



Sustainability of Screening, Brief Intervention and Referral to Treatment in Healthcare Settings

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WASHINGTON STATE'S Department of Social and Health Services (DSHS) received a five-year grant to implement Screening, Brief Intervention and Referral to Treatment (SBIRT) from 2011 to 2016. The grant was funded through the Substance Abuse and Mental Health Services Administration (SAMHSA). SBIRT is an evidence-based, universal public health approach to identify, prevent, and reduce substance use disorders (SUD),¹ for which adult patients complete an annual screen to assess risk associated with substance use. Individuals identified as at-risk receive a brief intervention (BI) by a medical professional to address their substance use. When indicated, high-risk patients may be referred to a specialty treatment provider for SUD assessment or treatment. Nineteen healthcare facilities in five counties provided SBIRT as part of the Washington State SBIRT Primary Care Integration (WASBIRT-PCI) project, conducting nearly 83,000 screens over the five-year grant period (Figure 1).

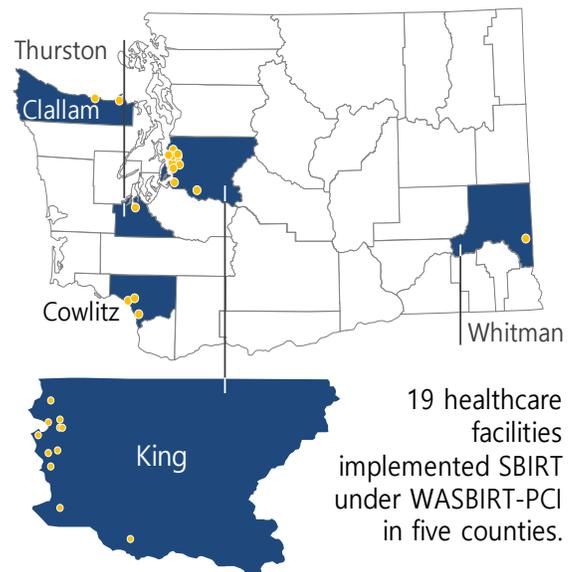
WASBIRT-PCI Goals

Two goals of the WASBIRT-PCI project were to:

1. Expand the continuum of care to include SBIRT services in community health settings and
2. Implement fee-for-service Medicaid reimbursement for SBIRT to increase the likelihood of implementing and sustaining the practice.

To better understand if these goals were achieved and sustained after the grant, DSHS researchers conducted key informant interviews with five WASBIRT-PCI healthcare facilities. Facilities were asked about their ability to sustain SBIRT in the absence of grant funding and to provide insight into the barriers and facilitators related to maintaining SBIRT. Facilities not interviewed received a short email survey to assess SBIRT sustainability and key challenges. This report provides qualitative descriptions from key healthcare facility staff on efforts to sustain SBIRT after the grant ended.

FIGURE 1.
WASBIRT-PCI Facility Locations



¹ SAMHSA: Screening, Brief Intervention, and Referral to Treatment (SBIRT). October 2015. Last Updated June 1, 2015. Available from <http://www.samhsa.gov/sbirt>.

Key Findings

- 10 of 19 original WASBIRT-PCI facilities continue to support all core components of SBIRT in their clinic workflow. Four facilities offer only one component of SBIRT such as universal substance use screening or brief intervention.
- While most facilities still follow SBIRT screening processes, primary care clinics struggle to consistently provide brief interventions to patients when indicated.
- Barriers to SBIRT implementation include confusion and difficulty with billing; low reimbursement; inadequate training and education; lack of performance monitoring tools; competing priorities; staff attitudes towards and knowledge about substance use; and lack of staff or leadership support for the SBIRT model.
- Factors contributing to sustaining SBIRT include adequate funding; coordinated, ongoing training; internal resources to assist with referrals to treatment; staff accountability; and staff and administrative support for the intervention, or “buy-in.”
- The State successfully established fee-for-service billing for SBIRT. Clinics, however, are not using established billing codes to support SBIRT but are incorporating SBIRT into their workflow using existing staff and alternative billing strategies.

