

## TRANSCRIPT OF AUDIO FILE:

### ADOLESCENT ALCOHOL USE

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#### **BEGIN TRANSCRIPT:**

MODERATOR: Good afternoon, everyone! And welcome to the SAMHSA-HRSA Center for Integrated Health Solutions webcast titled “Strategies for Early Intervention and Treatment for Adolescent Alcohol Use and Health Centers.” My name is Aaron Williams, Director of Training and Technical Assistance for Substance Use at the SAMHSA-HRSA Center for Integrated Health Solutions, and I will be your moderator for today’s webinar.

As you may know, the SAMHSA-HRSA Center for Integrated Health Solutions, or CIHS for short, promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavior health or primary care provider settings. [00:01:10]

In addition to national webinars designed to help providers integrate care, the center is continually posting practical tools and resources to the CIHS website providing direct phone consultations to providers as they go to groups, and directly working with SAMHSA Primary and Behavioral Health Care Integration grantees and HRSA funded health centers.

Before we get started, I wanted to get through a couple of housekeeping notes for you. To download the presentation, please click the dropdown menu labeled “Event Resources” on the bottom left of your screen. Slides for this presentation will be available on the CIHS website at [www.integration.samhsa.gov](http://www.integration.samhsa.gov). [00:01:58]

During today’s presentation, your slides will be automatically synchronized with the audio. So you will not need to flip any slides to follow along. You will listen to audio through your computer speakers, so please ensure that they are on and the volume is up.

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So before we move forward, we wanted to just quickly review the purpose of today's webinar. So today's webinar—we're going to provide practical and research-based information for how to implement alcohol prevention and treatment services for adolescents and HRSA-supported safety-net settings. This webinar will explore examples of how to talk with adolescents about alcohol use and learn practical implementation strategies to engage adolescents in services. [00:03:13]

So today's speakers will be Vivian Faden—Dr. Vivian Faden. She is the Director of the Office of Science Policy and Communications and Associate Director for Behavioral Research at the National Institute for Alcohol Abuse and Alcoholism at the National Institutes of Health. Dr. Shannon Gwin Mitchell. She is Senior Research Scientist at Friends Research Institute in Baltimore, Maryland. Laura Brey, Vice President for Strategy and Knowledge Management School-Based Health Alliance. And Dr. Tosan Oruwariye, Chief Medical Officer at the Morris Heights Health Center. [00:03:57]

Now, I'd like to turn it over to Dr. Vivian B. Faden, um, for a few brief opening remarks. Vivian?

DR. VIVIAN FADEN: Okay. Hello, everyone. I'm so pleased to be, uh, part of this webinar today. As he said, I'm Vivian Faden, and I won't repeat my title for you. I'll just remind you that I'm from NIAAA, or the National Institutes of, um—National Institute on Alcohol Abuse and Alcoholism, which is part of the National Institutes of Health.

So I'm pretty excited to have this opportunity to welcome you to this webinar on Screening, Brief Intervention, and Referral to Treatment—or SBIRT. This is a topic that concerns a broad section of the SAMHSA-HRSA Center for Integrated Health Solutions' audience and one that is also very central to NIAAA's public health goals. I want to thank both HRSA and SAMHSA for inviting NIAAA to participate today. We all feel that cross-agency collaboration is important. And it's really important on an issue as critical as this one. [00:05:03]

The screening and brief intervention and referral to treatment that you'll hear about today is especially relevant in the context of integrated care. And I'm aware of interest in this issue across HRSA programs—Maternal and Child Health, the Health Center program, as well as the Federal Office of Rural Health Policy, and the HIV/AIDS Bureau—all sectors of our health care system that are impacted by adolescent drinking.

SBIRT, of course, is important for all ages, but perhaps most-especially for our youths. As we all know, many young people drink alcohol and many of them drink a lot when they do drink. Underage drinking is common. For example, according to the 2013 National Survey on Drug Use and Health, about 35 percent of 15-year-olds report that they've had at least one drink in their lives. And by the time kids get out of high school, that number has pretty much doubled. [00:06:06]

According to that same survey, about 23 percent of people ages 12 to 20—which translates to almost 9 million young people—reported drinking in the past month. About 14.2 percent of

people in this age group—about 5-1/2 million young people—reported that they did binge drinking last month. And that's drinking five or more drinks on an occasion in that particular survey. And about 3.7 percent—which is 1.4 million young people—reported being heavy drinkers, which means they've binged five or more times in the last 30 days. [00:06:52]

All this drinking is not without consequences. First—and this is something that NIAAA has been very interested in and has supported a great deal of research on—there's the impact—potential impact—on the developing brain. Since we now know that the brain develops into a person's 20's, we've become concerned that alcohol use during the teenage years could interfere with normal adolescent brain development, compromising memory and other cognitive functioning—both in the short and the long-term. And we're also concerned that drinking this early in life may change the brain in ways that increases the risk of developing an alcohol-use disorder at some point in someone's lifetime. In addition to that, underage drinking contributes to a range of acute consequences—for example, injuries, sexual assaults, and even death—including those from car crashes. [00:07:53]

So, it seems clear we should be asking young people about their experience with alcohol and giving them advice. Screening sends a message of concern. It provides an opportunity for youths to ask knowledgeable adults about alcohol. And perhaps most importantly, it's an opportunity to intervene. You can intervene before or after drinking starts, as well as before or after problems develop.

But screening often doesn't happen. For example, data from the 2009-2010 Next Generation Health Study Survey—and that's funded primarily by NICHD—the National Institute on Child Health and Human Development—another NIH institute—um, showed that adol—among adolescents who saw a physician, about 52 percent were asked about drinking, 50—that's about half. So try to keep that number in mind. About 56 percent were asked about smoking. About 52 percent were asked about drug-use. 70 percent were asked about exercise. And 66 percent were asked about nutrition. [00:09:06]

But more specifically, I want to tell you about some 16-year-olds. Uh, so there was 10-graders in this survey—so, about 16. And in the past month, that group of 16-year-olds reported that 30—30 percent of them reported they drank. 27 percent reported they binged. And 22 percent reported they were drunk. Among those kids, 81 percent had seen a doctor in the past year; and half of them—that same half—were asked about drinking. But this is important. Only 17 percent were advised to reduce or stop drinking.

So recognizing that alcohol screening doesn't occur as routinely or as regularly in primary care as we would hope, but also recognizing the incredible demands on primary care providers and other clinicians, NIAAA developed two screening guides for clinicians to streamline the process. One is for adults 18 and older, and one is for youths. [00:10:07]

A couple of things about the one for youths—it's based on two very simple questions. We collaborated with the American Academy of Pediatrics on this. And, uh, what distinguishes it, in part, from other, uh, screeners is that it can be used with younger kids. It asks a ver—uh, like a very simple fringe question and makes it easy to, uh, integrate that into practice with younger

kids, as well as all the way up. So that it's developmentally staged so the questions are a little different for different ages.

So today's webinar includes speakers who will describe the clinical application of screening. I hope they're going to talk about NIAAA's guide. I think that's listed in the resources section for you. Um, and I hope that the guide—if you're not familiar with it, you'll take a look at it—and then it'll be of particular interest to you. [00:11:02]

We released the guide in 2011, and subsequently, we developed a very popular Medscape CME course that was released in 2013. And that course will be available for credit until next summer. And you can find the links. You get 2-1/2 hours of credits. Uh, that's for physicians and nurses.

Um, I also want to let you know that NIAAA has a robust research portfolio in this area. So, that—and that includes six implementation studies of our guide: two that are being carried out in primary care; one in a network of emergency rooms; one in schools; one in the juvenile justice system; and one with youth who have a chronic health condition, such as asthma or diabetes.

