THE EXAMINATION OF THREE SBIRT IMPLEMENTATION MODELS

Bonnie McRee, PhD; Janice Vendetti, MPH;
Karen Steinberg Gallucci, PhD; & Katherine Robaina, MPH
mcree@uchc.edu

INEBRIA Annual Conference
September 14-15, 2017
New York, NY

ACKNOWLEDGEMENT OF THE CT SBIRT PROGRAM

- Funding agency:
  SAMHSA-CSAT Grant #TI023459
- Project leadership and management:
  Connecticut Department of Mental Health & Addiction Services
- SBIRT training , technical assistance and program evaluation:
  University of Connecticut School of Medicine
- SBIRT implementation sites:
  12 Federally Qualified Health Centers (FQHCs) in Connecticut
- Program support for health center participation:
  Community Health Center Association of Connecticut

I have no conflicts of interest to declare.

BACKGROUND

The CT SBIRT Program employed three models to implement SBIRT services in 13 FQHCs

- Initially we utilized a *Contracted Specialist* (Health Educator) model to launch the program services
- Two yearsr later we shifted to an *In-house Specialist* model in which the Health Educators became employees of the health centers
- Finally, we implemented an *In-house Generalist* model to promote sustainability by training medical staff to provide SBIRT services

STUDY PURPOSE

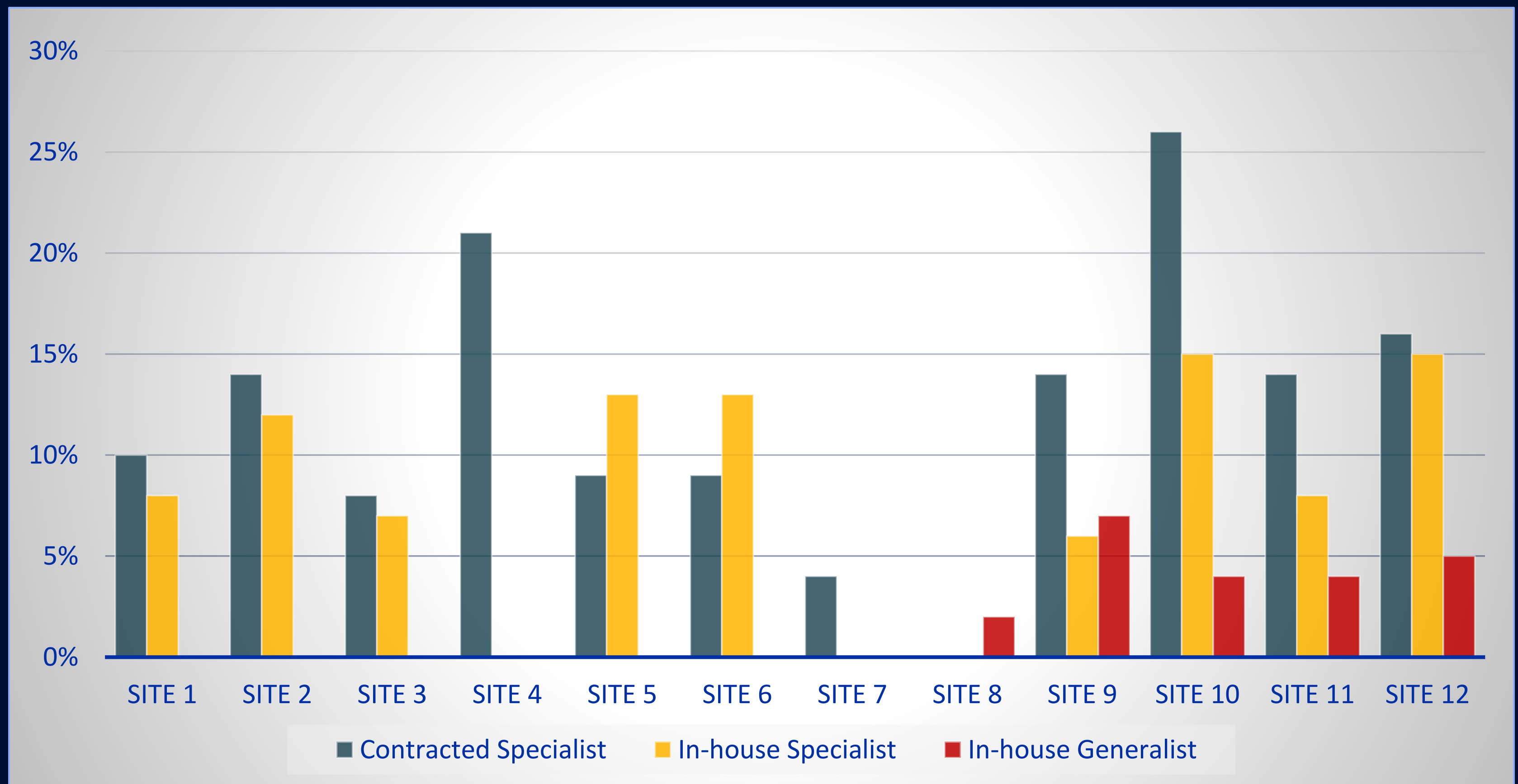
To examine program performance indicators as well as patient outcomes across the three implementation models.