Methods

Key informant interviews were conducted with five WASBIRT-PCI healthcare facilities in May 2017 by two researchers from the DSHS Research and Data Analysis Division. Six facilities were invited to participate, and five completed the interview. These six facilities were selected because they were receiving grant funding at the end of the project in August 2016.² Data were collected during six key informant interviews³ with one to four facility staff participating from each facility. Key informants included clinic managers, behavioral health specialists, medical directors, and medical assistants. Interview questions were adapted, with permission, from the OMNI Institute SBIRT Colorado Initiative Sustainability Interview survey.⁴

Interviews were conducted via telephone, recorded, and transcribed. The interviews lasted between 11 minutes and 52 minutes. Participant verbal consent was obtained prior to conducting the interview. After transcription, responses were analyzed to identify themes related to SBIRT sustainability.

The interviews investigated four areas of interest:

1. The SBIRT Model – SBIRT patient workflow, core components, staff responsibilities and involvement, and barriers and facilitators to sustain the program.
2. Training and Evaluation – past and current SBIRT training, anticipated training needs, barriers and facilitators to training and evaluation/monitoring.
3. Funding – how SBIRT is funded, barriers and facilitators to sustain SBIRT related to funding.
4. Issues Critical to Sustaining SBIRT – policies, resources, and staffing critical to sustain SBIRT.

To obtain input from all remaining WASBIRT-PCI facilities, RDA emailed a short survey to the sites that did not participate in the interview in July 2017. The survey was created using Survey Monkey and results were tabulated using the same software. All of the organizations completed the survey and their responses are incorporated into relevant sections of this report.

² WASBIRT-PCI facilities received funding for SBIRT implementation for an average of 17 months. Once SBIRT was established, facilities transitioned off the grant in hopes to sustain SBIRT with billing reimbursements.

³ One participating facility was given a follow up interview with the behavioral health specialist to clarify answers provided by the behavioral health manager.

⁴ Richmond, M., & Rivera, L. July 2012. SBIRT Colorado Sustainability Interviews: Final Report. Colorado Department of Human Services, Division of Behavioral Health & OMNI Institute.

Results

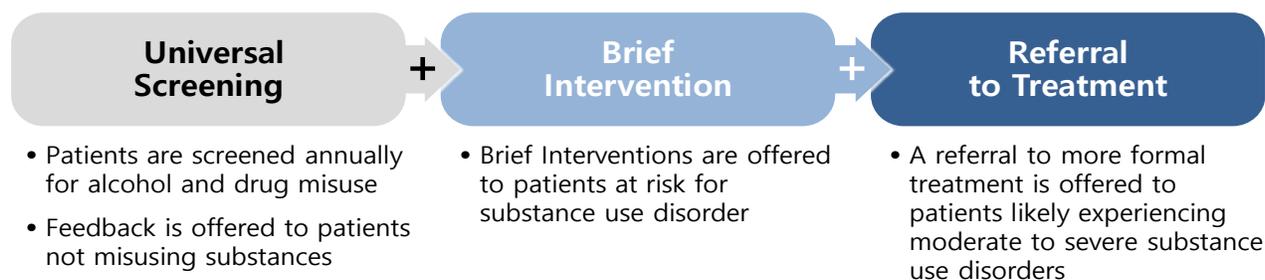
Clinics Sustaining SBIRT

SBIRT has three core components: universal screening, brief intervention, and referral to treatment (Figure 2). Of the 19 facilities that participated in WASBIRT-PCI from 2011 to 2016, 10 (53 percent) were still conducting the most critical components of SBIRT (universal screening for alcohol and brief interventions) in July 2017 (Table 1).⁵ Of the nine facilities no longer conducting the critical components of SBIRT:

- One closed,⁶ one never fully implemented SBIRT, and the remaining seven stopped providing critical components of SBIRT services after the WASBIRT-PCI grant funding ended.
- Two facilities were still conducting universal screening for alcohol or drugs but were not systematically conducting BIs or referrals to treatment.
- Two facilities were providing indicated BIs and/or referrals to treatment, but not the coordinated screening and brief intervention components required for the evidence-based practice.

FIGURE 2.

WASBIRT-PCI Core Components



The last six facilities to provide SBIRT under the grant were asked to participate in telephone interviews about their experiences and current practices. Key observations from five facilities (four primary care clinics and one ED) participating in those interviews are described in the following sections.⁷ These facilities screened nearly half (48 percent) of all patients served under WASBIRT-PCI.⁸ Information from the email survey completed by all other facilities is included where relevant.

The SBIRT Model

All facilities were asked about the components of SBIRT they maintained, staffing and barriers to sustaining SBIRT. This section reviews in detail the SBIRT model maintained by facilities since grant funding ended.

