Best in Show: Screening, Brief Intervention, and Referral to Treatment (SBIRT) Tips and Tricks Transcript

October 8, 2025

Webinar support: Welcome to the Behavioral Health Substance Use Disorder Integration Technical Assistance webinar, Best in Show, Expert Tips and Tricks. This webinar is supported by the Bureau of Primary Health Care of the Health Resources and Services Administration. Participants have entered in a listen-only mode. Submit questions by using the question and answer feature. To open the Q&A, click the Q&A icon at the bottom of your Zoom window.

If you experience any technical issues during the event, please message us through the chat feature or email bphc-ta@bizzellus.com. This event is being recorded. The slides, recording, and transcript will be available on the TA portal following this webinar. We offer Behavioral Health Continuing Education units for participation in BH/SUD Integration Technical Assistance events. You must attend the event and complete the Online Health Center TA Satisfaction Assessment Form after the event.

A link with instructions will be provided at the end of the session. CE certificates will be sent within five weeks of the event from the Health Center BH/SUD TA team via Smartsheet. We're excited to share that we have more Continuing Education opportunities coming up for you. Please register for the new fall events. We'll add the links to these events in the chat so you can take a closer look. I am pleased to introduce you to today's presenter.

Kevin Hylton is a medical sociologist with more than 25 years of experience managing and directing federal and private sector contracts in public health, education, and human services. He has served as a Technical Subject Matter Expert Lead for the Substance Abuse and Mental Health Services Administration, SAMHSA, SBIRT Program Implementation in Clinical Settings, and facilitated the training for medical residents and other healthcare professionals to administer the SBIRT model. Dr. Hylton holds a PhD in Sociology from Howard University and an MS in Higher Education Administration from SUNY College at Buffalo. It is now my pleasure to turn the webinar over to Kevin. Kevin, please go ahead.

Kevin Hylton: Thanks so much, Bailey. All right. Welcome, everyone. It's such a pleasure being here to discuss SBIRT (Screening, Brief Intervention, and Referral to Treatment) with you today. SBIRT is one of those interventions that I've been so incredibly proud of seeing how it has been implemented in such a wide array of settings throughout the United States and in other parts of the world. Let's get started with what we will aim to accomplish today. First and foremost, we're going to discuss the role of SBIRT in the delivery of behavioral health and substance use disorder integration in primary care.

We're going to do some evaluation of evidence-based screening and assessment tools for SBIRT use, not heavily. We're going to identify some key skills for brief interventions, for example,

motivational interviewing for training planning. We're going to outline staff and workflow considerations to ensure SBIRT fidelity and effectiveness. We're going to review some approaches to building accessible treatment referral networks. Next slide, please.

All right. Let's start by first defining SBIRT in practical terms. All right. SBIRT is a comprehensive, integrated public health approach combining universal screening, brief motivational conversations, and referral to treatment services for behavioral health risk. SBIRT is designed for early identification and timely linkage, not only for diagnosis, but for a specific set of steps related to managing behavioral health risk or treatment and or treatment. SBIRT supports patient-directed engagement, so core decisions are aligned with patients' values and with the patient's goals.

Next slide, please. One may start out by asking, in what ways does SBIRT aligns with integrative care models? First, it supports team-based workflow across medical and behavioral staff. Second, universal screening helps normalize behavioral health checks and reduce stigma, so one of the ways in which we do this. A key part of what we were hoping to do in integrating this in other settings was, can it be done where screening is treated the same way you would for high blood pressure or for a normal blood test? As you go in, a physician is likely to ask you a set of questions that reduces the likelihood a patient is likely to feel some sense of stigma admitting to any kind of substance use.

Then third, the key thing here in terms of how it aligns is that it centers around patient-directed conversation, which means care plans is reflected on what matters to the patient. We'll explore that as we go through that. The intent here it should feel for the patient like it's more about them and less about them being told what to do and so forth. Next slide, please. One of the key things to keep in mind before we transition is that when SBIRT is embedded in workflow, it strengthens coordination as well as continuity of care.

