NEW HAMPSHIRE
CHARITABLE FOUNDATION

The Power of Best Practices

LAUNCHING SBIRT IN A COMMUNITY HEALTH CENTER

JULY 2013

Acknowledgments

The New Hampshire Charitable Foundation manages a sizable portfolio to address substance abuse problems in local communities. In 2013, the Foundation supported Goodwin Community Health in its desire to adopt SBIRT, an evidence-based universal screening and early intervention protocol to identify alcohol and other drug misuse in patients before it causes harm or dependence. The Foundation granted funds to ONE Voice for Southeastern New Hampshire, a regional prevention network promoting best practices to prevent and reduce substance use, to support Goodwin Community Health in this sustainable best practice. Goodwin Community Health matched the Foundation's investment with significant in-kind contributions, leadership, expertise, and other resources to support SBIRT adoption.

INTRODUCTION

Goodwin Community Health, a Federally Qualified Health Center (FQHC), is one of New Hampshire's fourteen community health centers and the first such health center in the state to adopt an evidence-based practice for primary care settings to improve the prevention, early intervention and treatment of alcohol and other drug misuse. Goodwin's experiences in this endeavor have been documented in this publication to cultivate an appreciation for the opportunities and challenges that community health centers face in adopting the practice known as SBIRT (Screening Brief Intervention and Referral to Treatment). It is hoped that their story will serve to encourage resource and partner development to support community health centers in their efforts to improve the health of the individuals and communities they serve by successfully implementing universal SBIRT in their primary care setting.

A BEST PRACTICE APPROACH

Before talking about Goodwin Community Health's experiences in adopting SBIRT, it is important to understand why SBIRT has become a best practice in health and medical settings. In 1990, the Institute of Medicine (IOM) released a landmark publication on "broadening the base of treatment for alcohol problems." With its documentation of the prevalence and economic, personal and social costs of alcohol use, the IOM noted that over 95% of those with an alcohol abuse or dependence problem were unaware of their problem and unaware of how it was related to other health, social, economic, legal or other problems they were experiencing. The IOM's call to expand treatment was responded to by the World Health Organization (WHO) and others who joined together to develop screening questionnaires to identify a continuum of alcohol and drug misuse and to share effective strategies to intervene early in the primary care setting.

Following several years of studies, the research was clear that the combination of screening and brief interventions in medical settings for both alcohol and other drug misuse was effective in reducing substance abuse, substance abuse-related injuries, drinking and driving, and other harmful outcomes. The strength of the evidence after numerous replications with a wide range of populations led the American College of Surgeons in 2005 to endorse and recommend WHO screening and brief intervention protocols for primary health care settings and Level I trauma centers. These protocols were expanded to include referral to substance abuse treatment for a smaller percentage of patients for whom a brief intervention was not sufficient. SBIRT, as the protocols are now known, is now recommended by the U.S. Substance Abuse and Mental Health Association and is approved for federal Medicaid reimbursement.[1]

[1] *Drug and Alcohol Dependence*, 99 (1-3), January 2009, 280-295

New Hampshire ranks highest among the states for its rate of underage drinking, second highest for its rate of regular marijuana use by children ages 12 to 17 and fifth highest for its rate of young adult binge drinking.

"SBIRT addresses a critical system and infrastructure gap in that there is no standard, effective means in the state to screen adults or adolescents for risk for or development of substance use disorders or co-occurring disorders..."

WHY IS SBIRT ADOPTION IMPORTANT FOR NEW HAMPSHIRE?

New Hampshire is often referred to as one of the healthiest states in the nation based on low crime, low poverty rates, strong schools, and the overall health of its citizens. However, New Hampshire struggles with widespread alcohol and other drug misuse that has been on the rise over the last decade. According to findings from the 2011 National Survey on Drug Use and Health (NSDUH), New Hampshire ranks highest among the states for its rate of underage drinking (33.5% of 12 to 20 year olds reporting alcohol use in the past month), second highest for its rate of regular marijuana use by children ages 12 to 17 (11.4%) and fifth highest for its rate of young adult binge drinking (49.3% of 18 to 25 year olds reporting binge drinking in the past month). The state also ranks 5th for its rates of regular marijuana use by young adults (27%) and 10th for past year young adult prescription drug misuse (12.3%). The state is also significantly higher than the national average for the percentage of 12 to 25 year olds needing but not receiving treatment for alcohol or drug dependence. Please refer to Appendix A for a table comparing NH and US rates for a range of substance misuse indicators.

These high rates of substance misuse are leading to devastating impacts affecting all ages, from newborns to older adults. Understanding of these impacts has grown considerably over the last several years in part due to the NH Bureau of Drug and Alcohol Services' commitment to breaking down silos, promoting collaboration, and expanding the reach of substance abuse prevention, intervention, treatment and recovery supports.

As a part of the Bureau's efforts, federal funding was secured in 2006 to improve substance misuse prevention in the state, which led to the development of ten regional prevention networks (now known as Regional Public Health Networks or RPHNs) charged with engaging and promoting best practices within six core community sectors: **education** (schools and colleges), **safety** and law enforcement, **business**, **government**, **community**-based support organizations, and the **medical** community. Studying best practices for each of these sectors during regional strategic planning led to the identification of SBIRT as one of the prime best practices to be promoted within the medical sector. This selection of SBIRT by state level strategic planning and five of the ten regional networks was based on the following:

- The strong evidence-base of the approach – it is endorsed by U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and is sole focus of one of SAMHSA's largest infrastructure development grant programs to states
- The ability of the practice to be implemented in one of the state's most stable infrastructures that serves the highest risk populations in the state, namely the Community Health Center system
- The opportunity that SBIRT provides in supporting integration between primary care and behavioral health
- The alignment that exists between SBIRT practice and identified state and local risk factors that impede successful prevention outcomes and access to treatment, namely low perception of risk, stigma, lack of awareness and early identification of substance abuse problems
- SBIRT addresses a critical system and infrastructure gap in that there is no standard, effective means in the state to screen adults or adolescents for risk for or development of substance use disorders or co-occurring disorders; medical providers have limited readiness to address a behavioral health problem in which they receive little or no training; and most primary care settings lack capacity to refer those screened to specialty care systems and to coordinate their physical and behavioral health care.

For these reasons, SBIRT is important to New Hampshire as it holds the promise of universal screening, provider education, decreased barriers to early intervention and treatment, integrated care, and positive outcomes for patients.

WHY DID SBIRT ADOPTION BECOME IMPORTANT FOR GOODWIN COMMUNITY HEALTH?

Goodwin Community Health is located in Somerworth, NH, in the state's seacoast region. The seacoast of New Hampshire is characterized by an economy that relies heavily on tourism, resulting in a transient work force and thus communities with significant housing and employment turnover. The seasonal influx of summer visitors brings vitality to the local economy but not without the companion drawbacks of high risk alcohol consumption and a culture of substance misuse. The region is also home to the University of New Hampshire located in Durham, NH, that draws a large young adult population also influencing community norms relative to alcohol misuse and other drug use. Compounding these influences is the significant socio-economic stratification between the "have's" with oceanfront homes along the seacoast and the "have-not's"living at or below the Federal Poverty Level (FPL) due to unemployment or seasonal employment in low wage jobs. Race, ethnicity and poverty demographics for the county are provided below:

Strafford County Population Demographics[2]

2012 Total population	124,119
% White	94.1%
% African American	1.1%
% American Indian/Alaskan	0.3%
% Asian	2.7%
% Native Hawaiian/Other Pacific Islander	0%
% Two or more races	1.8%
% Hispanic or Latino	1.9%
% White, Non- Hispanic	92.6%
% Living below FPL	10.8% (2.8% above state FPL)

[2]U.S. Census, 2012. Retrieved from http://quickfacts.census.gov/qfd/states/33/33017.html

Goodwin Health Center Launches SBIRT July 2013

Strafford County has a significant socio-economic stratification between the "have's" with oceanfront homes along the seacoast and the "have-not's" living at or below the Federal Poverty Level...

