Connecticut SBIRT Program

Screening, Brief Intervention and Referral to Treatment

CT SBIRT Team Protocol

CT SBIRT
Office of the Governor, State of Connecticut
Connecticut Department of Mental Health and Addiction Services
CT Screening, Brief Intervention, Referral to Treatment Program

The CT SBIRT Team Protocol

This is a combination training, implementation and reference protocol. It is a living document, designed to support the CT SBIRT team training. The protocol will be expanded as the CT SBIRT team grows and its members gather experience and resources. It is one component of a larger training and resource manual that is being used by CT SBIRT. Additional materials utilized for training and reference purposes are listed as part of the larger CT SBIRT Training Manual.

The protocol has been adapted by staff at the University of Connecticut Health Center from manuals prepared by the SBIRT grantee states of Illinois, Colorado, and Missouri. The Illinois manual, prepared by the Great Lakes Addiction Technology Transfer Center was published in May 2004 and revised in March, 2009 by Peer Assistance Services, Inc. and OMNI Institute for Colorado SBIRT. The Missouri SBIRT manual (Dugan, Turner & Horwitz) was published in October of 2009. All projects were funded by the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT).

The current protocol is part of the same cooperative agreement funded by SAMHSA-CSAT. The principal grantee is the Office of the Governor, State of Connecticut, which has designated the Department of Mental Health and Addiction Services (DMHAS) as the Single State Agency to lead the CT SBIRT Program.

The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of SAMHSA-CSAT or any other part of the U.S. Department of Health and Human Services.
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Brief Program Description

The Connecticut Screening, Brief Intervention and Referral to Treatment (CT SBIRT) Program is a cooperative agreement funded by the federal Substance Abuse and Mental Health Services Administration through its Center for Substance Abuse Treatment (SAMHSA-CSAT). The grant was awarded to the Connecticut Department of Mental Health and Addiction Services (DMHAS) to provide leadership and management for the program. Collaborating agencies include nine Federally Qualified Health Centers (FQHCs), the Community Health Center Association of CT (CHCACT) and the University of CT Health Center (UCHC). The purpose of the CT SBIRT Program is to increase identification and treatment of adults, ages 18 and older, who are at risk for substance misuse or diagnosed with a substance use disorder through the implementation of SBIRT services in partnering FQHC sites statewide. CT SBIRT employs 10 full time equivalent (FTE) Health Educators (HEs), through CHCACT, who are deployed in participating FQHC sites. FTEs are allocated to health centers based on patient flow data.

Additionally, through its SBIRT Training Institute, the CT SBIRT Program provides SBIRT training, technical assistance and monitoring to embed SBIRT services in other settings and programs, including general hospitals and DMHAS’ Military Support Program (MSP), which includes a statewide panel of 425 licensed clinicians that provide behavioral health services to National Guard and Reserves members and their families.

Evaluation efforts, as required by SAMHSA, include Government Performance and Results Act (GPRA) performance measure data collected at intake, discharge, and 6-months after intake. Data at intake is collected via face-to-face interviews. Telephone interviews are utilized for data collected at 6-months after intake and discharge. A face-to-face interview at 6-months and discharge is arranged if it is requested by the participant. The complete grant narrative, modified to reflect program changes post funding, may be found in the Grant Narrative section of the CT SBIRT Training Manual.

Definition of the Problem

Alcohol, tobacco, and other drug (ATOD) misuse affect millions of individuals and families. Most individuals affected by ATOD problems do not receive appropriate services because of the stigma attached, the lack of appropriate available treatment, and the inability to pay for services. ATOD problems are as common among patients in primary health care settings as hypertension and type 2 diabetes but far less likely to be detected. It is the leading cause of preventable morbidity and mortality in the United States as few receive the care they need.

Analysis of national data shows that CT has a higher rate of alcohol use, binge drinking, and illicit drug use than the national average. CT’s rate of substance abuse or dependence (10.1%) is higher than the nation as a whole (10.1% vs. 9.2%). An estimated 268,000 adults have a current need for treatment for substance abuse or dependence. CT has a higher rate of past month use of alcohol than the national average (60.8% vs. 51.4%) and a higher rate of binge drinking than the national average (25.1% vs. 22.9%). National data show that CT also has a higher rate of illicit drug use (9.2%) in the past month than the national average (9.2% vs. 8.2%). In Connecticut, approximately 1-in-5 adults are risky drinkers and 1-in-12 are current users of illicit drugs, putting them at risk of
substance-related problems. Marijuana accounts for the largest proportion of both use and
dependence among CT adults who use illicit substances although misuse of prescription drugs is a
growing problem. Rates of risky drinking and illicit drug use, especially marijuana, tend to be
inversely related to socioeconomic level of the community with the highest levels of use found in
less affluent towns/cities.

Public and private resources for treating substance misuse are fragmented, isolated from the health
care mainstream and undersized to meet the need. The substance abuse treatment community
generally comprises highly specialized, freestanding and independent agencies that employ
traditional techniques with little or no coordination and integration with other health care service
providers. As with many other health problems, substance abuse is seldom recognized or treated
until serious physical and psychosocial impairments are manifest.

Solution to the Problem

In response to these issues, SAMHSA has implemented an evidence-based prevention and early
intervention oriented initiative that includes population based screening and brief intervention in
general health care settings. This approach expands the substance abuse treatment system beyond
the limitations of the specialized provider community, engages the general health care community in
screening, brief treatment and referral and builds a critical component in a more comprehensive
system of care for substance abuse.

The SBIRT initiative represents a paradigm shift in the provision of treatment for substance use and
abuse. The services are different from but designed to work in concert with specialized or traditional
treatment. The primary focus of specialized treatment has been persons with more severe substance
use or those who have met the criteria for a Substance Use Disorder. The SBIRT initiative targets
those with nondependent substance use and provides effective strategies for intervention prior to
the need for more extensive or specialized treatment.

SBIRT involves implementation of a system within community and/or medical settings—including
physician offices, hospitals, educational institutions, and mental health centers—that screens for and
identifies individuals with or at-risk for substance use-related problems. Screening determines the
severity of substance use and identifies the appropriate level of intervention. The system provides
for brief intervention or brief treatment within the community setting or motivates and refers those
identified as needing more extensive services than provided in the community setting to a specialist
setting for assessment, diagnosis, and appropriate treatment.

Clinical research trials have shown that large numbers of individuals at risk of developing serious
alcohol or other drug problems may be identified through screening in health care settings.
Interventions such as SBIRT have been found to:

- Decrease the frequency and severity of drug and alcohol use
- Reduce the risk of trauma
- Increase the percentage of patients who enter specialized substance abuse treatment
In addition to decreases in substance abuse, screening and brief intervention has also been associated with fewer hospital days and fewer emergency department visits. Cost-benefit and cost-effectiveness analyses to demonstrate net-cost savings from these interventions is ongoing.

Preliminary data from earlier cohorts of SAMHSA grantees suggest the approach is successful in modifying the consumption/use patterns of those who consume five or more alcoholic beverages in one sitting and those who use illegal substances. Grantees have implemented SBIRT in trauma centers/emergency rooms, community clinics, federally qualified health centers, and school clinics. CT SBIRT provides an opportunity to intervene earlier and more effectively in alcohol and other drug related problems by integrating universal screening, brief intervention and referral to treatment services into FQHC sites throughout the State.

Additional SBIRT background and related readings may be found in the Background Reading section of the CT SBIRT Training Manual.

