Cross-site Evaluation of SAMHSA's SBIRT Program: Preliminary Data from the 2008 Grantee Cohort

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SBIRT Introduction

- The United States Substance Abuse and Mental Health Services Administration (SAMHSA) Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - Addresses alcohol and/or other drug misuse
  - Screen using an evidenced-based screening tool such as the ASSIST
  - BI using a motivational approach to increasing insight facilitate behavior change
  - Adds Brief Treatment (BT) to the continuum of care
  - Includes referral to treatment (RT) for additional intensive services
- SAMHSA's commitment to SBIRT
  - 12 campus-based programs at colleges and universities; 17 medical residency cooperative agreements; 24 state/territory/tribal organization grantees across 5 cohorts
  - In just over a decade, administered ~US$225 million to support SBIRT services and evaluate grantees
  - Has funded a cross-site evaluation of SBIRT cohorts 1 and 3, programs in 11 states/tribal organizations

Session Overview

This session presents preliminary findings from the cross-site evaluation of the third cohort of grantees funded in 2008

- *Presentation 1* conceptually describes the SBIRT programs and workflow (Dr. Georgia Karuntzos)
- *Presentation 2* examines factors related to the successful implementation and delivery of SBIRT services (Dr. Manu Singh)
- *Presentation 3* presents estimates on the time practitioners took to deliver defined activities in delivering services (Dr. Alexander Cowell)
- *Presentation 4* combines data in presentation 3 and other sources to estimate the costs of delivering services(Dr. Carolina Barbosa)

Acknowledgments

- The presenters acknowledge the efforts and support from the United States Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) and the third cohort of SBIRT grantees who participated in the cross-site evaluation activities

  - Cohort 3 SBIRT Grantees
    - Georgia
    - Missouri
    - Tanana Chiefs Conference (Alaska)
    - West Virginia
  - SAMHSA/CSAT
    - Darren Fulmore, Project Officer
    - Reed Forman, Grant Project Officer
    - Erich Kleinschmidt, Grant Project Officer

SBIRT Models and Workflow

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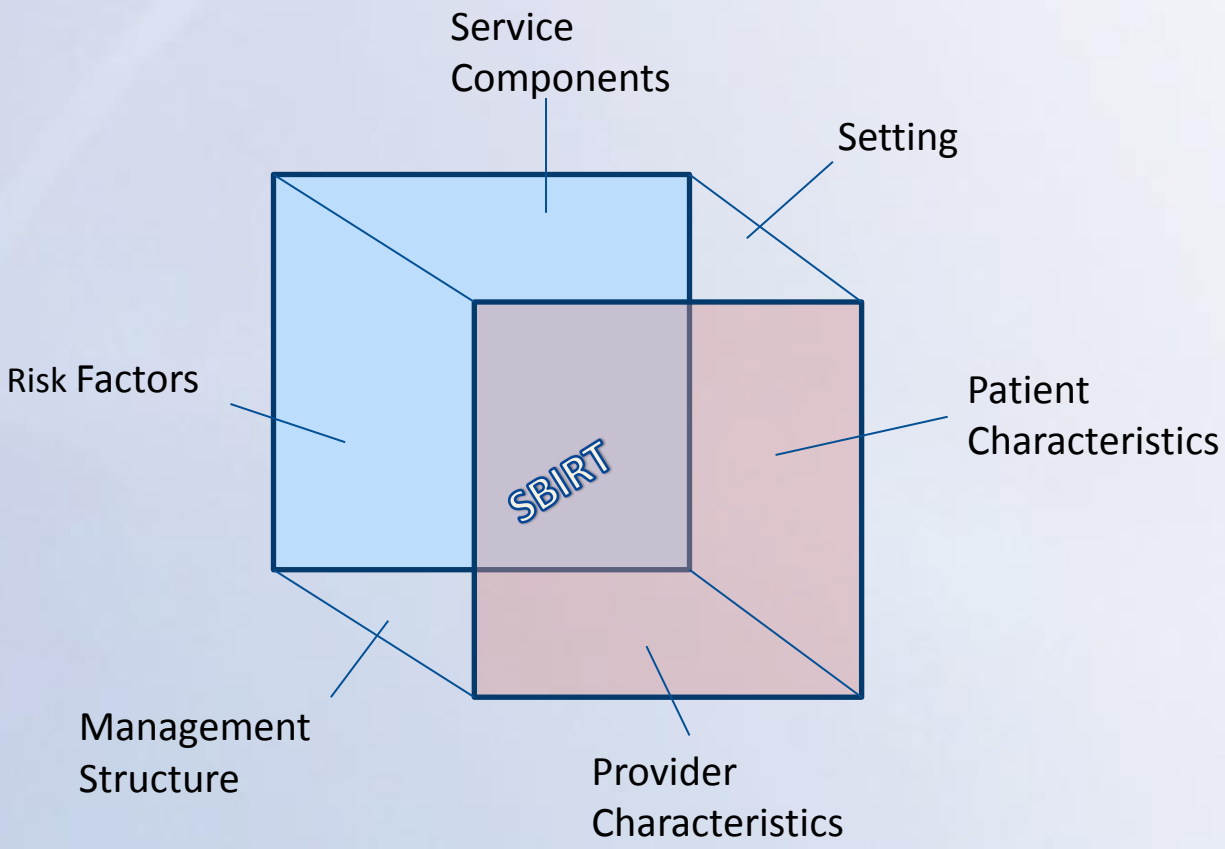
The SBIRT Cross-Site Evaluation