SBIRT Model and Staffing. Eight facilities continue to offer the three core components of SBIRT promoted by the WASBIRT-PCI project. Facilities engage multiple clinic staff to deliver the intervention: front desk staff, medical assistants, or nurses distribute the universal screen; behavioral health specialists, physicians or residents deliver the brief intervention (BI) and provide referrals to treatment.

⁵ This minimum standard is based on the U.S. Preventive Services Task Force recommendation for universal screening of adults for alcohol misuse and brief intervention for those engaged in risky or hazardous use.

⁶ The closure was not related to project funding.

⁷ Staff at the Franciscan Federal Way facility did not complete the interview. They did, however, respond to the email survey.

⁸ Speaker, Mayfield, Yakup, & Felver. 2017. Washington State SBIRT Primary Care Integration: Implementation – January 2012 through August 2016. DSHS Research and Data Analysis: RDA Report 4.98. Available at <https://www.dshs.wa.gov/sesa/research-and-data-analysis>.

TABLE 1.

SBI RT Components Performed by WASBIRT-PCI Clinics as of July 2017

FACILITY*	Universal Screening		Mental Health Screening	Brief Intervention	Referral to Treatment	Provides SBI for Alcohol**
	ALCOHOL	DRUGS				
Downtown Public Health	✓	✓	✓	✓	✓	✓
North Public Health						
Sea Mar Seattle Medical Clinic			✓			
Sea Mar Burien Medical Clinic			✓			
Longview Medical Clinic	✓	✓	✓	✓	✓	✓
Pullman Regional Hospital Emergency Department				✓		
Woodland Clinic	✓	✓	✓	✓	✓	✓
Sea Mar White Center Medical Clinic			✓			
Olympic Medical Center Emergency Department	✓	✓	✓	✓	✓	✓
Kelso Clinic	✓	✓	✓	✓	✓	✓
Swedish Cherry Hill Residency	✓	✓	✓	✓	✓	✓
Jamestown Family Health	✓	✓	✓	✓	✓	✓
Franciscan Medical: Enumclaw						
Sound Mental Health	✓	✓	✓			
Swedish Central Seattle	✓		✓	✓	✓	✓
Swedish West Seattle	✓		✓	✓	✓	✓
Providence St. Peter's Residency	✓	✓	✓	✓	✓	✓
Franciscan Medical at St. Francis	✓	✓	✓			
Franciscan Medical: Auburn				✓	✓	
TOTALS	19	12	10	15	12	10

* Listed in order of implementation on the WASBIRT-PCI grant. A description of each facility can be found in Speaker *et al* (2017).

** Universal screening of adults for alcohol use and brief intervention for risky users is the evidence-based standard recommended by the U.S. Preventive Services Task Force.

SBIRT oversight is generally the responsibility of the behavioral health specialist according to interviewed facilities. In some facilities, however, clinic management, preceptors, medical assistants and medical directors are also involved in program oversight. Since grant funding ended, most facilities report that they are unable to give sufficient attention to SBIRT oversight. The barriers to program oversight include less staff time committed to SBIRT, less accountability for performance, and inadequate program monitoring and quality assurance compared to what was available under the grant.⁹ Facility staff suggest that program monitoring is critical to establishing and maintaining a quality SBIRT program and without it, SBIRT implementation suffers to varying degrees.

No significant changes to SBIRT models were noted compared to clinical practices established while on the WASBIRT-PCI grant. However, the quality of implementation, particularly with respect to the BI, has degraded at some interviewed sites. Facilities noted that SBIRT works well when staff recognize the importance of addressing substance use with patients, particularly for patients with low-to-moderate risk that do not necessarily have a substance use disorder. When staff devalue SBIRT they are less likely to follow through and implement the model with fidelity. SBIRT also functions well when there is administrative support or buy-in. Administrators can act as champions for the program and have the authority to ensure SBIRT is implemented by staff. Additionally, funding to maintain behavioral health staff, technical assistance, and performance monitoring critical for establishing and maintaining SBIRT is no longer available at most facilities since the grant ended. The absence of these supports has contributed to the SBIRT processes breaking down.

“The most essential, I think, is buy-in from clinic providers and staff. That was definitely where the workflow and the model would break down, when people didn’t have that buy-in.”