- Percentage of positive cases identified
- Changes in days of substance use

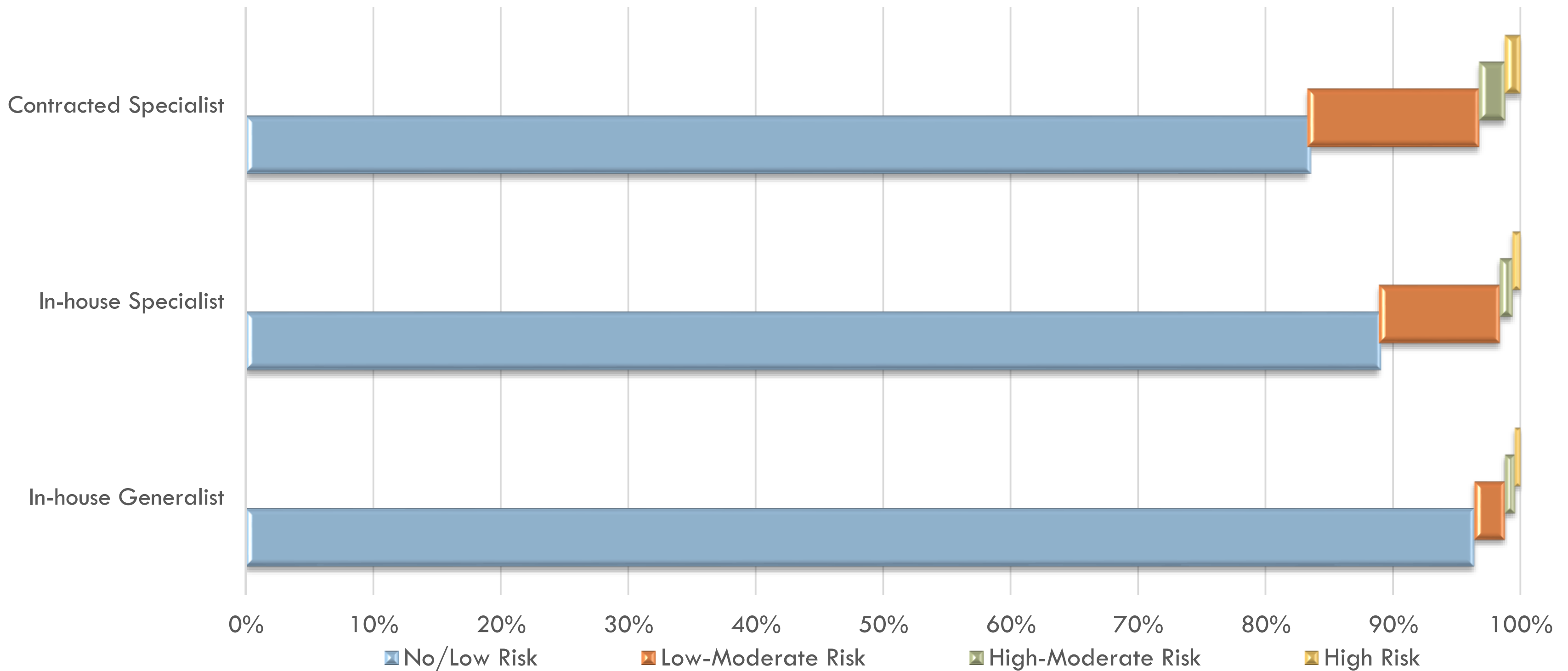
METHODS

- Screening data from 19 *Contracted Specialists*, 16 *In-house Specialists* and 37 *In-house Generalists* were used to examine program performance indicators.
- Outcome data from a subset of SBIRT patients followed 6-months after receipt of SBIRT services were used to analyze changes in days of alcohol binge use and marijuana use.