- In 2008 SAMHSA funded cooperative agreements with three States and one Tribal organization
  - Georgia
  - Missouri
  - Tanana Chiefs Conference (Alaska)
  - West Virginia
- RTI along with partners from University of Connecticut Health Center and JBS International funded to conduct a 5-year cross-site evaluation on:
  - Process Study -- implementation
  - Outcomes – individuals and grantee level
  - Economic -- costs and cost effectiveness
  - Systems impact – financing and systems of care, policies, regulations and public health impacts

Understanding the SBIRT Process

- ***What are the Theoretical or Logical Underpinnings of SBIRT? How do SBIRT programs vary in terms of:***
  - ***Service Models***
  - ***Risk Factors***
  - ***Performance Site Characteristics***
  - ***Patient Characteristics***
  - ***Management Structure***

SBIRT Model


Service Components
Setting
Risk Factors
Patient Characteristics
SBIRT
Management Structure
Provider Characteristics

Methods

Primary Data Sources

- Extensive program documentation (proposals; implementation plans; annual/quarterly reports, program service protocols, training manuals, etc.)
- Two multi-day site visits
  - 171 in-depth interviews with key stakeholders, program administrators, and front-line staff
  - 366 structured observations of SBIRT service delivery
- GPRA database with information regarding all screened SBIRT participants
- Practitioner Survey

SBIRT Services

Commonalities:

- All programs deliver (required) S, BI, BT, RT services.
- All programs also Pre-Screen (PS) participants
- All programs use similar evidence-based protocols (e.g., ASSIST screening, MI approaches in BI, BT).

Variations:

- Variability within, as well as between, programs.
- PS item sets/procedures; MH screening tools/follow-up services
- Service delivery mode (in-person, telephonic, computer-assisted)
- Number/duration of BI (1 to 6) and BT (6 to 20) sessions
- Different proportions of S+ patients receive BT vs. RT recommendations, depending on SBIRT resources and local treatment networks.

Risk Factors

Commonalities:

- All programs screen for alcohol and drug misuse
- All programs provide some screening for MH problems and tobacco use

Variations:

- MH S instruments and intervention/treatment options vary; some programs provide or refer participants to tobacco cessation programs, and some screen for additional risk factors (e.g., domestic violence).

Performance Sites

- **N = 200 across programs:**
  - 15 ED/trauma; 138 ambulatory; 3 hospital inpatient; 44 other, including community venues
  - Not all sites have operated continuously; many have served few SBIRT participants
- **Commonalities**:
  - All programs have multiple performances sites and most have some variation in setting types
  - All programs include ambulatory clinics.
- **Variations**:
  - 2 programs have large numbers (90, 94) of widely distributed sites
  - 2 programs have relatively small numbers of sites (6, 10), with target populations concentrated in specific geographic areas.

Provider Characteristics

Commonalities*:*

- Programs **tend** to use generalists (e.g., nurses) and ancillary staff for PS
- Behavioral health specialists **tend** to deliver clinically-focused SBIRT services (BI, BT).

Variations

- Background, education, and credentials among SBIRT providers vary within, and between, programs.

Patient Characteristics

Commonalities:

- All programs have screened large numbers of individuals
- All programs serve more women than men (50.6% to 62.6%)
- Patterns of alcohol/drug use:
  - Alcohol is the most prevalent (82.7% to 96.4%)
  - Marijuana is second (13.9% to 58.5%).

Patient Characteristics

Variations:

- Wide variation in screen volume, from just under 10,000 to almost 200,000
- S+ rates vary considerably, from 7.5% to 28.1%.
- Two programs primarily serve whites (74.1%, 92.1%); one Alaska natives (91.7%), and one African Americans (64.5%)
- Apart from alcohol and marijuana, pattern of substance use varies (e.g., cocaine/crack is used by 18.9% in one program, but virtually not at all in another, where Oxycontin ranks 3rd at 8.4%)

Management Structure/Activities

Commonalities:

- All programs SAMHSA-supported for 5 years; subject to same grant requirements:
  - Time-limited start-up phase
  - GPRA questionnaire administration/data entry
  - 6-mo. patient follow-up evaluations
  - Local program evaluation component and participation in cross-site evaluation.