— Behavioral Health Specialist, Family Practice



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Universal Screening. Twelve WASBIRT-PCI facilities still conduct annual universal screening for all adults: ten offer alcohol and drug screening and two offer alcohol screening only (Table 1, above). Among the interviewed facilities, none were systematically screening youth, but there is some interest in adding this component.

Under WASBIRT-PCI, facilities employed a two-part screening process: a brief prescreen and a full screen. The prescreen efficiently filters out individuals not engaging in risky substance use. A positive prescreen, however, indicates the need for a detailed full screen that stratifies patient substance use into levels of risk. All facilities that completed an interview continue to use validated screening instruments. For alcohol, these are the National Institute for Alcohol Abuse and Alcoholism (NIAAA) single prescreen question and the Alcohol Use Disorder Identification Test (AUDIT). To simplify their screening process, two of the interviewed facilities switched from the NIAAA prescreen to the validated Alcohol Use Disorder Identification Test – Consumption (AUDIT-C).¹⁰

Facilities screening for drugs continued to use the National Institute for Drug Abuse single- or modified two-question (with cannabis) drug prescreens and the Drug Abuse Screening Test 10 (DAST10). Two clinics discontinued universal drug screening to streamline their screening process and because SBIRT for drug use is not considered evidence based.¹¹ Because mental health conditions

⁹ While funded by WASBIRT-PCI, facilities met regularly with the DSHS project staff to review monthly performance reports generated by the DSHS evaluation team.

¹⁰ The AUDIT-C uses the first three questions of the AUDIT.

¹¹ The U.S. Preventive Services Task Force concludes that current evidence is insufficient to recommend universal illicit drug screening.

frequently co-occur with substance use disorder, WASBIRT-PCI facilities were instructed to screen for depression and anxiety for all positive alcohol or drug screens. The Patient Health Questionnaire 9 for depression and the Generalized Anxiety Disorder 7 for anxiety continue to be used at 15 of the WASBIRT-PCI facilities.

Interviewed primary care facilities explained that front desk staff perform chart reviews to flag patients requiring the annual screen and provide the patient a self-administered prescreen. Medical assistants (MA) review the prescreen upon "rooming" the patient and administer the full screen when indicated. Typically MAs or physicians score and interpret the full screen. In the emergency department, the triage nurse administers the prescreen if the patient is ambulatory or it is administered by the floor nurse if the patient is hospitalized (and once the patient is stable). An order is sent to the behavioral health specialist by the electronic health record system if a full screen is indicated.

SBIRT's screening component continues to present some challenges. Facilities cited staff turnover, time constraints, insufficient training, and screening for cannabis use as ongoing problems. Specifically, facilities struggle with cannabis screening because the DAST10 is considered overly sensitive for casual, legal cannabis use; there are no clear guidelines for safe cannabis use; and staff have differing opinions on the risks associated with cannabis and will often overlook positive cannabis screens.¹² Despite challenges, facilities note their screening processes work well and are accepted by patients.



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Brief Intervention. Patients with positive full screens are indicated for a brief intervention (BI), a short motivational interview-based discussion about substance use and risk.¹³ About 11 percent of WASBIRT-PCI patients required a BI.¹⁴ Twelve facilities continue to offer BIs conducted by behavioral health specialists¹⁵ or physicians and residents.

The estimated time spent delivering a BI at interviewed facilities ranged from 10 to 30 minutes (though no facility systematically tracked the duration). The duration of the BI varies depending upon the number of substances used and the severity of their substance use.

According to interviewed primary care facilities, MAs notify the physician or resident when a BI is indicated by the full screen. In some facilities the physician or resident reviews the screening results with the patient and either performs the BI or provides a warm handoff¹⁶ to the staff member designated to provide BI. In primary care facilities, the BI is completed during the patient appointment, immediately after the appointment with the behavioral health specialist, or at a follow up appointment.

The one ED facility that interviewed uses the electronic health record to issue an order to the behavioral health specialist when a full screen is indicated. The specialist provides the BI immediately after screening if needed. In the ED, BIs are delivered while patients wait for medical procedures or test results. When ED patients are admitted to the hospital, the behavioral health specialist follows up with patients in their room. Given the amount of time patients spend in the ED, the ED environment provides a considerable advantage over primary care settings with respect to providing BIs in a timely manner. All facilities described significant impediments to systematic provision of BIs when indicated.

¹² Marijuana use for recreational purposes was legalized in Washington State on November 6, 2012.