Now, there are three phases that SBIRT is built on, but they're interconnected phases that work together as a comprehensive approach to addressing substance use and healthcare settings. These three phases, we can break them up into phases. Phase one, screening. The first phase is screening. This is the assessment step where a practitioner identifies potential issues. As part of screening, we typically use a validated screening tool to determine the severity and risk levels of a patient's substance use behavior. Keep in mind that this isn't about judgment, however. Rather, it's about gathering objective data to guide what the next steps should be.

Quick, efficient screening can be integrated into routine care, often taking just a few minutes. There are different types of screening tools, and we'll get into that in terms of making it relatively efficient. Phase two, brief intervention. For those who screen positive, the goal here is to move to brief intervention. This uses motivational interviewing techniques. We're meeting the patients where they are. Again, in the spirit of this is about the patient. Therefore, when you're doing the intervention, the intent is to not have it feel in any way as if it's judgmental.

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

The intervention is tailored based on the screening results. The key thing to note here, it's not a one-size-fit-all. It's going to vary based on a whole host of factors. This is generally a collaborative conversation between the patient and the practitioner that helps them to recognize risk and builds the motivation that is needed for change. Phase three, referral to treatment. When specialized care is needed, the intent here is to connect the patient to appropriate treatment resources. This ensures continuity of care and gets patients the level of support that they truly need based on, again, the level of risk that they have.

Having established referral pathways is a critical part for this phase in order for it to work effectively. In most instances, what we generally convey to folks who are doing this is to really spend some time creating a list of, for example, treatment providers that would facilitate referral in a more efficient manner. Keep in mind that each phase build on the previous one, creating a seamless pathway for identification to intervention to treatment when needed. All right. Next slide, please.

I'd like to spend some time doing a polling question just to do a pulse check of sorts. My question to you is, what challenges are you and your team facing right now in terms of SBIRT? Which of the following might provide it? I won't read them all, but you could click on the one that resonates most with you, and we'll take a look at what the results are.

[pause 00:09:09]

Kevin Hylton: All right. Maybe 10 more seconds. All right. We can end the poll. It looks like the more common responses center around designating responsibilities within the clinical workflow, followed by maintaining accessible behavioral health substance use referral networks for patients. Then it seems like the other three are closely tied at like 11%, 10%, but the first one designating is about 36% of you indicated that would be the challenge, or that is a challenge, and then followed by referral. These are all reasonable challenges. I think we're going to speak to some of how this will play out as we go through. If I don't provide enough there, you can feel free to ask questions in the chat and so forth.

All right. Next slide, please. All right. SBIRT is a framework based on motivational interviewing strategies. Motivational interviewing is central to SBIRT. It is collaborative. It honors patient's autonomy and explores ambivalence about change. In many instances, when a patient is screened, it is that tricky balancing act between recognizing that, again, this is patient-directed, so there is a need for some autonomy around this. In many instances, the patient may have some ambivalence about how to proceed, and this is where motivational interviewing becomes really, really key and central.

The techniques include open questions, reflective listening, affirmation, and summarizing, and really zoning in on the fact that it's more about question rather than directing. How does this make you feel in terms of the score? Can you share what might be occurring? It has more of

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

that feel. Then, as the patient speaks, the intent here is to reflect back what you hear them saying. If it isn't captured correctly, it provides an opportunity for the patient to provide more confirmation around what it is that they shared with the practitioner. Motivational interviewing also helps elicit change talk and supports patient-directed decision-making.

Again, as part of this core, you might ask some questions around what are some of the barriers, what are some things that might facilitate, and so forth. It's usually done in a way, or should be done in a way where the patient has a certain level of comfort, recognizing that it's really about their autonomy or their decision to make the changes. Motivational interview shifts conversation from telling to partnering, which is going to be an essential part of a brief intervention.