That's all I have to say except that I'm looking forward to hearing the presentations, as well as the question and answer period that follows. Thanks. [00:11:57]

MODERATOR: Thank you, Dr. Faden! Um, before we move on to our, um, next presenter, we wanted to take some time here to briefly get a sense of, you know, what the activities are of the folks who are on the webinar. So we have a poll question that we'd like for you all to answer for us really quickly. And so that poll question is, "Do you currently use a screening tool to assess adolescent alcohol and substance use?" We want to get a sense of that. Yes or no? (pause) So you can enter in your answer in now. (pause) Alright, folks—we're waiting. I'll give you a little bit of time to enter that in so we can get a sense of, you know, where people are with the issue of screening for adolescents. (long pause) Alright, a couple of more seconds. Okay. (pause)

Alright, so we have some results. So about 57 percent of you have some sort of process for screening for adolescents already. Um, and about 42 percent say that you don't. So I think, you know, the coming presenters will be giving you some good information about screening and, you know, other implementation and engage in strategies that you can use around this, um, issue of adolescent alcohol use. So, you know, folks that aren't implementing—you know, maybe there are some ideas here for you to begin implementing. And for others, maybe there's some alternatives in terms of enhancing what you're already doing. [00:13:28]

So, okay. I want to move into our next presenter. I'll turn it over to, uh, Dr. Mitchell—Shannon Gwin Mitchell. So, Shannon—please go ahead?

DR. SHANNON MITCHELL: Thank you so much. Um, I'm going to be talking today about, uh, a study that we've been working on for about 3-1/2 years now. It was a cluster-randomized trial. So we were looking at different ways to implement adolescent SBIRT in federally-qualified health centers.

Um, just to briefly start, I want to make sure that I acknowledge NIDA for their funding of our study. And the wonderful implementation research team—anyone who's tried to get something like this, um, off the ground knows that it takes a tremendous amount of skill from various disciplines in order to really examine the processes that work. [00:14:22]

Um, as Vivian already defined for us, SBIRT is basically a continuum of services that, um, can be provided based on the level of risks being shown by the patient. So, in this particular study, we were looking at 12 to 17-year-olds, and we were assessing screening and risk-use associated with alcohol, tobacco, and drug-use, of course.

Once someone has been screened and a problem has been identified, there is a continuum of services that can be provided—everything from BRACE advice supportive services, uh, brief interventions, and then, of course, referral to treatment, if necessary. [00:15:10]

Um, as was mentioned by Vivian, as well, there is a little bit a lack of consensus concerning SBIRT with drugs and alcohol, but there is (inaudible) research support for, um, conducting SBIRT with alcohol—particularly among adults. And although the US Preventive Services Task Force indicates there's inadequate support of providing BI's in primary care at the current time, but the American Academy of Pediatrics and, of course, NIAAA recommend the pediatricians provide substance use screening and counseling to all adolescents. Um, as we've also heard, this is not done very frequently. [00:15:55]

So, this—those who are familiar with randomized clinical trials—often the randomization occurs at the patient level. But because this was a service delivery implementation study, we randomized at the clinic level. So, the organization that we worked with was an urban, federally-qualified health center in Baltimore city. Among all of their clinics, seven of them, uh, were providing care to adolescent patients, either through their pediatric practice or their family medicine. And, uh, that basically covered about 3,600 unique patients that were 12 to 17 years of age.

Um, all of these clinics, at the time that we began this study, has co-located mental health services. So, there was at least a master's-level counselor, if not a doctoral-level provider at each of these clinics, but they were not well-integrated with the primary care staff. They were—they were providing behavioral health services but, um, to sometimes primary care patients—sometimes to other just behavioral health patients. But they were not integrated in primary care. And, um, the organization was very interested in looking at, uh, ways to better integrate their behavioral health staff. So, that was one of the things that we were trying to examine in our—in our present study. [00:17:24]

So, we were going to implement, um, both—the focus of the intervention was on, um, who was conducting and how to best conduct brief interventions and brief advice using different sort of [solibrium] (ph) models. But before you can get there, um, as was previously mentioned, you have to ask the questions. You have to know what kind of behaviors are going on. So, um, as part of the process, we ended up also implementing screening procedures.

So for our cluster-randomized trial, what we did is we took these seven different clinics here in Baltimore city and, um, we—we grouped them and according to the size of the clinic—meaning the number of adolescent patients and the number of providers. And then we randomized the clinic level and we ended up with four that were randomized to the generalist—what we’re calling the generalist—condition, and four—and three to the specialists condition. [00:18:23]

So basically, the screening procedures that were implemented were the same across both of these service delivery models. So, in both of the models, an adolescent patient would come in for a visit—whether it was an acute visit or a well-child visit—and the MA, the medical assistant, would screen them as part of the regular intake procedures using the CRAFFT. And I’ll talk a little bit about more of what we selected and how this all became implemented. But the MA would do the screening; and then enter the information from the screening into the electronic medical record; and then open basically what was a primary care physician response screen so that when the physician walked in or the nurse practitioner walked in, she or he could see the screening results and would check off what they were going to do in response to, um, the use-level of alcohol, tobacco, or drug use. [00:19:26]

In what we were calling the generalist service deliver approach, the primary care provider would conduct the brief intervention. If the youth said, “I’m not using any drugs or alcohol. I haven’t been using any drugs or alcohol,” you know, the primary care provider would say, “That’s great. Keep up the good work.” If the youth indicated that they had used, but they weren’t experiencing any significant problems, a brief advice would be given regarding reducing or eliminating their substance use. And if they scored positive on the CRAFFT, which is the screener that we implemented—or they indicated any tobacco use—the primary care provider would deliver a brief intervention and then, if necessary, schedule follow-up or referral services. [00:20:08]

For the specialist service delivery approach, it was exactly the same in terms of the screening and everything that was done with the MA’s. But the primary care provider would either—would provide brief advice if there was minimal use that was indicated, and then would, um—or if there was a high level of use that was indicated—and then they would have a warm hand-off to the behavioral health counselor who was there in the clinic and say, “I would like you to talk to, um, one of my colleagues, Dr. So and So or Ms. So and So. She’s a behavioral health counselor here and she’s going to talk about ways to reduce your use.” And then the BI would be conducted by the behavioral health counselor.

And the behavioral health counselor would be the one who would then determine whether or not additional assessment was needed—if a follow-up session or a referral to treatment was needed. [00:20:59]

Uh, for those who kind of like are more visually-oriented, this is a consort diagram. And as you can see, the adolescent patient comes into the clinic. The MA does the screening, um, and then opens the provider checklist. And then, in the generalist site, the bulk of the work is all done by the primary care provider.

In the specialist site, just at face-value, you can see there’s [some] (ph) more complex model. There’s a lot more elements that have to fall into a place in order for appropriate services to be

delivered. So that's obviously something that we're looking at when we're looking at outcomes from our study.

Um, I'd like to talk a little bit about how we prepared for implementation because I think that has a—that's something that's going to appeal to folks whether you're into research or you're really trying to add to the implement that's in your particular clinic because there was a lot of background work that went into it. [00:21:55]

Um, first of all, while drugs, alcohol, tobacco use was often asked, it was not asked consistently across providers. And it wasn't asked in a consistent manner. So, one of the first things we had to do in developing the implementation plan for this particular trial was to—was to figure out what sort of evidence-based screening tool we wanted to us—and/or the clinic wanted to use—and to make sure that it was used in a systematic, consistent manner. Um, so it was discussed at various levels throughout the organization. They decided they would, um, utilize the CRAFFT, which the pre-screeners ask about alcohol, marijuana use specifically, and then other drug use. [00:22:50]

Um, and then we, as part of our training, we train both with the MA's, nurses, and the primary care providers to administer and score the CRAFFT. And I'll tell you a little bit about why that was.

Um, also, while some providers were asking about alcohol and drug and tobacco use sometimes, um, they were—if they were going to ask it, it was usually at a well-child visit. And what they told us straight out was that the older the kids get, the less likely they are to come in for a primary care visit—you know, a well-child checkup. And, particularly if you want to catch a 16 or a 17-year-old, catch them when they're in. So it was decided that it would be universal screening, all youths 12 to 17, at any kind of visit with the hopes that they would be able to catch a larger percentage of their patients. [00:23:41]

Um, in the EMR—the electronic medical record—the screening was moved to a section that was accessed both during routine and acute care visits. There was also a tobacco item that was in their EMR in a different section that was moved to be asked in conjunction with the alcohol and drug use questions.