¹³ For more information on the components of SBIRT, please see: Speaker, et al. 2017. Washington State SBIRT Primary Care Integration: Implementation – January 2012 through August 2016. DSHS Research and Data Analysis: RDA Report 4.98.

¹⁴ Ibid.

¹⁵ Behavioral health specialists were typically psychologists, nurses, chemical dependency professionals, and social workers.

¹⁶ A warm handoff is an approach where the primary care provider does a face-to-face introduction of a patient to the behavioral health specialist to which he or she is being referred. (SAMHSA-HRSA Center for Integrated Health Solutions: Glossary. Available at <https://www.integration.samhsa.gov/glossary>.)

Facilities noted a broad range of challenges, some of which were logistical:

- Facilities are busy;
- Staff shortages and turnover;
- Behavioral health specialists' availability for warm handoffs;
- BIs are time consuming; and
- Billing for a BI is "not worth it" and too administratively burdensome.

"When you have a patient presenting for primary care with basic bio-medical needs, [SBIRT] is kind of the one thing that is...seen as optional...or less urgent...It gets triaged out more readily."

— Licensed Social Worker, Family Practice

Facilities also described other challenges to providing BIs that were rooted in staff knowledge, beliefs and priorities:

- Staff who do not believe that mild-to-moderate substance use risk—a significant focus of SBIRT—needs to be addressed.
- Positive screens for casual cannabis use are not a priority and are often ignored.
- Primary care and competing physical health care needs take priority.
- Inadequate training and skills for the intervention.
- And—for seriously ill ED patients—providing medical care and monitoring patient health status can make it difficult to find time to deliver a BI.

"I think people [medical providers] often don't understand that [SBIRT] is largely a preventive intervention...they think of it more as a substance abuse intervention...They often don't see the need for it, or the importance of it...Having people understand the value of [SBIRT]...from a preventive standpoint, but [medical staff] don't think of it that way."

— Clinical Psychologist, Family Practice

To address challenges related to providing BIs, some facilities increased their capacity by training additional staff, such as physicians and residents, or providing on-going training to other staff providing BIs. Some facilities augmented the availability of the behavioral health specialist by increasing the hours these staff are available. As mentioned previously, staff struggle to address cannabis use in the absence of clear clinical guidelines and differing opinions about the risks associated with casual cannabis use. With respect to cannabis-related BIs, interviewed facilities defer to physician discretion rather than adhere strictly to the intervention indicated by a full screen score.



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Referral to Treatment. Referral to treatment is indicated when patients screen as having high risk for substance use disorder. About two percent of WASBIRT-PCI patients were indicated as needing a referral to treatment.¹⁷ Eleven of the 19 WASBIRT-PCI facilities continue to offer referrals to treatment in the context of SBIRT; one facility only refers when patients present with problems associated with substance use. Among interviewed facilities, most referrals are made by the clinician performing the BI.

¹⁷ Speaker, et al. 2017. Washington State SBIRT Primary Care Integration: Implementation – January 2012 through August 2016. DSHS Research and Data Analysis: RDA Report 4.98.

In some settings, physicians or residents make a warm handoff to the behavioral health specialist when a referral is indicated. Referrals take place during the initial office or ED visit or at a subsequent visit to address the patient's substance use.

Due to the variability of referral options and patient needs, the referral to treatment process is one of the more challenging, complex aspects of SBIRT. The referring clinician considers the patient's medical coverage—Medicaid, Medicare, or private insurance—which influence treatment referral options. Staff also consider the patient's proximity to treatment providers, prior treatment experiences, readiness to accept a referral, and the severity of substance use. Approaches to referrals also vary. In some facilities, the referring clinician simply reviews a description of referral resources available to the patient and encourages the patient to make an appointment. In other facilities, the referring clinician may assist the patient with navigating the treatment system and ensure the patient obtains an appointment at a treatment facility for an assessment, or that they are admitted to a treatment or detox facility.

In addition to the complexities described above, facilities cited patient frustration and disinterest in a referral to treatment because of the cumbersome referral process, previous negative treatment experiences and stigma, or problems with transportation. Treatment availability was also a common barrier described by facility staff: in rural areas treatment options may be limited or non-existent and in urban settings treatment providers may have long waitlists. Most WASBIRT-PCI surveyed facilities also cited treatment access or the treatment referral process as barriers to offering SBIRT.