"The rate of alcohol or drug dependence among 12-17 year olds in New Hampshire is fourth highest of all states"

Goodwin Community Health serves approximately 8,000 patients a year, serving 66% Medicaid or uninsured, including approximately 322 pregnant women, 3,417 Medicaid recipients, and 2,602 uninsured individuals. Goodwin currently serves 1,541 children birth to age twelve, 711 thirteen to eighteen year olds. The health center also serves the state's regional substance abuse efforts by housing the Regional Public Health Network, ONE Voice for Southeastern NH, the network that serves the substance misuse and other public health priorities of greater Strafford County.

In partnership with Goodwin and the NH Bureau of Drug and Alcohol Services (BDAS), ONE Voice led a grass roots assessment of substance use problems in the region that included surveying high school students in the area's public schools, reviewing hospital discharge data, studying law enforcement data, and listening to community sectors and members during focus groups. These assessments were conducted in 2007-2008 and again in 2011-2012. The most recent assessment data was compiled in a regional data profile available at http://www.nhcenterforexcellence.org/resources/item/61-southeastern-region.

Findings from this assessment included the following:

For children and youth in the region, alcohol and marijuana are the most prevalent substances of misuse.

- In the southeastern region, alcohol is the most prevalent substance of abuse, with the percentage of high school respondents indicating alcohol use in the past 30 days ranging from 31.4% of Farmington High School youth to 45.8% of Nute High School youth, while the state rate for past 30-day alcohol use was 38.1%.

- Past 30-day use of marijuana by high school youth in ranged from 15.8% of Farmington High School youth to 35.9% of Portsmouth High School youth. The 2009 state rate of past 30-day use of marijuana by high school youth was 24.3%.

- Southeastern region youth reported rates of past 30-day prescription drug misuse that ranged from 7.7% of Oyster River High School youth to 13.1% of Portsmouth High School youth. The state rate of past 30-day prescription drug misuse among youth was 9.3%.

- Approximately 1/3 of high school students who drink started before the age of 13.

- In the state and the region, the 12-17 year old age group has rates of use of alcohol and marijuana that are ranked in the top 10 among the 50 states and the District of Columbia (3rd highest for regular alcohol use, 4th highest for regular binge drinking, and 2nd highest for regular marijuana use).[3]

- The rate of alcohol or drug dependence among 12-17 year olds in New Hampshire is fourth highest of all states.

[3] 2010-2011 National Survey on Drug Use and Health

For young adults

- In a survey sample of young adults across the state, young adults in the region were more likely to report problem drinking than young adults who were surveyed in other regions of the state.

- Data from the Medical Examiner's office substantiate that many of the state's drug overdose deaths occur in the southern tier of the state; the 21-30 year old age range is the 3rd most prevalent age range for drug-related deaths.

- In the state and in the region, the young adult age group (18-25 year olds) has rates of use of alcohol, marijuana and prescription drugs that are ranked in the top 10 among the 50 states and the District of Columbia (3rd highest for regular alcohol use, 5th highest for regular binge drinking, 5th highest for regular marijuana use, and 10th highest for prescription drug misuse).[4]

For adults

- According to the Behavioral Risk Factor Surveillance System in the state, the region had the highest rate of adult heavy drinking at the time of the assessment.

- Data from the Medical Examiner's office substantiate that many of the state's drug overdose deaths occur in the southern tier of the state; the 41-50 year old age range is the age range with the highest prevalence of drug-related deaths.

- Focus groups of professionals from the medical staff indicated that substance abuse was a major factor in poor health outcomes in their patient populations.

These and other prioritized problems led to the development of the Southeastern Regional Network (ONE Voice) Strategic Prevention Plan.[5] This plan, developed in large part in the community outside of the medical practice, introduced SBIRT as the core strategy for the region's medical sector to prevent and reduce substance abuse among adolescents and adults.

From the inside looking out, however, did Goodwin Community Health recognize what the larger community had? According to the behavioral health director Dr. Sandy Rose, "the more patients I saw the more curious I became about the population that was coming to the clinic so I started to ask questions and look for our own data internally. I'll call it the ostrich effect. It seemed so pervasive in our population yet we were collecting almost no data on it in the practice setting." When CEO Janet Atkins was approached, she agreed with Rose's perspective. Atkins then supported and helped lead the process of studying the problem in the patient population. This leadership began to counter the reluctance of providers that was due in part to the lack of resources to address substance abuse problems if universal screening was to be adopted. "Basically, there was a general shift toward recognizing that not asking the questions about alcohol and drug misuse was not a solution – it had become part of the problem," according to Rose.

[4] 2010-2011 National Survey on Drug Use and Health
[5] http://www.nhcenterforexcellence.org/pdfs/strategicplans/SoutheasternSP_Final.pdf

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"Basically, there was a general shift toward recognizing that not asking the questions about alcohol and drug misuse was not a solution – it had become part of the problem."

WHY IS SBIRT THE SELECTED RESPONSE TO SUBSTANCE ABUSE PROBLEMS IN THE COMMUNITY HEALTH CENTER SETTING?

AN EVIDENCE-BASED APPROACH

Ten years ago, New Futures, an alcohol policy group, was one of the first to take a leadership role in encourage state and community systems to consider SBIRT for several reasons: it had a clear potential for sustainability through its adoption within sustained health and medical settings, implementation was relatively straight forward, and it had very positive outcomes in multiple medical and health settings.

Since that time, SBIRT has gained prominence in the national landscape, with significant federal investment in its study and promotion. In 2003, the Federal Government established the SBIRT grantee program within SAMHSA's Center for Substance Abuse Treatment to fund SBIRT services in primary care and community health settings for adults with substance use disorders.

The National Institute on Drug Abuse (NIDA) encourages the use of SBIRT in traditional medical settings in order to:

- Identify drug users early and briefly educate them about the adverse consequences of continued drug use and available resources for quitting;
- Enhance medical care by increasing awareness of the potential impact of substance use on physical health—more specifically, the interaction of substance use with a patient's medical care, including potentially fatal drug interactions; and
- Improve linkages between primary and secondary health care services and specialty drug and alcohol treatment services.

In recognition of the evidence base of SBIRT, its feasibility in the community health center system, its federal support, and its potential for sustainability, the NH Governor's Commission on Alcohol and Drug Abuse included SBIRT in its 2013 strategic plan for preventing alcohol and other drug misuse and promoting recovery, encouraging medical professionals to adopt the practice. Also, as a member of the Commission promoting SBIRT, the NH Bureau of Drug and Alcohol Services worked with the NH Maternal and Child Health (MCH) Section that oversees the community health center (CHC) system to consider SBIRT. MCH responded positively and in 2012 included universal alcohol and drug screening of adults as a required activity of all CHCs. Although MCH sets important protocols and requirements, it recognizes the challenges of preparing for such a change in practice; therefore, to increase resources for clinical preparation such as EMR adaptations, staff training, and unrecoverable costs such as brief intervention, care coordination and referral to treatment, MCH applied for federal SBIRT funding in May of 2013 to support full SBIRT adoption within CHCs. Notice is due by late September 2013.

READINESS OF THE COMMUNITY HEALTH CENTER

Goodwin Health Services had several key assets that led to its emergence as an early adopter of SBIRT. Primarily, in addition to providing primary care services, it also has specialized clinics for maternal and child health, pediatrics, family planning, on-site integrated dental care, and, most relevant to SBIRT adoption, on-site integrated behavioral health and mental health services.

