



Clinical Addiction Research and Education



# Massachusetts SBIRT at Medical Centers & Community Health Centers

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AOD-SBI Meeting/INEBRIA Conference

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Substance Abuse and Mental Health  
Services Administration (1UT1018311)



**Boston University** School of Medicine

# The MASBIRT Model



- SAMHSA cooperative agreement to Massachusetts DPH subcontracted to BMC (9/2006 - 9/2011)
- Clinical sites (ED, inpatient, & outpatient):
  - Boston Medical Center
  - Quincy Medical Center
  - St Elizabeth's Medical Center
  - 5 Community Health Centers
- SBIRT performed by Health Promotion Advocates (HPA) supervised by a masters-level social worker
- Data (screen & assessment) collected via web-based tool integrated with Electronic Medical Record



# Health Promotion Advocates

- 28 hired, 5-18 employed at any one time
- **Training:** 3 week didactic and experiential & annual boosters
- **Supervision:** direct observation, group, and in-services

Gender	64% female
Age	68% under 30
Race/ethnicity	61% minority
Education	64% bachelors degree
Language	39% bilingual (Spanish, Haitian Creole, Portuguese, French)
Personal experience with addiction	18% previous work experience 7% in recovery; 18% family member
Average duration of employment	27 months (range 5-54 months)

# MASBIRT Process



- **Universal screening** for unhealthy substance use:
- **Screen** (“Pre-screen”)
  - Have you used tobacco in the past year?
  - In the past 3 months, **how often** have you...
    - had more than X drinks in a day?
    - used marijuana, cocaine, heroin or other drug?
    - used narcotic pain medications, sedatives or stimulants without a prescription or in amounts greater than prescribed?
- **Assessment** (“Full Screen”)
  - Alcohol, Smoking & Substance Involvement Screening Test (ASSIST)
  - Government Performance and Results Act (GPRA)

