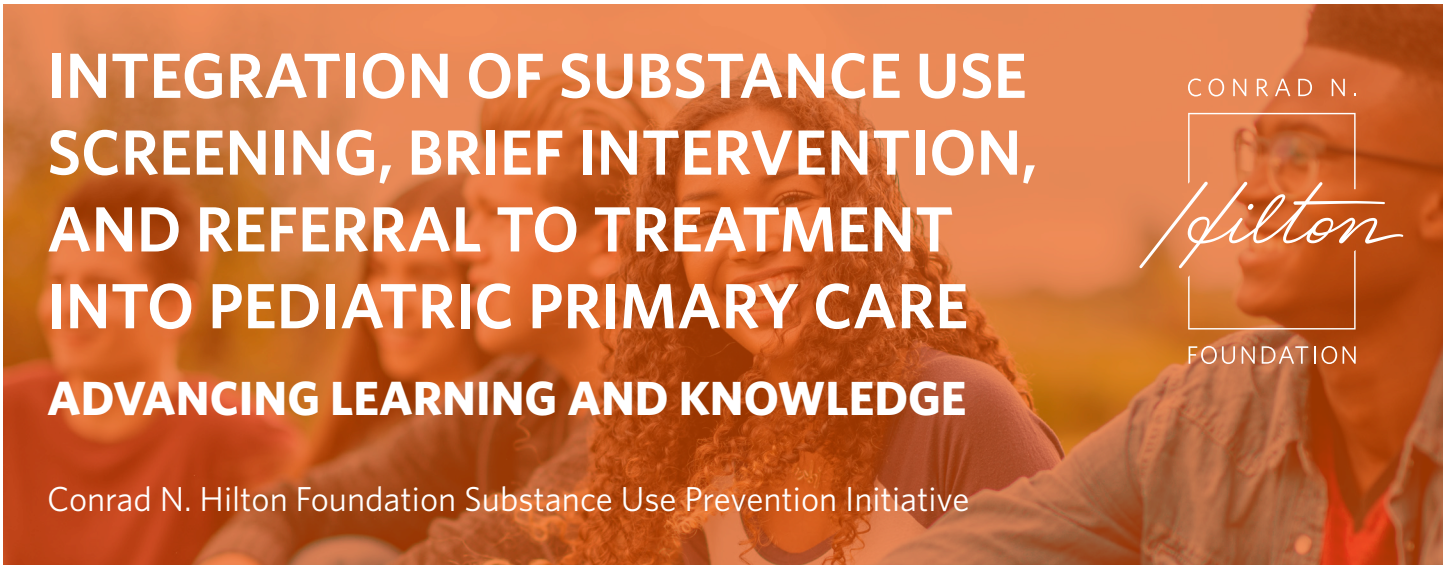

INTEGRATION OF SUBSTANCE USE SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT INTO PEDIATRIC PRIMARY CARE

ADVANCING LEARNING AND KNOWLEDGE

Conrad N. Hilton Foundation Substance Use Prevention Initiative

CONRAD N. Hilton FOUNDATION

HIGHLIGHTS

This paper explores how the Conrad N. Hilton Foundation's (the Foundation) Youth Substance Use Prevention and Early Intervention Strategic Initiative (the Initiative) has contributed to the development and testing of various approaches to integrate adolescent substance use screening, brief intervention, and referral to treatment (SBIRT) into primary care settings. Since 2013, the Foundation has awarded more than $81 million to fund the work of 56 grantees. Several overarching lessons have emerged from the Foundation's first six years of substance use prevention grant making. Through the Initiative, the Foundation was interested in examining the feasibility of integrating SBIRT into pediatric primary care settings, including community health centers and school-based health centers. Three systemic challenges associated with implementing SBIRT in primary care settings emerged, and grantees have since identified promising solutions to each.

1. Pediatric primary care providers typically do not receive training or education on substance use disorders as part of their formal medical education, and, as a result, often feel inadequately equipped to identify and address substance use. In response to this issue, the Initiative supported the development of addiction medicine fellowship programs to build a national workforce of addiction medicine physicians, expanded curricula for schools of nursing and social work, and trained pediatric primary care providers to implement SBIRT.

2. Clinic workflow, confidentiality regulations, and billing and reimbursement issues can hinder the integration of SBIRT in primary care systems. The Initiative funded efforts to enhance the capacity of primary care systems to administer SBIRT by identifying clinic champions, developing workflow processes, creating tools to promote understanding of confidentiality requirements, and advocating for system-level changes regarding SBIRT reimbursement.

3. Pediatric primary care providers have limited access to, and knowledge of, substance use treatment and community-based services for adolescents. The Initiative's grantees built relationships with behavioral health service providers, incorporated follow-up in SBIRT protocols, and strengthened relationships with families to improve treatment initiation and engagement.

This brief discusses what we have learned from grantees who encountered these challenges in primary care settings over the past six years. These lessons can

About The Authors

Abt Associates serves as the Monitoring, Evaluation, and Learning (MEL) partner for the Conrad N. Hilton Foundation's Substance Use Prevention Initiative. Abt Associates works with the Hilton Foundation and its grantees to measure progress toward advancing the goals of the Initiative; identify key areas of learning and develop recommendations for the Foundation, grantees and stakeholders; collect data and advise on improvements needed to strengthen delivery systems and improve local evaluation capacity; and identify aspects of systems change needed to sustain implementation prevention and intervention activities and support scalability.

About The Foundation

The **Conrad N. Hilton Foundation** was created in 1944 by international business pioneer Conrad N. Hilton, who founded Hilton Hotels and left his fortune to help individuals throughout the world living in poverty and experiencing disadvantage. The Foundation invests in 11 program areas, including substance use prevention, providing access to safe water, supporting transition age foster youth, ending chronic homelessness, hospitality workforce development, disaster relief and recovery, helping young children affected by HIV and AIDS, and supporting the work of Catholic sisters. In addition, following selection by an independent international jury, the Foundation annually awards the $2 million Conrad N. Hilton Humanitarian Prize to a nonprofit organization doing extraordinary work to reduce human suffering. From its inception, the Foundation has awarded more than $1.8 billion in grants, distributing $112.5 million in the U.S. and around the world in 2018. For more information, please visit www.hiltonfoundation.org.

provide important insights, further the understanding of implementation of SBIRT in primary care settings, and contribute to additional movement forward to overcome these systemic challenges.

METHODOLOGY

The brief draws on interviews with grantees; information abstracted from grant applications, annual and cumulative grant reports; grantee-developed tools and resources; and evaluation data collected between 2013 and 2019. Data were collected quarterly from each grantee, and reflect both process and outcome measures. The key questions addressed are:

- Have the Initiative's efforts improved health providers' capacity to integrate substance use prevention and intervention services into pediatric primary care?
- What strategies have been effective in overcoming common challenges to implementation of SBIRT in pediatric primary care?

