (an artifact of providers’ comfort with the protocol).
- Physician and counselor turnover at Specialist sites = challenges due to siloed management, training, and supervision.

Current efforts to institutionalize adolescent SBIRT trainings for new staff -- and increase accountability for all staff.
Thank you

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