SBIRT Service Delivery Definitions

SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons at risk of developing substance use disorders, as well as for those with substance use disorders. Primary care offices, community health care settings, hospital emergency rooms, trauma centers and other settings provide opportunities for early intervention with at-risk, non-dependent substance users.

Screening assesses substance use and identifies the appropriate level of treatment. Screening is a quick, simple way to identify patients who need further assessment or treatment for substance use disorders. The goal of CT SBIRT is to make screening for substance misuse a routine part of health care. CT SBIRT HE’s will use a computerized version of the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) to screen patients in each of the cooperating FQHCs. Included within the screening tool are several “pre-screen” questions (AUDIT-C; Single drug-use question) to shorten the interview for patients who have never used substances or have not used in the recent past.

Brief Intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Brief intervention (BI) can be used as a stand-alone treatment for those at-risk as well as a vehicle for engaging those in need of more intensive levels of care. BI lasts, on average, 5-10 minutes and generally takes no longer than 20 minutes. A motivational interviewing (MI) approach is used to help patients evaluate the pros and cons of their substance use and level of concern.

MI is an effective style of counseling that can be used to perform the BI. MI helps patients prepare for change, and to uncover motivation in patients who are ambivalent about changing. Learning MI takes training, supervision and practice.

Change talk statements are those made by patients during a BI in favor of change.

Status quo refers to statements made by patients during the BI in favor of not changing.
Referral to Treatment provides those identified as needing more intensive treatment with access to specialty care. The effectiveness of the referral process to specialty treatment is a strong measure of SBIRT success. The referral process involves a proactive and collaborative effort between SBIRT Health Educators and those providing specialty treatment to ensure access to the appropriate level of care. Patients will be referred to either Brief Treatment (BT) or more intensive treatment based on a diagnostic assessment completed by a licensed substance abuse therapist. High risk patients who are not willing to participate in more intensive treatment or who are wait-listed for treatment will be offered BT as an alternative.

Brief Treatment consists of 2-9 sessions of manual-guided therapy aimed at substance use disorders such as alcohol abuse or marijuana dependence. The services will be offered through the health center’s behavioral health department if licensed to provide substance abuse treatment or through partnering substance abuse treatment agencies.

A key aspect of CT SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community’s specialized treatment programs with a network of early intervention and referral activities conducted in health care and social service settings.

Training Overview

Training description

The two-week classroom training, held at the University of Connecticut Health Center in Farmington, is an interactive training on the roles and duties of a CT SBIRT Health Educator (HE). The training includes didactic lecture, group discussion, interactive exercises, role-play activities and lots of practice! Participants will receive the instruments and protocols that form the core of their work, supported by a wide variety of materials and skill training. Motivational interviewing principles and practices form a foundation for all the functions the HEs and staff will fulfill. Health Educators will receive individual motivational interviewing coaching throughout the training exercises and during post-training activities. Following the two-week classroom training period, HEs will receive individualized mentorship at the health center sites to familiarize them with the health care setting culture and the SBIRT protocol specific to that site.

Central training themes

The themes of the CT SBIRT team training are unity, respect, appreciation of each team member’s expertise and a clear understanding of the ways in which the many SBIRT roles and services fit together. The training combines the wisdom, knowledge and skills of multiple disciplines in service of the patient’s wellbeing. Key elements of the overall training structure include:

- Orientation to the project’s underlying concepts, tools and unique health care environment
- Training on the ASSIST screening tool and associated brief intervention
- A foundation in motivational interviewing theory and principles
- Instruction in ethical issues, culturally competent services, alcohol and other drugs, co-occurring disorders, charting and data flow within the CT SBIRT system
• Instruction on collecting and reporting the federally mandated GPRA data
• On-site mentorship and job shadowing for integration of the training materials and procedures

Training Goals and Objectives

Goal

The goal of this training is to prepare the CT SBIRT team to provide the most effective and respectful screening, intervention and referral services to patients in Connecticut.

Objectives

During this training, HEs will have multiple opportunities to role-play and practice program protocols, motivational interviewing, etc. At the end of the training participants will begin the process of planning for ongoing team development.

Upon completion of this training, HEs should have a complete working knowledge and understanding of:

• The overall structure and the need for the services provided by CT SBIRT
• Roles and duties of all members and member organizations that are part of the CT SBIRT team
• The continuum of CT SBIRT services as they relate to the continuum of substance use
• The conditions likely to be encountered in the health center settings, challenges that may arise from those conditions, appropriate responses to those challenges and appropriate modes of communication with staff
• Motivational interviewing theory, key principles and practiced motivational techniques
• CT SBIRT protocols for screening, brief intervention, and making referrals to brief therapy and more intensive treatment
• Importance of patient confidentiality and ways in which confidentiality might become an issue in delivering CT SBIRT services
• HIPAA regulations and necessary steps for compliance with those regulations within CT SBIRT
• Elements of cultural proficiency and ways of working with patients, hospital staff and the CT SBIRT team
• Flow of information throughout CT SBIRT and ways in which one can ensure information is processed appropriately
• Relevant GPRA requirements and the importance of meeting those requirements
• Relevant ethical requirements and the importance of meeting these requirements
SBIRT Approach

CT SBIRT approach the use of alcohol, tobacco and other drugs as a health care issue and substance use disorders as health conditions. The CT SBIRT team approaches patients as equals without judging their use of alcohol and other drugs. If a patient’s pattern of use indicates a risk of developing consequences or if consequences are already occurring, then it is the risk or consequences the CT SBIRT HE addresses rather than the “rightness” or “wrongness” of the patient’s alcohol or other drug use.

The core value and guiding principle of all of CT SBIRT activities is respect for:

- The staff and the unique culture within each setting
- People of all cultures and disciplines and the values that underlie their choices
- The dignity of each patient and the pain and difficulty inherent in the conditions that bring people into each setting
- Each patient’s right to choose to receive or not receive CT SBIRT services
- The complexity and difficulty of substance use disorders and the many stages individuals might move through in order to be ready to change
- The experience, skills and expertise of each member of the diverse CT SBIRT team

To build that respect the CT SBIRT team takes a motivational interviewing approach toward services to patients, integration of CT SBIRT staff and services into each setting and the CT SBIRT brief treatment model.

In using this approach, we understand and respect the timetables of individuals and systems as they move toward change. We respect their right to choose whether or not to accept services and whether or not to try to change. We do not take an “all-or-nothing” attitude but rather recognize small changes can add up to large changes over time. We support the change process by helping people see their options and helping them change at their chosen pace.

SBIRT Terminology

Most of the words we as a society use to refer to substance use disorders—and to the people who have these disorders—sound critical and stigmatizing. For example, the common terms used to refer to someone who is dependent on alcohol or other drugs is “alcoholic,” “addict” or most commonly, “substance abuser.” This term carries all the negative impact of the word “abuser” and implies the person is intentionally doing wrong. Another example is the term “problem drinker” which subtly implies the person is the problem.

CT SBIRT uses terms that are not critical, not stigmatizing and not even particularly dramatic. The intent is not to insult or shock people into changing, but rather to give them valid information they can use in making decisions about alcohol and other drugs and tools they can use if they choose to try doing things differently. CT SBIRT recognizes the patient as the person who is capable of making change in their lives.
CT SBIRT also uses a “people first” approach. Rather than identifying people by their behaviors, conditions or disorders, as “addicts” or “problem drinkers” for example, CT SBIRT uses the terms “people with substance use disorders” or “people who are experiencing consequences from their alcohol and other drug use” and other similar terms.