INTRODUCTION

Background

Youth substance use is a critical public health concern across the nation. Research indicates that most substance use disorders manifest in adolescence and the young adult years. Still, in 2018, the National Survey on Drug Use and Health reported that 2.2 million youth 12 to 17 used alcohol, and 2.0 million used illicit drugs (primarily marijuana), in the past month (Substance Abuse and Mental Health Services Administration, 2019). Additionally, 1.2 million 12 to 17 year olds reported binge drinking in the 30 days prior to the survey. Early use of substances can also portend later substance use disorder issues. Two in three adults treated for opioid use disorder first used opioids when they were under the age of 25 (Uchitel, Hadland, Raman, McClellan, & Wong, 2019). Addressing substance use early in life is a critical to mitigating the associated risks to youth, families, and communities (McCance-Katz, 2019), and can help reverse the current opioid overdose epidemic and other substance use-related public health issues (Levy, 2019). Consequently, there is a vital need to identify evidence-based prevention and early intervention strategies for youth. As a result of health reform in recent years, new policies and initiatives have been implemented that mandate coverage of substance use disorder services as part of healthcare, and emphasize the value of preventive services within primary care and behavioral health delivery systems. These include models for primary care and behavioral health integration, engagement of communities in population health strategies, and increasing access to substance use and mental health services.

Screening, brief intervention, and referral to treatment (SBIRT) is a public health approach to identifying and addressing substance use and related risks – including health, social, and legal consequences. While SBIRT was originally intended as a process to reduce adult alcohol misuse, research demonstrates that intervening with adolescents at low to moderate risk of substance misuse is effective in reducing substance use, in preventing health and other related consequences, and in saving healthcare costs (SBIRT Colorado, n.d.). The Foundation's Initiative builds on the successful utilization of the SBIRT framework with adults in health care settings, and assesses its utility for youth in a variety of settings, including primary care, schools, community based organizations, community mental health centers, and juvenile justice programs. Since 2013, the Foundation has awarded more than $81 million to fund the work of 56 grantees implementing SBIRT in 1,266 sites across the United States. One of the goals of the Initiative is to further the evidence base for adolescent SBIRT and disseminate findings to the broader prevention field. The Foundation has funded rigorous, longitudinal studies designed to answer complex research questions pertaining to the efficacy and effects of various SBIRT tools and models. Since 2013, the Initiative has supported the evidence-based substance use screening of over 141,000 youth. Of those, nearly 12,300 (9 percent) have received a brief intervention; and over 2,200 (2 percent) have been referred to substance use disorder treatment.

Each step of the SBIRT process provides information and assistance to the adolescent patient and the patient's family or caregivers.

Screening refers to the routine, universal administration of validated questions to identify potential risks related to alcohol and drug use, followed by positive reinforcement for youth who screen as 'no' or 'low' risk.

Brief intervention includes one or more short, motivational conversations, typically incorporating feedback, advice, and goal setting around decreasing 'moderate' risk related to substance use. This step is intended to prevent progression to more serious levels of use.

Referral to treatment describes the process of connecting individuals with more high risk substance use to appropriate assessment, treatment, and/or additional services based on their level of need. SBIRT has emerged as a critical strategy for targeting the large but often overlooked population of adolescents that have initiated substance use but have not yet experienced adverse consequences that are attributed to high risk use.

The Initiative's Reach into Primary Care

The Foundation was particularly interested in examining the feasibility of integrating SBIRT into pediatric primary care settings, including community health centers located in underserved areas and school-based health centers. Ideally, through regular visits, primary care providers establish consistent and long-term relationships with youth and their families, and can become trusted members of a family's healthcare team. Overall, 54 percent of adolescents aged 9 to 21 years visit primary care providers, and 35 percent have an annual preventive visit with a primary care provider (Rand & Goldstein, 2018).

The American Academy of Pediatrics (AAP) describes pediatric primary care as encompassing "health supervision and anticipatory guidance; monitoring physical and psychosocial growth and development; age-appropriate screening; diagnosis and treatment of acute and chronic disorders; management of serious and life-threatening illness and, when appropriate, referral of more complex conditions; and provision of first contact care as well as coordinated management of health problems requiring multiple professional services" (AAP Committee on Pediatric Workforce, 2011).

School-based health centers are also an essential part of the primary care landscape. Their location within schools makes them an integral part of the healthcare safety net in the United States, providing a critical access point to healthcare services for populations of underserved and vulnerable youth. Students depend on school-based health centers for a full range of health care services, including comprehensive primary care, behavioral health care, reproductive health care, oral health care, health promotion and education, and treatment for acute or chronic illnesses, in a location that is safe, convenient, and accessible (School-Based Health Alliance, n.d.). With an emphasis on prevention, early intervention, risk reduction (Health Resources and Services Administration, n.d.), and integrated care, school-based health centers are a natural venue for delivering youth SBIRT services.

Substance use assessment and treatment for adolescents and their families in primary care settings potentially offers better access and a less stigmatized environment for receiving treatment than specialty programs (Sterling, Valkanoff, Hinman, & Weisner, 2012). In these routine care settings, SBIRT provides a process to engage youth in difficult conversations around substance use, and gives primary care providers the tools and language to be successful (Tew & Yard, 2019). Historically, the primary care system has been siloed; physical and behavioral health services have operated separately, and primary care providers did not typically address substance use. The Foundation's Initiative examined the feasibility of the integration of behavioral health and substance use prevention into primary care settings and promoted a more holistic approach to health and prevention. SBIRT is a framework to anchor this approach.

The efficacy of SBIRT to identify and address unhealthy alcohol use among adult primary care patients is well documented (Ballesteros, 2004; Bertholet, Daeppen, Wietlisbach, Fleming, & Burnand, 2005), and has been endorsed by the U.S. Preventive Services Task Force (USPSTF) (US Preventive Services Task Force, 2018), The Joint Commission (The Joint Commission, 2010), the National Committee on Quality Assurance (National Committee for Quality Assurance, 2019), and the American Medical Association (Substance Abuse and Mental Health Services Administration, n.d.). Research continues to emerge about the effectiveness of using SBIRT with youth, and in 2011, the American Academy of Pediatrics (AAP) released a policy statement and clinical guidelines that recommended the use of SBIRT as part of routine pediatric care (AAP Committee on Substance Use and Prevention, 2016). Universal screening of adolescents in general medical settings can be instrumental in identifying substance use early, before further problems develop and when brief interventions are more likely to be effective (Harris, Louis-Jacques, & Knight, 2014).

Interest in adolescent substance use screening has grown over time, resulting in a number of screening tools have been studied and established as valid indicators of current and future problematic substance use. In fact, the AAP – along with federal agencies like the Substance Abuse and Mental Health Services Administration, the National Institute on Drug Abuse, and the National Institute on Alcoholism and Alcohol Abuse – recommends routine youth screening, brief intervention, and referral to treatment and provides a list of validated screening instruments.

A study from Kaiser Permanente in Northern California found that three years following receipt of SBIRT, adolescent patients in primary care settings had lower utilization of psychiatry services and lower overall outpatient utilization, which are proxy indicators for overall health and wellbeing, than those who did not receive SBIRT (Sterling et al., 2019). The study also found that adolescents who received SBIRT were less likely to have a mental health or medical diagnosis within one year and less likely to have a substance use or depression diagnosis at the three year follow-up period.

The Initiative has made important strides in understanding the feasibility and utility of integrating SBIRT into 392 primary care sites and 478 schools and school-based health centers.[1] Grantees found that multiple systemic factors influence the degree to which SBIRT services can be implemented in primary care, including limits on provider time, staff turnover, changes in workflow, organizational buy-in, availability and utility of technology (e.g., tablets for screening, electronic health records), access to specialty treatment networks, and reimbursement for services. By identifying these factors and testing strategies to address them, grantees have contributed to the evidence base for utilizing adolescent SBIRT in primary care.