All right. Next slide, please. All right. We are presenting a flow chart here that allows you to just at the 30-foot view level to get a sense as to how screening and the response pathway. We typically start with the universal screening, and by universal screening, in a setting, the question is, is everyone screened in that setting? It doesn't have the feeling as if one person is being singled out. Again, it's part of the routine care, just the same way you would for blood pressure or any other initial screening that a healthcare setting is likely to engage in.

The positive screens usually prompt a secondary. If it's positive, you'll do it a second time to just ensure that the risk that was identified is on point. A positive screen prompts a secondary screen, more detailed assessment to stratify risk. Risk-stratified results then guide the reinforcement, brief intervention, or referral. If it's negative, no risk, you affirm the current health behavior, see you're doing a remarkable job here, keep doing what you're doing, and then there's no need for any further screening. Now, based on the secondary full screening, you could be in three different categories.

A patient could be in three different categories. First, it might be low to mild risk or moderate risk, or severe high risk. You'll see here, based on low mild risk, that might lead to brief intervention. We described a little bit what that entails. If it's moderate risk, it might be brief intervention coupled with brief treatment and or referral. Then if it's severe high risk, then it's brief treatment with referral to treatment and or referral to treatment.

All right. Next slide, please. What is really screening and why does it matter? Screening determines severity and risk levels of the patient's behavior or use. It informs which steps will be most effective and safe. Screening should be objective, brief, and integrated into clinical flow, keeping in mind that you're going to be doing this with a set of screening tools, which I'll discuss with you in a few minutes. Effective screening generally leads to targeted patient-directed intervention.

Next slide, please. Now, there are some, as I shared, some common universal and secondary screening tools. We've broken these up into two buckets, if you would, one related to mental

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

health, and the other related to substance use disorders. If we start with the mental health screening tools, the first one is the Patient Health Questionnaire (PHQ). There are two versions of these, the PHQ-2 and a PHQ-9. A lot of that's going to have to do with the brevity of either of those instruments. The second would be the Generalized Anxiety Disorder-7, or GAD. Then the third would be the Patient-Reported Outcome Measurement Information System, which is PROMIS.

In terms of the substance use disorder tools, the first on the list here is NIDA Quick Screen. This is the National Institute of Drug Abuse Quick Screen. You can readily access that at their site. We'll provide some of these resources at the end. Then, the Drug Abuse Screening Tool, DAS-10. Generally, you use this one for other substances beside alcohol. Then you'll have TAPS, the tobacco, alcohol prescription medication, and other substance use. The BSTAD, the brief screener for alcohol, tobacco, and other drugs. Then lastly, and perhaps maybe the more popular of the bunch in this group, is the AUDIT-C, the Alcohol Use Disorder Identification Test.

There are two, I think, versions of these. There's a lengthier version and a shorter version. This one is perhaps used more frequently, largely with an emphasis on alcohol. For most people who may show up in a clinical setting, you may hear your physician asking you, as an example, "How many drinks do you normally have? In one setting, how many?" I think this one is perhaps more common in some of the clinical setting. Any of these can be used based on who you're patients are and what specific risk you're looking to assess.

Next slide, please. All right. Another polling question for you. What validated behavioral health or substance use disorder screening and assessment tool does your health center use, and what do you like about them? You could place your answers in the chat if you're comfortable doing so. What screening tools do you use, and is there something that you like about the ones that you use, or why do you use those? I'll wait a minute or so to see if I have another response.

Webinar support: Please enter your questions to the poll through the Q&A chat that is on your screen. You can open that by clicking the Q&A icon at the bottom.

[pause 00:18:33]

Kevin Hylton: All right. Is it reasonable to assume that maybe this is a scenario where no one is using a screening tool as yet? If that's indeed the case, are there just challenges with determining which ones might be most appropriate for your setting or your patients?

[pause 00:19:03]

Kevin Hylton: All right. Some responses. TAPS, I like how it's organized. DAS. We use the AUDIT-3, GAD, and the PHQ-2 and 9. DAST is coming up again here. PHQ again. CRAFT, one that was not listed. All right. That's another one that's often used as well. DAS-10 and AUDIT-C. PHQ-2, 9.

