Integrating SBIRT into Collaborative Care: Improving identification and management of SUD in primary care

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Project Aim

To proactively identify substance use disorders (SUD) in patients referred to Collaborative Care and subsequently connect them with treatment and resources, as measured by positive screen rates and number of patients served.

Project Design/Strategy

To devise a strategy for better identifying and managing patients with SUD, Partners Center for Population Health convened a group of experts in SUD from across Partners. The group carried out a needs assessment that drew upon several data sources, including an inventory of services across Partners and previous survey data on practitioners’ comfort with managing patients with SUD. In addition, key informants representing a range of disciplines were interviewed. Drawing upon this knowledge as well as the evidence base on effective interventions for SUD, the group used an iterative process to develop a stepped care proposal to address the gaps identified in the system. Included in the proposal was the integration of screening, brief intervention, and referral to treatment (SBIRT) into primary care, which has demonstrated efficacy for reducing risky alcohol use. Despite the availability of validated tools to screen for alcohol and drug use in primary care, few Partners clinical sites have implemented universal screening. We believed that providing SBIRT training, implementing standardized screening, and incorporating related metrics into the electronic medical record would help clinicians to better monitor and care for patients with substance-related problems or SUD.

Changes Made

To better integrate with existing behavioral health programs, we decided to implement these interventions in practices where we had embedded behavioral health support staff as part of Collaborative Care teams. Screening would consist of the single-question alcohol and drug screens, followed by further screening with the Alcohol Use Disorders Identification Test (AUDIT) or the Drug Abuse Screening Test (DAST-10) for patients who screen positive on the initial single-question screen.

Embedded behavioral health support specialists (BHSSs) would follow an algorithm that would assist in triaging patients to the appropriate level of care. The algorithm used the scores on the screening tools to categorize patients as being at either low to moderate or high risk. For those at low to medium risk, the BHSS would provide a brief intervention, utilizing skills learned in SBIRT training. For patients at high risk, providers would be advised to consider pharmacotherapy treatment as appropriate, and the provider could utilize consulting psychiatry support to assist with medication induction or refer patients to higher levels of care. Staff received two trainings from SBIRT experts in delivering SBIRT as well as other targeted trainings related to identifying and managing patients with SUD. SUD treatment experts were employed to provide support and expertise to the staff in working with this population as well. The team consisted of BHSSs, primary care providers, Collaborative Care psychiatrists, licensed social workers, and addiction experts.

We piloted this program in one hospital system first with one BHSS for four months. During the pilot, regular meetings with the Collaborative Care team and SUD clinical leaders were implemented to develop workflows and algorithms to identify possible pathways for positive screens. Our SUD clinical leaders attended one to two case reviews with the BHSS to ensure that the workflows and algorithms were working effectively and that the team felt supported in identifying the appropriate pathways for the patients. After the pilot, SBIRT expanded to the community sites in February 2017 and the remaining sites in July 2017. Informal surveying of the BHSSs was conducted at staff meetings to determine what support was needed to effectively implement SBIRT at their sites. A few key areas were identified: increased training and support, one-to-one support on working with patients on readiness, and enhanced documentation. Changes were made post-pilot to capture all of these areas: Skills-based workshops were implemented to enhance ability around motivational interviewing and other brief interventions; the SUD resource specialist visited sites to coach BHSSs on working with difficult-to-engage patients; and screening tools were built into electronic record management tools.

Lessons Learned

This process improvement project demonstrated that it was feasible to implement SUD screening in all patients referred to our primary care-based behavioral health management in two hospital systems and suggested that screening could indeed help identify previously undetected SUD. We found it was a relatively small lift to implement screening for SUD into our existing workflows and team structure of Collaborative Care, as the team members were already in place to help support patients who were identified, and it placed little to no additional burden on primary care. This suggests that other systems across the country that are implementing integrated behavioral health care may be able to add SUD screening without too many technical barriers. In the six months after screening was implemented, we found a 6.4% rate of positive screens (up from 2.4% in the six months prior) for alcohol use disorder and 5.4% (up from 4.6%) for other drug use disorders in patients who were referred for reasons other than substance use, illustrating its utility. That said, we heard feedback that more than one SBIRT training was required for staff who are new to the work to better understand how to work with patients with SUD and to deliver appropriate interventions to the patients identified by our screening process.

I’ve been trying for five years to get this patient into treatment.

Thanks so very much for what you have done for me. You have no idea how much you have helped.

SBIRT Pilot PCP

Referred Patient

Center for Population Health
Institute for Healthcare Improvement
25th Annual National Forum