Referral to treatment was enabled in some cases by onsite clinicians that can conduct substance use disorder assessments; the availability of Drug Addiction Treatment Act (DATA) waived physicians to administer medication assisted treatment with buprenorphine¹⁸; and the availability of training on how to provide treatment referrals and motivational interviewing. Additionally, facilities felt patients were more likely to follow through on the referral when they could confirm a scheduled appointment with a treatment agency.

Training and Evaluation

Sustaining SBIRT with fidelity requires ongoing staff training and a means to evaluate performance. Interviewed facilities described a range of informal and formal SBIRT training approaches used with their staff:

- Certifying selected clinic staff to provide the four-hour SBIRT certification training.¹⁹
- Encouraging staff to use online resources to complete the four-hour SBIRT certification training.
- Using new employee "on-boarding" to orient new hires to the SBIRT principles and work flow.
- Requiring that all residents, physicians and behavioral health specialist staff complete the four-hour SBIRT certification training.
- Providing periodic reminders and feedback about SBIRT at staff meetings.

All interviewed facilities described additional and ongoing training needs: additional training on motivational interviewing to improve BI skills; refresher trainings for staff delivering BIs in the context of SBIRT; and education about the value of SBIRT, especially for addressing mild to moderate substance use. In-person training was preferred to online courses—particularly with respect to practicing BIs and motivational interviewing skills—and availability of regularly scheduled training opportunities would address staff turnover and the need for refresher training. In general, facilities reported a lack of resources to provide their own ongoing SBIRT training. They perceive online training

¹⁸ SAMHSA. February 2017. Buprenorphine Waiver Management. Retrieved October 2017 from www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management.

¹⁹ To bill for SBIRT in a healthcare facility, staff must complete an approved four-hour SBIRT certification training per the Washington State Health Care Authority regulations for Medicaid billing.

as less effective as in person training, and the current reimbursement rates offer no incentive to complete required training.

“[W]hile the online training is valuable, I think that...the roleplaying that we did was invaluable..., both in team building and also in practicing motivational interviewing...The in-person training is much more effective.”

— Behavioral Health Specialist, Emergency Department

While receiving grant funding, facilities were routinely provided reports monitoring their SBIRT performance. Most sites acknowledged the importance of receiving these reports for ongoing program monitoring and process improvements. However, most interviewed sites reported a lack of resources to sustain program monitoring since grant funding ended. Only one interviewed site routinely monitors and evaluates SBIRT performance for process improvements and to inform executive leadership of the program’s success.

“We haven’t developed [performance monitoring] reports yet...but being able to demonstrate over time that the program is successful will be important to sustain [SBIRT] in the organization.”

— Case Management Manager, Emergency Department

Funding

WASBIRT-PCI facilities were provided grant funds to hire behavioral health specialists to perform brief interventions and referrals to treatment. Once grant funding ended, the expectation was SBIRT would be sustained through newly established billing reimbursements. While all interviewed facilities were providing SBIRT services, none of them reported routinely billing for SBIRT and most never billed. Reasons for not billing include the low reimbursement rate, confusion around billing requirements, and the time-cost of completing the four-hour SBIRT certification training. Additionally, the low revenue generated from billing would not justify the administrative costs of implementing SBIRT billing and submitting claims. Of the surveyed facilities, 11 cited challenges with obtaining funding to maintain the program.

“I think SBIRT is a worthwhile and a needed program. Unfortunately it is time consuming and the amount of resources it needs to succeed are not available here in the E[mergency] D[epartment].”

— Director, Emergency Department

No interviewed facilities acquired additional funds to sustain their SBIRT program after grant funds were exhausted. To sustain SBIRT activities, facilities integrated SBIRT screening into the general scope of practice along with other routine screenings, such as tobacco screening and blood-pressure monitoring. Brief interventions are provided in the context of other billable behavioral health services, such as mental health appointments. In some instances, facilities bill for office visits when brief interventions are provided, however none are using the designated SBIRT billing codes.²⁰ To help offset some of the costs to deliver SBIRT, three WASBIRT-PCI facilities partner with the University of Washington’s Masters of Social Work SBIRT program. Student interns are placed in the facility to assist with brief interventions and referrals to treatment. These students are trained on SBIRT service delivery through a SAMHSA SBIRT training grant.

²⁰ The Healthcare Common Procedure Coding System (HCPCS) codes available in Washington for SBIRT include 99408 for a 15 to 30 brief intervention and 99409 for a brief intervention lasting longer than 30 minutes. They are reimbursed at \$20 and \$40, respectively.