Through the Initiative, several grantees expanded the implementation of youth SBIRT in pediatric primary care settings and school-based health centers, and over 131,000 youth were screened as a result. Of those screened, five percent received a brief intervention and one percent received a referral to treatment.

Grantees working in primary care settings have:

- Trained 38,249 health care providers in the SBIRT protocol through:
  - » Addiction medicine fellowship programs and prevention and intervention curricula for medical, nursing, and social work students, and
  - » Innovative multi-modal, on-the-job training approaches enabling primary care providers to identify risk and intervene early through routine conversations with youth;
- Developed tools and provided key insights to help address common challenges related to confidentiality, clinic workflow, and reimbursement for screening and brief interventions; and
- Established relationships with community-based substance use disorder treatment providers and increased the capacity of internal behavioral health specialists to assess and treat youth with more serious substance use issues.

1 For the purposes of this paper, primary care sites include pediatric clinics, community health centers, and school-based health centers. The Initiative data presented on schools and school-based health centers include schools that do not have a school-based health center. Due to the method of data collection from grantee sites, authors were not able to analyze data separately for the two types of settings.

KEY LEARNINGS

This section identifies three systemic challenges associated with implementing SBIRT in primary care settings and describes promising strategies and mitigating solutions that emerged from the Initiative. The key learnings highlight strategies, tools, and approaches that grantees developed and tested to overcome barriers to SBIRT implementation in primary care settings.

Systemic Challenge #1:	Solution:
Pediatric primary care providers often feel inadequately equipped to identify and address substance use.	**The Initiative supported the development of addiction medicine academic programs and trained pediatric primary care providers to implement SBIRT with confidence.**

Pediatric primary care providers are in a unique position to identify and prevent substance use. However, many may not recognize the key role that they play and may not feel prepared to take action (Tew & Yard, 2019). A study in Massachusetts found that only one tenth of medical students surveyed felt that they received adequate training in addiction medicine, while nearly all respondents reported that addiction medicine is an important area in which to receive training (Bäck, Tammaro, Lim, & Wakeman, 2018). The study concluded that there is a need for additional training in addiction medicine for medical students, more clinical exposure to patients with substance use disorders, and increased mentoring from faculty members who specialize in addiction medicine to prepare medical students to address the needs of patients at risk for or with a substance use disorder.

In addition to investing in academic programs, ongoing on-the-job training can bolster provider skills for addressing and preventing substance use disorders among youth and help eliminate stigma around discussing substance use. Skills-based training for providers has increased their confidence in implementing SBIRT and instilled a greater sense of responsibility to screen youth (Bernstein et al., 2007). SBIRT training does not have to be elaborate or complicated; it can be as simple and straightforward as providing links to standard SBIRT training materials and specifying a time frame within which they are to be completed (Stoner, Mikko, & Carpenter, 2014) so providers have the flexibility to complete requirements when convenient. Research suggests that single trainings of medical providers may not be sufficient to establish effective SBIRT interventions (Chossis et al., 2007). Ongoing support and training to address questions regarding the appropriate identification and treatment of patients who need substance use disorder treatment is necessary (Pringle, Kowalchuk, Meyers, & Seale, 2012). As the health system in the United States moves toward integration of physical and behavioral health, providers who are equipped with screening and intervention skills are well positioned to promote integration of these traditionally siloed services, increase quality of care, improve patient outcomes, and reduce healthcare costs (New Hampshire Charitable Foundation, 2017).

Through the Initiative, grantees have trained 38,249 youth-serving providers in community health centers, primary care clinics and school-based health centers. This training encourages conversations with adolescent patients and their parents or caregivers around an array of difficult topics, including substance use. In addition, these trainings have creatively addressed major challenges related to the time limitations providers' face in primary care settings, and grantees have even looked further upstream at ways to enhance academic preparation of health professionals before they formally enter the workforce as practitioners.

Academic training on addiction medicine and prevention of substance use disorders prepares the primary care workforce to address these issues with youth.

Training pediatricians to integrate substance use services in their practices can increase their confidence and skills to address an array of substance use disorders (Levy, 2019), though workflow issues surfaced among grantees instituting SBIRT in primary care. Practicing primary care providers face a multitude of demands and are left with little time available during the day to take advantage of various trainings or professional development opportunities. Ensuring academic programs include more robust substance use prevention and addiction medicine requirements can help prepare providers before they enter the workforce and avert some of the challenges of limited provider availability once they are practicing. The Initiative addressed the need for fully integrating addiction medicine into the adolescent health care system recognizing that primary care providers play a critical role in disease prevention and treatment. Providers must understand and be equipped with the skills and confidence to identify risk factors for substance use and addiction, screen for risky substance use, intervene when necessary, and treat or refer patients for services to manage addiction as they do for any other chronic health condition or disease (The National Center on Addiction and Substance Abuse at Columbia University, 2012). Recognizing this need, one grantee established the National Center for Physician Training in Addiction Medicine to promote permanent systemic change in medical education and health care systems to build a new medical subspecialty of addiction medicine and ensure prevention and early intervention are part of standardized addiction medicine education, training and practice. To accomplish this, the grantee developed a range of approaches to support the continued growth of addiction medicine fellowships with a particular emphasis on recruiting physicians with an interest in youth health promotion and prevention and early intervention. Strategies include developing physician mentors, recruiting potential fellows, and placing graduating fellows in health care settings where they can most effectively advance addiction medicine. In addition to primary care physicians, other members of the primary care workforce such as nurse practitioners, physician assistants, psychologists and social workers, are critical parts of the solution and need to have addiction medicine and substance use prevention integrated into their academic

The American College of Academic Addiction Medicine (ACAAM) created a new medical subspecialty of addiction medicine and ensured that prevention and early intervention are part of standardized addiction medicine education, training and practice.

NORC at the University of Chicago is leading the first large-scale educational initiative aimed at equipping the next generation of social work and nursing professionals with the knowledge and skills needed to conduct SBIRT with youth. NORC is engaging with professional associations and stakeholders to support the changing landscape of social work and nursing education, while bringing resources to build knowledge, self-efficacy, and skills among practitioners providing services to youth.

and licensing requirements. Another grantee addressed these gaps in training related to substance use and adolescent SBIRT for nursing and social work students, faculty, and clinical preceptors as part of the first large-scale educational initiative aimed at equipping the next generation of social work and nursing professionals with the knowledge and skills needed to conduct SBIRT with youth.

Utilizing various SBIRT training modes, making trainings convenient, and offering provider incentives helps accommodate provider learning styles and time constraints, while building skills and self-efficacy.