An important point is the use of the term “alcohol and other drugs” rather than “alcohol and drugs” which implies that alcohol is not a drug. The table below lists the preferred terminology used in CT SBIRT and the definitions of these terms or criteria for inclusion in these categories.

<table>
<thead>
<tr>
<th>SBIRT Preferred Terminology</th>
<th>Definitions or Criteria</th>
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<tbody>
<tr>
<td>Abstinence</td>
<td>No use of alcohol or other drugs</td>
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<tr>
<td>Lower-risk use</td>
<td>Screen negative for risks and consequences</td>
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<tr>
<td>At-risk use</td>
<td>Screen positive for risk but negative for consequences</td>
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<tr>
<td>Substance use disorders</td>
<td>The DSM-IV designation that includes both “Substance Abuse Disorder” and “Substance Dependence Disorder.” Use this term when referring to this larger category of disorders</td>
</tr>
<tr>
<td>Use with consequences</td>
<td>Screen positive for consequences whether or not the patient assesses positive for a DSM-IV Substance Abuse Disorder</td>
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<tr>
<td>Dependence</td>
<td>Positive assessment for dependence on alcohol or other drugs</td>
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<tr>
<td>Substance Dependence Disorder</td>
<td>The DSM-IV diagnostic classification for dependence on alcohol or other drugs</td>
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<tr>
<td>Substance Abuse Disorder</td>
<td>Use this term only in referring to the DSM-IV diagnosis by the same name</td>
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### Sample Training Schedule

#### CT SBIRT Team Training Agenda Week 1, UCHC Training Institute, Farmington, CT

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<thead>
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<th>Day</th>
<th>Presentations and Activities</th>
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<tbody>
<tr>
<td><strong>Day 1</strong></td>
<td><strong>Introductions and Overview</strong></td>
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<tr>
<td></td>
<td>• Introduction of trainers and health educators</td>
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<td>• Introduction if training goals and description of activities</td>
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<td>• Introduction to CT SBIRT</td>
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<td>• Overview of SBIRT</td>
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<td></td>
<td>• ASSIST advocacy video</td>
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<td>• Definitions, efficacy &amp; implementation</td>
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<td></td>
<td>• Group discussion of background readings</td>
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<tr>
<td><strong>Day 2</strong></td>
<td><strong>Screening for Psychoactive Substance Misuse</strong></td>
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<tr>
<td></td>
<td>• Substance-related disorders</td>
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<td></td>
<td>• Classifications of psychoactive substances</td>
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<td></td>
<td>• Introduction to the ASSIST screening tool</td>
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<td></td>
<td>• Video demonstration (ASSIST vignette #2)</td>
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<td></td>
<td>• ASSIST role play</td>
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<td></td>
<td>• Screening proficiency coding (audio demos)</td>
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<td><strong>Day 3</strong></td>
<td><strong>Components of the Brief Intervention</strong></td>
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<tr>
<td></td>
<td>• Video demonstration (ASSIST/BI vignette #2)</td>
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<td></td>
<td>• BI components and FRAMES approach</td>
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<td></td>
<td>• MI techniques, strategies and SOC</td>
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<td>• BI role play and proficiency coding</td>
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<td>• BI role play/alcohol</td>
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<td>• BI proficiency coding (audio demos)</td>
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<td><strong>Day 4</strong></td>
<td><strong>BI Demonstration, Role Play and Proficiency Coding</strong></td>
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<td>• Tobacco cessation medications/NRT demonstration</td>
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<td></td>
<td>• Video demonstration (ASSIST/BI vignette # 4)</td>
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<td>• BI role play with tobacco</td>
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<td>• Video demonstration (ASSIST/BI vignette #3)</td>
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<td>• BI role play with other drug use</td>
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<td>• BI proficiency coding (audio demos)</td>
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<td><strong>Day 5</strong></td>
<td><strong>Screening and Brief Intervention, Putting it All Together!</strong></td>
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<td>• MI skills practice (BMDC video demonstrations)</td>
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<td>• Round table SBI practice – standardized script</td>
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<td>• “Real patient” practice in round table format</td>
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<td>• Coding partner for proficiency</td>
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<td>Day</td>
<td>Presentations and Activities</td>
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<td><strong>Day 6</strong></td>
<td><strong>GPRA Tool and Administration</strong></td>
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<td>• Administration of intake GPRA</td>
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<td>o Description of GPRA sections</td>
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<td>o CSAT's SBIRT requirements</td>
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<td>o Audio demonstration</td>
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<td>o Role play</td>
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<td></td>
<td>o Coding for proficiency</td>
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<td>• Recruiting patients for follow-up</td>
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<td><strong>Day 7</strong></td>
<td><strong>SBIRT Implementation</strong></td>
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<td>• Cultural competency</td>
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<td>• Implementation barriers</td>
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<td>• Obtaining accurate self-report from patients</td>
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<td>• Patient confidentiality</td>
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<td><strong>Day 8</strong></td>
<td><strong>Referral to Treatment Procedures</strong></td>
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<td>• CT substance abuse service system</td>
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<td>• Brief treatment</td>
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<td>• Site-specific referral procedures</td>
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<td>• Role play</td>
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<td><strong>Day 9</strong></td>
<td><strong>Learning to use the WITS system</strong></td>
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<td>• WITS basics</td>
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<td>• Using standardized patient practice</td>
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<td>• Uploading data to the system</td>
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<td><strong>Day 10</strong></td>
<td><strong>Role play SBIRT practice</strong></td>
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<td>• Individual taped practice</td>
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<td>• Coding self for proficiency</td>
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<td>• Coding partner for proficiency</td>
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<td></td>
<td>• Certification exercises</td>
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Section 2: CT SBIRT Partners, Services, Goals and Organization

- CT SBIRT Overview
- Program Services and Goals
- Project Organization, Management and Staffing Roles
- CT SBIRT Program Organizational Chart
- CT SBIRT Contact Lists
CT SBIRT Overview

CT SBIRT provides an opportunity to intervene earlier and more effectively in alcohol and other drug related problems by integrating screening, brief intervention and referral to treatment services into 9 Federally Qualified Health Center sites throughout Connecticut. Through its SBIRT Training Institute, the CT SBIRT Program provides SBIRT training, technical assistance and monitoring to embed SBIRT services in other settings and programs, including general hospitals and DMHAS’ Military Support Program (MSP), which includes a statewide panel of 425 licensed clinicians that provide behavioral health services to National Guard and Reserves members and their families.

In 2011, Connecticut was one of nine states awarded five-year cooperative agreements with the federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration and the Center for Substance Abuse Treatment for the Screening, Brief Intervention and Referral to Treatment program.

Partners in CT SBIRT include:

- Office of the Governor, State of Connecticut
- The CT Alcohol and Drug Policy Council (ADPC)
- Department of Mental Health and Addiction Services (DMHAS)
- University of Connecticut Health Center (UCHC)
- Community Health Center Association of Connecticut (CHCACT)
- Substance abuse treatment agencies statewide
- Regional Action Councils (RACs)
- General hospitals and other community health care sites throughout Connecticut
- Connecticut’s Military Support Program (MSP)

Toward its goal of reducing the incidence, progression and severity of substance use disorders, CT SBIRT seeks to make screening, intervention and referral to treatment an integral part of the CT health care system and to serve as a model for other states and systems. A central belief of the team is that substance use disorders and at-risk use of alcohol and other drugs are health conditions. It is both appropriate and important to identify, discuss and intervene in these conditions within health care settings.

Screening, assessment and intervention services are provided by CT SBIRT Health Educators hired for the project. Supervisory staff from DMHAS, CHCACT and UCHC will assist the Health Educators in the referral function and Health Educators may provide personal support services.