And then because some drug and alcohol use, um, can basically have sexual risk behaviors associated with it, it was decided that any youth who scored positive on the CRAFFT would also be asked some sex-risk questions. So it was, “Well we're having this discussion. Let's talk about other risk behaviors you might be engaging in.” So there was—the screening ended up being a far more comprehensive screening than anything that had prior been—priorly been conducted at the [FQHC]. (ph) [00:24:34]

Once we had developed the implementation protocol, all staff were trained at the site levels. So, the nurses, the MA's, and the primary care providers, even administrative staff who sometimes were the ones to help make sure that a youth got the screening instrument that was—that was needed. They were all trained at their site level. Both—first—first on SBIRT principles. What is

SBIRT? Why would we do it? The importance of screening for alcohol, drug, and tobacco use, and how associated HIV sexual risk behaviors should be asked in addition. [00:25:12]

How to handle positive screens? And again, we conducted these trainings at the clinic level because some of the clinics were randomized to the specialist condition and some were randomized to the generalist condition. So, the training varied depending on that particular clinic's service delivery model.

And then, um, information on local adolescent drug abuse treatment providers. Um, some folks told us that "I don't refer because I'm not—you know, I don't talk about this because I don't feel like I know where I could send them. I don't know what to do." —which is why we train them in brief interventions and SBIRT in general. Or, "I don't know who to send them to if I have a positive screen and I think they actually need drug treatment." So we've provided a list of resources in the community, as well. [00:25:54]

There were additional trainings that were conducted for the primary care providers and a special training just for the behavioral health counselors—or behavioral health specialists—on brief intervention training, um, using motivational interviewing. While the behavioral health counselors often had some background, it was very important that they were providing brief interventions and not therapy.

Um, while primary care providers might've been very good at providing very practical information, maybe they weren't as fluid in, uh, motivational interviewing techniques. "Well, what is your readiness to change? Why do you use? How likely are you to use? What kinds of things do you think might help you reduce [user stop use]. (ph)

So, all of these trainings occurred. And then we launched into what we were calling our implementation phase. This particular phase of the study—there were a lot of supportive elements that went into it. And again, these are the kinds of things that, um, are worth keeping in mind as you're trying to establish how effectively you're providing adolescent SBIRT services. [00:26:59]

So I'm going to talk about some of the supportive elements that—that we used in our study with the hopes that they might be helpful to you, as well.

Um, as I mentioned, there was a lot of training and work that went into implementing the adolescent SBIRT screening and the follow-up procedure documentation into the electronic medical record. Because we were told if it wasn't in there, it wasn't going to stick. So, there was a lot of focus on, "Are you doing the screenings? Are you documenting it properly in EMR? And here's what your numbers look like." And basically, we would—every two months we would go into the electronic medical record and extract their own data and feed it back at the site level and say, "Here is what you said you did. And if it wasn't recorded, then we're assuming it didn't happen

And, um, there was a lot of troubleshooting that went into, um—uh, figuring out the best way to sort of synthesize the information and feed it back to the staff at the clinic level in very meaningful ways. [00:28:01]

The bi-monthly feedback was largely directed at the clinic managers. So the clinic managers— [we could go on] and say, “You know what? It looks like we only hit half of the 12-17 year olds for screening that we were supposed to. Let’s figure out what’s happening.”

Um, there was very specific provider-level feedback that was given to the physicians—each and every primary care provider that said, “You saw—over the last two months, you saw 100 youths that were 12-17 and, um, let’s say 80 percent of those were screened, and 80 percent of those—and of those that were screened, half of them were positive, but you actually only did brief interventions with—or appropriate follow-up with “X” percent. So it’s very specific for that particular provider. And they couldn’t say, “Oh, that’s everybody else! That’s not me,” because it was their data. [00:28:50]

We also went in every three months and did in-person, 30-minute refresher trainings. “Remember, here’s what we’re doing. Here’s how it’s supposed to happen. Here’s what your numbers look like, and let’s troubleshoot.”

Um, about six months into the implementation study, the FQHC changed to a completely different electronic medical record. And as you can imagine, it turned everything on its head. Um, the way it was, everything was visually represented and the old EMR didn’t translate into the new EMR. And there was a tremendous amount of re-training that had to happen to make sure people knew how to do what they were supposed to do and document it appropriately in the system.

Um, these are the study findings from our implementation phase. So our implementation—we did all of these supportive elements for a little over a year-and-a-half. And now we’re in the sustainability phase. As of December 31st, we’ve pulled back all of our resources. We’re still monitoring data in the EMR and collecting survey data, as well. But, we are not in there, um, providing refreshers. So we’ll be looking at sustainability issues, as well. But I want to talk about, um, you know, what we found. What was actually happening? [00:30:02]

So when we talk about penetration, it’s okay. What is the denominator? Over the course of any given month, how many 12 to 17-year-old visits came in? So, sometime a youth might come in for an acute visit and then for a follow-up within the same, uh, 30-day period of time. They were supposed to be screened twice. So, it’s really not the number of patients; it’s the number of visits. [And we’ve looked at]—of those, how many were screened appropriately. And there was no difference in terms of the generalist or the specialist condition in terms of screening, which is good. That’s what we expected because they were trained to screen in exactly the same way.

The results are no different in a brief advice delivery. (clears throat) The brief advice was supposed to be provided by the primary care provider, um, both in the generalist and the specialist condition—and the generalist condition—when they recorded very low levels of

youth—youth with no problems. And always provide brief advice before a warm hand-off in the specialist condition.

Where we did see differences was in the penetration of the brief intervention delivery and, um, generalist condition had significantly higher penetration of BI delivery than the specialist condition. [00:31:12]

Um, by and large, the primary care providers were doing something, but they were not able to effectively do a warm hand-off to the behavioral health specialist—the behavioral health counselors. And we are still examining our data to get a better understanding of why that—where the breakdown was in that process.

Um, very quickly some points for consideration. Um, these are things we've noted and learned that are worth keeping an eye on if you're trying to implement SBIRT at your organization. One is just organizational buy-in. A lot of times, um, this is really where you need to start. We didn't have to spend a lot of time at the organizational level to establish buy-in because this particular organization was very committed to SBIRT. They had already implemented adult SBIRT. And it was just a process of us going in and helping them figure out the optimal service delivery process for their adolescent SBIRT. [00:32:07]

Um, perceived need and acceptability of providing adolescent—we call it aSBIRT—little “a” SBIRT is for little adolescent. But, basically the—the clinic staff—the primary care staff—the MA's, the nurses, and the primary care providers—understood it—really felt that this was what they were supposed to be doing. They knew there was a high need within their community. They saw multi-generational substance abuse. And they wanted to make sure that they did something to help their patients.

Um, there was much less awareness of SBIRT and how, um, behavioral health—what behavioral health optimal roll was from the behavioral health side of it. And while—while I said that behavioral health, who's on-site at all of these clinics, is very (inaudible)—it is not an integrated service. And, it was very—it's—it's still an ongoing process for them to—to determine the optimal role for, um, behavioral health within the SBIRT process at their clinic. [00:33:07]

Um, we did a lot of assessments at baseline just before we launched the trainings, and we wanted to keep track of what they—the staff thought the barriers were going to be for screening. The MA's thought the time—they thought that perhaps the youth wouldn't be honest. And they thought that if a parent was present that the youth definitely wouldn't answer honestly. Um, what they had found—and one of the reasons that we asked them to ask these questions over and over is maybe they're not honest the first time you ask them. Maybe they don't feel like telling you the second time. But maybe by the third time you sort of normalized that conversation. It's become a part of what they expect to be asked at any visit. And maybe that's the time they tell you the truth.