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

GAD-7. I'm seeing RODS here. Not as familiar with RODS. Someone is saying not as yet. PHQ-9, PHQ-2 coming up again, GAT-7, AUDIT. All right. We're seeing some of a theme here in terms of the ones that everyone's using. All right. This is really, really nice to see that some of you are actually using these already, and they're in alignment with some of the ones that are coming up.

All right. Ashley's saying, "I can't see any of these answers." I apologize. It's okay. If you click on the Q&A at the bottom, I think you should be able to see the responses there. All right. Thanks for the clarity, Kevin. Rapid Opioid Dependence Scale. All right. That's helpful for anyone who's screening specifically for opioid dependence. All right. Keep them coming, and I'll click back over ever so often to see if any additional ones come up. All right, next slide, please.

All right. How do we go about defining risk? How do we translate these screening scores into risk tiers is another way to view these. Let's start with no/low risk, so minimal or no use with no consequence. This might be where someone is screening, and the response is typically, "I don't drink. I've never used any drugs or any other substances." Then you may have moderate at-risk use. This is regular use that exceeds low-risk guidelines but has not caused major problem "yet" or doesn't have any limited consequences. Third level of risk is high risk, and this is where you'll have harmful use.

There's clear evidence of alcohol/substance-related harm or consequences. These may include physical, social, legal, or any other psychological problems. Then lastly, we may have severe risk dependence. These are signs of tolerance, usually withdrawal, loss of control. There's significant impairment in daily functioning. Keeping in mind that each of the screening tool will allow you to determine what the level of risk are. Most, if not all of them, will have some protocol around how to calculate the scores and ultimately calculate what that translates in terms of these risk tiers that I'm discussing here. The risk categories will guide the appropriate next steps.

Next slide, please. Sorry. All right. When we look at screening results that will inform the next steps, presenting here this triangle that gives a pyramid of levels of risk and how you might approach this. If we start with briefing of whether or not it's severe risk dependence, we'll more than likely go into brief intervention, brief treatment, and referral to treatment. That just has a lot to do with the level of all the things that might be at play.

If there's high risk, harmful use, it tends to be more intensive brief intervention and brief treatment. If it's moderate, at-risk use, then typically it's brief intervention. Then lastly, if there's no risk, again, it's just positive reinforcement, general health education about some of the strengths or some of the good things about just keeping the risk level where it is.

All right. Next slide, please. All right. None of this is occurring in a vacuum. There are some factors that we typically suggest that anyone who's doing SBIRT should keep in mind. The first is that medical conditions, medication interaction, co-occurring behavioral conditions may be

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

playing a role in everything that you're seeing. In some instances, once you get into doing the BI, this is where you can ask certain questions of the patient. An example of this I can recall is we were looking at how this was implemented in a clinic setting centered around pain management.

A fair amount of the patients there were taking pain medication. When you did screen, the question was what's that tricky balance and act between their results, just if it was against their prescribed medication, and how best is that managed or navigated? Second, medication that interact with alcohol, drugs. A third factor is mental health comorbidities. Sometimes we will, in doing both screening and brief intervention, and a lot of things that have been written around this, how you deal with comorbidity, where there is indeed mental health, and there is alcohol or other drug use.

Again, you'll need to consider that and consider ways to best navigate some of the issues that might be associated with that in terms of the screening risk. Then last, on the side, pregnancy, age. For example, adolescents versus older adults. I think I'd be remiss if I didn't include some information on college students as an example here and how that sometime plays out. Then there's occupational hazards. For example, driving, operating machinery. Then lastly, family history. Are we dealing with folks who are in households where there are other family members that are likely to have substance use disorders or other kinds of alcohol use, in addition to whether or not there are any genetic disposition that might be at play?

All right. Next slide, please. All right. Other considerations. Beyond screening scores, there are some non-clinical influences that might affect follow-through. Some key points to keep in mind here is going to be centered around the patient's readiness to change in previous experiences with care. In some instances, some patients might not have experiences with care. I know that seems a little strange, but you'd be surprised once some of the things that we observed when these things were implemented.