Program Services and Goals

The CT SBIRT logic model for the program can be found on the next page.
CT SBIRT Team Protocol 12-5-12

CT SBIRT LOGIC MODEL

### Conditions and Context

**Target Population:**
Nondependent young adult and adult populations (aged 18 and over) who are presenting for primary health care treatment in the participating Federally Qualified Health Center Sites.

**Collaborators:**
- Governor’s Office
- CT DMHAS the SSA for alcohol and drug abuse
- Community Health Center Association of CT
- UCHC SBIRT Training Institute
- UCHC Evaluation Team
- 9 Community Health Care Centers

### Activities

**Screening:**
ASSIST will be used by Health Educators to identify simultaneously all psychoactive substances with determination of level of risk.

**Brief Intervention (BI):**
The BI lasts an average of 6-8 minutes but is generally no longer than 15 minutes. A motivational interviewing (MI) approach is used in which patients evaluate the pros and cons of their substance use and their level of concern. Feedback and advice about the use of the primary substance identified through the highest ASSIST score is given and behavioral change strategies are discussed.

**Brief Treatment (BT):**
BT consists of a diagnostic assessment and 6-8 sessions of manual-guided therapy for substance use. Individuals who meet dependence criteria will be referred to appropriate treatment within the existing community substance abuse treatment system.

**Placement & Treatment Referral:**
Individuals who meet dependence criteria will be referred to appropriate treatment within the existing system.

### Outputs

**Number of Patients & Services Provided:**
- A minimum of 42,000 unduplicated individuals (4,200 in Year 1; 9,450 annually in Years 2-5) will be screened over the 5-year project period
- A minimum of 10,500 unduplicated individuals (1,050 in Year 1; 2,362 annually in Years 2-5) will receive brief interventions.
- A minimum of 3,500 unduplicated individuals (350 in Year 1; 787 annually in Years 2-5) will receive brief treatment.
- A minimum of 700 unduplicated individuals (70 in Year 1; 157 annually in Years 2-5) will be referred to existing treatment services.

### Outcomes

**Reduction in Risk Activity:**
- Reduced involvement with illegal substances
- Reduced involvement with illegal activities
- Reduced involvement in and exposure to physical harm

**Improvement in Clinical Symptoms:**
- Reduced substance use
- Better compliance with on-going treatment

**Improvements in lifestyle & self-esteem:**
- Positive primary health care impact
- Less time spent in criminal & risk behaviors
- Development of sense of hope
- Greater integration with general community, less with substance abuse community
- Greater participation in workforce
CT SBIRT Program Services

- Tobacco, alcohol and other drug use screening of all patients at community health centers throughout the State
- General health information about alcohol and other drugs for patients who screen negative or low risk for problems with these substances
- Brief advice about the health risks of alcohol and other drugs for patients who screen positive for risk, but negative for consequences
- Brief intervention for patients who are using alcohol and/or other drugs with consequences, including motivational interviewing and practical techniques for cutting down or quitting
- Referral to assessment for patients who are experiencing more severe issues related to their alcohol and/or other drug use
- Brief therapy for patients who are using alcohol and/or other drugs with consequences based on Motivational Interviewing and Cognitive Behavioral Therapy techniques
- More intensive therapy for patients with severe alcohol and/or other drug use problems
- Training for health centers’ health care teams who will be hosting the SBIRT services to increase the adoption of this new service
- Training for hospital staff and Connecticut’s Military Support personnel to promote long term sustainability of the services
- Six-month follow-up and evaluation provided by UCHC

Guiding principles of all of CT SBIRT’s activities include respect for:

- The entire health care team and the unique culture within each health care setting
- People of all cultures and disciplines and the values that underlie their choices
- The dignity of each patient and the pain and difficulty inherent in the conditions that bring people into the health care setting
- Each patient’s right to choose to receive or not receive CT SBIRT services
- The complexity and difficulty of substance use disorders and the many stages that people must move through in order to be ready to change
- The experience, skills and expertise of each member of the highly diverse CT SBIRT team

CT SBIRT Program Goals

CT SBIRT can best be described as universal screening and brief intervention for substance use. The broad vision of CT SBIRT is to improve the health and lives of all Connecticut residents through inspiring, sustained and universal early substance use intervention. CT SBIRT will increase identification and treatment of adults, ages 18 and over, who are at-risk for substance misuse or diagnosed with a substance use disorder.

Additionally, CT SBIRT will provide training, technical assistance and monitoring to embed SBIRT services in other settings and programs including general hospitals and Connecticut’s Military Support Program which includes a statewide panel of 425 licensed clinicians that provide behavioral health services to National Guard and Reserves. To realize the vision and goals of CT SBIRT, the management team has developed a strategic plan for long-term outcomes:
**Program Components and Plan**

- Implement screening and brief intervention as part of the system of care in community health throughout Connecticut
- Develop and implement a referral system through the health centers’ behavioral health departments or through collaborating substance abuse treatment agencies
- Develop Brief Treatment certification throughout the State’s licensed substance abuse counselors
- Develop an expanded and trained workforce with SBIRT competencies through state-of-the-art SBIRT training/technical assistance to targeted community health center sites, general hospitals and the Military Support Program to sustain these practices
- Identify systems/policy changes that will ensure continuity of SBIRT in CT
- Conduct a comprehensive program evaluation of the CT SBIRT program

**Long-Term Outcomes**

- Universal screening as the standard practice of care implemented in health care statewide
- Health care providers offer brief interventions and referrals to brief treatment and more intensive treatment as appropriate
- Appropriate services in place and accessible to all people in Connecticut
- Systems in place to insure payment for screening services and treatment services for privately insured patients as well as uninsured patients
- Awareness of the importance of early screening and treatment for alcohol and other drug use
- Expansion of continuum of care with a focus on prevention
- Eliminating the stigma of substance use and abuse

**Project Organization, Management and Staffing Roles**

**Substance Abuse and Mental Health Services Administration’s Center for Substance Abuse Treatment (SAMHSA-CSAT):** Funding agency.

**Office of Governor, State of CT:** Grantee of SAMHSA-CSAT’s CT SBIRT program.

**Connecticut Department of Mental Health and Addiction Services (DMHAS):** Single State Agency designated by the Governor’s Office to lead the CT SBIRT program. DMHAS is the administrator of the program, provides fiscal oversight and coordinates the program with other state agencies. DMHAS works with each partnering organization to ensure comprehensive, culturally based SBIRT services and to strengthen supportive community-based services.

**Alcohol and Drug Policy Council (ADPC):** A multidisciplinary body convened by the Office of the Governor to provide leadership and assist in the ongoing development and sustainability of the program. Goals are to examine the means to 1) implement SBIRT statewide and monitor, enforce and maintain a database for reporting compliance with Public Act 98-201; 2) formalize infrastructure needed to sustain SBIRT, by exploring payment mechanisms for SBIRT, i.e., third party
reimbursement, entitlements, private insurance and special contractual services; 3) explore innovative methods of implementing SBIRT in primary care settings, including use of interactive computer screening and kiosk stations; 4) propose legislation that holds harmless hospital and CHC staff implementing SBIRT; and 5) establish a statewide multidisciplinary policy team to further implement SBIRT services in CT.

Community Health Center Association of CT (CHCAct): State-wide association for the Federally Qualified Health Centers. CHCAct serves as the umbrella organization under which the Health Educators are hired and deployed to the health center sites. CHCAct directly supervises the Health Educators and coordinates training and TA activities with UCHC. CHCAct fosters the collaboration of health centers with planning, designing and implementation of the project and ensures the integration of the SBIRT program within the host settings.