Some grantees experienced challenges with training uptake among primary care providers due to competing demands and time constraints. Primary care providers are often incentivized to see as many patients as possible, so offering a variety of training modes as options is an effective way to accommodate schedules and learning styles of primary care providers (Tew & Yard, 2019). To account for these demands on providers, grantees conducted on-site and virtual technical assistance and training for primary care providers to build the skills and self-efficacy of the existing workforce. Utilizing online training platforms, including virtual simulations to practice delivering interventions in different patient scenarios, allowed providers to complete trainings and practice skills when convenient without having to miss

The University of New Mexico's Strategic Implementation of SBIRT in school-based health centers project, implemented an in-depth training program for school-based health centers providers focused on youth-centered communication and holistic views of substance use, including comorbid conditions of depression and anxiety. The training used both in-person and telehealth methods with didactic components. They measured the effectiveness of the training on provider interactions at the provider-level throughout the project by surveying participating youth post-interaction.

appointments with patients during the day. Grantees created their own SBIRT training curricula and tailored it to their specific primary care practice settings to better resonate with providers. Grantees incorporated formal and informal feedback from participants to ensure continuous quality improvement in training, to address the evolving needs of participants, and to ensure the technical support offerings are addressing salient and emerging topics. Additional examples of training modes grantees utilized under the Initiative included:

- Tailored on-site trainings
- Affinity group or cohort calls with small groups of providers
- Individual on-site consultation
- Phone and email consultation
- Informational webinars
- Virtual human simulations
- In-person and virtual learning collaborative sessions.

Grantees also designed trainings to vary in length, offering some multi-hour comprehensive SBIRT trainings with shorter booster trainings (such as 45-60 minute "Lunch and Learn" sessions) to provide additional support for refining new skills and building confidence. However, practices found it more difficult to cover the content in depth in the shorter trainings. Grantees suggested that more convenient virtual training options, such as a podcast or making training available on mobile devices or tablets, could improve provider training uptake and allow busy providers to do trainings "on-the-go" or at times of their choice.

Grantees also found that offering continuing medical education credits to providers was an effective incentive for participating in SBIRT training because it helps fulfill existing professional requirements.

Ongoing training and resources for primary care providers supports learning throughout the phases of SBIRT implementation.

Many primary care providers are learning and developing new sets of skills through SBIRT training. Grantees have found that brief intervention skills, such as motivational interviewing, need to be practiced on an ongoing basis to instill confidence in providers to use these techniques with youth. Offering ongoing training and multiple touchpoints to support primary care providers may effectively foster continued learning and adoption of SBIRT. However, providing SBIRT training too far in advance of implementation with patients may cause providers to feel less confident in their skills. It is important to account for delays in launching SBIRT implementation and train providers as close to launch as possible. It can take primary care practices several weeks or months to adjust their workflows and processes to prepare for implementation. Providing short booster trainings throughout implementation helps reinforce skills and provide additional support, especially if there are delays with implementation. In addition to shorter trainings, grantees also found that occasional longer sessions where providers had the opportunity to practice new skills were helpful.

A wide array of practical tools and resources on SBIRT implementation can facilitate ongoing learning and further support primary care providers and practices. Practices can make these materials easily accessible through shared Web platforms or websites, or as handouts to help disseminate information and reinforce skills between trainings and for those providers who are unable to attend in-person training sessions. Resources such as implementation checklists can provide guidance on integrating SBIRT into clinic workflows and routine practices. One grantee designed a checklist that included information such

The School Based Health Alliance led and facilitated a National School-Based SBIRT Learning Community. The initiative compiled and disseminated collectively agreed upon school-based SBIRT best practices to the field for widespread adoption and standardized implementation. They also developed a comprehensive web-based toolkit to create a sustainable legacy of school-based SBIRT learning tools so that school-based health centers nationwide can replicate this model.

as working with clinic leadership, building strong multidisciplinary implementation teams, utilizing the electronic health record, billing and coding for services, and using data to ensure ongoing program improvements. Another grantee developed an SBIRT change package, a resource designed to support primary care providers as they implement program changes and measure progress for each stage of SBIRT implementation. Other grantees have developed materials such as self-assessment modules for continuing medical education, a video highlighting key insights from primary care providers implementing SBIRT, fact sheets and tools to help primary care providers and practices understand federal confidentiality regulations around substance use disorder records and how that relates to SBIRT services for youth, and training curricula. One grantee was instrumental in having addiction content inserted into the Common Program Requirements for physicians in training. Additional information about grantee-developed tools and resources can be found in in the Appendix.

Systemic Challenge #2:	Solution:
Clinic workflow, confidentiality regulations, and billing and reimbursement issues can hinder the integration of SBIRT in primary care systems.	**The Initiative enhanced the capacity of primary care systems to administer SBIRT by identifying clinic champions, developing workflow processes, creating tools to promote understanding of confidentiality requirements, and advocating for system-level changes addressing SBIRT reimbursement.**

The most recent guidelines issued by the AAP prescribe universal substance use screening for adolescents during both routine and acute care appointments (AAP Committee on Substance Use and Prevention, 2016). However, implementing these guidelines is not without challenges. Primary care settings are some of the busiest places in which to incorporate any additional steps to routine care and practices may find it difficult to find sufficient time to create a workable fit for the SBIRT protocol into an already established routine. Clinical champions can help encourage provider buy-in and manage change seamlessly, making the adoption of SBIRT smoother. Time constraints in primary care settings are also a major barrier, and providers have several developmental and preventive screenings for youth to fit into a short appointment. Brief, user-friendly, adolescent focused screening tools that can be administered by clinical and non-clinical staff alike, will fit more seamlessly into primary care settings. A critical leverage point for SBIRT implementation has been in developing and using payment structures. Primary care providers must bill for their time, and having specific reimbursement codes available can support sustainability of SBIRT in primary care settings. Capitated payment financing structures, which pay providers a set amount per patient for all health care services over a defined time period, can eliminate this barrier.

Confidentiality requirements and regulations can be challenging for providers to navigate. This issue is particularly nuanced for pediatric primary care providers serving youth patients under the age of 18. Youth may want privacy when having discussions about these sensitive issues, and some substance use disorder treatment programs require family participation which necessitates sharing confidential information. Families and caregivers may also be concerned about documenting substance use in electronic health records because of any potential discrimination and future impact on youth. Through the Initiative, grantees developed and tested potential solutions to address these systemic challenges of SBIRT implementation in primary care settings.

Having a clinic champion and buy-in from providers is critical to successful implementation of SBIRT in primary care settings.

Implementing new processes, tools, or addressing systems-level change in busy primary care settings can be challenging. There are often well established roles and routine workflows in place. Providers may be skeptical or hesitant to shift their approach to delivering care. Having a clinical leader or decision maker as a champion for SBIRT implementation can provide important perspective and encourage adoption of new behaviors in primary care clinics. Ensuring clinic decision makers are involved in the process can help streamline the integration of SBIRT into clinic practices and workflows. Having leaders and clinic champions frame the SBIRT process as a tool for providing more complete and better health services for youth, rather than positing it as just another task to be completed was effective in gaining buy in of providers at many grantee sites (Tew & Yard, 2019).

Grantees noted the value of clinic champions who embraced SBIRT and shared powerful experiences connecting with youth and seeing the impact of SBIRT when utilized correctly. Clinic champions can serve as SBIRT advocates at primary care sites and promote systems change, especially when they are able to use data to support their personal anecdotes and experiences.

Including members on the clinic team with a strong health care quality improvement experience can help make SBIRT implementation more successful.

A quality improvement perspective on clinic teams implementing SBIRT is invaluable. A team with a strong quality improvement orientation involves:

- Interest and readiness to participate in quality improvement activities
- Identification of a champion and commitment from an interdisciplinary team of primary care providers and staff members to engage in regular meetings
- Developing key performance indicators and discussing both system and clinical issues regularly
- Readiness, willingness and capacity to develop and/or modify clinic strategies to address youth substance use
- Commitment to collect and report on key performance indicators.