There's this issue of trust that comes up sometimes, in terms of I'm interacting with a physician and they're asking these questions, and I'm not sure what to make of this in terms of trust and whether or not I'm even ready to do anything. Two, social support systems and non-medical factors like housing and transportation, or financial stress. There's a person in a position to, if you were to refer them to a service, might you need to consider do they have access to transportation to make it to those services? Do they have the resources to access the transportation and so forth?

All right. Then previous treatment history, and then severity of consequences experienced as a result of the substance use. Again, might be in a family context. It might be as it relates to work or other social settings. Then again, as I alluded to it, just keeping in mind co-occurring disorder. Key thing is, consider how patient's environment and values also might shape next steps. You

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

won't really know that. You'll determine that based on the brief intervention and your engagement with that patient in terms of the questions that you're likely to ask.

That might give you some sense as to the environment that they're living in, working in, as well as their own values around this, and then how best to engage them in a way that leads to some motivation in terms of them taking some autonomy related to their care. Being mindful of these factors certainly will improve engagement and will improve the outcomes. Next slide, please.

All right. Brief intervention. I've kept on mentioning BI or brief intervention. What is brief intervention? What does it look like in practice? It's a structured, usually 5 to 15-minute counseling conversation using motivational techniques to help patients reduce risky substance use and prevent progression to more serious problems. When I was learning this for the first time before going out, as a test case, one of the things that made this a lot easier is that I had a teenager at the time, and the person who was training suggested, "Try this out on your teenager who's likely to have some resistance to whatever change you're trying to get them to make."

It was really, really instrumental, but was able to see how it played out when interacting with physicians and other providers. Key point here in terms of brief intervention, it's generally no more than 15 minutes, structured conversation. It's focused on the patient's own reason for change. It's collaborative, it's respectful, and centered on practical next steps. It can be delivered by various team members who are trained on how to do it. The key takeaway here that I would add is that it doesn't necessarily mean that in one brief intervention session that the patient is likely to feel motivated to change.

It may need to occur over several sessions before you get to that point. In each of those sessions, it should still continue to feel collaborative, respectful, and centered on the patient's autonomy and willingness to do what they believe is the appropriate thing to do for themselves. Short conversations can motivate lasting changes what we discover in how this is implemented. Again, no need to do it in one setting. It may take several settings.

All right. Next slide, please. This leads to the question of what's the difference between brief intervention and brief treatment? Let's talk about the structure and effectiveness of both of these. The goal for brief intervention is to increase the patient's motivation to reduce their risky behavior. Again, as I had alluded to, the duration here, it might take more than 1 session, maybe 1 to 5 to 60 minutes. We typically are on the side of 15 minutes. It's sometimes generally rare that you'll get this far out in terms of the 60 minutes, but at a minimum, 5 minutes. The sweet spot is somewhere between 15 and 20 minutes.

The staff usually can be primary care providers, nurses, behavioral health staff, including social workers, counselors, and, again, depending on the setting. In terms of brief treatment, the goal

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

here is to change behavior and provide support to maintain a change in behavior to support long-term adoption of healthier behavior or behaviors. The duration here is generally more sessions, just larger because again, you're dealing with treatment. At a minimum, it might be five sessions and upwards of 12. The duration here is usually closer to those 5 to 60 minutes, again, because it's more involved.

The staff here is usually a behavioral health consultant, less likely to be done by a provider or physician, or a nurse, or a nurse practitioner, or anyone in that role. Keep in mind here that the follow-up is going to reinforce the patient's progress. In some instances, you do one session, it might require contacting or sending out an alert, however, your system is set up, to the patient around reminding them of an appointment or following up with them around any challenges that they may be having. That usually will give the patient a sense of developing a rapport of sorts with the practitioner.

All right. Next slide, please. All right. In terms of brief intervention, to get into the finer details of this, a key thing here, it's going to center around three core things. First, engagement. This is where a practitioner builds rapport and review progress between the sessions. Second, it's going to be the intervention, which will provide a rationale, deliver feedback, reflect, and help generalize learning.