The behavioral health team at Goodwin includes a psychologist, a psychiatric nurse practitioner, licensed social workers, and a licensed alcohol and drug counselor who work closely with the primary care provider section. In addition, team social workers follow up with patients and families and provide education, resources, and assistance in monitoring patient outcomes.

The integrated behavioral health and mental health services was an obvious advantage to SBIRT adoption as the integration of these services had already addressed significant logistical issues relative to referral processes, coordination of care between primary care and behavioral health services, and the sharing of patient data.

In addition to integrated behavioral health services, Goodwin had other assets that indicated its high readiness to adopt SBIRT, including:

- Leadership support for SBIRT adoption, including Executive Director Janet Atkins, Behavioral Health Director Dr. Sandy Rose, and ONE Voice Regional Coordinator Melissa Silvey
- An Electronic Medical Record (EMR) capable of supporting SBIRT
- A group purchase and technical support agreement with Centricity for EMR management and changes necessary for SBIRT through Goodwin's membership in NH's Community Health Access Network (CHAN)
- Existing processes for mental health screening and referral that could be followed for substance use screening and referral
- A licensed drug and alcohol counselor on staff and on site
- An existing memorandum of understanding with an area alcohol and other drug treatment facility to support SBIRT referrals
- A service population with a relatively high rate of substance use disorders

Goodwin's readiness is also evident in its recognition of challenges and obstacles to effective patient care for individuals with a substance abuse problem. Specifically, Goodwin recognized the challenge of its limited ability to receive reimbursement for screening and assessing patients for substance abuse and mental health conditions. Although these services are technically reimbursable through federal Medicaid under bundled service rate agreements, for patients without insurance or with private insurance, they often not reimbursable. This

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challenge leads to other clinical practice implications, including insufficient resources for technology adaptations, care coordination, and other infrastructure necessary for effective SBIRT implementation. Care coordination in particular is critical to effective SBIRT practice because of its role in the on-going relationship between a patient and multiple levels of care within and outside of the health center. Care coordinators often become the main point of contact for patients who are interacting with both primary care and specialty care supports. Care coordinators may also assist patients with accessing other supports to reduce barriers to services, such as finding child care for pregnant women or transportation and scheduling for treatment and recovery supports.

Care coordination in particular is critical to effective SBIRT practice because of its role in the on-going relationship between a patient and multiple levels of care within and outside of the health center.

WHAT STEPS DID GOODWIN TAKE TO IMPLEMENT SBIRT?

ONE Voice, the region's Regional Public Health Network located at Goodwin, took an immediate leadership role as its strategic plan was unveiled in the summer of 2012. Coordinator Melissa Silvey began with informal interviews with Goodwin Executive Director Janet Atkins and Behavioral Health Director Sandy Rose. A presentation was made to the Goodwin board of directors, to different provider groups (physicians, MAs, and care nurse practitioners). One-on-one meetings were also held for key leadership in the health center. Ultimately, Both Atkins and Rose recognized substance abuse as a significant concern among the health center's patients but also were realistic that launching universal screening would take time and effort.

The first hurdle Goodwin was to face was ensuring that the Medical Record, EMR could accommodate and support SBIRT protocols. Early in January 2013, Ms. Silvey and Dr. Rose met with Goodwin EMR coordinator Sharlene Poitras, Director of Quality Improvement Jannell Levine, and Stacy Allard of the Community Health Access Network that manages Goodwin's EMR system. Goodwin also encouraged a partnering community health center in the region, Families First, to join the early brainstorming sessions and technical assistance (TA) meetings. These meetings reinforced the ability to have SBIRT protocols embedded in the health center's EMR.

The team of Melissa Silvey and Sandy Rose then requested TA from the NH Center for Excellence in substance abuse services for consultation on what steps they should take next. The Center worked with the team and consulted with SAMHSA-sponsored states such as Colorado to prepare a resource document listing key activities and lessons learned from Colorado's experience. The TA response included sample work flows, training sites and contacts, and reflection on Goodwin's assets to support SBIRT adoption.

From this information, Goodwin accomplished the following:

- Applied for and received $15,000 in funding from the New Hampshire Charitable Foundation to cover preparation costs, such as EMR adaptation and training

- Reviewed and selected screening instruments

- Adapted electronic medical records to accommodate brief and full screen questions for alcohol and drug use; see Appendix B for summary of adaptations and modifications made

- Consulted with Shari Van Hook of Boston Children's Hospital/Harvard University's Adolescent Substance Abuse Program

- Consulted with Leigh Fisher of Peer Support Services, Colorado SBIRT's technical assistance provider

- Reviewed sample workflows and designed custom workflow for Goodwin with provider input from all levels of the health center

- Determined that medical assistants would implement initial quick screen during annual check ups and if indicated, the EMR would prompt the medical assistants to continue with the full screens; determined that if brief intervention was warranted, physician/provider would then counsel the patient on risk and behavior change using evidence-based Motivational Interviewing

- Established workflow and and means to introduce patient to behavioral health specialist on site if screenings indicated a need for brief treatment (on site) or specialty care treatment (off site)

- Obtained state referral guide as a provider resource for referrals to specialty substance abuse treatment, with modifications being made for updated and additional information such as average wait time and notations regarding whether the agencies accept insurance, Medicaid, or other third party payment

- Incorporated depression screening using Patient Health Questionnaire and appropriate protocols into EMR and workflow changes

- Legal Consultation by Attorney Sally Friedman from the Legal Action Center on sharing patient data within boundaries of federal laws protecting patient privacy and confidentiality

- Acquisition and dissemination of "Helping Patients Who Drink Too Much: A Clinican's Guide" (updated 2005 Edition) and "The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care" by Thomas F. Babor John C. Higgens, John B. Saudners, Mariestela G. Monteior (2nd Edition)

- Trained physicians, medical assistants and other health center staff:

    - Two agency-wide MI trainings with Lisa Stockwell, MINT

    - Two mandatory trainings with Peter Fifield, MLADC, LICSW, from Families First - Portsmouth and Dr. Sandy Rose on MI use with GCH SBIRT protocols (one for MAs and nurses; one for providers)

    - A training by Dr. Nowak, area psychiatrist and addiction specialist, on using medical therapies as therapeutic responses to addiction (for primary care physicians)

    - Consultation and training by Dr. Edward Berstein, emergency physician and Vice President of Academic Affairs and Director of the Public and Global Health Section in the Emergency Medicine at Boston University

    - EMR training provided to care coordination teams, medical assistants, and providers

Following the preparatory activities noted on the previous pages, Goodwin Health Services began screening all adults universally during annual physicals on July 8, 2013. In their first two months of SBIRT implementation, over 90% of comprehensive clinic appointments included a brief screen and 30% of those screened were identified as needing a brief intervention.

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– Dr. Rose

WHAT LESSONS DID GOODWIN LEARN AND CHALLENGES DID IT ENCOUNTER IN PREPARING TO IMPLEMENT SBIRT?

Goodwin Community Health faced many challenges in its pursuit of practice change to better serve its patients with respect to alcohol and other drug misuse. Interviews with key staff in the change process reflected on the past year of SBIRT preparation to share their story with other health centers ready to embed SBIRT into their practice. Their experiences help to highlight to investors in substance abuse and primary care integration the continuing investments needed to further support the growth and sustainability of SBIRT.

Goodwin acknowledged what community assessments had identified: providers were underestimating the prevalence of substance use disorders. Understanding the root causes, such as reluctance to ask about substance misuse when they were unsure what to do with the answers they might get, was the first barrier to overcome. But Goodwin pushed the envelope because as a practice they knew their patient population needed attention, and they had the internal commitment and passion of a few key staff who were willing to step out in front and lead colleagues to a better standard of care.