Um, we indicated in the EMR whether or not the parent was present during the initial screening so that if the primary care provider came in, looked at the screening, and saw that the parent was present, when they asked the parent to step out of the room when they were having another

private conversation with the youth, they would rescreen them, which is why the primary care providers also needed to be affluent in understanding how to score the CRAFFT and interpret the—the results. [00:34:14]

Um, brief intervention barriers. The primary care providers definitely said time was an issue. They were far more concerned of the lack of—perceived lack of honesty in their patients, um, than the behavioral health counselors were. But, um, they—the primary care providers and the behavioral health counselors had different levels of comfort in terms of discussing drug or alcohol use with their patients.

Um, rates of primary care providers delivering BI's varied more by site than approach. Basically, some of the physicians really, really dig SBIRT. They want to do it. They love it. And they feel like this is something I should do. And there was, uh, maybe some reluctance to hand off their patients to the behavioral health counselor because this is a new person who doesn't know this person's [issues] (ph) as well as I do. [00:35:06]

The, um—there were, however, some primary care providers that really were not comfortable with it no matter how many times they were retrained. And we're very reluctant to really address positive screen. Um, but we kept saying, "What kind of a message does it send to the youth if you ask them about their use, they tell you they're using drugs or alcohol, and then you fail to bring it up?" And—because it really does send a message. It doesn't just—it's not a null-message. It sends a very powerful message to them.

Uh, one thing that I'm sure everyone is very [aware] (ph) of is that there is constant turnover with the physicians, the primary care providers, the behavioral health counselors. And when you look at the complexity of the warm hand-off and that service delivery model and the specialists like when you have primary care providers' turnover and counselors turning over, it really does make it more complex. Um, so you really have to make sure you do things to institutionalize it, whether it's, um, integrating, SBIRT discussions, and training into your on-boarding for any new primary care providers or nurses, or you establish annual competency training for your MA's or your nurses to make sure that they know how to screen, and that if the people who are really good at it leave, there's training in place to continue it and so that the services don't leave when the people leave your system. [00:36:28]

Thank you so much.

MODERATOR: Okay, great. Thank you, Shannon. Um, so now before we move into our second presenter, given what we've talked about here, uh, we wanted to take a little bit of time for another poll question, um, as we're going to be presenting some information about, um, different types of health centers—so, school-based health centers—and some of the work that's being done there around adolescent screening.

So we want to get a sense of what folks are doing as it relates to schools. So the question is, "Do you or your organization provide primary care, mental health, and/or substance abuse services in schools?" Uh, yes or no. So we'll give you a little bit of time to answer that poll question, um,

and then we'll show the results. (long pause) So we're tabulating the results now. We'll give it about 10 more seconds or so. (long pause)

Okay! Alright, so a good majority of you are actually doing some work with us with schools. Um, you know, in schools. So, um, the next couple of presenters will be able to provide some information that will enhance a lot of what you're doing and, you know, maybe even provide some other opportunities in terms of, um, you know, changes or other implementation—changes you may want to make to your particular, uh—you know, work you're doing with schools. [00:37:55]

So with that being said, I will turn it over to our next presenter—Laura Brey. Laura, go ahead?

LAURA BREY: Thank you very much. Well, the school-based health alliance—uh, the organization with which I am employed—um, previously the National Assembly on School-Based Health Care is a non-profit membership organization. And we advocate for school-based health care and services, as well as provide technical assistance training and consulting at a national state and local level. And in this role, we were actually approached about three years ago by the Hilton Foundation.

And, for those of you that don't know about the Conrad N. Hilton Foundation, it is a family foundation, um, that's been funding substance abuse prevention since 1982. But their current vision is around youth substance use and abuse. And that's truly their focus. And they want to look at early detection—and as a path to healthy living for young people. [00:38:58]

And so they're looking at how they could basically focus on improving substance use outcomes for the 15 to 22-year-old age group by doing early intervention. And they have funded this initiative nationally that looks at increasing skills and knowledge of SBIRT within the medical community, um, within those that are youth-serving organizations, and just indeed strengthening the evidence base and promoting learning.

This, um—they started this work over three years ago. They've, uh, provided—they've worked with service youth and, uh, young adult organizations in 350 health care organizations, schools, and community-based organizations through 28 states—through 28 local state and national partners. So it's pretty, um, comprehensive. [00:39:52]

And so when they approached us, they wanted to look at how we could—how they could work with school-based health care in terms of actual clinical services provided, um, in the school setting so that access wasn't a big issue and parental, um—or parental and, uh, guardian involvement wouldn't be as prevalent because in the adolescent population, they access care without their parent or guardian present but they, for the most part, have their parent or guardian consent to use the services of the school-based health center.

Um, so they wanted to test SBIRT in non-traditional settings, um, use an evidence-based intervention because of the fact that all of the school-based health centers we wanted to work with had primary—had both primary care and behavioral health providers on-site, integrated together—not co-located. We wanted to do an evidence-based intervention—um, an early

intervention—and we chose Teen Intervene, which is an evidence-based intervention by Hazleton. And then we also wanted to develop a dissemination strategy for how to do this type of work nationally across the United States. So that's the entire project. [00:41:09]

We are still conducting the project. And so, I'm going to tell you a little bit about where we are so far and how we rolled it out.

So, first of all, we recruited teams of primary care and behavioral health providers. And some of the centers, because of the need to have buy-in, as was mentioned by our earlier presenter, that we involved administrators from the school-based health centers, as well.

Um, so we recruited 14 school-based health centers. And you can see the participants here across two cohorts. So, the first cohort, um, is just finishing up and Cohort II started in January 2015. And then our last six months of our initiative is basically looking at, um, doing the evaluation and coming up with a national strategy for dissemination. [00:42:01]

So what we did was we started out with these sites doing an actual webinar with their schools and with their sponsoring organizations that partnered together for these clinics. So we really wanted buy-in not just from the, um, health care organization and the health care provider, but from the school itself.

After that, we began to collect baseline and—we collected baseline data. And then we also held a day-and-a-half training, face-to-face, for both cohorts—you know, different times. At that point, we also collected, um, self-efficacy data on a pre-test basis. And so we will be doing, um, at baseline, and then at endpoint, another self-efficacy exam with, um, all of the participating sites.

At the day-and-a-half training, they received, um, training on alcohol and substance use and abuse with adolescent populations—just SBIRT, in general—and the SBIRT model of what has been going on with adolescents. They were trained on the use of the CRAFFT. They were also trained on the PHQ-9 because we decided depression screening was really important because so many of the students that were using alcohol or other substances also are at risk or may be exhibiting, um, symptoms of depression. So we wanted to add that on, as well. [00:43:24]

They were also trained on motivational interviewing strictly for conducting behavioral interventions and on how to give brief advice—uh, a large section on linkage agreements for referrals, particularly for referrals to the community settings that would accept use and that use would find accessible—acceptable, as well as accessible financially to them in case they actually needed treatment beyond the Teen Intervene intervention.

Um, in addition, all of the participants were—um, received an overview of Teen Intervene—quality improvement planning—how to do “plan, do, study, act” improvement cycles—how to collect data. And then, on the—that was the first day. And then on the second day, we split them up and the, um, primary care providers received training on how to do behavioral—I mean, brief interventions. And the, um, behavioral health providers received a half-day training on Teen Intervene. [00:44:21]

And then after—since the training, they go back and they're implementing, but also they receive monthly on-line coaching from our organizational staff that are on the project, as well as quarterly learning sessions. And then they provide data to us quarterly.

So, how did they do this?