The key thing that's occurring here is, on the engagement side, it's really that rapport building is going to be really super important. Keeping in mind that patients are often, or a person is often, sometime, will have some discomfort around how much they share with someone that they may deem or view that they don't know as well. The rapport-building or the engagement part of it is going to be critical. Then, for the intervention side, this is where you get into the meat of it, if you would. In terms of the transfer of learning, this is where you would summarize and plan for next steps and confirm commitment.

In those brief intervention session, you're likely to be summarizing what you heard, what was agreed upon, and then you may negotiate between "How's this as a plan in terms of what we'll do?" The patient might say, "I'm not sure that I'm ready for that," or "Could we do it this way instead?" That kind of thing. Then you typically get to end with negotiating whatever it is that the patient has committed to.

All right. Next slide, please. All right. Now there are some key training considerations. Some of this comes out of-- Again, one of the beauty when SAMHSA was implementing their SBIRT across a variety of different setting, it was really fascinating to see how all of the practitioners were trained, because that was such a key part, from the physicians all the way down to behavioral health staff and everyone in between. One of the things that we typically emphasize is that to train all care team members, and if at all possible, use role play and scripting to build brief, efficient delivery.

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

One of the ways in which this was done in medical schools when it was being implemented as part of the SAMHSA's initiative was with standardized patient practice with the physicians, getting to do role play and learning how to, one, screen, then, two, how to do some brief intervention. I think the same held true for some of the other practitioners. Three, offer interactive workshops and real-time coaching. It takes a little bit of time. It's just not a lot for people to build the skills that are needed. The more you can do that-- In some settings, they would make it real formal, in terms of where everyone would be required to do it.

In other settings, it took other forms. I'll just leave it at that high level. Then, if you can, incorporate ongoing skill assessment and refresher training. Perhaps it's on a quarterly basis. There's some assessment to see whether or not people are doing it the way that they were trained to do it. If there's a need for a refresher training, those sort of assessment may serve as a way to say, "Here's what we need to do some refresher training on." Then, fourth, leverage telehealth and e-learning modules for flexibility. There are some settings that will do this, where they make it a requirement for these quarterly training, but the training is set up in a way where it could be done asynchronously.

That is to say, a person gets an alert that might trigger them to do this training before they can do anything else. They sit through it as a refresher again, and they get to do this remotely and from wherever. Key thing here is that ongoing skill development will ensure that there is some maintenance of fidelity to the SBIRT steps and the specific practices within SBIRT.

Next slide, please. All right. Referral to treatment. This is the RT side of SBIRT. As you might imagine, there are some operational aspects of referral. As we noted from the first poll, this was one of two of the areas in which people responded in terms of just having some challenges or concerns around that. Referral to treatment is the process of connecting patients with moderate to severe substance use disorders to appropriate specialized treatment services, including assessments, active linkage or linkages, and follow-up to ensure successful engagement in care.

What we typically suggest is that when you're doing the referral, you should only refer when patients are ready. Again, it's about the patient directing their care. It's about their autonomy. It's not the type of thing where you can say to the person, "You need to go to care." That's not the way SBIRT works. This is usually for patients with moderate to severe substance use disorder. We strongly emphasize, including warm handoffs and active facilitation.

What does that mean? Rather than just doing a referral and you say to the patient, you're going to go to this treatment center across this area of town, and so forth, usually there's a phone call and there's a connection where the practitioner engages the practitioner who's going to be engaging in the treatment. It might even be a three-way call between the patient, the practitioner, and the treatment provider in a way where it feels warm, it feels caring. It does take some little time, but it's been found to be more effective when there is a warm handoff

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

and you can do follow-up as part of that warm handoff. The referral to treatment may range from outpatient counseling to residential treatment. Again, a lot of this is going to have to do with the severity of care that's needed or treatment that's needed. It will need to include some follow-up to confirm engagement. Again, that's part of that warm handoff. Even so, with the follow-up, I think in some instances, what we have learned is the patient view that was likely to view that sometimes as their practitioner caring about them.