Other than the challenges discussed throughout this document, other challenges included "information overload." Dr. Rose shares, "We received so much information from our initial TA that we gave a lot of time to digging in, reading through, discussing pros and cons of different tools, materials and strategies. SBIRT is definitely not a packaged set of instructions. It's not a simple activation of a screen module in the EMR. It is a change in practice with as many questions as answers, and it took a great deal of time determining the right path for Goodwin."

The work of sifting through tools, materials, options and decision-making led to unanticipated delays. Communications with the EMR vendor, provider turnover, and even a layoff of staff during this time period challenged morale during SBIRT preparations. "It wasn't a great time to roll out SBIRT – reimbursements are a constant challenge to keeping health centers financially viable," according to Dr. Rose. Therefore, Goodwin had to invest significant time to changing minds one provider and professional at a time. "Listening to and respecting their concerns required time. Providers wanted to make sure that protocols did not create redundant workflows, and third party payers such as Medicare (for geriatric patients) and specialized grants for prenatal patients required separate protocols," commented Dr. Rose. These concerns led Goodwin to rethink and change direction many times throughout the process, carefully reviewing existing screens and creating unique and responsive SBIRT protocols within workflows for different patient populations and payer systems.

The development of SBIRT protocols for adolescent patients was even more complex, given the need to navigate legal and ethical issues and decision points such as age of consent for substance use treatment and privacy issues. These challenges included federal and state laws regulating age of consent and protecting the confidentiality of alcohol and drug information of minors, in some cases from their parents. As a result, Goodwin decided to roll out universal screening for adults first, and hold implementation of adolescent screening for later in the year following further technical assistance on these issues. However, the specific adolescent screens and evidenced based recommendations for intervention were included in the original EMR design for easier facilitation once protocols were established (See Further Investments Needed in the next section).

Goodwin acknowledges that challenges will continue to emerge as the clinic initiates universal screening in early July but feels more ready now than fearful, having already overcome significant challenges. They are committed to not just changing the way their center addresses patient wellness; as early adopters they recognize they are paving the way for other providers and patients for whom substance abuse disorders will be treated the same as any other preventable disease.

LESSONS LEARNED

"We could not have done this without the New Hampshire Charitable Foundation," reflects Dr. Sandy Rose. Their funding not only covered the necessary training and EMR changes, it covered Dr. Rose's time to work with Ms. Silvey to prepare trainings, talk with medical providers, organize existing resources, and to lead change from within.

"Having our Executive Director's support and willingness to stand behind us, next to us, and beside us as we faced challenges was critical. Janet [Atkins] couldn't have been more supportive, and that really made a difference," acknowledged Silvey. In addition to key leadership support, "having an internal champion and giving her the time she needed to move this forward was what made it happen. I could do a lot, but I wasn't from the medical field. Our doctors needed to hear this from their peers, so Dr. Rose and the experts from Boston University really made the difference in changing attitudes and embracing SBIRT," Silvey reflected.

Gaining the buy-in of the medical director was also key to Goodwin's success. They had just had a change in the position, and the SBIRT champions at Goodwin took the opportunity to set up an early meeting with the newly hired medical director. Dr. Rose recalled this seminal meeting, "I actually braced myself to hear 'this is ridiculous' and we were so far along in the process I couldn't imagine dropping the work. But he was open and supportive. What a relief!" This led to the scheduling of the necessary lunch-and-learn time for the medical staff to receive training without losing patient time.

Goodwin ultimately learned to envision implementation as a process rather than an end point and that individual provider preferences and flexibility was something to embrace, allowing on-going evaluation and hands-on experience to continue to refine and improve the new processes. They also recognized that engagement is a never-ending process, and bringing the right expertise and stakeholders at the right time goes a long way. Sometimes, they found, buy-in comes from one colleague talking to another, but sometimes it takes someone from the outside to inspire and reassure. Goodwin learned to use a wide range of resources and strategies to slowly change the paradigm from adopting SBIRT because "someone said so" to implementing SBIRT because "it's the right thing to do."

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WHAT FURTHER INVESTMENTS ARE NEEDED?

A significant challenge that has yet to be fully resolved concerns understanding and complying with laws impacting consent and confidentiality of alcohol and drug information. For example, the federal alcohol and drug law, 42 CFR Part 2, holds stringent protections around this information by providers who are bound by its provisions. In a primary care setting, rapid access is required and alcohol and drug diagnosis and information routinely may be communicated for healthcare reasons across providers using only general consent. If an embedded provider is a specialist such as a licensed alcohol and drug counselor, Part 2 prohibits this kind of information exchange in health centers without additional safeguards that are often cumbersome for providers and systems. While work-arounds were developed, improved protocols must allow for more efficient, rapid communication and protections and consent by patients for this information to be exchanged.

This challenge prompted Goodwin Community Health to delay adolescent screening until resources were available for legal counsel to determine a means to protect the rights and responsibilities of all parties, including the patient, parents, providers, practitioners, and the clinic. CHAN has made some progress in developing configurations within the EMR to sequester some information while allowing access to other information, but the issue remains a roadblock requiring expert consultation and facilitated decision-making.

Another significant challenge remaining is the lack of reimbursement for services within the SBIRT array. Currently, some private insurers cover some SBIRT services as does the federal Medicaid program, which allows FQHCs to cover costs under bundled encounter rate agreements. However, the NH Medicaid Plan does not currently cover SBIRT-related services, and parity in insurance coverage for treatment services outside of the primary care setting exists still very much in theory rather than in standard practice. Care coordination and non-traditional behavioral health services can be difficult to get adequate reimbursement for. These financial challenges relative to substance abuse exacerbate an already stretched service system. In the words of one optimistic staff person talking about SBIRT in spite of systemic financial challenges, "We're broke, but we care about patients."

Access to and availability of treatment, even in Goodwin's ideal integrated primary and behavioral health care setting, continues to cast a shadow over SBIRT's projected success in NH CHCs. Utilization data and anecdotes from individuals in New Hampshire struggling with addiction continue to underscore the challenges in accessing services, including wait lists for treatment placement. These wait lists require people in need of substance abuse treatment, incredibly vulnerable people often in the most desperate situations, to call several times each day for availability, and a missed call one day puts them at the bottom of the wait list again. One can only imagine such limited access to and availability of treatment for cancer, heart disease, or diabetes – the traditionally higher priorities of federal public and community health funding.

These systemic challenges related to SBIRT reimbursement, the needed expansion of specialty substance abuse treatment (e.g. residential treatment, medication assisted treatment, recovery support services), and the intricacies of screening and treating adolescents require significant investment at the systems level to support the adoption and sustainability in primary care settings.

CONCLUSION

In closing, behavioral health disorders, and substance abuse disorders in particular, continue to fight an uphill battle for recognition as a chronic, relapsing, yet 100% preventable disease. In the meantime, each day the stigma, under-resourced systems, and unaware or unprepared health care field continues their business as usual, adolescents and adults continue to suffer not just a biological disease, but to suffer the shame, self-blame, anxiety, depression, economic fallout, and relationship deterioration that are byproducts of this preventable disease. Goodwin Community Health is to be commended for its courage and assiduity in bringing to light the opportunities that exist in the community health clinic setting to eliminate stigma, alleviate shame, and help restore good people to good health. Their story of embracing SBIRT illuminates that with a few committed professionals, investors willing to help them reach their goals, and change agents willing to support them with training and TA, a community health center really can succeed in countering the stigma, the under-resourced systems and even to counter doubt and reluctance of peers to make a difference in the behavioral health of individuals, families and communities.