So, we decided to be prescriptive in terms of the best two opportunities we knew in our setting to require them to, um, conduct and S—to include an SBIRT screening using the CRAFFT. So, on the well-child visits, which we do as an anchor in school-based health care, uh, they would screen using a risk assessment as well as adding the CRAFFT and the PHQ-2 or 9 into their screening. Then—that as on the well-child visit, and then on— (pause) for the students that were having problems with discipline or acting out in school, other kinds of behaviors that the administration was aware of—they would refer them to, um, the school-based health center for screening and intervention as an alternative to discipline in the school. So that was another entry point—or just any students coming for behavioral health. [00:45:41]

And so, the primary care providers would, after the assessment with the CRAFFT or the PHQ-9, they would either give brief advice, or they would do a brief intervention. They may do a series of brief interventions. And if the student was then, um, a good candidate for Teen Intervene—and what is a good candidate for Teen Intervene or on early intervention?—would be those that are actually using alcohol or other substances on somewhat of a regular basis, but not showing signs of true addictive behavior. They would be then referred for this other intervention. But if they were truly, uh, being—showing evidence of possible addiction and that they would be referred to treatment with one of the organizations that the school-based health center had developed a linkage agreement with. And usually the Teen Intervene was done by the behavioral health provider. And the brief interventions, as I mentioned, were done mostly by, um, the primary care providers, but on occasion, the mental health providers, or behavioral health providers, were doing that work, as well. [00:46:53]

I—I'm going to go over quickly Teen Intervene, and for those of you that are not familiar with it, it—it was a stand-alone, um, evidence-based intervention that was, uh, made to be delivered in three sessions. So, we had to use translated into about six sessions—five to six sessions in the school-based setting. So, in terms of how it could be administered, well it could be done individually or in a group. And, um, a number of the high school sites decided to do it in groups. Others did it individually. But it has, um, and incorporates motivational interviewing, stages of change, and cognitive behavioral work into its approach.

As I mentioned, it had three sessions to it—the actual adolescents—so we would do that in four—four sessions—and then probably a fifth session with a parent. The only groups that really tried to engage parents, or have so far, are those that are the middle schools, school-based health centers—not so much the high schools. It's very difficult sometimes to get the parents to come to, um, school, in general—and to get them to come in for an intervention like that. But this intervention is, um, more effective if you brought—bring the parent's in—especially in the younger-aged student. And then, um, usually a week between sessions was what was done. And then, there are client questionnaires that you administer before each session to get information. There's homework for them. And there's a parent questionnaire, as well. [00:48:27]

So that's a little bit about that. The research, like I said, has shown that significant improvement on alcohol and substance use is evident—is evidence-based after two and two—and it even goes up higher after three sessions. Um, and they definitely report that students—or any young people that go through this—improve their problem-solving skills. And they definitely become aware of how to use community services.

Um, in our project, we were not as lucky as our previous presenter to be able to have electronic health records that actually would record the CRAFFT or the PHQ-2 or 9 into the data base, or what was going on with the type of delivery. So, for our evaluation and monitoring, we created our own data-collection tool. And this is the information that we require them to collect, um, at every visit. And this is reported to us quarterly. They did it through an Excel spreadsheet, which seemed the easiest way for them to do that. And so this is the act—an actual example of an Excel spreadsheet that, um, the providers of any type use to collect their data and report. And then we accumulate it into, um, our quarterly report. [00:49:46]

So, we—we want to know, “What kind of lasting influences have happened so far as a result of this initiative?” And this was just a pilot in 14 sites. And there's many other sites across the country. But, um, all the sites were determined to continue to do, um, and implement this process into their routine. So they would continue it beyond our project. Um, most of the school-based health centers—it's interesting if you're not familiar with education that a zero-tolerance was pretty much the policy about alcohol and drug use. So, yes, you might talk about it, but an administration would do discipline in the past for it and not so much use intervention—positive intervention—both at the behavioral health site or at the primary care site—to deal with these kinds of issues. And so, school-based health centers—especially the, um, mental health providers—didn't have a lot of skill set around alcohol screening or intervention or drug screening or intervention other than they would be asked to do drug testing, perhaps. So—they didn't like to do that, either. That would not have been the—the way they'd want to go. [00:50:53]

So, now they have a new understanding of drug and alcohol prevalence, and they feel more competent to deliver this kind of work now that a lot of the zero-tolerance issues have been lifted by the Department of Education.

Um, they found that the brief advice and brief interventions definitely had a significant impact on students. Uh, they never doubted their honesty, uh, because of the fact that, uh, we know from the research that the adolescents are very honest. And because there were no parents or guardians present with them, and they tend to trust their providers there, they're pretty honest about what they're doing.

Um, we had one of the groups so far that met for the Teen Intervene went ahead and formed its own support group afterward where they continue to meet and they do coaching and buddy systems if they're going to kinds of events so they don't drive—they never drive with anyone who's drinking and different things like that. So they've developed their own kind of support group for that. [00:51:54]

Um, areas that, um, they still feel they need for growth—they feel that some of the staff is still not totally comfortable with Teen Intervene because it's different. You know, usually there's not a prescriptive intervention for behavioral health providers, and so it's difficult for them sometimes to, um, follow a scripted intervention.

Um, they still continue to want to improve their referral system within the school for the discipline areas. That didn't come super easy. Some sites it was easier than others. And I said, "If you'd looked back—we have some that are only like midway through their implementation, at this point."

And then, also community-based behavioral health providers that can deal with treatment—it's difficult in some places to find sites that actually, um, are what we would consider truly accessible to the adolescent population—especially in the areas where some of these vulnerable populations live. [00:52:55]

Um, as I mentioned the EHR, an electronic system for screening—and having it in EHR is difficult. All the sites do use EHR's that, um, implemented this project, and they reported that they would scan the actual form into their, um, charts, but it doesn't actually show the, um, intervention and what's going on with it. So we had to track that a different way.

Um, coding and reimbursement is a big issue. And I did include for you a coding—kind of a coding quick guide for SBIRT for those of you that are thinking of doing this. And coding varies for, um—depending upon the type of reimbursement you're going after—if it's Medicaid or if it's, um, going to be through a private insurance company, or if it's in managed care. And it's also different in many states. And so it's important to find out, um, if your state even reimburses for SBIRT if those codes are turned on, for example, for Medicaid, or if your providers are paying for that. And with a little bit of advocacy, um, many of the states we've worked with have found out that it's just a matter, for Medicaid, of getting them to turn on the switch for those codes. [00:54:09]

Um—but anyway, that's something important to keep in mind. And then, they've noticed—just like we did in days past when they would do screening—that there's new health issues that come to light once they start screening for alcohol and substance use. And you have to be prepared to deal with whatever kinds of issues come up. And, again, that means continuing in-service and being ready to look at what that might be.

Um, we did have some educational materials and resources at our sites [felt that were very helpful to them]. (ph) And again, here is the NIAAA Brief Intervention for Youth Guide. The practitioners found that extremely helpful, and all of our practitioners are using that.

And then, for the actual teenage population, they felt they needed more resources for them that were no to low-cost. And so, they went to the NIDA for Teens' website and found a lot of resources there. [00:55:04]

Several of our sites—because they're in the high schools—they were doing the "Baby, Think it Over," or there's other kind of pregnancy kinds of projects. And they did have some of these

dolls where you would—to get to an adolescent about how important it is that they don't drink. Many of them are—you know, they're at risk of pregnancy. And so, they were—they found it very helpful to use and to show them how a drug-affected baby or a fetal alcohol syndrome baby—these dolls are simulated technology—can help adolescents really understand the impact, rather than just talking. It's the closest they could actually see to, “Oh my goodness. If I drink during pregnancy—if I did get pregnant and I—I drank, this could happen to my baby. Or if I use drugs.” You know, they listen to the cry of withdrawal—and different things like that.

So it's pretty impactful. And many of the sites found it's not that expensive. And that was something, if they didn't have it already, they would consider purchasing it. [00:55:59]

And, I'd like to conclude with if you are interested in finding out about the coding and reimbursement for, um, SBIRT and related kind of intervention services in your state, this is the website—one of the websites—you can go to. And it will help you find that out. It will also help you look at resources for, uh, substance abuse referrals and so on.

Thank you.

MODERATOR: Alright. Thank you, Laura. (laughs) Now, uh, we will turn it over to Dr. O for her to talk about, you know, how her health center began implementing a lot of these services. Uh, so, Dr. O?