Then lastly, it's coordinated with primary care for ongoing support. The one takeaway here is that just keep in mind that active facilitation will improve access and success in terms of whether or not the patient not only goes to treatment but actually stays the duration of that treatment.

Next slide, please. All right. Some additional information on referral to treatment. It connects the patient to more extensive and supportive services. It follows coordinated decision-making across different providers, for example, medical and behavioral health and services, and only done after screening and brief intervention. You cannot do it and should not do it before you have had a chance to screen to determine risk and engage the patients as part of a brief intervention. The goal here is to determine an appropriate substance use disorder and behavioral health or other specialty treatment program. Then a second goal here would be to facilitate engagement of the patients in SUD or BH treatment services.

All right. Next slide, please. All right. Polling question for you. How does your health center develop BH and SUD-referral networks? Since this was one of the theme that came up, I'm really curious to hear what-- This might help us to get into some of the challenges. A set of core questions, response options here. If you can just respond, that'd be great.

[pause 00:42:13]

Kevin Hylton: All right. 10 more seconds.

[pause 00:42:53]

Kevin Hylton: All right. It looks like we have a close tie in terms of what you all are indicating that you do. One is employing patient navigators, wow, and or social workers who focus on this daily. All right. I probably should have specifically made reference to the navigators. Those work quite well, especially in terms of warm handoffs. Then the second popular response was building community partnerships with complementary organizations. All right. Then the others pursuing state and federal grants to train on clinicians and creating inter-community networks came in, maybe I'd say third, and then other, and they shared their response.

It looks like for the responses here, you all are hitting some of this spot on, if you're using navigators or social workers, because those work wonders in terms of referral. One of the key

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

thing for anyone who might not be as familiar with the navigators, this is where you might actually have a person who's employed by an agency. In some instances, they may literally walk or go with the person to the treatment setting, or they're largely responsible for really making sure that that warm handoff goes as one efficiently and as warmly as possible. All right. Very good.

Next slide, please. All right. There are some best practices in referral to treatment. Keep in mind that best practice strengthen the referral outcomes. That's really one of the core things in terms of what we're trying to really accomplish here. There's six key things here. One, try to develop and maintain a community resource, guided providers, recovery meetings, wellness classes, and so forth. In some settings, where people have done this, this can be done by database, this can be done by manual. There are any number of ways that you can do this.

All right. Then, as part of the training, just making sure that everyone is aware that this resource is available, so in the event there's a need to do referral, while the practitioner is interacting with the patient, it doesn't give the appearance as if they weren't ready to do the referral or anything like that. Try to conduct referral to treatment only if the patient is ready and motivated for the referred treatment services. Again, this comes back to when you're doing the BI, why it might take a little bit longer, because the patient, in some instances, might not be ready to move to the next phase.

Conduct warm handoffs with the staff actively involved in following up on the handoff process. Then determine how you will interact and communicate with the provider. You could do that if you're using a navigator or if you're using someone else. Again, it helps when the patient is aware in terms of the strategies or the approaches that will be used to remain in contact with them as well as in contact with the provider who's engaging in treatment. Confirm your follow-up plans with the patient and then decide on the ongoing follow-up support strategies that will be utilized.

Next slide. All right. I wanted to at least say something about referral network expansion. Five key points here. Explore how you will use technology to support the referrals. Depending on what systems you use, most people who are using some form of navigator, they may have something that allows them to link with providers. If information is keyed in on the other side, someone might know an array of technology that you could use to do that. Two, formalize memorandum of understanding of other behavioral health substance use disorder providers.

Everyone is clear in terms of that, one, you will be referring patients to them, or two, you're open to receiving patients that are referred to them. Three, consider using community health workers or care navigators, which I had spoken to. Invest. The key thing with community health workers, it helps in a way where for a person who is receiving SBIRT and is likely to be referred to treatment. In some instances, if they're seeing and interacting with people who feel and look

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

like them or they feel like the person understands them, it builds the rapport. It's a much, much more effective way of building rapport.