...challenges related to SBIRT reimbursement, the needed expansion of specialty substance abuse treatment and the intricacies of screening and treating adolescents require significant investment...

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APPENDICES

Appendix A: Substance Use Rate Comparisons

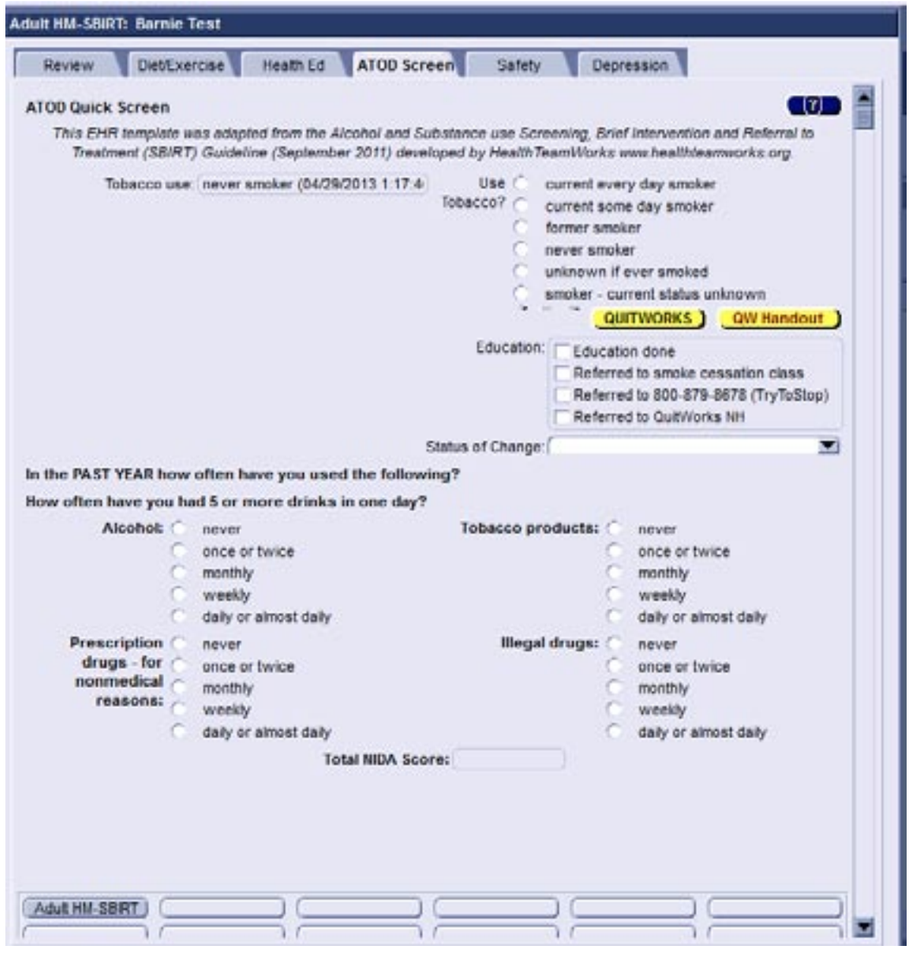
Table 1. HOW NH RANKS IN SUBSTANCE USE AMONG THE 50 STATES & DC
(Based on 2010-2011 NSDUH State Estimates)

INDICATOR	AGE RANGE	US RATE	NH RATE	+/- US
Alcohol Use in Past Month	18–25 yrs.	61.0%	73.2%	+**12.2***
	26+ yrs.	55.0%	64.9%	+**8.9***
Binge Drinking in Past Month	18–25 yrs.	40.2%	49.3%	+**9.1***
	26+ yrs.	21.8%	21.7%	-.01%
Illicit Drug Use in Past Month (not marijuana)	18–25 yrs.	7.5%	10.6%	+**9.1***
	26+ yrs.	2.5%	3.0%	+0.5
Marijuana Use in Past Month	18–25 yrs.	18.8%	27.0%	+**8.2***
	26+ yrs.	14.8%	5.4%	+0.6
Cocaine Use in Past Year	18–25 yrs.	4.6%	7.5%	+**2.9***
	26+ yrs.	1.2%	1.5%	+0.3
Non-Medical Use of Pain Relievers in Past Year	18–25 yrs.	10.4%	12.3%	+1.9
	26+ yrs.	3.4%	3.2%	+0.2
Alcohol Abuse/Dependence in Past Year	18–25 yrs.	15.0%	17.0%	+2.0
	26+ yrs.	5.7%	5.3%	+0.2
Illicit Drug Abuse/Dependence in Past Year	18–25 yrs.	7.7%	9.1%	+1.4
	26+ yrs.	1.6%	1.5%	+0.1
Any Mental Illness in Past Year	18–25 yrs.	30.0%	32.7%	+2.7
	26+ yrs.	18.1%	19.3%	+1.2
At Least One Major Depressive Episode in Past Year	18–25 yrs.	8.3%	9.4%	+1.1
	26+ yrs.	6.4%	6.8%	+0.4

** denotes a statistically significant difference between the state and national rate at p < .05.*

Appendix B: Adaptations and Modifications made with CHAN/Centricity for SBIRT implementation at Goodwin Community Health (Spring 2013)

The NIDA-Quick Screen –Male Adult version (Female version has "4 or more drinks in one day").



Scoring for NIDA Quick Screen:

For alcohol: any score indicating once or more is positive. (For women and men over 65, positive score =4 or more drinks in one day. For pregnant woman and minors, any drink is positive).

For drug and tobacco questions, any use is positive screen.

Source: Screening for Drug Use in Medical Settings, NIDA, Revised, 2012
Downloaded: http://www.drugabuse.gov/publications/resource-guide .

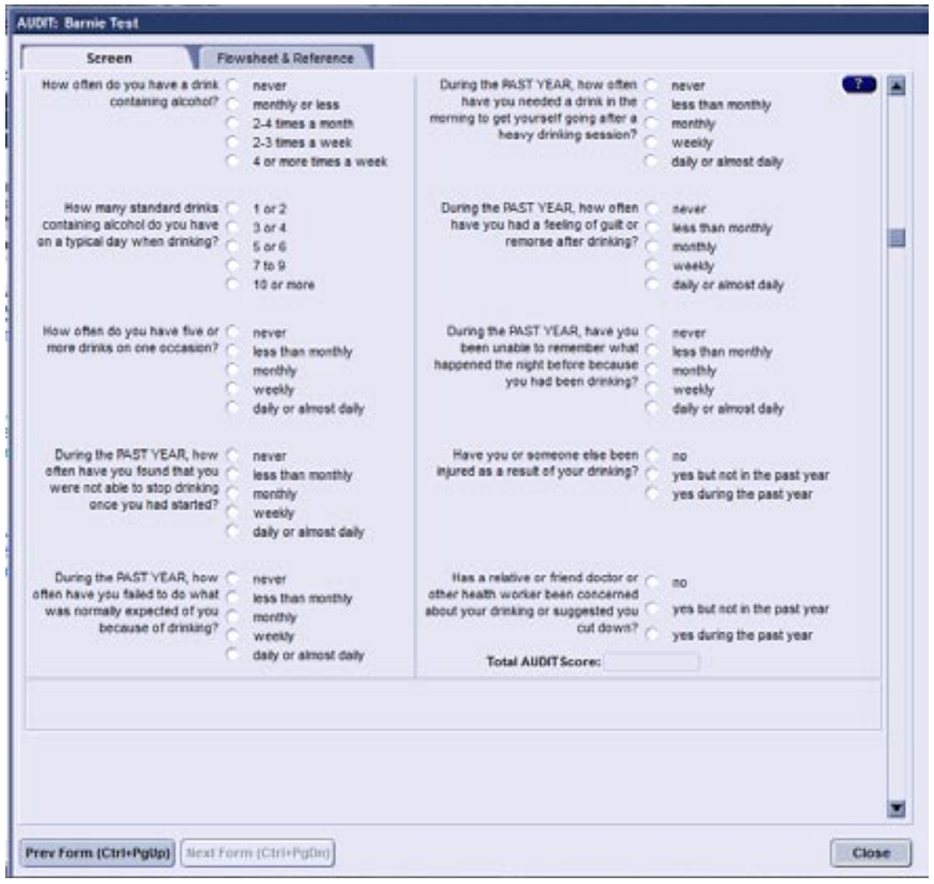
Scoring for full AUDIT and DAST-10 and CRAFFT screens. See following pages for actual screens.