DR. TOSAN ORUWARIYE: Hello everybody! Um, it's good to be here. So everybody calls me Dr. O. And of all the presenters, I can tell you I'm the one in the trenches, so I have a different perspective to this webinar. And I can tell you how we started this process. For us, it was a bit of a research project. It was part of what we were seeing. And we had to figure out, “How do we do this?” Hopefully it will tell you—hopefully these slides will show the journey we went and, um, how we [it is there] (ph) to address the problem we saw in our practice. [00:57:17]

So I'm a pediatrician, and I work in school health clinics. And, um, we're part of Morris Heights Health Center. (long pause) Uh, Morris Heights Health Center is a [non-for-profit] (ph), federally qualified health center. We have a school-based health network serving over 17,000 students in about 17 schools in the Bronx. And we provide comprehensive primary care service that includes both behavioral health and medical services—and very important because the integration is built into school-based health centers.

(inaudible) focus is a (inaudible) school-based health center network is on confidentiality, and we try to follow the New York state law. And [this is the importance of going through the slides] (ph) because we have to think of what we needed to do when engaging the team. [00:58:11]

Routinely in our practices, we screen for risky behavior. So it's offered at all visit types: both routine visits and walk-in visits. And we use something called a GAPS, [which is] (ph) Guidelines for Adolescent Preventive Services. That screening tool covers a whole lot of issues from eating to, um, sleeping, and also has a few questions on alcohol and drug use.

When we go into the school, because we do this routinely we noticed the response on the GAPS form in this particular school was so high, everybody kept on saying they were doing alcohol and drugs—they were doing alcohol and drugs. Now in the past three months we looked at those screening questionnaires and we found about 54 percent of the kids, you know, had [checked off] (ph) they were doing alcohol or drugs. For us it was just like, “What are we going to do?” Um, in that new school, we also noticed there was a lot of violence—a lot of fights. Um, by midday, the principals, the school administrators—a lot of commotion in the school. We also see the students coming to the clinics—some of them tired in the morning—some of them in fights. And I the history of talking to them, we realized there was something here that was a little bit unusual. [00:59:35]

So what we did was, since we had the patients there, we decided to do what we call “detailed interviews” just to see what the problem was. And we decided to have meetings with the principals after we did this. [So when we] (ph) had the [facts focus groups] (ph) we—all the kids [would say], “Oh, yeah,”—that they “have these drinking parties—these drug parties after school.” And they really told they had a lot of risky behaviors. Many of them come late to school. They—they get drunk. They are tired. And the school was on probation for academics, so it was a problem affecting the school.

And we decided to go to the school community, knowing that there was a risk her because they don’t tolerate alcohol or drugs in schools, but to let the principal know that we’re identifying this problem and we need to—well, collaborate with you to see how can we address it. So it was a risk we took. We probably had to because we couldn’t function in any other way.

So luckily the principal said, “Yes! [It’s been] (ph) a problem for us. We can’t cope with this. We’ll walk with you.” Um—and so that reassured us. And the first thing we did was to set up a team because we didn’t know anything about SBIRT when we started. We just knew we had a problem. These kids were coming here every day. They were fighting. We had cuts. We have knives. There would be knives all from fights after getting drunk. [01:00:51]

So we got a team, and the team was to set up to identify what [were our] weaknesses and our gaps to address this problem. And so we identified we had lacked the knowledge, the skill, or the financial resources. Um, we [needed an] (ph) intervention that could be integrated into our (inaudible) clinic workflow. [And third], we have to engage the school community while maintaining confidentiality because we felt if the students knew that the school principals were involved, they may not want to share their stories with us.

And as we did the research, we said, “Who’s going to pay for this? What time do we have?” These were real questions we had to address with the clinic team. I remember, in our team we had just four people. We had a health educator—we had the social worker—the medical provider—and the assistant in the front. So we all—we all met every day because it was really a problem for us. They wouldn’t care for other kids because of all these fights. [01:01:47]

So we looked for some local funding, and we got about, um, \$40,000. So we went into the New York City Council member that covered that district and said, “We have a problem in this school. You know, we’re trying to figure out how to help the school. Is there any funding for us

to do this project?” And after much representation and lobbying, we got \$40,000. And so we identified within the school-based health center (inaudible) do some research. We learned about SBIRT, Teen Intervene, the NIAAA Guidelines, ASSIST, (ph) the DAST, the CRAFFT—all of them new acronyms to us. And we had to decide how—which one do we use? How do we do this?

Well the first thing we wanted to do was to train the staff. [We had to train] all our school-based health (inaudible) center staff out of the 17 schools—not just the four involved—because we felt, “Let us learn the skills of the group.” Because when we looked at some other GAPS forms from other schools, we found that although it wasn’t a high percentage, there were students still admitting to drugs and alcohol use. And we never addressed it. So we thought everybody should learn this. So [01:02:53]

So we got some training on SBIRT. We also got training on Teen Intervene. And we had different people come to talk to us about the best practices about them. This journey took us about six to nine months. Let me just, um, add that.

So, when we got the training, we realized, “Oh, at least we can do something.” And, in fact, the (inaudible) was very eager. You didn’t need to convince them. Um, when they saw, they realized, “This tool could really help us care for the students and the patients we see. We are very, very eager to use the tools.” But because it was a pilot with (inaudible) small, and we used that school as a pilot site, and another school that we found that they had a high incidence of, um, admitting to alcohol and drug use.

One of the [deliverables] we defined when we got the pilot—we were going to do classroom presentations—we are going to screen students. And those responses (inaudible) going to offer will set a brief advice and a brief treatment. And then we’re going to do substance use (inaudible). [01:03:57]

So we really went all out to see—though, we’re going to look at all means to educate, to inform, um, the school community. (long pause)

So in implementing this, we have to decide, you know, which dates are we going to meet with the students, if we’re going to do a brief advice [out of the screen]. (ph) These are real considerations for the clinic. Um, we want to use a Teen Intervene that allows parental involvement that has shown to be beneficial, but the students (inaudible) [01:04:28] they don’t want to get parents to be involved. When do we involve the parents if we’re going to? Do we use incentives because teenagers (inaudible) if you tell them to come in, will they come back for this brief intervention? Will that be valid if we use incentives? [01:04:43]

And then I talk about the choice of tools. You know, do we want them to self-report? Or [do] we interview and check off? If we let the students complete it, we need to choose a simpler form [instead of the] (ph) user form that the clinicians have to do. And so we integrate this tool, or [do] we use it alone? And do we expand screen opportunities to not just the beha—not just the medical provider but the social workers, the health educators, and to all the (inaudible) of certain types of visits.

But these are the conversations we had as a team on, “How do we do this going forward?” And then we have to prepare the school for implementation. We wanted to make certain that the principals did not say, “Oh, we have told you...” Well, we tell them we needed to see this patient for a brief intervention, and they wouldn’t let them come down. Or if they know we were having this service, they will punish them. Um— [01:05:36]

We also wanted the curriculum for the school. We felt if we’re going to do this work, you know, (inaudible) have curriculums for health education. We said, “What do you have about alcohol and substance use?” (inaudible) to really engage the school communities for it to be successful. Because we realize we’re just in the tip of the iceberg, but—although students might be doing the same thing. So they looked at what kind of curriculums would they use in the classrooms to educate them so they’re hearing the same message from across—across the board in the school.

And we said we had to look at the clinic workflow where we designed the clinic workflow. We had to design our own data collection tool. We had to get educational materials and we got that from the city—from NIAAA. We had the pocket guide. And one of the first things we did [is] we had to identify community resources and build those linkages because we knew that if we had a high risk patient, where do we them? And we also had to explore billing and reimbursement opportunities from the beginning because we felt if we had to sustain this, we had to think about that earlier rather than later. [01:06:39]

So the team really met a lot after work because [this] was new for us and we had to see patients between 8 and 4. So most of our meetings were from 4 to 5 to figure out how do we do this, how can we sustain it, and how can it work? (long pause)

We agreed we had to use the PDSA cycle because that was the only way we could monitor, track, and improve. And we felt we had to give ourselves about six months to, um, get this pilot going, learn from it, and tweak it as we went along. We all agreed that it won’t be perfect, but we’re going to change, figure out what works, look at it again—and we kept on doing this. For instance, one of the workflows we had was that the assistant will give the students the forms as they come in. And then the students will fill out the form before they come to the medical provider. [01:07:35]

But, as soon as we did that, we realized that some of the students didn’t like that. They wanted the forms to be given to them when they saw the provider and they would fill it out themselves. So we had to tweak it because it wasn’t quite the flow we planned.