Grantees found that including clinicians with quality improvement expertise on SBIRT implementation teams helped facilitate prac-

tice-wide engagement in implementation (New Hampshire Charitable Foundation, 2018). Team members with quality improvement expertise promoted the use of SBIRT data to inform the strategy for implementation and the content and timing of ongoing training and technical assistance sessions for providers.

Evidence-based, brief screening tools are essential for incorporating SBIRT into primary care practices.

Primary care practices are incredibly busy addressing youth and family needs on a daily basis. Utilizing brief, validated screening tools can help accommodate SBIRT into packed clinic schedules and short appointment times. Grantees have developed and customized evidence-based screening tools for primary care settings and utilized the widely adopted CRAFFT instrument, Screening to Brief Intervention (S2BI), or effective one question screener (*How often have you used [substance] over the past year?)* (Levy et al., 2014). Leveraging technology, such as the use of tablets and electronic screeners, can also be effective and efficient. Grantees found that utilizing screening tools that youth are able to complete in waiting rooms or in other private spaces before appointments can also ensure there is more time available during their actual appointment to discuss the results of the screener. Providers may offer encouragement and positive reinforcement for those youth scoring at no or low risk, or conduct a brief intervention for youth who score at moderate or high risk. Additionally, integration of SBIRT measures into electronic health records can be an efficient way to prompt providers to conduct screenings and capture important data for follow-up conversations with youth.

SBIRT must be integrated into the standard delivery of routine health services in order to provide holistic care for youth.

In a survey conducted as part of the Initiative, over 80% of primary care and school-based health centers provider respondents reported that a primary care provider was responsible for conducting the screening in their clinic, placing the burden primarily on either the physician or nursing staff. Across the country, health systems are exploring how to more effectively address the spectrum of health needs of their patients. Primary care providers are increasingly looking more holistically at their patients, which includes any behavioral health or unmet social needs. Taking a team-based approach to conducting SBIRT and sharing responsibilities across care teams may improve clinic workflow. Grantees have found that having an effective workflow provides infrastructure for implementing SBIRT. For example, involving receptionist staff, medical assistants, or nurses to help facilitate the screening process, primary care providers (i.e., physicians, nurse practitioners, or physician assistants) can conduct brief interventions and initiate the referral process to an addiction medicine physician if appropriate or make a hand-off to a behavioral health clinician for further assessment and services. Integrated care practices have also used behavioral health providers for both the screening and brief intervention portion of the protocol, relieving medical staff of the activity. As discussed above, another promising strategy for improving clinic workflow and maximizing provider time with youth is to leverage technology such as tablets or laptops to administer the screening phase of the protocol. Research has demonstrated that the use of such technology relieves the administrative burden, increases accuracy, routinizes and perhaps de-stigmatizes the process, and can quickly add results to electronic health records (Gadomski et al., 2015; Wissow et al., 2013).

Confidentiality issues are complex to navigate with youth, but focused trainings and tools can help make providers feel at ease.

Confidentiality issues may emerge throughout the SBIRT process, but can be especially complex for primary care providers to navigate when addressing substance use issues with youth and their families. Confidentiality considerations impact workflow, documentation in the electronic health record, referral relationships, and parental and caregiver engagement (New Hampshire Charitable Foundation, 2018). In addition to laws and regulations around confidentiality, families may be concerned with documentation of substance use in electronic health records, and the potential impact on the youth's future academic or employment prospects. Grantees have developed a number of strategies to address these issues. They have created tools and provided technical assistance to primary care sites to help them understand confidentiality issues under state and federal laws and regulations to overcome any potential barriers or hesitations to implementation.

Primary care providers also may face challenges keeping sensitive substance use information private when parents are present at appointments. Grantees implemented creative approaches to allow youth to complete brief screeners privately without their parents or caregivers present, such as setting up private spaces or asking caregivers to complete paperwork while youth complete screenings. Primary care providers also have to balance the benefit of having parents involved when discussing substance use with youth. To help providers feel equipped to facilitate these difficult conversations, grantees had specific trainings and technical assistance engagements to enhance provider skills. Some grantee sites included confidentiality consent forms for parents and caregivers as a routine part of the process when patients enter care. This helped protect information about youth referrals to behavioral health or substance use treatment services.

The Legal Action Center created a series of fact sheets and tools to help providers and practices understand federal confidentiality regulations around substance use disorder records and how that relates to SBIRT services for youth. The tools include decision trees for practices to use to determine their particular confidentiality restrictions. These tools aim to help raise awareness and understanding among providers about these important policies.

Reimbursement for screenings and brief interventions facilitates sustainability of SBIRT in primary care settings.

Developing payment structures to support SBIRT is a major contributor to its sustainability in primary care settings. As the largest source of coverage for behavioral health services, including those related to substance use disorders, Medicaid can play a powerful role in addressing substance use disorders (United States Government Accountability Office, 2015). Effective January 2008, state Medicaid plans may reimburse for SBIRT services. However, health care organizations may not be able to bill for SBIRT services for a variety of reasons, one being that the necessary Medicaid billing codes have not been activated in many states. Furthermore, even when the screening and brief intervention reimbursement codes are activated, many

Community Catalyst fostered advocacy coalitions in six states, including in Georgia where the team contributed to the activation of the state's Medicaid SBIRT codes, enabling provider reimbursement. Project staff also created an SBIRT financing toolkit for medical settings and schools.

providers are not using them due to the time-based nature of the code. An SBIRT encounter needs to last a minimum of 15 minutes for payment under certain billing rules (SBIRT Colorado, 2008). A 2011 study noted physician concern with conducting SBIRT interventions and the feasibility of adding time to already overbooked medical practices (Fussell, Rieckmann, & Quick, 2011).

The Foundation invested in increasing access to financing for SBIRT through policy analysis, advocacy, and dissemination of information regarding usable cost reimbursement codes and strategies across the states for reimbursement. For example, a grantee developed an online, interactive map with information on billing for substance use prevention and early intervention that also includes information on each state's Medicaid coverage. Another grantee encouraged Medicaid health plans to actively collaborate with their state Medicaid agencies to enable the use of, or "turn on," state codes for the brief intervention portion of the protocol and to publicize the existence of appropriate codes to create an incentive for primary care providers to use SBIRT. Grantee primary care sites are leveraging private foundation funding, federal grants, state grants, and other sources to finance SBIRT in spite of health care payment reform and movement towards paying for outcomes and value across the country. This also reflects the need for continued advocacy and education efforts around the critical issue of SBIRT financing and sustainability.