Facilities see value in and are dedicated to offering SBIRT. They are, however, interested in learning more about sustainable SBIRT models that include a reliable funding stream through billing or other reimbursement. Ultimately, most clinics expressed concern that without adequate reimbursement SBIRT will be difficult to sustain with fidelity.

“If [SBIRT] were reimbursed at a better rate and we could demonstrate the...financial benefit of the extra ten minutes, even if it were just up-coding, or just billing separately, you know, that would go a long way.”

— Behavioral Health Specialist, Family Practice

“This program’s been very valuable to meet the need in our community. I feel like we are making a difference.”

— Behavioral Health Specialist, Emergency Department

Issues Critical to Sustaining SBIRT

Facilities were asked to identify factors most critical to SBIRT implementation and sustainability. They noted a number of issues associated with staff attitudes and knowledge about SBIRT, billing and certification policy, staffing and other supports they believe significantly influence SBIRT service delivery and overall sustainability.

Staff Knowledge and Acceptance of SBIRT. Respondents noted that new staff often lack sufficient knowledge on SBIRT procedures and existing staff would benefit from continuing education. In addition to skill training, all agree staff buy-in—acceptance of the SBIRT model—is critical to implementing and sustaining the program. Without buy-in, staff is less likely to perform the core components of SBIRT consistently and with fidelity. For instance, a primary care provider who does not appreciate the value of discussing a patient’s risky—but not disordered—alcohol use, is less likely to provide a brief intervention when indicated or to hand-off such a patient to a behavioral health specialist.

Some staff are generally unwilling to address patient substance use and tend to minimize the risks associated with mild to moderate substance use. Respondents suggest that these staff can be “won over” to SBIRT after witnessing improvements in patients’ health or changes to their substance use over time. Observing the value of SBIRT increases staff buy-in and makes them more willing to adhere to SBIRT procedures, including addressing mild to moderate substance use.

Respondents also stressed the importance of leadership support for SBIRT. Even if facility staff is knowledgeable and appreciate the value of SBIRT, without the accountability imposed by leadership, SBIRT gradually becomes less of a priority and program fidelity degrades. In addition to educating staff about their roles and the effectiveness of SBIRT, facility staff acknowledged the importance of educating executives and managers about the value of SBIRT and to provide them tools to effectively monitor the program.

“It’s critical that we have buy-in from the leadership and the providers and medical staff, and...the recognition that [SBIRT] is a really important part of primary care...And if we have buy-in from leadership, then it’s a lot easier for SBIRT to work.”

— Medical Director, Family Practice

Billing and Certification Policy. While interviewed facilities are satisfied with their own internal policies and procedures, they noted specific concerns regarding State billing and certification policies and recommended the following solutions:

- Increase the reimbursement rate for SBIRT brief interventions. The current reimbursement rates (\$20 for 15 to 30 minutes and \$40 for over 30 minutes) for brief interventions are “not worth the effort” of submitting a claim.
- Reduce the training time required to become a certified SBIRT provider. Currently, the state requires four hours of training to become certified. The low reimbursement rate does not justify the time investment, particularly for primary care providers.
- Allow a broader range of providers who can be credentialed to bill SBIRT services. For instance, currently Chemical Dependency Professionals and nurses cannot be certified to bill for an SBIRT brief intervention.
- Change SBIRT billing codes. Currently SBIRT is reimbursed as a fee-for-service claim. Billing protocols and contracts should be revised to support facilities operating under managed care.

Staffing and Support. Facility interviewees noted four areas where staffing and other resources influence the quality and sustainability of SBIRT:

- Competing priorities: when short-staffed, SBIRT workflow breaks down as other patient medical needs are given priority.
- Performance monitoring: program fidelity requires staff dedicated to monitoring clinic performance and act as a champion for effective SBIRT implementation.
- Information Technology: electronic health records with an “SBIRT module” improve performance monitoring capabilities and simplify workflow.
- Improved training: training for new staff and continuing education for existing staff establishes roles and expectations, improves SBIRT skills and increases buy-in.