So we managed to do a successful outreach. Um, the school gave us permission to access all classes. And so we had a little presentation that we had come up with. So every student in the school heard about the prevalence of substance use among youths. They also learned about the consequences. And we also shared with them the school data—the safe impact in the school—we can help—we’re here to help. And that was really very powerful.

Because we are a school-based health clinic, the school also had resources. They had substance use counselors, as well. They were not engaged at all because many of the students did not trust

them. They didn't utilize their services. So we brought them onboard. We talked about how we could use a referral pattern because they could support (inaudible) of the effort. We also told them about the SBIRT trainings. And luckily we're in New York City where the city had offered free SBIRT trainings for different (inaudible) of staff. We made sure that the school staff, as well, had the opportunity to learn about SBIRT. And we—the agencies that we engaged that were (inaudible) of the school, we met with them—they came to the school to talk to the principal. We really felt at that school we had to have a whole community and collaborative approach all focused on the same goal: reducing the risk associate with this behavior. [01:09:05]

(long pause) So as I mentioned, um, we decided to use the CRAFFT in the end because that was the easiest. And, uh, we integrated a workflow. We decided that if it was a positive screen, they could either go to the social worker or the health educator—not the provider—after we had talked about it.

In another pilot [because] (ph) it was different—they tell the provider how to have that. But I wanted to just share the variability of how we implemented it.

And we decided we needed to do a deeper dive to capture the level of risk from substance use. So initially we said (inaudible), which is a different tool. But later on we found the NIAAA tool was easier for our providers to use. So that actually quantified it in a very simple way—the volume of alcohol use and the risks associated with it. [01:09:59]

So we also decided what we'll do before time—that it was a low to moderate risk how much intervention will do. And then if it's moderate to higher risk—and then if it's high risk—we were very clear to the staff and the clinic, but we didn't need to guess. All this was the work we did beforehand—before we ruled it out. So once they saw the—the patient—it was a low risk—immediately they finished with the identification of that risk. They then schedule the appointments for the brief advice—or the brief intervention—depending on what the effect, and, um, to do the documentation of behavior change.

Before we did the implementation, all the staff we also trained on motivational [interviewing]. (ph) We had motivational interviewing, full [custom] (ph) substance use, as well—as well as overall motivational interviewing. We learned about the stages of change. So that was very useful. [01:10:55]

We also decided that we'll have every four months—every six months, I think—have refreshers for the staff, um, in terms of skill sets because we felt since we trained the whole school-based health program, some of them might not have the (inaudible) to use the skills. So we didn't want them to lose those—lose those skills.

(long pause) So when we use the brief intervention—as I said, it was a stand-alone approach—and [we used it] as a prelude to participate in some more extensive treatment. Sometimes the brief intervention—we used it to bridge time for higher-risk youths because some of the agencies we worked with, we saw that [there was] a waiting list. And we found that even when—we only had a few students that we classified as high-risk—but we saw that that time allowed us to facilitate change because [in] the beginning we said, “If there's a high (inaudible) four brief

interventions—intervention sessions. And if it's low risk, we call it "brief treatment." We just use different terminology. I think somebody called it "brief advice?" Um, the intervention was intense. [01:12:00]

(long pause) Here are some of the results we got because we have to share this with, uh—with a funder. So we did a lot of presentations—about 225 sessions over a 6 to 9 month period. Almost all the grades in two schools from 9th grade to 12th grade we presented to. The principals give us the time. And that was the beauty of having everybody engaged. They wanted to do this, um, and the teachers were with us in the classrooms when we did this to talk about the risks of this—the [prevalence] (ph) in the school community.

We did a lot of CRAFFT screenings. And this data is from over a two-month period. Um, we had over 250—or 225 screenings done. Um, and these are the two schools that we focused on.

(long pause) So for those with a positive screen, um, we had about—in one school, we had about 25 students with a positive score screen. And in another school, we had about 20 students. And those we—we documented how many came back. One of the [problems] (ph) was getting them to come back. That's why the incentives we gave them. This concern materialized because they'll come for the first one, um, but they wouldn't come back for the second one. [01:13:18]

So we had to think, "How else could we bring them back? Could we combine, um, some intervention or make it sort of tighter—right?—and break it up into little pieces?" But the students were just not coming back for the four sessions. And what pieces could we, um, combine?

(long pause) We also at this time explored, you know, what we could get paid for. In New York City, it's a little bit different when SQAC, we learned the different payment rate—the different rate code. And I think every state is different. It was very, very important for us because we [had] to find out how to sustain this effort once it's done. [01:14:00]

So, I just wanted to just share what we had done, you know, and some of the results we found. But, when we finish this, we ought to think, "How do we share this with the health center?" So (inaudible) back in the same thing. We have to educate the staff. We have to educate them on the prevalence of the alcohol and substance use in the community. Then we have to train the staff. And we sat with one—we have seven primary care sites in our health center. We sat with one site at a time. We—this time we figured the social worker needs to play a key role. We now integrated this type of tools into our EMR. We integrated the screening to the routine workflow. And we constantly shared the data with all the staff.

(long pause) So I want to talk knowledge OASIS and the New York cities because they really supported this effort. I can tell you as up to date, all our school-based health centers routinely screen. Um, not all of them have the SBIRT training because of high turnover. But the few that—the few that are (inaudible) continuously use it (inaudible) the BI level because we have the infrastructure in place for the [referrals]. (ph) We have the infrastructure for what to do at different risk levels, which is very, very important. And we keep on doing the PDSA cycle—to get better.

So thank you. [01:15:23]

MODERATOR: Alright. Thank you, uh, Dr. O. So now at this time, uh, we will open it up for you guys to ask questions to our presenters about anything that you've heard here today. If you have questions that haven't been answered or, you know, things that are popping into your mind about the wonderful content that was presented here, now is your opportunity to ask a, uh, question of the presenters. Um, so you may type or submit those questions now into the question box that's below the, um—where the slides are being presented. I will give you guys a chance to type in a couple of questions here before we, uh, start and—and open it up. So— (computer sound) (long pause) [01:16:19]

So while we're waiting for folks to, uh—for them to type in their questions here, we did have one from earlier asking some questions about, um, you know, where one can find some resources about the, uh, Teen Intervene? Um, our materials that were presented—I believe it was, uh, by— Laura Brey presented those materials?

LAURA BREY: That's correct. Um, the Teen Intervene is available through Hazelden. Hazelden is a non-profit organization that does a number of different things in the alcohol and substance abuse arena. There is a charge. It's not very expensive. And you can contact them. They're in—I believe they're in Minnesota? So, um—

MODERATOR: Mm hmm.

LAURA BREY: —[you] can contact them. They have a website and they also have great people that work there. So yes, you can get those materials. They're not that expensive.

MODERATOR: Okay. Alright, thank you. Um, so we have another question here. Um, and it, I think, is to any one of you. Um, do you all have any thoughts about the, um, type of provider that was most appropriate? Or how do you go about selecting the type of provider to engage in the screenings and/or brief interventions? Um, speak a little bit more about that process. (long pause) [01:17:38]

DR. TOSAN ORUWARIYE: Um, this is Dr. Oruwariye. I can tell you for us it depends on your resources—what kind of staff you have. Um, in the school-based health centers in New York City, they have an integrated model. And in some clinics, they don't have a social worker. So it really depends on your staff. But, um, the good thing about the SBIRT is that different people can do it. The health educators can do it. The MA's can do it. The providers can do it. Just—and they will have a different level of training. So, it's really looking at your staff resources and educating them so they can see the—the value of it—and sharing the information—the data of the screen. They see for themselves the responses.