Systemic Challenge #3:	Solution:
There is limited availability, access to, and knowledge of various substance use treatment services for adolescents available to primary care providers.	**Grantees built relationships with behavioral health and treatment providers, incorporated follow-up in SBIRT protocols, and strengthened relationships with families to improve treatment initiation and engagement.**

The National Survey on Drug Use and Health reported that in 2018, 3.7 percent (916,000) of adolescents 12-17 years old reported levels of drug and/or alcohol use that qualify as a substance use disorder; but less than one percent (547,000) of youth received treatment (Bernstein et al., 2007). These data highlight the critical problem of limited or non-existent substance use treatment services for youth (Paquette, Pannella Winn, Wilkey, Ferreira, & Donegan, 2019). Many primary care providers have never interacted with the specialty substance use disorder service system before, and may not be aware of the continuum of substance use treatment options and services available. The new field of addiction medicine provides trained physicians who can provide consultation to primary care providers, perform assessments and diagnoses, appropriate interventions and both inpatient and outpatient treatments. Other options, such as community-based interventions (e.g., mentoring programs) may also be appropriate. It is difficult for providers to remain up-to-date on this resource landscape, as many of these resources are administered by smaller organizations embedded in the community, and providers have existing patient and administrative demands they must prioritize. Information about the populations these organizations serve, types of services provided, hours of operation, and organizational capacity to meet the needs of youth are important details to primary care providers, but difficult to track. As a result, many providers feel unprepared to determine the type of referral most appropriate to meet the needs of youth and their families.

Primary care providers have also reported they sometimes do not hear back from their patients after referring them to treatment services, leading providers to believe that treatment was ineffective (Palmer, Hughey, Jones, & Mark, 2015). There is often no mechanism to formally close the loop on whether the youth received treatment, and for the provider to learn about the outcomes and next steps that resulted. Incorporating formal follow-up steps and processes into SBIRT protocols, as well as existing relationships with treatment providers, may help keep providers more engaged throughout the referral to treatment process and improve care transitions. Additionally, embedding substance use services within pediatric primary care settings, including school-based health centers, and engaging primary care providers in managing substance use as they do other chronic diseases and health conditions, has the potential to dramatically increase access to substance use disorder treatment for youth (Levy, 2019). There is minimal burden on the primary care provider when either services or staff with expertise are fully integrated or co-located with physical health care.

Building relationships with treatment providers and establishing cross-sector partnerships can facilitate access to services for youth.

Communicating regularly with treatment providers can help better coordinate care for youth; however, primary care providers have limited time to initiate and foster these relationships. Establishing relationships can facilitate the referral process and help primary care providers stay updated on services youth are receiving and progress or barriers they may be experiencing. This process is enabled by addiction medicine physicians who are already part of the health care system. Some grantee sites have regular meetings with treatment providers to share general information about their programs and review referral processes and protocols. This is more common in community-based and school-based programs than in primary care settings, due to time constraints. Established relationships with treatment services can also help primary care providers understand and communicate wait times and other details to youth and families seeking appointments.

Primary care practice sites in the New Hampshire Charitable Foundation's project reached out to community-based providers across New Hampshire to develop referral relationships. Nearly 70% of practice sites have established new partnerships with organizations in their communities as a result of their youth SBIRT implementation work.

Establishing cross-sector partnerships can also help relieve the burden on primary care providers to retain details about the treatment landscape. A few partnerships with community organizations, juvenile justice programs, and schools can be key. Instead of having to keep track themselves, primary care clinics can communicate and consult with these trusted partners who do know the ins and outs of the community. Grantees developed tools to help primary care providers build and strengthen relationships with behavioral health and community-based resources for youth, including a checklist outlining steps to take to identify and organize resources by region and the support services available for youth and families.

Incorporating a follow-up step in the SBIRT protocol allows providers to stay in the loop about youth treatment initiation.

Follow-up after screenings, brief interventions, or referrals to additional services are necessary to holistically address youth health needs. However, protocols and processes for follow-up in primary care settings are often unclear and these conversations may not be reimbursable, making it challenging for providers to conduct these important activities. Follow-up may include conversations with youth, families or treatment/service providers via phone, or an interim appointment to check-in. Primary care practices have also found it difficult to log follow-up interactions in electronic health records. Without clear mechanisms for having these conversations, providers are often unaware of whether youth were able to initiate and engage in treatment services before the next annual primary care visit. Additionally, multiple follow-up conversations may be required with youth and their families, before they engage in treatment, making follow-up an important step in the SBIRT protocol. Due to the time constraints on primary care providers, a team-based approach to follow-up may be particularly effective. A recent randomized trial found that having a behavioral health clinician based in pediatric primary care who can facilitate referrals to specialty care can significantly increase the chances that patients who need it will start treatment; patients with access to that service were four times more like to start treatment than those receiving usual care (Sterling et al., 2017). A care coordinator, health educator, or other staff member may also conduct follow-up depending on the staffing structure and capacity of the particular clinic (New Hampshire Charitable Foundation, 2018).

Grantees explored and shared insights on the various challenges with follow-up in primary care settings and developed strategies for beginning to address these issues. Grantees noted that clinics with integrated behavioral health services or relationships with local treatment providers made follow-up more seamless. Assigning a staff member to follow-up directly with patients was an effective strategy, and clearly delineates responsibilities across team members to ensure this step is incorporated into the SBIRT process.

Engaging families and caregivers supports the success of referral to and engagement in treatment services.

Confidentiality issues with families and caregivers can be complex to navigate for pediatric primary care providers wanting to protect privacy and build trust with youth patients. Involving parents and other caregivers in substance use treatment offers the potential for more significant impact. Research suggests that in addition to promoting trust and confidence between the youth and medical provider, thoughtful engagement with parents or caregivers that support and mobilize the entry into treatment or engagement with additional services is essential (Ozechowski, Becker, & Hogue, 2016).

FUTURE DIRECTIONS AND RECOMMENDED NEXT STEPS FOR INTEGRATION OF SBIRT INTO PEDIATRIC PRIMARY CARE

Grantees have conducted research to shed light on challenges and promising approaches to integrating SBIRT into pediatric primary care settings, created tools and resources to overcome barriers, and promoted a more holistic view of prevention, health, and well-being in primary care settings to help youth thrive. While grantees developed a variety of promising approaches, challenges remain related to time constraints on primary care providers, reimbursement, and siloed systems of care between physical and behavioral health services. Recommendations to further address these systemic issues are described below.

Expand substance use prevention and addiction medicine curriculum in academic training for primary care providers.

Provider training uptake was a major challenge for primary care practice sites due to competing demands and lack of time to take on any additional or optional work outside of seeing patients. While grantees developed some creative strategies to overcome these challenges, a promising solution is incorporating more robust behavioral health, addiction medicine, and substance use disorder prevention (including SBIRT) into academic preparation and ongoing licensure requirements of physicians, physician assistants, nurses, social workers, psychologists, and other professionals who interface with youth. Additionally, while training students is effective, unless their clinical preceptors are also trained, the students will not have an opportunity to practice the SBIRT skills they have acquired in school. Due to the difficultly students have experienced influencing change in existing practices, the provision of training to preceptors should be a priority emphasis. National standards and core competencies around addiction medicine and SBIRT would ensure these subject areas are included in academic programs. State continuing education and licensure requirements should also incorporate substance use prevention and addiction medicine to support the ongoing learning and skill building of providers in these areas.

Utilize data to monitor performance, address gaps in implementation, and identify opportunities for training and quality improvement.

Electronic health records can be used to monitor delivery of services, including follow-up; track treatment referrals; and assess substance use and other related outcomes over time. Grantees found there was often inconsistency in the availability and quality of data, making it difficult to track progress and identify promising practices and challenges. Practices may experience a time lag in seeing screening and brief intervention rates if they are using claims data. Additionally, the SBIRT billing codes may be too general to know what specific service or intervention a youth may have received. More accurate and robust data on screening and brief intervention rates can help drive practice improvement (Tew & Yard, 2019).