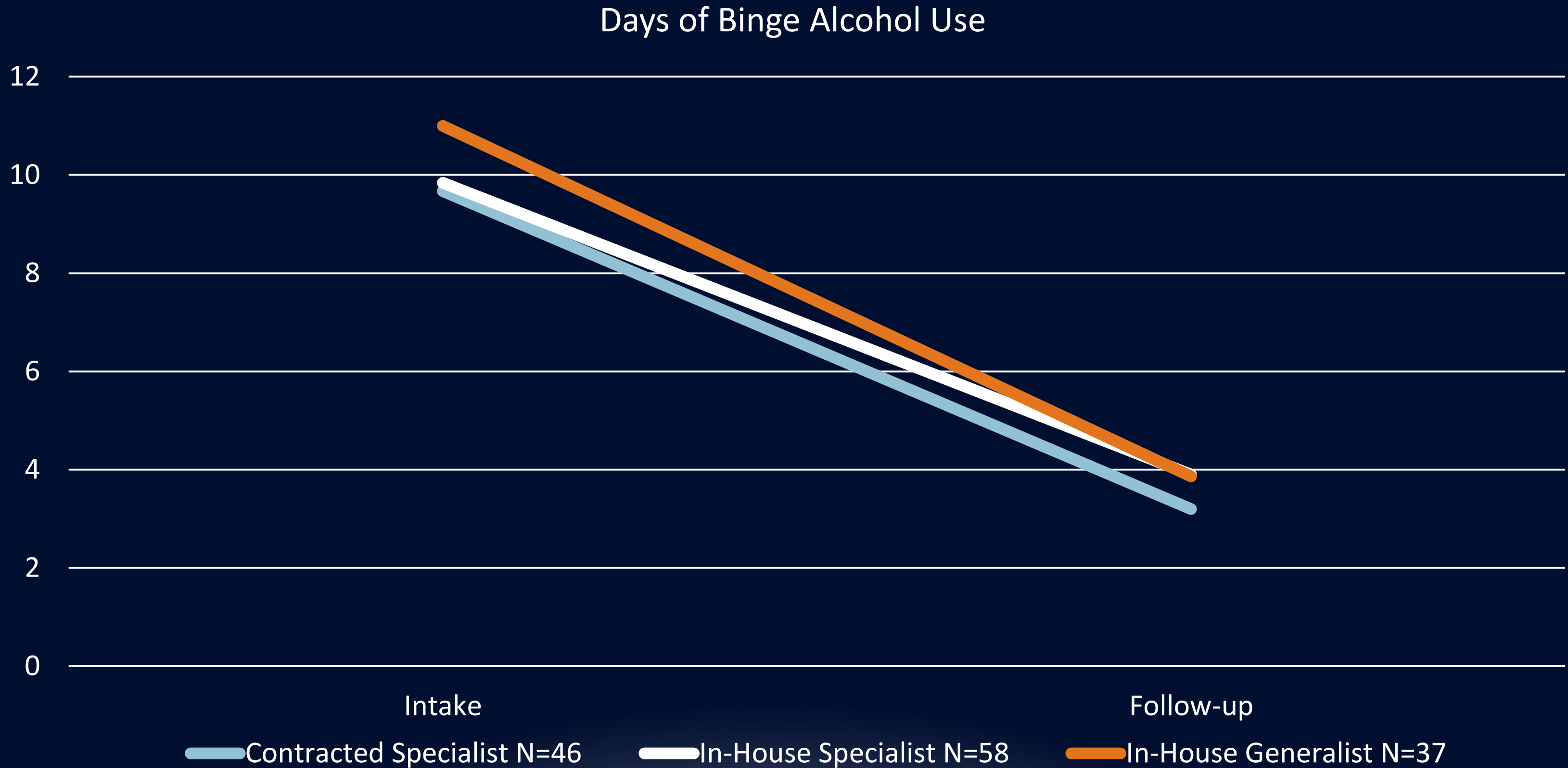
PERCENTAGE OF POSITIVE CASES IDENTIFIED BY MODEL