University of Connecticut Health Center (UCHC): Academic partner to the program responsible for the overall planning, management and execution of the SBIRT services through its SBIRT Training Institute. UCHC provides training to the Health Educators and Brief Treatment specialists and conducts routine performance monitoring of services. UCHC conducts train-the-trainer services for additional community partners that are initiating SBIRT services but are not actively participating in the funded program. UCHC also manages the SBIRT program evaluation activities including the GPRA follow-up protocol.

Federally Qualified Health Centers (FQHCs): Community health centers providing accessible, comprehensive and quality health care, including medical, dental and related services to primarily uninsured, low-income and ethnically/racially diverse populations. Nine FQHCs across CT serve as host sites for the CT SBIRT program. They are:

- Community Health Services, Inc., Hartford
- CT Institute for Communities, Community Health Center of Greater Danbury, Danbury
- Fair Haven Community Health Center, Inc., New Haven
- Generations Family Health Center, Inc., Willimantic
- Optimus Health Care, Inc., Bridgeport (Barnum Ave. & Park City)/Stamford
- StayWell Health Center, Inc., Waterbury
- Southwest Community Health Center, Inc., Bridgeport
- United Community and Family Services, Inc., Norwich/Jewett City

Health Educators (HEs): Provide direct patient care including screening and brief intervention for tobacco, alcohol and other drug use, and referral to specialized substance abuse treatment. HEs are responsible for consistently implementing CT SBIRT services according to program protocols and utilizing program tools for recording services. HE functions are to:

- Administer screening assessment to patients using the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- Provide brief intervention using motivational interviewing techniques to individuals with identified needs
- Identify and facilitate referrals to appropriate treatment services for individuals with more serious drug or alcohol problems
• Participate in ongoing training and quality improvement activities
• Participate in regular meetings with internal and statewide SBIRT teams
• Meet federal requirements for data collection and enrolling patients for outcomes evaluation
• Liaison with CT SBIRT partners around program implementation and expansion opportunities
• Assist with educational opportunities for onsite health care providers to ensure the sustainability of SBIRT services
• Communicate with the evaluation team regarding data collection
• Other duties as identified by the program management staff

**Brief Treatment Specialists:** Designated licensed substance abuse counselors, within the health center service areas, providing program-specific brief treatment to referred patients. Brief Treatment Specialists will be trained in the SBIRT evidence-based protocol by UCHC staff.

**FEi Systems:** IT provider catering to Federal and local government institutions. Its *Web Infrastructure for Treatment Services (WITS)* is used by CT SBIRT to manage patient screening information and to upload the required GPRA data directly to CSAT in accordance with the specifications outlined in the GPRA protocol.
CT SBIRT Program Organizational Chart

Office of the Governor
State of Connecticut
Dannel P. Malloy, Governor

Department of Mental Health and Addiction Services (DMHAS)
Alyse Chin, Principal Investigator
Anne Marie Fitzpatrick, Program Manager

Alcohol and Drug Policy Council

State Licensed Substance Abuse Treatment Agencies
Brief Treatment Specialists

Community Health Center Association of Connecticut (CHCACT)
Rashad Collins, Program Administrator
Kathleen Henley, Program Manager

University of Connecticut Health Center (UCHC) Training Institute
Bonnie McRee, Training and TA Director
Karen Gallucci, Brief Treatment Supervisor
Donna Damon, SBIRT Monitor
Katherine Robaina, SBIRT Monitor

University of Connecticut Health Center (UCHC) Evaluation Team
Thomas Babor, Evaluation Director
Janice Vendetti, Data Manager/Analyst
Robin Odell, Follow-up Specialist

9 Federally Qualified Health Centers

10 FTE Health Educators

FEi Systems
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# CT SBIRT HEALTH EDUCATOR CONTACT LIST

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<th>SBIRT SITES</th>
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<tr>
<td>CICF-Community Health Center of Greater Danbury</td>
<td>57 North St. Danbury, CT 06810</td>
<td>Diana Trumbley Dr. Tom Draper</td>
<td>Vinny Barreto 203-297-8373 (VM Google) <a href="mailto:vbarretoshirt@gmail.com">vbarretoshirt@gmail.com</a> M &amp; T 12:30 pm – 7:30 pm, Fri: 9:00 am – 4:00 pm</td>
<td>Diana Trumbley 203.743.0100 x305 <a href="mailto:TrumbleyD@ct-institute.org">TrumbleyD@ct-institute.org</a></td>
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<td>40 Mansfield Ave. Willimantic, CT 06226</td>
<td>Arvind Shaw Missy Bonsall Dr. Morton Glasser Fran Boulay Heather Hintz Irma Ross</td>
<td>Raisa Negrón (860) 450-7471 x6198 <a href="mailto:rnegron@genhealth.org">rnegron@genhealth.org</a> <a href="mailto:rnegronsbirt@gmail.com">rnegronsbirt@gmail.com</a></td>
<td>Fran Boulay 860.456.6222 <a href="mailto:fboulay@genhealth.org">fboulay@genhealth.org</a></td>
</tr>
</tbody>
</table>
Section 3: CT SBIRT Process Flow and GPRA Program Evaluation

Overview

• The Patient Flow Process
• Patient Flow Process Diagram
• GPRA Program Evaluation
• GPRA Section Completion Protocol
The Patient Flow Process

Patients presenting to CT SBIRT program clinical sites receive pre-screening for tobacco, alcohol and other drug use by SBIRT Health Educators (HEs). Patients screening positive receive more in depth screening (ASSIST) and SAMHSA-mandated program evaluation data collection (GPRA). HEs conduct the screening either prior to the patients’ medical appointment, during the appointment, or immediately following, depending on the clinic flow and particular design of the program at each site. Depending on the screening scores as illustrated in the Patient Flow Process Diagram, HEs provide Brief Intervention (typically one session) immediately following the screening process. Referrals to specialized treatment (RT), including Brief Treatment (BT), are arranged as soon as possible after the BI. The referral process is coordinated through the health centers’ designated SBIRT BT counselor via a “warm handoff” process, where possible. In instances where there is no in-house BT counselor available, efforts are made to connect the patient to the designated BT counselor at the partnering substance abuse treatment agency through immediate telephone contact or through patient navigators to maximize patient follow-through. The designated Screening, BI, BT and RT classification are considered “planned services” based on the patient’s ASSIST or pre-screen score. They are key clinical components of the SBIRT program and are described in detail in Sections 5-7 of this manual.

CT SBIRT makes extensive use of laptop computers in all phases of the screening, intervention, referral and evaluation process. CT SBIRT includes online screening instruments together with questions required for the health centers’ Patient Centered Medical Home status, patient feedback required for administration of the BI and referral linkages to assist HEs in connecting more severe risk patients with appropriate services.

In addition to the computerized clinical aspects of the program, the laptop computers are also utilized for the GPRA program evaluation efforts. GPRA stands for the Government Performance Results Act and is a Federal accountability data collection tool that is required by the funding agency for use in SBIRT initiatives. It asks about a patient’s substance use patterns as well as other contextual life issues such as education, employment, mental/physical health etc. The CT SBIRT program implements Web Infrastructure for Treatment Services (WITS), a web-based and open-source application designed to capture patient treatment data and satisfy mandatory government reporting requirements. The WITS application uploads data directly to CSAT in accordance with the specifications outlined in the GPRA protocol. The application has built-in error checking and cross-field validations designed to ensure that data is accepted by the Federal data repository. The manual fully describing the WITS system and data entry instructions may be found in the WITS Section of the CT SBIRT Training Manual.