Determine a mechanism to sustainably finance SBIRT in primary care settings.

Health care organizations and providers may not be able to bill for SBIRT services for a variety of reasons. Medicaid billing codes have not been activated in many states and even when the screening and brief intervention reimbursement codes are activated, many providers are not using them due to the time-based nature of the codes, low reimbursement rates, concerns around documenting substance use in the medical record, and lack of awareness regarding the availability of the codes. Sites are turning to other funding mechanisms such as private foundations and state or federal sources to finance SBIRT and continue to report billing and coding as a barrier to implementation. The Foundation is funding a project with the Center for Health Care Strategies to move beyond the discussion of using fee-for-service principles to drive SBIRT implementation. They will convene experts in substance use prevention, health care service delivery, and financing to explore considerations for using alternative payment models to shift how primary care identifies and addresses youth substance use and report their findings.

Integrate addiction medicine and other behavioral health services into pediatric primary care to improve SBIRT implementation and access to treatment for substance use disorders.

While policy efforts in the United States have increasingly focused on expanding access to evidence-based treatment over the past several years, the treatment infrastructure remains almost nonexistent for youth (Levy, 2019). While developing and fostering relationships across sectors and with external mental health, substance use, and other community-based service providers can facilitate access and treatment uptake for youth, these relationships take continued investment of time and effort by key individuals in primary care clinics. Many primary care settings are not set up to support this type of ongoing outreach, and providers may have to do this on their own time because it is not a billable service. Integrating behavioral health and substance use services within pediatric primary care can facilitate warm handoffs from primary care providers. Ideally, SBIRT fits into a comprehensive behavioral health screening and integrated approach to care to address comorbid substance use and mental health conditions. Further, engaging primary care providers in managing substance use as they would other chronic diseases or health conditions has the potential to increase access to substance use disorder treatment for youth (Levy, 2019). Follow-up with youth and specialists is more seamless and straightforward when all providers are working within the same setting. In these situations, time constraints are less of a limiting factor. Additionally, multidisciplinary, team-based approaches to care can ensure that the health of youth is addressed as a more whole-person care experience.

CONCLUSION

The Foundation utilized a strategic, multipronged approach to advance the implementation of SBIRT in pediatric primary care. The Initiative supported the development of addiction medicine fellowship programs, expanded substance use disorder prevention curricula for schools of nursing and social work, and trained pediatric primary care providers to implement SBIRT. It enhanced the capacity of primary care systems to administer SBIRT by identifying clinic champions, developing workflow processes, creating tools to promote understanding of confidentiality requirements, advocating for SBIRT reimbursement, and strengthening treatment referral networks. Systemic challenges remain related to the integration of substance use prevention into routine primary care practice, and future work is needed to improve and sustain SBIRT implementation. Further expansion of academic preparation and skills-based training for primary care providers, use of clinical data to monitor SBIRT implementation and outcomes, access to financing models for SBIRT, and the integration of addiction medicine and other behavioral health services into primary care settings are promising directions for future work.

APPENDIX: Pediatric Primary Care SBIRT Implementation Resources

This list of pediatric primary care SBIRT implementation resources represents a subset of journal articles and evaluation reports, implementation tools and resources, and policy briefs published and disseminated by the Initiative's grantees. For each item, we provide the citation and a brief description of the material and its associated grant project.

Botzet, A., Fahnhorst, T., Laschen, M., & Jones, A. L. (2015). *MPower program parent manual.* Minneapolis, MN: University of Minnesota. Oakland, CA: Kaiser Permanente. The MPower Program serves to increase family communication and understanding around sensitive topics, especially alcohol and drug use, empower teens to make educated, healthy choices, and ultimately, reduce adolescent alcohol and drug use. The parent manual is designed to provide parents/guardians with additional information and resources to most effectively implement the MPower Program in the home setting. Information in the manual includes: background on adolescent brain development and cognitive emotional regulation to give parents a better understanding of teen behavior and provide guidance for promoting independence and cognitive/emotional regulation; techniques for effective communication; effective methods to cope with life stressors; and tips to help parents facilitate positive decision making styles. Accompanying exercises are provided throughout. The manual concludes with a reading list and resource guide for further exploration.

Botzet, A., Fahnhorst, T., & Jones, A. L. (2015). *MPower program interventionist's manual.* Minneapolis, MN: University of Minnesota. Oakland, CA: Kaiser Permanente. Created as part of the MPower Program, this manual serves as a guide for interventionists to implement the MPower program in a clinical setting. The manual describes a 4-session individual and family therapy model for use with adolescents who may be experiencing mild or moderate problems associated with alcohol or drug use and/or mild to moderate levels of mental health problems, such as anxiety or depression. The manual includes proposed scripts for each session as well as accompanying reproducible worksheets to be distributed to participants. Guidance is also included for providers who need to refer a participant for further treatment.

Center for Health Care Strategies. (2019). *Improving access to screening, brief intervention, and referral to treatment in primary care for adolescents: A resource center.* https://www.chcs.org/resource/improving-access-to-screening-brief-intervention-and-referral-to-treatment-in-primary-care-for-adolescents-a-resource-center/. As part of a three-year *Improving Access to SBIRT Services for Adolescents* learning collaborative, the Center for Health Care Strategies, Inc. created a resource center to provide practical tools and strategies for health plans and providers interested in using SBIRT for adolescents in the primary care setting. The resource center includes various modules that range from helping providers understand how SBIRT can be integrated into the primary care setting to providing insight into the billing codes available for SBIRT services in the primary care setting. The website also contains numerous links to related projects, resources, and blog posts on the topic of SBIRT.

Community Catalyst. (2019). *Advocate toolkit: Funding screening, brief intervention and referral to treatment (SBIRT) with young people.* https://www.communitycatalyst.org/resources/tools/sbirt-resources/pdf/Funding-Youth-SBIRT-Toolkit-Updated-July-2019.pdf. This toolkit provides a roadmap for advocates to identify and leverage a range of funding sources to support the implementation of SBIRT in schools and medical settings. Several policy and advocacy strategies are highlighted throughout that have the potential to bring funding and resources to youth SBIRT initiatives. The first section includes strategies for leveraging Medicaid reimbursement, state and local budget resources, and federal funding to support prevention initiatives, including SBIRT, in the school-based setting. The second section offers strategies for incentivizing and reimbursing providers for conducting SBIRT with adolescents in medical settings. Three payment sources are addressed: Medicaid payment models, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and Private Insurance. The toolkit also contains links to numerous resources that may help advocates to engage community members and providers to generate awareness for SBIRT.

Community Catalyst. (2019). *Training resources for the implementation of screening, brief intervention, and referral to treatment (SBIRT) with young people.* https://www.communitycatalyst.org/resources/tools/sbirt-resources/pdf/Pew-SBIRT-Training-Resources-CC.pdf. This one-pager offers online and face-to-face training resources for individual providers and organizations interested in implementing SBIRT with adolescents. The trainings include an introduction to evidence-based screening tools and instruction in motivational interviewing. Several of the resources also provide implementation coaching and support. This resource also includes links to two training toolkits, both of which provide detailed guidance for clinicians or organizations interested in delivering SBIRT with adolescents.