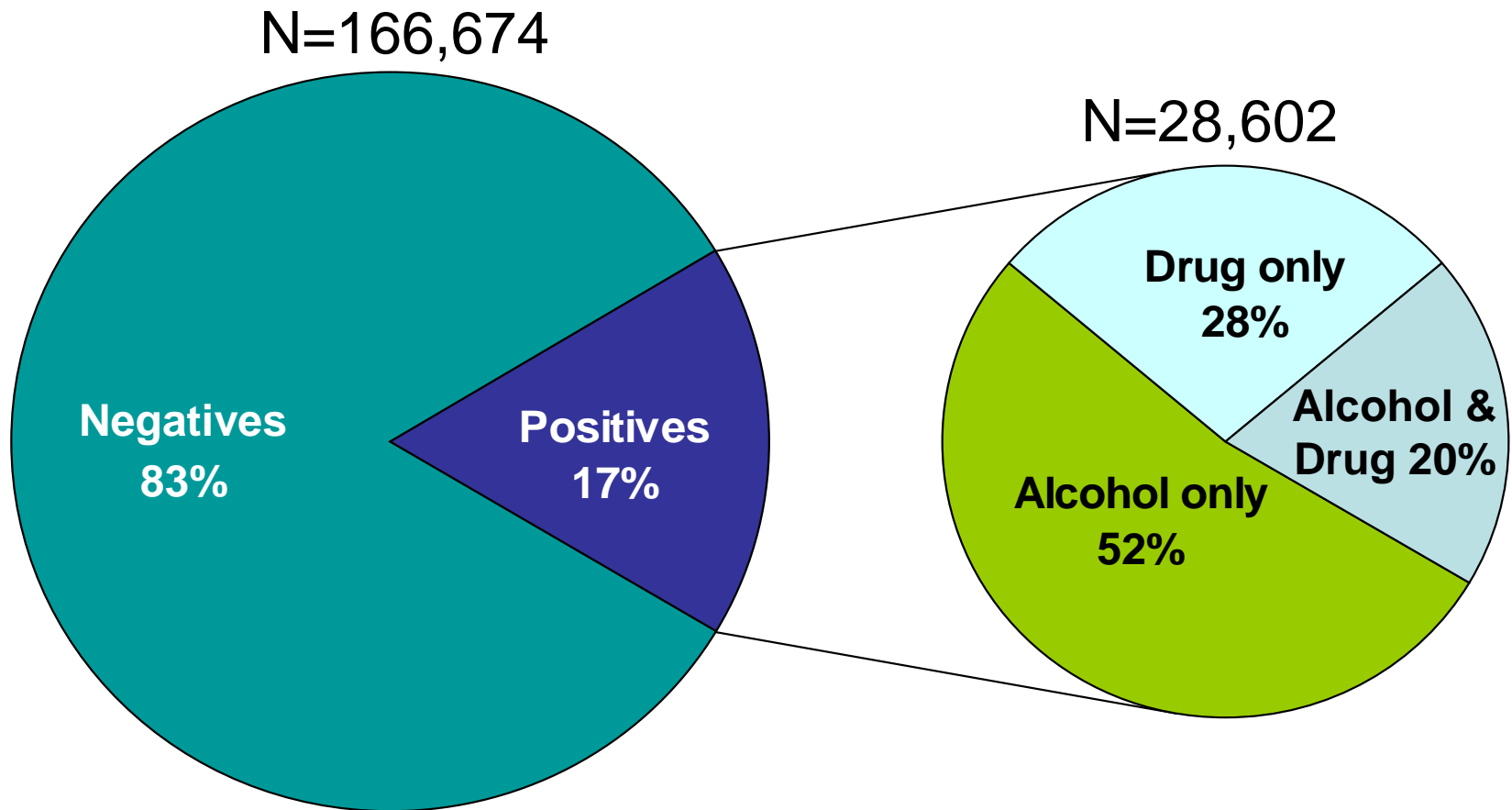
# MASBIRT Process



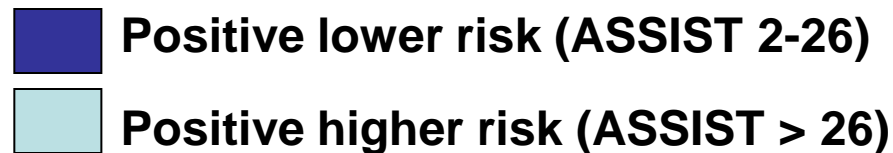
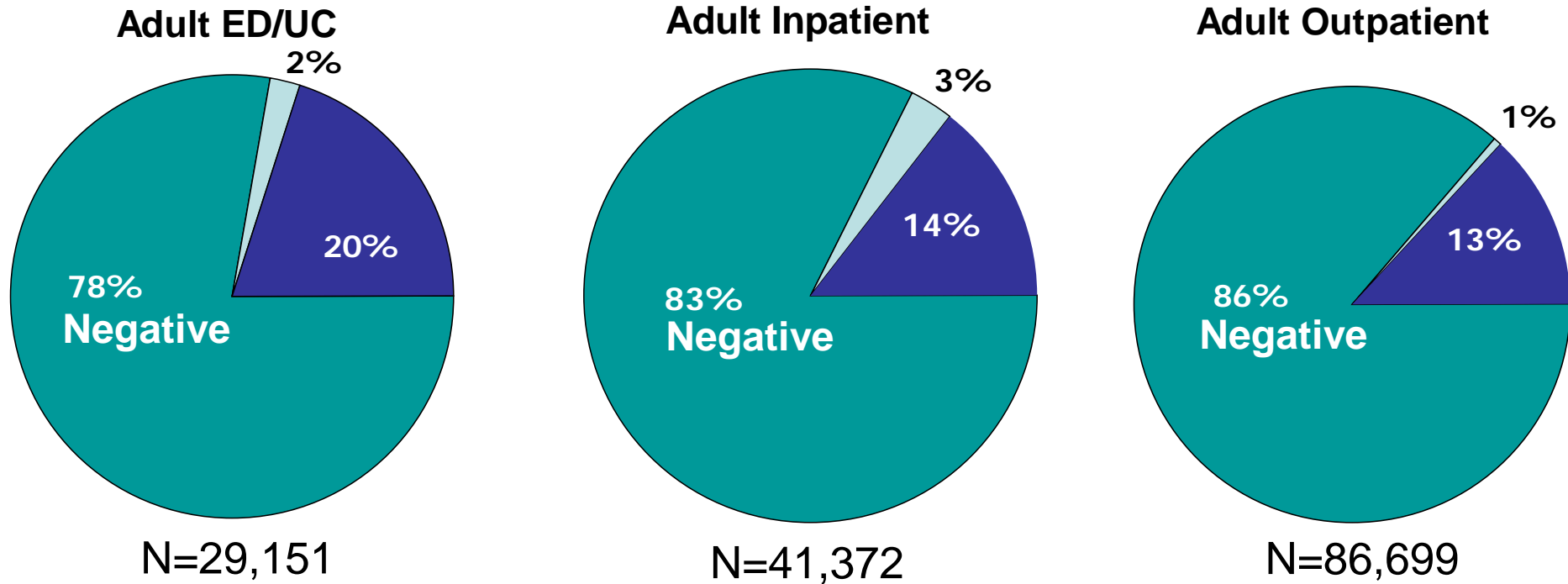
- BI delivered by HPA immediately after screen/ assessment
- RT conducted by HPA in collaboration with other resources (BPHC, BMC Project ASSERT)
  - **Brief Treatment (BT):** onsite outpatient, up to 12 sessions of manualized MET and CBT
  - **Specialty Treatment:** acute treatment services (“detox”), residential, transitional, clinical stabilization, acupuncture
- Additional services:
  - Rescreened every 3 months (positive) or 12 months (negative)
  - “Booster” calls to patients not showing to BT
- 6-month follow-up for random sample of positive screens

# MASBIRT Screening Results

(March 2007-August 2011)