Following is a patient flow process diagram and the GPRA section completion protocol.
Patient Flow Process Diagram

- Conduct Screening
  - Negative Screen
    - Positive Screen
      - Elevated Risk
        - Low-Moderate Risk: Brief Intervention
          - ASSIST
          - Alcohol Score 11-19
          - Drug Score 4-19
          - GPRA Baseline Sections A, B
          - GPRA Follow-up Sections A, B, I
        - High-Moderate Risk: Brief Intervention & Referral
          - ASSIST Score 20-26
          - Marijuana 20+
          - Diagnostic Assessment & Brief Treatment
          - GPRA Baseline Sections A-G
          - GPRA Follow-up Sections A-G, I
        - High Risk: Brief Intervention & Referral
          - ASSIST Score 27+
          - Diagnostic Assessment & More Intensive Treatment
          - GPRA Baseline Sections A-G
          - GPRA Follow-up Sections A-G, I
  - Lower Risk: Feedback
    - AUDIT-C:
      - <4 Men; <3 Women
      - ASSIST Drug Score 0
    - GPRA Baseline Section A
    - GPRA Baseline Sections A-G
    - GPRA Follow-up Sections A-G, I

CT SBIRT Team Protocol 12-5-12
GPRA Program Evaluation

All SAMHSA-CSAT grantees including SBIRT grantees collect GPRA program evaluation data which is required by the funding agency. All screened patients will be asked one or more sections of the GPRA evaluation questions depending on the screening score (as illustrated in the Patient Flow Process Diagram). Approximately 10% of patients from each “planned service” category (Screening, BI, BT, RT) will be randomly selected to participate in a six-month follow-up interview. For patients who agree to participate, staff from UCHC will re-administer the GPRA questions by telephone at the 6-month timeframe. The follow-up interview allows the funding agency to measure, among other things, changes in substance use and associated problems. There are several key features about GPRA that are seamless within the WITS data collection system, as described below.

- The GPRA is divided into sections. As illustrated in the Patient Flow Process Diagram, HEs do not complete all sections of the GPRA for every patient screened; this is dependent on the level of service determined by the ASSIST or AUDIT-C score.
  o **Section A**: demographics, military status and record management components
  o **Section B**: substance use patterns
  o **Section C**: living situation and family
  o **Section D**: employment and education
  o **Section E**: involvement with the criminal justice system
  o **Section F**: mental and physical health, violence and trauma
  o **Section G**: social connectedness
- Most GPRA questions ask about the last 30 days of the patient’s experience.
- The GPRA is potentially conducted at three time points:
  o **Intake**: When patients are screened. Response choices in all capital letters indicate that HEs DO NOT offer those choices to patients, but wait for a response and interpret a reasonable response choice. If one cannot be determined, HEs probe patients further to get more accurate answers.
  o **Discharge**: If patients are referred to Brief Treatment, Health Educators will contact the individuals by telephone to re-administer the appropriate sections of the GPRA at the completion of treatment. HEs will remain in contact with treatment providers so that they may complete the discharge interview on time.
  o **6-month follow-up**: For those patients who are randomly selected for follow-up, UCHC staff will ask the appropriate sections of the GPRA again.
- The GPRA time points are used for the evaluation of services. UCHC tracks how these contextual items in sections B-G change over six months (e.g., reduction in substance use patterns, increase of quality of life etc.)
What is “level of service”?

There are four levels of service, according to the GPRA, and they are based on the screening score in the ASSIST:

- Screening and Feedback (SF)
- Brief Intervention (BI)
- Brief Therapy (BT)
- Referral to Treatment (RT)

The level of service (determined by the ASSIST score) determines which sections of the GPRA are completed:

- SF – well over half of patients – GPRA Section A
- BI – approximately 20% of patients – GPRA Sections A - B
- BT/RT – approximately 6-7% of patients – GPRA Sections A - G

Exceptions:

Tobacco: In addition to the four GPRA service level categories, CT SBIRT tracks tobacco-only users as well. For current tobacco users (scoring in the positive risk-range for tobacco on the ASSIST), HEs report the services rendered for those patients in the WITS system under the Encounter reporting section:

For patients who are currently at lower-risk for alcohol and other drug use, but smoke or use tobacco, a brief intervention for tobacco cessation will be provided. However, SAMHSA does not recognize tobacco-only users as eligible for their BI pool. Patients who only use tobacco are counted in the “Screening and Feedback” (SF) category for the GPRA protocol. Only Section A of the GPRA is required for these patients, since they screen negative for alcohol and other drugs.
GPRA Section Completion Protocol

Intake:

For each patient screened, records require valid answers for all questions in GPRA Section A, Record Management. Additional sections are required based on the “Planned Service” category that the patient falls into as a result of the screening process. The “Planned Service” category is based solely on the ASSIST screening score, not the intended or actual service provided to the patient by the HE. Many of the GPRA questions are populated by the WITS system from questions asked earlier in the intake and screening process. The sections that are required based on the “Planned Service” category are as follows:

<table>
<thead>
<tr>
<th>Screen Result</th>
<th>Planned Service</th>
<th>GPRA Sections Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative*</td>
<td>Screening and Feedback</td>
<td>A (no other data required)</td>
</tr>
<tr>
<td>Positive</td>
<td>Not willing to participate in the SBIRT Program (refused service)</td>
<td>A (no other data required)</td>
</tr>
<tr>
<td>Positive ASSIST score 11-19 for alcohol and/or 4-19 for other substances, or ASSIST score 0-10 for alcohol and the AUDIT-C binge question (#3) ≥3.</td>
<td>Brief Intervention</td>
<td>A, B</td>
</tr>
<tr>
<td>Positive ASSIST score 20-26 for alcohol and/or other substances, or ASSIST score 20+ for marijuana use</td>
<td>Brief Treatment</td>
<td>A, B, C, D, E, F, G</td>
</tr>
<tr>
<td>Positive ASSIST score 27+ for alcohol and/or 27+ for other substances (except marijuana)</td>
<td>Referral to Treatment</td>
<td>A, B, C, D, E, F, G</td>
</tr>
</tbody>
</table>

* Negative refers to screening negative for both alcohol and other substances.

6 Month Follow-up Interview:

Only patients whose ASSIST score (Screen Result) is positive (BI, BT, RT) will be eligible to be in the follow-up sample pool. SBIRT grantees are required to attempt a follow-up interview with every person selected to be in the sampling pool. There must be a minimum sampling pool of 10% per modality of treatment (BI, BT, RT). SBIRT grantees are required to obtain a follow-up rate of 80% for each of the modalities regardless of the size of the sampling pool.