Variations:

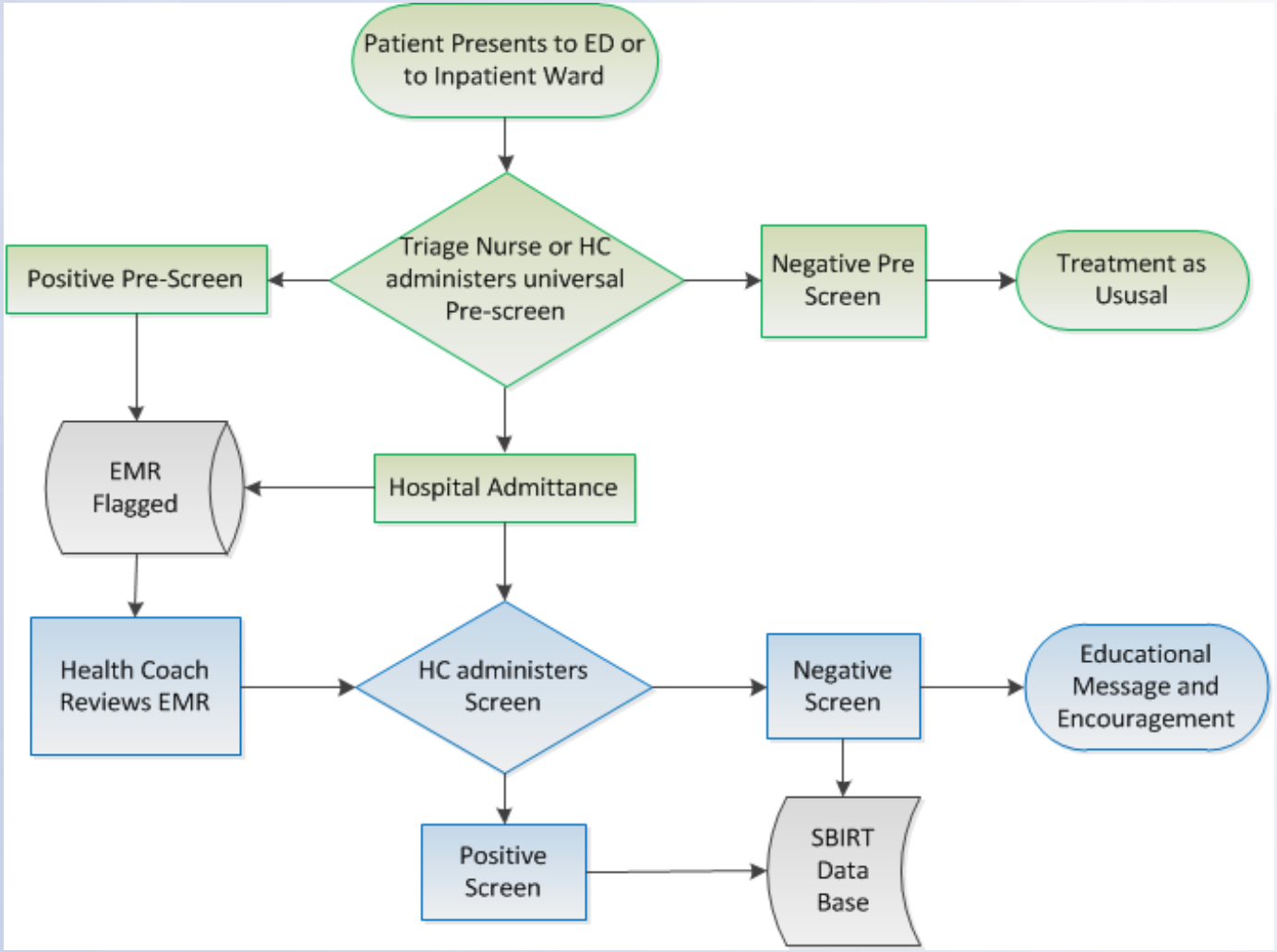
- Differences in supplemental funding sources
- BH specialists primarily “in-house,” but some are employed contractually
- Variations in QA practices:
  - Degree of protocol manualization
  - Level of staff training, supervision and monitoring;
  - Extent of QA centralization

Workflow

- ***How do the workflow process vary across performance sites***
  - *What service delivery protocols are used at each performance site?*
  - *How do service delivery protocols vary in terms of patients served?*