Brief Assessment Instruments Available at www.coloradoguidelines.org/guidelines/sbirt.asp			
	AUDIT *(adult alcohol use)*	**DAST-10©** *(adult drug use)*	**CRAFFT** *(adolescent alcohol & drug use)*
Hazardous use *(risky use)*	Score 8-15 for men Score 7-15 for women	Score 3-5	Score of 2 or more positive items indicates need for further assessment
Harmful use *(use plus consequences)*	Score 16-19	Score 6-8	
Possible dependence *(compulsive use)*	Score ≥ 20	Score 9-10	

Copied from the Colorado Clinical Guidelines Collaborative (presently the Colorado HealthTeam Works): Guideline for Alcohol and Substance Use Screening, Brief Intervention and Referral to Treatment, approved 7/15/08, downloaded at http://www.improvinghealthcolorado.org/files/documents/SBIRT_guideline.pdf

Goodwin Health Center Launches SBIRT | July 2013

AUDIT

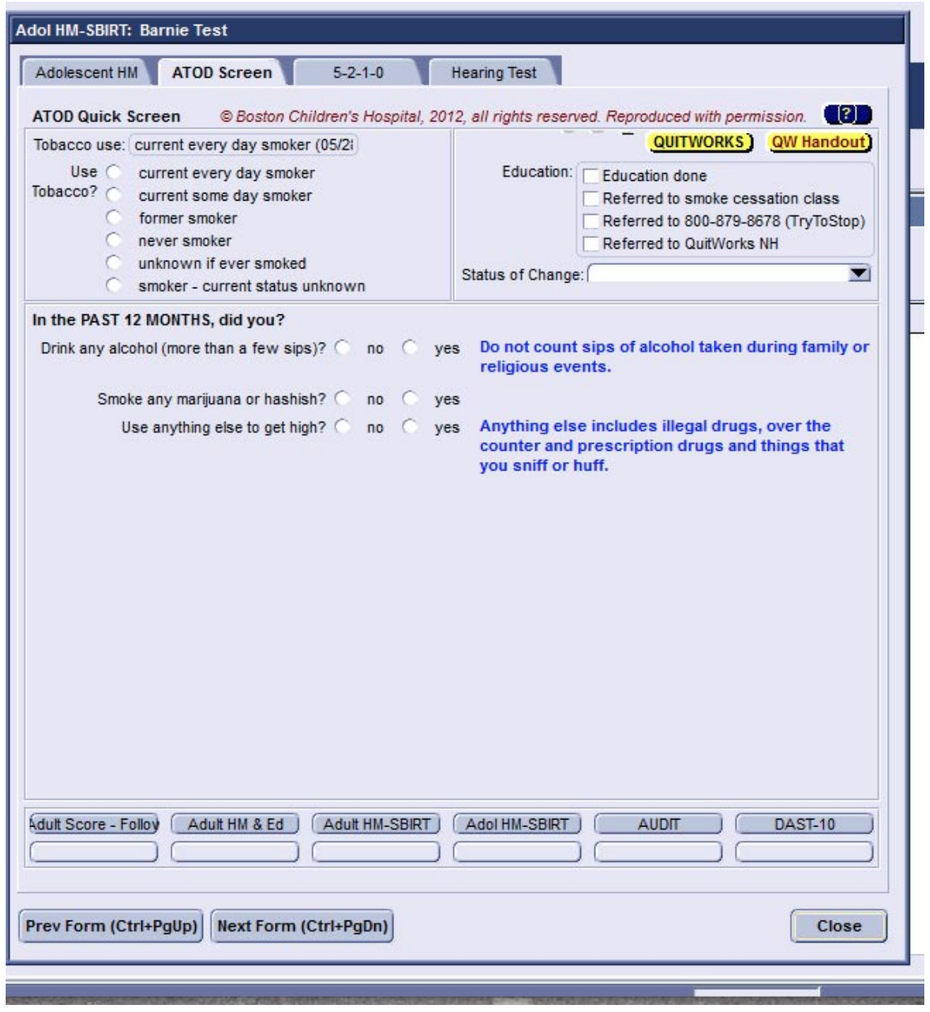


Each of the questions has a set of responses to choose from, and each response has a score ranging fro 0 to 4. In the interview format (Box 4) the interviewer enters the score (the number within parentheses) corresponding to the patient's response into the box beside each question. All the response scores should then be added and recorded in the box labeled "Total"

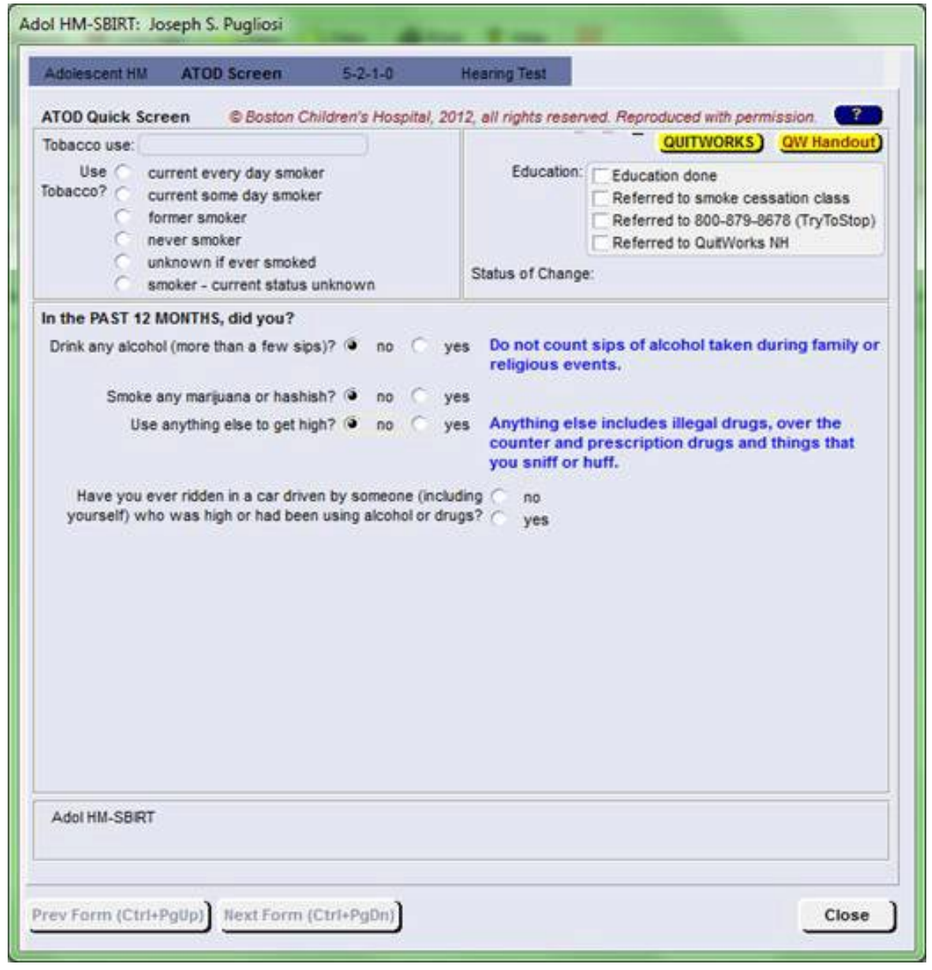
Copied from Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B. and Monteiro, M. (2001) The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, Second Edition.