Follow-up interview records require valid responses for GPRA Section A, Record Management (interview date is required only if a follow-up interview was conducted). GPRA Sections that are
required for follow-up interviews based on the type of “Planned Service” category (as indicated on the intake record) are as follows:

<table>
<thead>
<tr>
<th>Was the Patient in the Sampling Pool?</th>
<th>Planned Service</th>
<th>Was the Interview Conducted</th>
<th>GPRA Sections Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>All service types (BI, BT, RT)</td>
<td>No (e.g., patient lost)</td>
<td>A, I</td>
</tr>
<tr>
<td>Yes</td>
<td>Brief Intervention</td>
<td>Yes</td>
<td>A, B, I</td>
</tr>
<tr>
<td>Yes</td>
<td>BT &amp; RT</td>
<td>Yes</td>
<td>A, B, C, D, E, F, G, I</td>
</tr>
</tbody>
</table>

Discharge Interview:

Only patients whose ASSIST score (screen result) is positive, and were provided SBIRT-funded services (BI, BT) require a discharge interview. Discharge interview records require valid responses for interview type, interview indicator and interview date in Section A (interview date is required only if a discharge interview was conducted). GPRA Sections that are required for discharge interviews based on the type of “Planned Service” category (as indicated on the intake record) are as follows:

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Length of Treatment</th>
<th>Was the Interview Conducted?</th>
<th>GPRA Sections Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Intervention</td>
<td>&gt; 7 days</td>
<td>Yes</td>
<td>A, B, J, K</td>
</tr>
<tr>
<td>Brief Intervention</td>
<td>&gt; 7 days</td>
<td>No (e.g., patient lost)</td>
<td>A, J, K</td>
</tr>
<tr>
<td>Brief Intervention</td>
<td>&lt; 8 days</td>
<td>Interview not required</td>
<td>A, J, K</td>
</tr>
<tr>
<td>Brief Treatment</td>
<td>&gt; 7 days</td>
<td>Yes</td>
<td>A - G, J, K</td>
</tr>
<tr>
<td>Brief Treatment</td>
<td>&gt; 7 days</td>
<td>No (e.g., patient lost)</td>
<td>A, J, K</td>
</tr>
<tr>
<td>Brief Treatment</td>
<td>&lt; 8 days</td>
<td>Interview not required</td>
<td>A, J, K</td>
</tr>
<tr>
<td>Referral to Treatment</td>
<td>Upon discharge from SBIRT program and &lt;8 days</td>
<td>Interview not required</td>
<td>A, J, K</td>
</tr>
</tbody>
</table>

Completion of Section A: Record Management

Section A: Record Management of the GPRA Tool is required for all patients screened in the CT SBIRT Program, even for those whose screening result is negative. As mentioned above, records require valid answers for all questions in GPRA Section A. Many of the GPRA items are populated by the WITS system from questions asked earlier in the intake and screening process. Required fields are highlighted in bright yellow and must be complete before the record can be saved.

On the initial screen, the Client Type field defaults to (and should always indicate) “Treatment Client.” This field should be the same for every patient in the CT SBIRT Program. At intake, the co-
occurring mental health and substance use field should always indicate “No.” This is because, the co-occurring mental health screening is only completed for patients who participate in Brief Treatment or are referred to more intensive treatment. The co-occurring mental health screening occurs during the intake assessment for treatment and the results of the screening will be updated once the patient has been discharged from treatment and the discharge report provided to the HE.

The following screenshots illustrate the required fields on subsequent Record Management screens.

How the client screened for the SBIRT Program and the subsequent screening scores will be populated based on the answers to the AUDIT-C and ASSIST screening tools. The last field on this screen, “Was he/she willing to continue his/her participation in the SBIRT program?” will be answered “Yes” by HEs, unless the patient explicitly states that he/she is no longer interested in answering the questions and/or no longer interested in receiving any SBIRT services.
Planned Services: Modality defaults to (and should always indicate) “Yes” for item 12. Other: SBIRT Program. All other Modality fields default to (and should always indicate) “No.”

Planned Services: Treatment Services defaults to (and should always indicate) the appropriate and highest service indicated as a result of the screening tools (AUDIT-C and ASSIST). These fields should not be changed by the HE under any circumstance. Only the first four options are used for SBIRT Programs. All other Treatment Services fields (numbers 5-13) default to (and should always indicate) “No.” These services are not services paid for by the CT SBIRT grant.
Planned Services: Case Management Services, Medical Services, Aftercare Services, Education Services and Peer-to-Peer Recovery Support Services, all fields default to (and should always indicate) “No.” These services are not services paid for by the CT SBIRT grant.

Demographics are populated based on the items entered in the Client Profile screen in WITS. These fields should be double-checked by the HE, however, it is not likely that they will be changed. If a field is edited and no longer matches information entered in the Client Profile, an error message will appear, prompting the HE to edit the respective items in the Client Profile to match the items in the Demographics section of the GPRA.
Military Family and Deployment fields are required and follow logical skip patterns. Required fields are highlighted in bright yellow and must be complete before the record can be saved.

**Note:** Question 5, 5a and 5b are required for all patients who screen positive or negative for the SBIRT program. Questions 6, 6a – 6d are only required for those who screen positive. Items not required will be grayed out.
Section 4: Before Approaching the Patient; Medical Record Data and GPRA-A (Demographics)

- Checking the Medical Record
Checking the Medical Record

How and whether the HE has access to patient medical records is determined on a site-by-site basis and may vary between sites. However, in most instances, the HE checks the medical record prior to approaching the patient. At many health centers, tobacco and alcohol screening questions are asked of the patients by the medical assistants or generalist medical staff, however the questions are often not administered in a consistent or reliable manner. A primary goal is to determine if the patient has screened positive for tobacco, alcohol or other drugs in the past (or during the current visit) and to gather patient demographic information before approaching the patient for screening. In most health care settings, there is limited time in which to complete SBIRT services and it is important to maximize the in-person interview time with the patient.

After the HE reviews the site-specific screening results and demographics and makes a note of the results, s/he then approaches the patient to administer the ASSIST. Please note that it is important for the HE to approach all patients, regardless of a positive or negative score on any health center-specific screening tool. In some cases, HEs may get different results when administering the CT SBIRT screening tools. For example, a patient may score negative on the health center’s screening tool and positive on the ASSIST. This is due to several factors including rapport building between the HE and the patient, differing techniques in asking questions, patients’ understanding of the purpose of the questions, etc. If, however, the HE can verify that patient’s negative health center screen with the negative AUDIT-C pre-screen and single drug use question, the remainder of the ASSIST assessment is not necessary. In this case, the HE provides positive reinforcement of the patient’s healthy lifestyle choices.

It is often possible to collect demographic information pertinent to GPRA A before approaching the patient. In general, demographic information is available on patient charts. At many CT SBIRT sites, this information is accessed using the electronic medical record, which includes a range of details, including name, DOB, social security number, race, ethnicity, etc. If there is remaining GPRA A information that cannot be collected using the charts or EMR, the HE collects it during the screening process.

The demographic information gathered from the chart or EMR will be verified as part of the SBIRT introduction; this can aid in building rapport when the HE presents him/herself as part of the health care team.
Section 5: ASSIST Screening and Associated GPRA Sections; Assessing Substance Use in Patients

- Approaching the Patient
- The Pre-Screen Questions
- What is the ASSIST?
- Problems Related to Substance Use
- ASSIST Components
- GPRA Program Evaluation Questions
Approaching the Patient

When addressing the patient for the first time, it is crucial to quickly develop rapport. The patient’s comfort level with the HE greatly influences the effectiveness of the screening process and the Brief Intervention if required. Each HE has his or her own style and technique for addressing patients, but there are certain key elements that are emphasized in the initial interaction in order to make the screening process successful. In addition to accurately explaining what the SBIRT screening process entails, emphasis is placed upon:

- Universal screening
- Confidentiality
- Tobacco, alcohol and other drug screening as a standard of care

Offer a warm greeting and address the patient by name. Example of an Introduction:

Hi Mr. Sanchez, my name is ____________, How are you feeling? (Pause and offer sympathy if the patient is sick or in pain.) I am a Health Educator here at ____________, and a member of your treatment team. As part of a new program that will allow us to provide better care for patients, we are asking all patients about lifestyle factors that may have an impact on your health. I’ll start by asking you some questions about tobacco, alcohol, and other drug use and we will provide health education services based on your risk. May I begin?