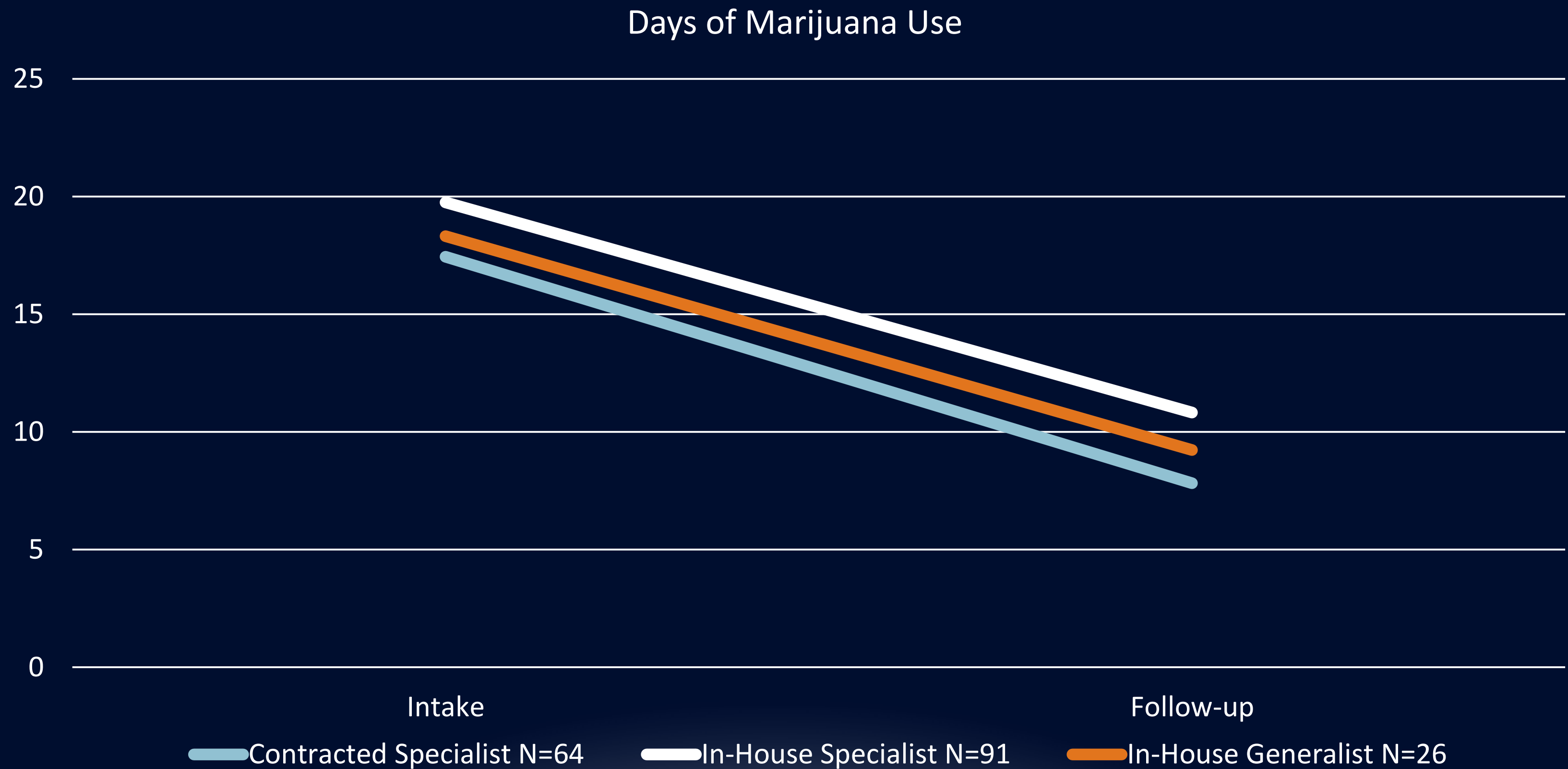
IMPLEMENTATION MODELS



RESULTS: REDUCTION IN DAYS OF BINGE DRINKING BY MODEL



RESULTS: REDUCTION IN DAYS OF MARIJUANA USE BY MODEL



CONCLUSIONS

- The examination of implementation models has implications for health policy and clinical practice.
- Dedicated staff provide higher quality screening services by identifying at-risk patients at rates more consistent with those defined in the literature.[2]
- Patients receiving services from paraprofessional staff have outcomes that are similar to outcomes when services are provided by higher-lever staff.
- Medical provider reluctance to implement SBIRT services continues to be a major challenge.