Appendix B

CRAFFT pre-screen



CRAFFT pre-screen with car question



If no to all 3 pre-screen questions, administer only the “car question” on full CRAFFT as below. No text translation will go into the note and all questions will store to an observation term for flow-sheet review.

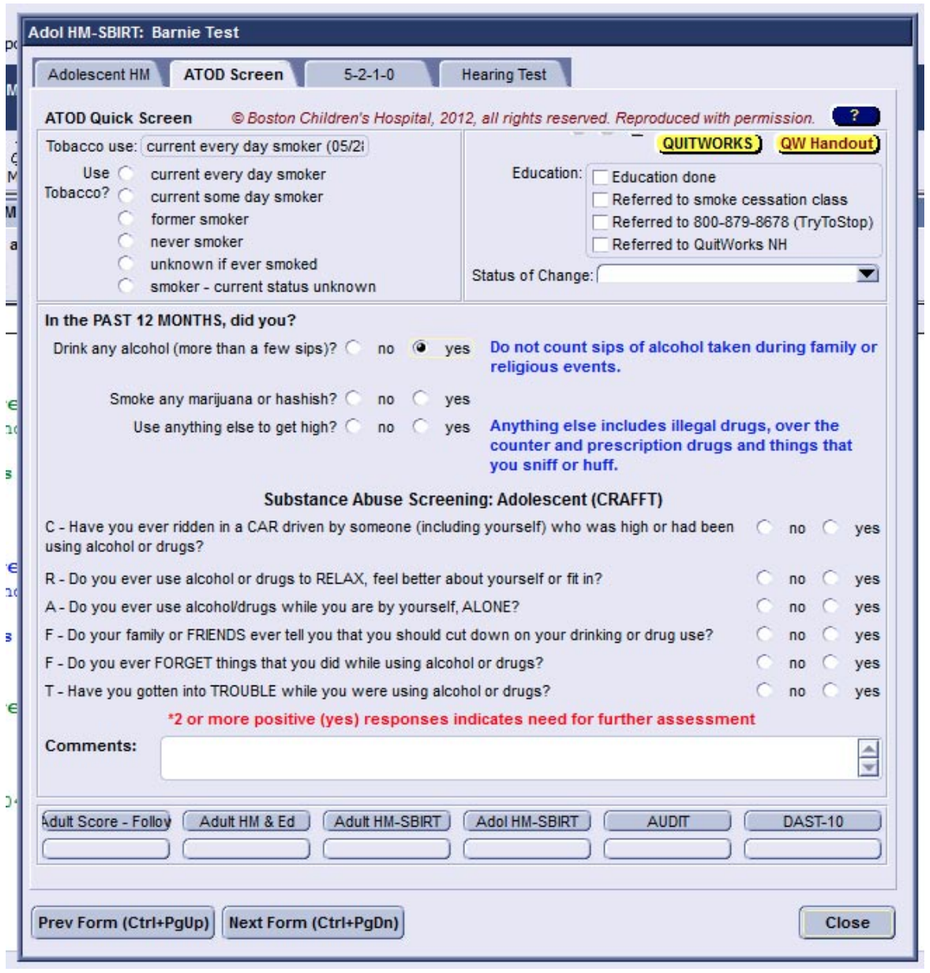
If the patient scores yes to any of the pre-screen questions, then administer the full CRAFFT.

Source: Center for Adolescent Substance Abuse Research, CeASAR, Boston Children’s Hospital