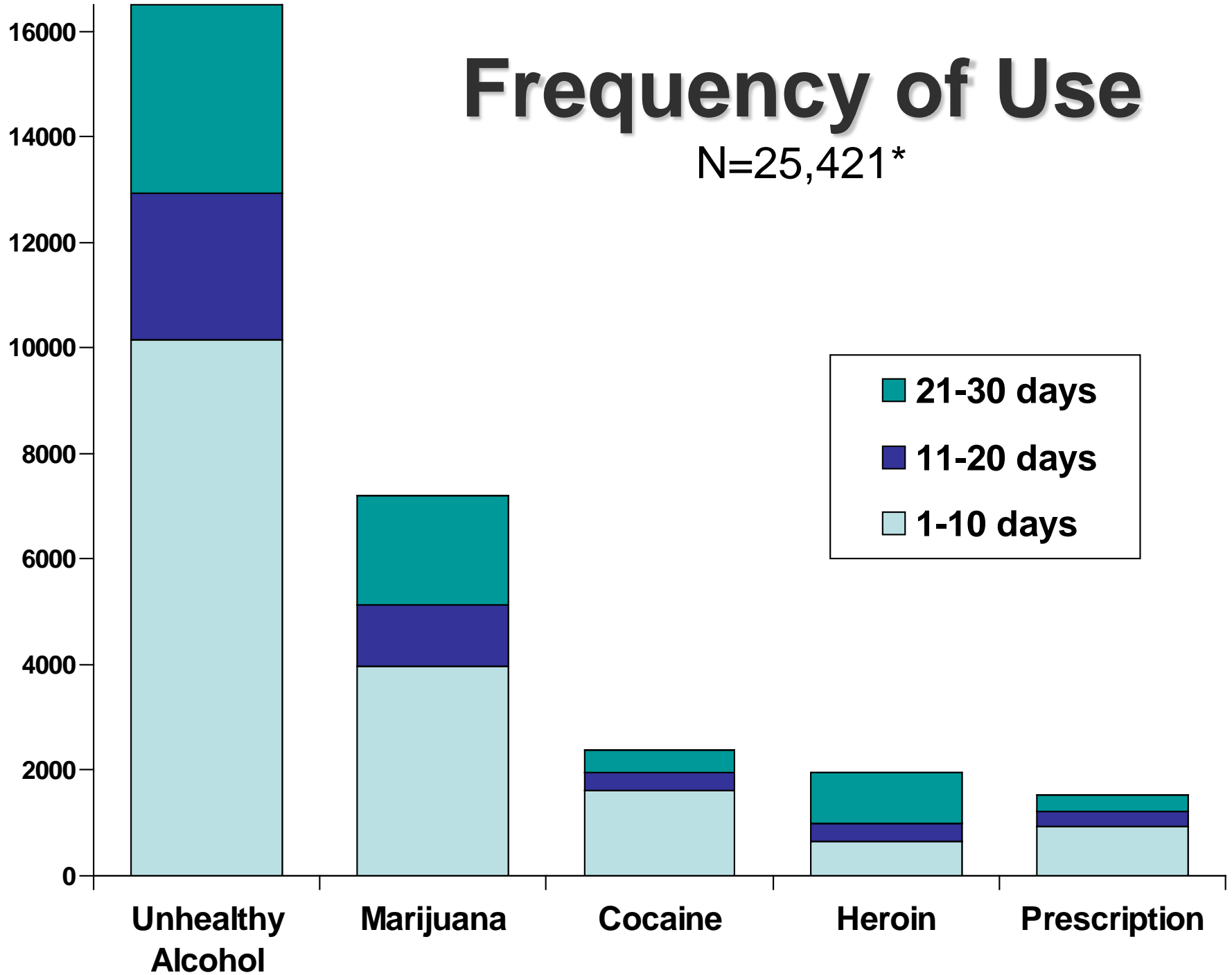


# Screening by Site



# Frequency of Use

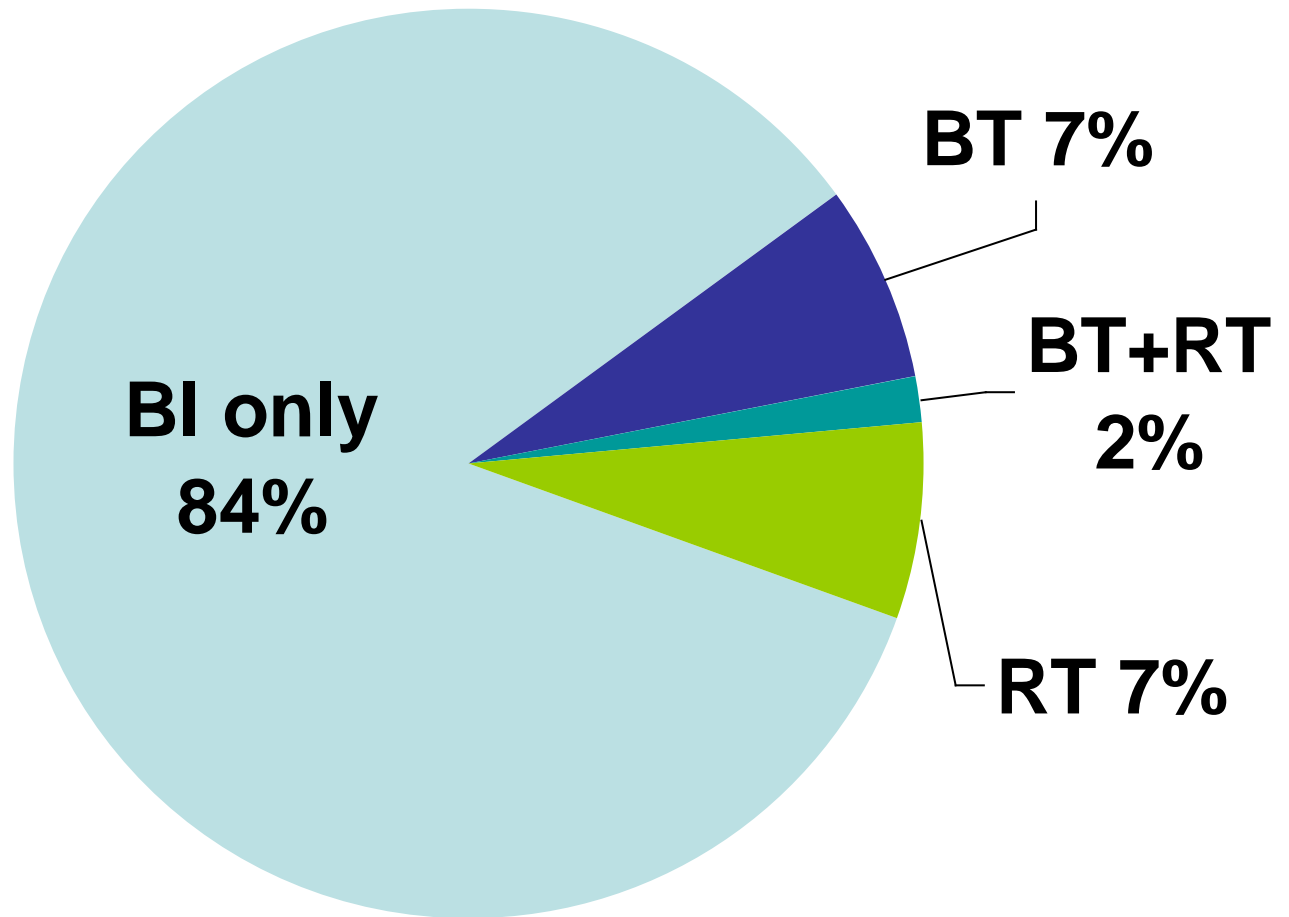
N=25,421\*





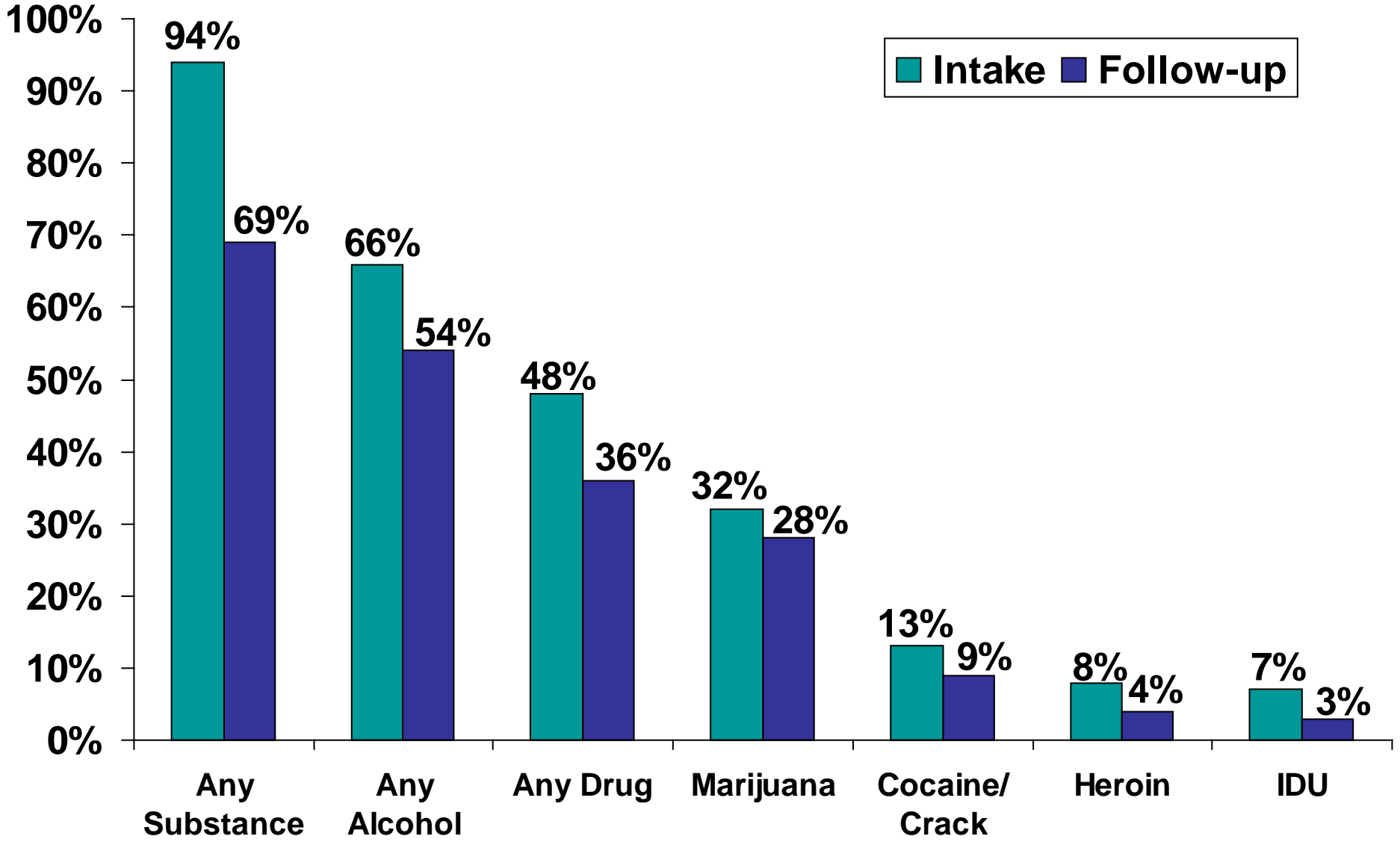
# Services Delivered

N=25,421



# Reduced Substance Use at 6 Months

N=769



# SBIRT Implementation Challenges

- Providers and staff are under time pressure
- SBIRT creates more work
- Lots of competing 'new' priorities
- Every clinical site is unique (or believes they are)
- Sites overly focused on substance use d/o & RT
- Outside funding impacts program design and implementation

# S BI Challenges

- Who should do it and how should it be done
- Difficult to truly screen everyone (i.e., “universal”)
- Benefits of SBI not fully appreciated by general healthcare providers and staff
- Screening fidelity hard to maintain (“How often..?” vs. “Do you..?”)
- Screening by other methods (e.g. self administered paper, IVR) was problematic
- HPA BI skills decay due to time pressure,.. become more focused on giving out resources

# RT Challenges

- No referral has historically been an acceptable practice
- Addiction specialty treatment is a black box
- RT is infrequent and dissimilar to other types of healthcare referrals
- Non-treatment seeking patient low motivation for RT resulting high no-show rates
- Patients' poor adherence with RT results in provider and staff burn-out

# Lessons Learned

- SBIRT achieved w/out disruption of clinical flow
- Patients, providers and staff find SBIRT acceptable
- Staff with varied backgrounds can perform SBIRT
- Physician champion is helpful but is difficult in reality
- Sustain clinical site education (e.g., full spectrum of unhealthy use, efficacy of SBI)

# Lessons Learned

- Foster and maintain engagement of site staff (natural decay in interest)
- Specific feedback to site can be double-edged sword
- Invest time in RT for clinical site buy-in
- Foster and maintain relationships with high quality specialty treatment programs
- State partnership (e.g. regulation, licensing) critical to improving referral to specialty treatment process