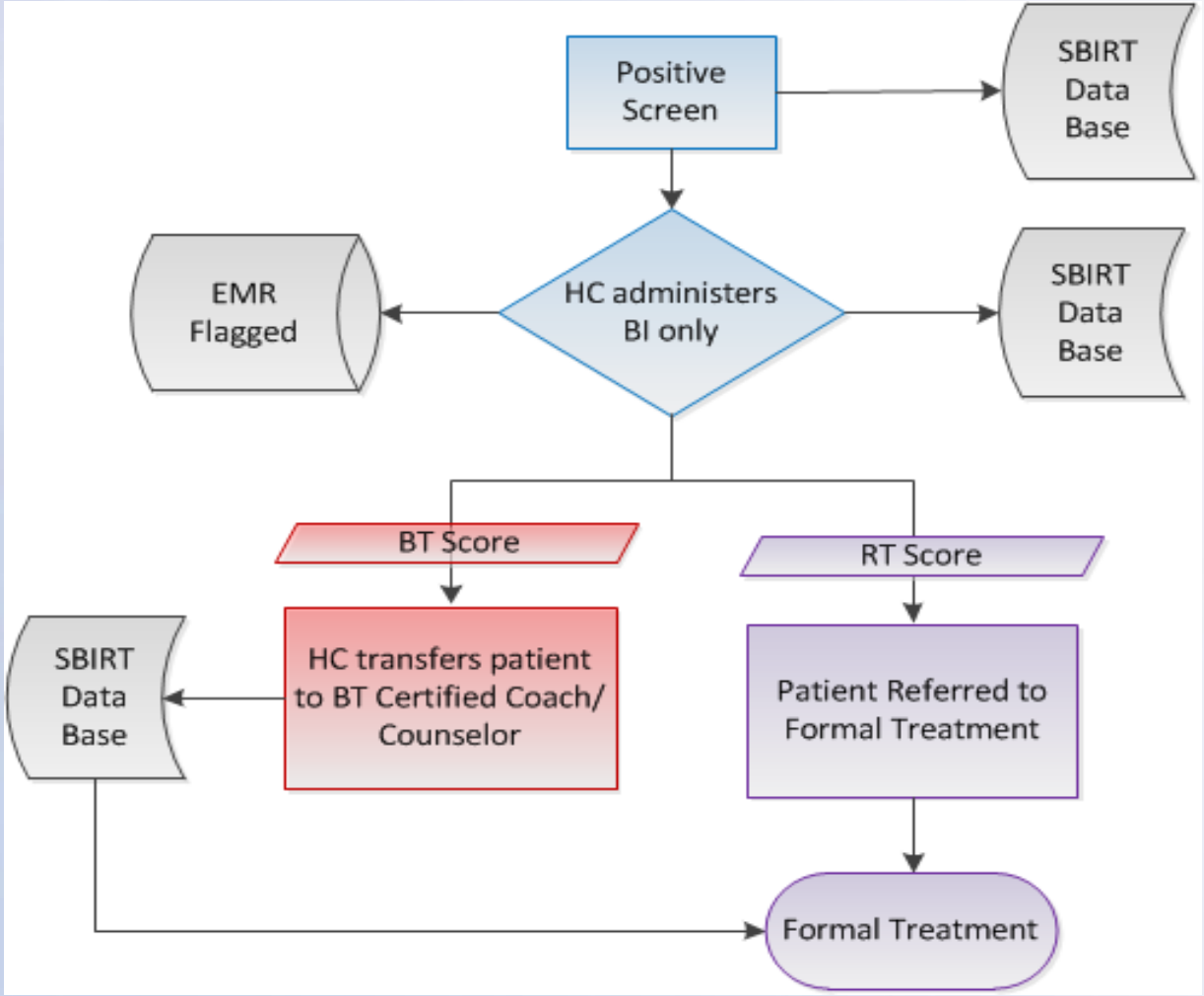
Inpatient Screen Workflow

Inpatient Hospital SBIRT Workflow



Inpatient BI/BT/RT Workflow

Inpatient Hospital SBIRT Workflow



ED Screen Workflow

ED BI/BT/RT Workflow

- Commonalities
- Variations
  - Variations in triggers, data processes, etc
  - Variation in patients served (i.e., percentage screened positive, percentage receiving BI, BT, RT) – From Bill's tables

Conclusions

- There is considerable variability within, as well as between, the four programs, as a function of setting type and the size/location of performance sites.
- Many commonalities across the four programs are likely a consequence of grant requirements (e.g., use of the ASSIST); major variations appear to be related to specific grant recipient circumstances.
- Program choices appear to be informed by the experiences of earlier cohorts of grant recipients (e.g., adoption of PS, use of specialist SBIRT providers).
- Conclusion on workflow……..

Next Steps

- Variations in Program Matrix components associated with :
  - Performance indicators (e.g., implementation effectiveness)
  - Participant outcomes
  - Program Costs

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