Four, invest in staff support to develop and regularly maintain a listing of virtual and local partners. Then lastly, engage with community organizations and collations. Is it collations? All right. The key thing here is that the proactive partnership will sustain effective referral pathways. The more you can formalize it, utilizing these MOUs or MOAs, along with some technology, it really, really helps in terms of just ensuring that you can monitor and track the care that's being received. In many instances, again, it allows the patient to have the sense of receiving the highest level of care around their substance use disorder or their other behavioral health things that might have been screened for.

Next slide, please. In closing, I wanted to at least share some final thoughts in terms of SBIRT enhancing and integrated care systems. First, it's going to improve early detection. Two, it's going to support patient-directed care, which will lead to the destigmatization of care with universal screening. Three, it's going to enhance quality metrics and compliance. It's going to support uniform data system measures related to behavioral health screening and treatment.

Then lastly, it's going to maximize funding and sustainability. In many instances, the services are often reimbursable under Medicare and Medicaid, although there might be some variation by states. The key thing here, it maximizes your ability to bill, which then leads to sustaining SBIRT as part of your practice.

Next slide. All right. In closing, I wanted to at least have some helpful resources that might go for deeper learning. I think at some point we'll share the slides of these resources. I'll give you some time to explore the references to strengthen your practice or enhance your knowledge. I'd just like to say it was really, really a pleasure being here with you today. On a personal level, I just want to say how much I appreciate seeing so many folks here with a strong interest in SBIRT. Years later, it's just really, really, really nice to see that. Best wishes with integrating SBIRT into your practice.

Let me stop here and see if there are any additional questions that anyone might have related to what I've shared. All right. Let me see if I can work backwards because it might be easy for me to scroll upwards. First question, can you talk about billing and showing separate, distinct SBIRT services? I won't get into the details of billing because that, again, you're going to have some variability by states, and you're going to have some things that you'll need to consider around screening tools and when you get into BI as well. I think we'll be providing some resources around billing. Once you get that, you could look at that a little bit more closely.

Some of it is going to be centered around who's doing the screening. It's going to be centered around the jurisdiction where you're located. Then, if AUDIT and DAS-10 are screens, what further assessment is best? The additional assessment might be, do you want to do any

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com

comorbidities or co-disorders? AUDIT is alcohol, DAS is other drug, but there might be some mental health things that you should consider screening for that might be creating some of the risk that we're seeing here. Question on is AUDIT-C better than just AUDIT? One is a shorter version than the other.

It's a function of how efficiently you want to get through doing the screening. Again, if you go with the shorter one, you might need to go with the longer version of the AUDIT if you're using that. All right. There's a question about CCBHC.

Lisa Jacobs: Then that might have been a response to the poll.

Kevin Hylton: Ah, okay. All right. I think I might have attended to all the questions that are listed here. I'm going to hand this over to you, Bailey.

Webinar support: Thank you. We offer behavioral health continuing education units for participation in BH/SUD integration technical assistance events. You must attend the event and complete the Online Health Center TA satisfaction Assessment Form after the event. A link with instructions will be provided at the end of the session. CE certificates will be sent within five weeks of the event from the Health Center BH/SUD TA team via Smartsheet. The slides, recording, and transcript will be posted to the TA portal. References are included so you can delve more deeply into this topic.

Don't forget, we offer behavioral health continuing education units for participation. You must complete the Online Health Center TA Satisfaction Assessment to receive credit. We have added the link to the chat for your reference. Access more behavioral health substance use disorder integration technical assistance opportunities by emailing the team, visiting the TA portal, and scanning the QR code to subscribe to the Hub in Focus. We have other fall webinars coming up for your consideration. We'll add the links to these events in the chat so you can take a closer look. Thank you for your attendance. This concludes today's webinar. You may now disconnect.

Bizzell US
8201 Corporate Dr., Suite 920, New Carrollton, MD 20785
+1 301-459-0100 | info@bizzellus.com | BizzellUS.com