So, I'll say first your staffing model. And then I always feel the more people have the skills, the better, because they have so many touch points that the patient has as they go through the clinic.

LAURA BREY: Uh, this is Laura. I'd like to comment. I mean, it's—it's great to think about, "Who are the appropriate staff?" But in the school-based setting, as Dr. O just mentioned, you know, we don't—we have certain providers, and usually we don't have the luxury of trying to pick a specific provider. So it's more you're looking for when you hire staff to work in that setting that—that feel comfortable discussing those kinds of topics with young people. And, um, or if they don't have the skill set, are willing to be trained—because that is an issue constantly. You do have turnover in any work setting. And as you hire those people, you have to hire staff that are willing to be trained. But also, you have to have a, um—a mechanism in place to do that training for them. So that's how I would comment on that. [01:19:24]

MODERATOR: Okay. (pause) Alright. We have another question here, um—someone mentioned the Adolescent Preventive Services questionnaire? Um, and they wanted you to speak more about what that questionnaire is.

DR. TOSAN ORUWARIYE: So the GAPS—[G-A-P-S]. It's, um, Guidelines for Adolescent Preventive Services. [It's a] (ph) this standardized, structured, validated questionnaire used, um, by pediatricians to screen teenagers. And they have one for the middle adolescents and the older adolescents. And it covers things from the foods you eat—to how you sleep—to your relationships with your peers. It's a very comprehensive questionnaire. And what we like to—what I like about that questionnaire is it doesn't target the child to say, "Oh, why are they asking me questions about sex? Why are they asking me questions about drugs?" It has everything in it. And that was the first—that's what we use as a screening tool for the teenagers. And in those questions where, um—that—in those questions where they talk about alcohol and substance use, we pick up those positive screens as a first step. That is called GAPS. If you Google it, it's done by the AMA. You can get it free—um, GAPS is you Google it. You can get it free. And you can use it. It's been around for pediatricians for a few years. And it's pretty comprehensive in terms of screening. But we found that wasn't enough for our project. We had to get a specific tool for substance use that helped us classify the risk and stuff like that. [01:21:03]

LAURA BREY: Um, this is Laura. Actually, I was on the staff at the AMA at the time when we created the GAPS forms, and they are available in English and Spanish. But it is—it's been around a long time—since 1994. So, it did—it's last update was quite awhile back. And many of the questions have been incorporated into the American Academy of Pediatrics Bright Future questionnaires—

FEMALE: Mm hmm.

LAURA BREY: —which providers, um, administer. The main problem with it is that the GA—or not problem—the advantage to GAPS is that it's self-administered and the adolescent answers it themselves versus the way Bright Futures is set up, the provider asks the questions. And so in many instances, GAPS is still preferred by many people.

Um, but the other side of it is there is another, um, paper and the actual online database called RAPPS—R-A-P-P-S.

DR. TOSAN ORUWARIYE: Yes.

LAURA BREY: Or R-A—yeah, R-A-P-P-S—and— (overlapping talking)

DR. TOSAN ORUWARIYE: (overlapping talking) R-A-P-P-S.

LAURA BREY: Also does screen for many of the same risks, um, if not more. So—and there are a number of other different tools out there that you can use for the screening. But as Dr. O said, none of them are as specific—I mean, they're —they're risk assessments versus screenings, which actually do go heavier into helping you diagnose a condition, so. If they've given you a flag from one or two questions on a risk assessment, then definitely around alcohol or substance use, you'd want to go to the CRAFFT. Or something similar—there are a number of other questionnaires out there. We just—for us, we chose the CRAFFT on our—our implementation. [01:22:42]

DR. SHANNON MITCHELL: (overlapping talking) Uh, this is Shannon. I—

MODERATOR: (overlapping talking) Okay. Um—

DR. SHANNON MITCHELL: I think it's also very important to point out that it is—if the screening and the providers that we work with are FQHC, use the youths' responses to the CRAFFT as an [entry] (ph) to have a conversation. It's not a diagnostic tool. It's a—it's a way to understand if there's something going on. And it is an opportunity, and it gives you some areas to probe for future, um, exploration to see if there is—there are additional problems going on. And it's—it's an assessment writ—very small. It's not a diagnostic tool by any stretch of the imagination.

MODERATOR: Okay. Thank you. Uh, we have—look at—we have time for about two more questions here. Um, so we have one question. I believe it's for Shannon. “Um, do you have any information about, um, the perceptions from the providers about, um, you know, once they began implementing the, uh, screening of brief intervention protocols?” So how did they feel about introducing this new activity to their agency? Or were the providers excited? Upset? How did that work? [01:23:52]

DR. SHANNON MITCHELL: Um, I—you know, it's funny because I've talked with a lot of providers and other organizations and, um, some of my other NIDA awardees. And they're also implementing things in health centers where the person delivering the service is often the primary care provider. And, um, everyone thinks it's important and everybody often thinks they're too busy to do it. But once they've done it, they realize it doesn't take very long.

Um, we've done data collection for The Economist. We have an economic evaluation. It's part of our implementation study. And the providers are spending on average no more than five minutes actually having a brief intervention. They are very brief. And if it takes more than that really it's a further conversation and you bring them back. And you say, “Let's talk about this. You said you wanted to reduce your risks and you're going to—you're going to, you know, try and not engage in “X” behaviors. You know, I want you to come back and see me in a couple of weeks and let's talk about this some more and see how—how well that was going for you.” [01:24:58]

Um, the providers' perceptions—I think it—they didn't change them from the (inaudible). They might have changed in terms of how challenging they thought it might be. Um, but by and large, I think there was a lot of buy-in. It was just showing them that they could get it done. And like I said, there is a broad range in terms of how effectively, um, providers are giving brief interventions for those that need it. And there's those—there are those providers that—that really believe it's a powerful tool to start to have this conversation, and they will use it regularly. And there are others who really weren't comfortable with it and even after 2-1/2 years of—of being reminded about it, to this day probably are not doing it. [01:25:48]

FEMALE: (inaudible)

DR. TOSAN ORUWARIYE: Just to add, [as a provider], (ph) I feel as a provider, if you make the work easy for me, I'll do it. And if you look at it from a teen perspective, I don't need to do the screening, too. I can interpret it. So if you look at the workflows that help the providers interpret it, it's very—it's very, very—they can do it. Because right now we integrate into our EMR, so they don't need to do the screening. The MA does it before they see them. They see the score. And if they have the skill, they can then talk to the patient. So the workflows are important for the providers because as Shannon said, everybody's very busy. So we're looking at a team-based care model in terms of how you implement and this kind of program becomes very important. [01:26:34]

MODERATOR: Okay, thank you. Um, it looks like that's all the time that we have right now. Um, so we wanted to make sure that you guys were aware of the resources that are available. Um, CIHS has an SBIRT clearing house. So if you're looking for resources around, uh, screening—brief intervention, you can go to our website—[www.integration.samhsa.gov](http://www.integration.samhsa.gov). And we have a number of different resources we pulled from a number of different agencies—NIAAA—others—um, around screening and brief intervention. Uh, we also loaded up on this, uh, particular webinar. We have a number of, um, other resources that are available, as well.

So we just wanted to make sure that we highlight those, um—and, you know, I wanted to say thank you again for, uh, participating in this webinar. Um, a recording and transcription of the webinar will be available on our website. Once you exit the webinar, you'll be asked to complete a short survey. Um, please be sure to offer your feedback on that survey. Um, your input is important to us, and informs a development of future CIHS and National Council webinars.

Again I'd like to thank our presenters for this particular webinar—um, and also Dr. Vivian Faden for joining us today. And I also thank all of you for participating. With that being said, have a nice day, everyone. [01:27:58]

**END TRANSCRIPT**