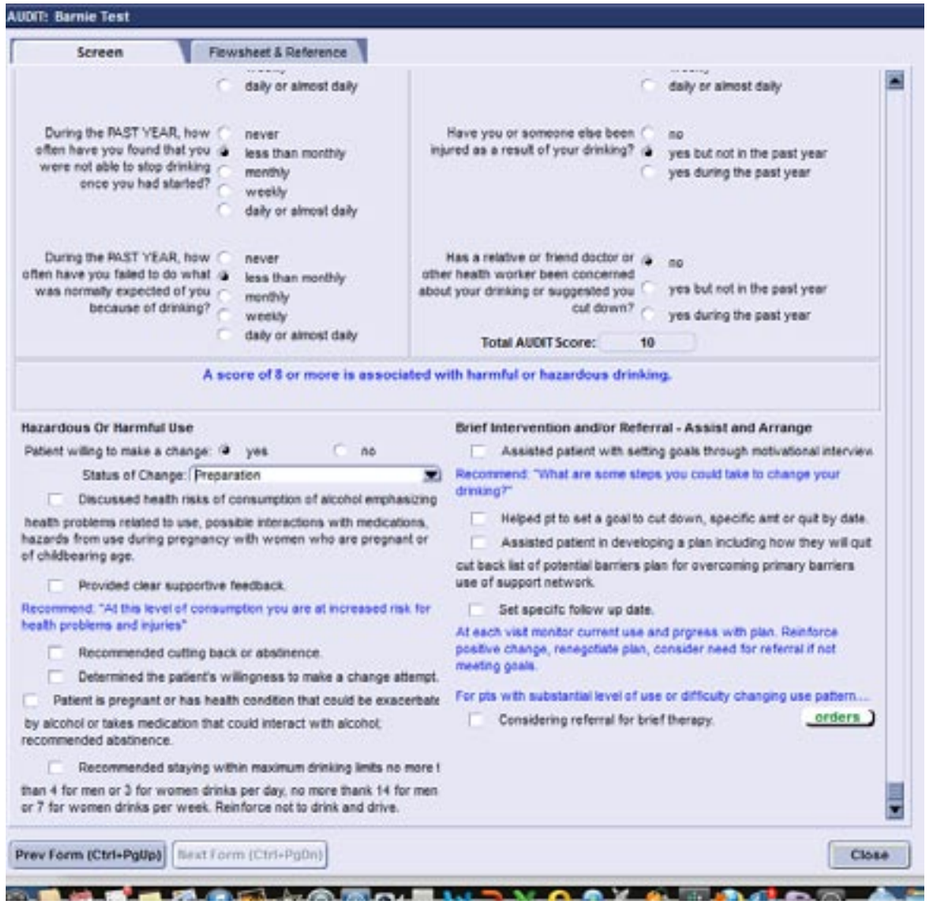
Appendix B

Goodwin Health Center Launches SBIRT | July 2013

Full CRAFFT

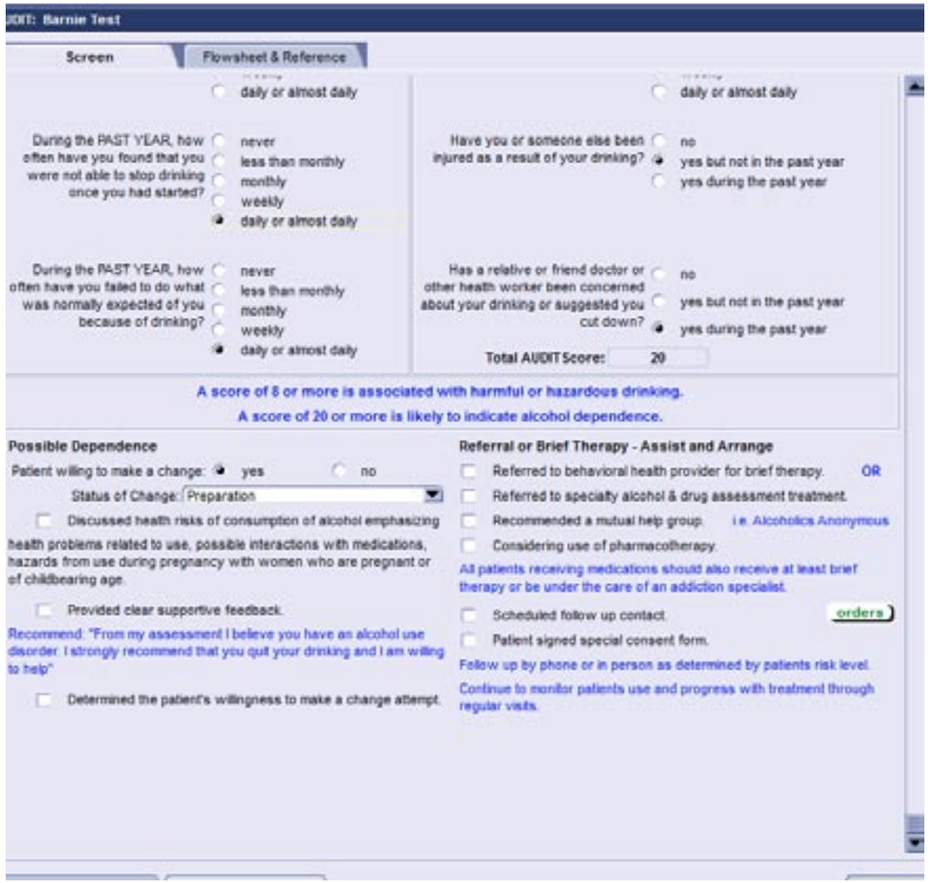


Screen shot of harmful/hazardous AUDIT result

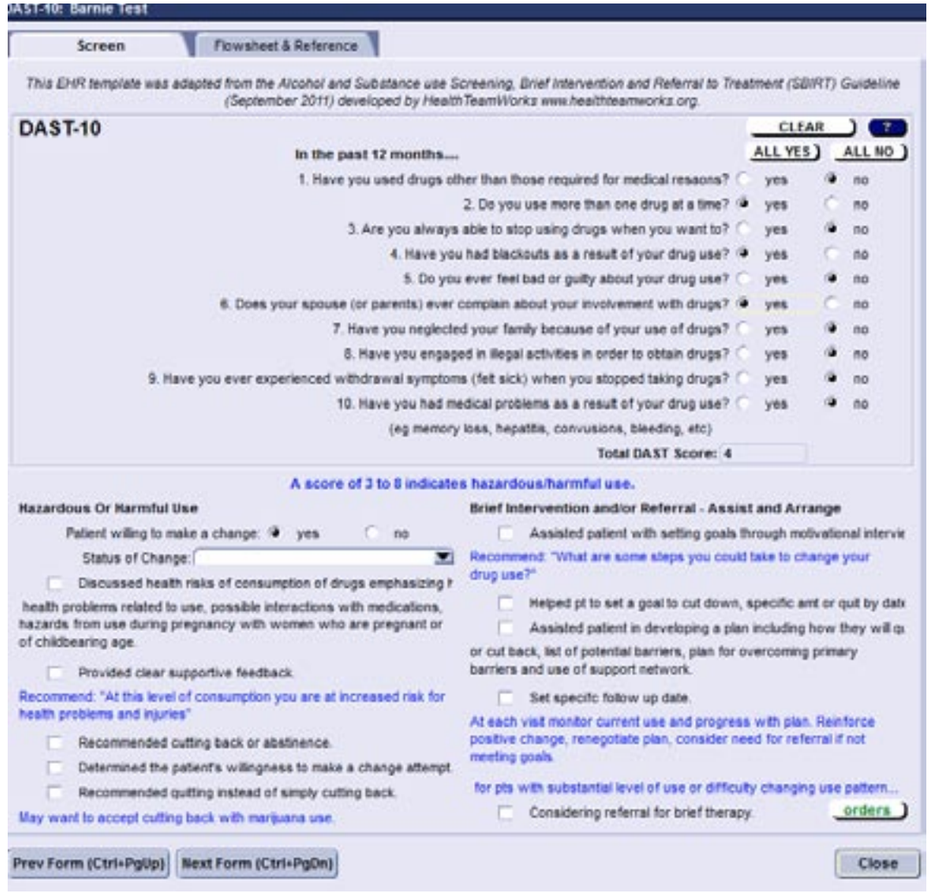


Appendix B

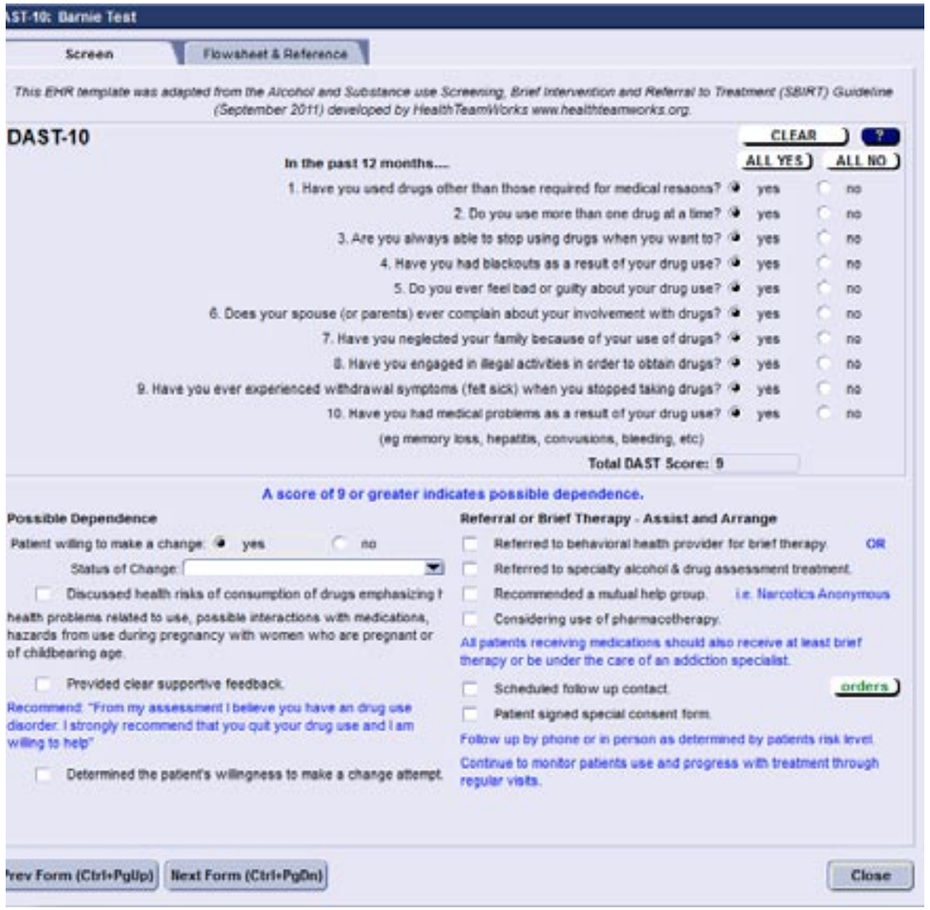
Screen shot of AUDIT dependence result



Screen shot of DAST hazardous/harmful result



Screenshot of DAST dependence result



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