Frameworks Institute. (2018). *Reframing adolescent substance use and its prevention: A communications playbook.* http://frameworksinstitute.org/assets/files/adolescence_youth/reframing_adolescent_substance_use_playbook_2018.pdf. The Reframing Adolescents Substance Use and Its Prevention playbook provides a step-by-step guide to using evidence-based framing strategies to communicate about adolescent substance use. The playbook presents findings from extensive multi-method research to develop and test effective strategies for communicating about adolescent substance use. Explanations of each framing strategy, models that illustrate how to apply them, and other helpful user notes are included throughout the playbook. The playbook is divided into three sections: strategies that move communication forward, strategies that require caution, and strategies to avoid.

Legal Action Center. (2016). *Tool #1 fact sheet - Do federal alcohol & drug confidentiality rules apply to your SBIRT services?* https://lac.org/wp-content/uploads/2016/11/SBIRT_Tool1_FactSheet.pdf. This tool is the first in the series of fact sheets about how the federal confidentiality regulations around substance use disorder records, known as "42 CFR Part 2" (Part 2), relate to SBIRT services for youth. This first tool is intended to help SBIRT providers determine

whether or not they need to follow Part 2 regulations. Even if a provider does not operate within a Part 2 program, authors of the fact sheet advise that they still be aware of the policy in the event that they communicate with Part 2 programs. The toolkit is available here: https://lac.org/confidentiality-sbirt/.

Legal Action Center. (2016). *Tool #1 decision tree – Do federal alcohol & drug confidentiality rules apply to your SBIRT services?* https://lac.org/wp-content/uploads/2016/11/SBIRT_Tool1_DecisionTree-1.pdf. This tool is part of the Legal Action Center's series on confidentiality regulations as they relate to SBIRT services for youth. Building upon "Tool # 1 – Fact Sheet", this tool includes a decision tree to help SBIRT providers determine whether their SBIRT services are subject to federal confidentiality rules for substance use disorder records, known as Part 2. Part 2 confidentiality rules apply to SBIRT service providers in federally assisted program settings. The toolkit is available here: https://lac.org/confidentiality-sbirt/.

Legal Action Center. (2016). *Tool #2 SBIRT and the federal alcohol & drug confidentiality rules: The basic requirements.* https://lac.org/wp-content/uploads/2017/03/SBIRT_Tool2.pdf. Building upon Tool # 1 – Fact Sheet and Tool # 1 – Decision Tree, this tool provides SBIRT providers with an overview of the basic requirements of Part 2. The tool is for providers who have determined that they are covered by Part 2 (see Tool # 1 – Decision Tree) as well as those who are not covered, but communicate with programs which are. Part 2 protects patient information privacy in all written and oral communications, prohibiting disclosure even to persons who already have the information, have official status, or have a subpoena or warrant. SBIRT programs may disclose patient information under 10 main Part 2 exemptions: proper written consent from the patient, internal program communications, Qualified Service Organization Agreements, medical emergencies, audits/evaluations, court-ordered disclosures, research, reports of child abuse/neglect, disclosures that do not contain patient-identifying information, or crimes committed by a patient on program premises or against program personnel. The toolkit is available here: https://lac.org/confidentiality-sbirt/.

Legal Action Center. (2016). *Tool #3 SBIRT and the federal alcohol & drug confidentiality rules – Common scenarios.* https://lac.org/wp-content/uploads/2017/06/SIBRT-Tool-3.pdf. A third tool in the Legal Action Center's series on confidentiality regulations as they relate to SBIRT services for youth, this tool outlines how Part 2 applies to common scenarios involving SBIRT. The tool provides guidance around security of records, disclosures to parents and guardians, consent form strategies, and disclosure to third-party payers. Part 2 is also discussed in the context of particular settings, such as SBIRT in schools, juvenile justice settings, or primary care and integrated health settings. The toolkit is available here: https://lac.org/confidentiality-sbirt/.

Mosaic Group. (2016). *Adolescent SBIRT implementation checklist.* http://www.groupmosaic.com/resources/2016/10/26/adolescent-sbirt-implementation-checklist. The Adolescent SBIRT checklist was designed to provide organizations with a detailed but flexible step-by-step guide for integrating SBIRT into routine health care. The checklist features 10 key steps: (1) gain commitment from senior leadership, (2) build a strong multidisciplinary implementation team, (3) conduct organization workflow analysis, (4) develop a personalized SBIRT protocol, (5) modify the organization's electronic health record, (6) find effective ways to bill and code for SBIRT services, (7) train relevant staff, (8) establish a smooth referral to treatment process, (9) track data to ensure ongoing program improvements, and (10) build toward a sustainable SBIRT practice. The checklist is meant to support a 12-month implementation process, with the first three months principally devoted to planning. Authors of the checklist hope that it can be adapted for various settings, and provide recommendations for using it in school-based health centers, behavioral health providers, primary care settings, and community-based health organizations.

National Council for Behavioral Health. (2019). *Improving adolescent health: Facilitating change for excellence in SBIRT.* https://www.ysbirt.org/. This 'change package' strives to be specific enough for clinicians to implement program changes and measure their progress while being generalizable enough to be scaled to use in multiple settings. The change package includes broad goals ('change concepts') and specific plans to measure success ('outcome measures') for each stage of SBIRT implementation. The ultimate goal is universal screening of youth with every health maintenance visit (and at other visits as applicable). Outcome measures place an emphasis on engaging young patients and granting them age-appropriate power over the terms of their care. This includes negotiating a behavior change plan together, agreeing on the need for and acceptable level of intervention, and asking the patient for permission to include their parents or caregivers. Implementation considerations for health practices include identifying organizational capacity for SBIRT implementation, developing a sustainable financing strategy based on relevant reimbursement systems, and designing a data collection process that can enhance service delivery. The change package also addresses the special patient-facing considerations of co-occurring medical and mental conditions, poly-substance use, and the need for cultural competence.

New Hampshire Charitable Foundation. (2017). *New Hampshire Youth SBIRT Initiative Playbook*. https://sbirtnh.org/playbook/. This playbook is a compendium of actions and/or strategies identified through the New Hampshire Youth SBIRT Initiative implementation and related work that will not only give providers a shared understanding of SBIRT, but will also help organizations to more effectively implement SBIRT in their clinical setting. The playbook is organized in sections, each of which include a "purpose of the play," pertinent definitions, team members involved, and measures of success.

NORC at the University of Chicago. (2016). *Adolescent SBIRT curriculum*. https://sbirt.webs.com/curriculum. This curriculum offers skills-based education on adolescent SBIRT. It includes an Instructor's Toolkit as well as a Web-based *SBI with Adolescents* simulation program. The Instructor's Toolkit and simulation program prepare educators to screen adolescents for alcohol and drug use using validated tools; deliver effective brief interventions using motivational interviewing; link adolescents to treatment services; and provide follow-up. The Instructor's Toolkit includes the *Learner's*

APPENDIX: Pediatric Primary Care SBIRT Implementation Resources

Guide to Adolescent SBIRT as well as sample interactions between practitioners and adolescents, suggested readings, sample course syllabus, and evaluation tools, among other supplemental resources. The simulation program teaches the basics of screening, brief intervention, and motivational interviewing and provides various scenarios to implement new skills.

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