Most respondents noted that without the initial support of the WASBIRT-PCI grant they would not have been able to implement SBIRT. In addition to providing resources to hire necessary staff, the grant also provided initial in-person training and ongoing technical assistance, frequent meetings with State project staff to identify opportunities for process improvement, and regular reports on clinic performance. Of these, routine performance monitoring and associated accountability were commonly cited as keys to sustainability. These implementation resources, however, are no longer routinely available to facilities and financial support for sustaining SBIRT has not been replaced by SBIRT-billing revenue. Although most facilities are still using behavioral health specialists to conduct SBIRT, this staff also address other behavioral health needs of patients. Competing priorities within the clinic make it difficult for any one staff member to fully commit to championing the SBIRT program.

Despite these challenges, more than half (10 facilities) of the original WASBIRT-PCI facilities continue to offer SBIRT services for their adult patients, and some facilities are contemplating expanding services to partner facilities in their organization or to other patient populations, such as youth. Interviewees described their interest in improving their practice by: streamlining the SBIRT workflow, reestablishing routine performance reporting, and advocating for a more sustainable, reimbursable SBIRT model. Of the facilities that no longer offer SBIRT services, common challenges reported were staff turnover, inadequate training, lack of accountability and staff performance, uncertainties about billing and funding. Among the nine facilities that stopped offering some or all core components of SBIRT, the program had an impact on staff. Some facilities that discontinued SBIRT services expressed remorse to have lost a service that was helpful for their patients.

“The greatest challenge...is just so many competing priorities...and it’s a little tricky to meet the requirements for billing, so when you have competing priorities and you have a service that you want to offer, but it’s hard to get reimbursed for it, then it’s easy for that to get nixed in favor of something that you can more easily get reimbursed for.”

— Clinical Psychologist, Family Practice

“The growth of this program was extraordinary, and the benefits to our patients were immeasurable. So many patients were left unattended and without this type of care [SBIRT], with nowhere to go once it was discontinued.”

— Clinic Manager, Family Practice

Summary

Two of the primary goals of the WASBIRT-PCI project were 1) expand the continuum of care to include SBIRT services in community health settings, and 2) implement fee-for-service reimbursement for SBIRT to increase the likelihood of sustaining the practice. Over the course of the grant, WASBIRT-PCI expanded SBIRT services into nineteen healthcare facilities (in ten organizations) across Washington State. As of July 2017, and absent continued grant funding, ten of the original 19 facilities continue to provide the core, evidence-based components of SBIRT (universal screening for alcohol and brief intervention for risky users). While Washington State successfully established SBIRT billing procedure codes to support fee-for-service Medicaid reimbursement, none of the WASBIRT-PCI facilities use the codes systematically to seek reimbursement for SBIRT brief interventions.

There are key differences between the WASBIRT-PCI facilities that continue to offer SBIRT and those that discontinued SBIRT. Facilities that continue to offer SBIRT still employ key staff who were involved in the facility’s grant-funded implementation of SBIRT; they tend to have clear executive and staff commitment to the SBIRT model and staff who act as champions for the program; and they have integrated SBIRT into their behavioral health services to address reimbursement, resource and workflow challenges. Among facilities that discontinued SBIRT services, common themes were the loss of the program’s champion or advocate and a lack of executive support.

According to staff interviewed, easing the billing and certification requirements and increasing the reimbursement rates for SBIRT services would encourage broader adoption of SBIRT and help sustain the practice. In addition to improved reimbursement, respondents also described a number of strategies that will improve the adoption and sustainability of SBIRT:

- Increase access to online and in-person SBIRT training and continuing education;
- Improve staff acceptance of SBIRT by promoting its effectiveness with patients who have mild or moderate substance use risk;
- Provide guidance regarding SBIRT for substances other than alcohol—in particular, cannabis;
- Provide technical assistance and incentives to encourage the use of performance monitoring and evaluation tools that improve accountability; and
- Cultivate executive-level support of and advocacy for SBIRT.

The challenges identified by WASBIRT-PCI facilities are consistent with other research on SBIRT sustainability.²¹ Despite these challenges, most WASBIRT-PCI facilities have found ways to sustain the practice to varying degrees of fidelity and effectiveness: bundling the SBIRT practice into other behavioral health services, continuing to engage leadership in support of SBIRT, training additional staff to perform brief interventions, and enlisting trained interns to assist with brief interventions. Reliable funding or other incentives, staff knowledge and acceptance, training resources, leadership and accountability remain ongoing challenges to the adoption and sustainability of SBIRT.

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²¹ Richmond, M., & Rivera, L. July 2012. SBIRT Colorado Sustainability Interviews: Final Report. Colorado Department of Human Services, Division of Behavioral Health & OMNI Institute.