### SCREENING BLURBS

<table>
<thead>
<tr>
<th>PATIENT CONCERN</th>
<th>POSSIBLE RESPONSE</th>
</tr>
</thead>
</table>
| I am here for (health concern), why are you asking me questions about alcohol and other drugs? | We are asking all patients these standard questions because these some substance use can affect your health and interfere with medications and treatment.  
We may provide information to your health care provider that can help with your diagnosis and treatment. |
| Why are you asking me about so many drugs?                                      | There are a lot of new drugs out there and we are trying to provide education to patients about all possible substances.  
This information will help with diagnosis and treatment. |
| Will this information get back to my health care provider?                     | We do discuss the information with your health care provider to ensure that your overall health is being addressed.  
Yes, and everything we talk about here will be treated confidentially as is other information in your medical record. |
| Where did these questions come from?                                          | The screening questionnaire was developed by the World Health Organization. |
Checklist for a Patient's Capacity to Be Interviewed:

Before conducting the screening, HEs check whether the patient is medically stable and able to provide accurate information. Is the patient:

- In too much pain
- Too drunk or high
- Disoriented
- Having great trouble understanding you
- Speaking another language
- Hard of hearing
- Having trouble tracking what you are saying, giving illogical responses or seems “out of it”?
- Check in with the patient by asking: “Can you tell me what you are being asked to do?” to verify that a patient is capable of answering the screening questionnaire.

If the patient is NOT capable of answering the screening questionnaire:

- Graciously thank them and explain that this may not be the best time to have a conversation and that you will try to talk with them later.

If the patient is not coherent enough to continue once the interview is started:

- Graciously thank them and explain that this may not be the best time to have a conversation. If the interaction is promising, make a special effort to determine when a more appropriate time to continue might be.
- Make a note in the WITS Encounter (for example): “Patient altered; could not continue screen”
- If you have already begun entering Patient Profile data in WITS, end the screening and if possible, complete the screen later, updating the record as appropriate.

Patient's family members:

For many reasons, patients often bring a special person with them when attending a health care visit, particularly if they are concerned about comprehending medical information or are having a health scare. This person may be serving one of many roles. And depending on what you know about the patient and the reason for the visit, you might address the situation in different ways. For example, the guest may be an interpreter if the patient does not understand English. He or she may be serving as a “second set of ears” to help the patient understand and remember important information. He or she may be acting in a supportive role for a frightened patient. Alternatively, the guest might simply be a child for whom the patient is caring or the relative who gave the patient a ride to the appointment. Regardless of the relationship to the patient, it is important to understand that there are many reasons why a patient may have someone with them and respect the patient’s wishes to have a family member or friend present for their visit. However, it is also important to keep the patient’s personal health information private. Since the questions we are asking are of a sensitive nature, it is essential that you try to interview the patient outside the presence of others. If a patient is accompanied by another individual, use the following script to ask the person to allow the patient privacy.
“Hi my name is _________, and I’m here to do an assessment with Mr. Wilson. It shouldn’t take us too long. Since this is a confidential interview, we ask family members to step out of the room for about 10 minutes. The waiting room is right around the corner. I appreciate your cooperation and respect for his/her privacy. (Smile).”

If the patient requests that guests be allowed to stay, let him know that some of the questions may be very personal. If he still requests their presence, proceed with the screening assessment and make a note of this in the Encounter Record and on the feedback form.

**Patients are most likely to consent to screening and give accurate answers to questions about substance use when the HE:**

- Is actively listening to the patient
- Is friendly and non-judgmental
- Shows sensitivity and empathy towards the patient
- Provides information about screening
- Carefully explains the reasons for asking about substance use
- Gives assurances that the patient’s responses will be confidential

HEs may explain that screening for substance abuse is similar to other screening activities such as blood pressure measurement, or asking about diet and exercise. Linking the screening to the presenting complaint, where it is relevant, may help patients to see the connection between their substance use and their health and make them more receptive to screening with the ASSIST.

Begin the interview with the GPRA A demographic information. If most of the information has already been gathered from the medical record, quickly verify the data with patients before continuing on to the pre-screen questions.

**If the patient is reluctant to honestly provide his or her social security number:**

Remember that, in general, patients are most likely to respond positively and honestly to questions if the health educator is friendly and non-judgmental, shows sensitivity and empathy, shows they are listening, and remains objective. In this case, it may also be necessary to reassure the patient that the personal information they provide is protected in accordance with HIPAA privacy regulations. The patient may also be more responsive if he or she understood why the information is being collected. Prior to collecting the Patient Profile information, paraphrase the following script.

“I’d like to confirm some of the information that is in your record and collect anything that I may not already have. Please be assured that the information you provide is protected in accordance with Health Center privacy regulations.”

If they are still reluctant to give SSN.

“Because there are often many individuals with similar names, we only use this number as a secondary means by which we can identify you in our system.”

Still reluctant.

“I understand if you do not wish to provide me with your social security number at this time. That’s OK, I’ll continue.”
HE’s should NOT enter a “fake” social security number into the WITS system. If you are unable to collect the SSN for a patient, use the following numbering system. The first uncollected SSN should be entered as 000-00-0000 (this number may actually be used more than once), subsequent uncollected SSNs can be entered as 000-00-0001, 000-00-0002, etc. DO NOT enter random, inaccurate numbers.

Seeking permission to record:

After the patient completes the demographic information (GPRA A questions), it is important to get permission to record the rest of the session. A suggested approach is:

“May I have your permission to audio-record this assessment for quality assurance purposes? The tape will not contain your name and will be identified by a number only. The recording will be used by my supervisors to provide feedback to me so that I may provide better services to patients. After the tape is used for this purpose, it will be immediately erased. Is taping our conversation OK with you?” If the patient agrees, begin taping.

Once the session is completed, the HE immediately uploads the tape to the UCHC secure server following the procedures TBD.

The Pre-Screen Questions

After the GPRA A demographic section and prior to asking the full set of ASSIST questions, several pre-screen items are asked of the patient. These pre-screen items are intended to screen out those patients who are not currently at risk for alcohol or other substance related problems, and for whom the full screening tool is not necessary to administer. The first set of pre-screen items includes tobacco use questions, which are necessary to demonstrate the application of required Meaningful Use measures to collect tobacco use information on patients. The next set is comprised of the AUDIT-C questions which screen for at-risk alcohol use. Finally, the first question of the ASSIST serves as the single-item drug use pre-screen test for other substance use. The ASSIST tobacco and alcohol items are only asked if the patient scores positive on the tobacco use or AUDIT-C questions.

The Meaningful Use tobacco items include history of use, smoking status, age of onset, type of tobacco used, and quantity/frequency of tobacco use. The pre-screen is considered positive if the patient describes current tobacco use.

The AUDIT-C items are scored as positive if the sum of the answers to the three questions is \( \geq 4 \) for men, or \( \geq 3 \) for women and those over age 65. The AUDIT-C queries the patient about the quantity and frequency of alcohol use as well as the frequency of binge drinking (more than 5 drinks on one occasion if male; or more than 4 drinks on one occasion if female).
What is the ASSIST?

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Guidelines for Use in Primary Care is located in the Screening section of the CT SBIRT Training Manual and on WHO’s ASSIST website: http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf

The ASSIST is the Alcohol, Smoking and Substance Involvement Screening Test. It is a brief screening questionnaire designed to assess an individual’s use of psychoactive substances. It was developed by the World Health Organization (WHO) and an international team of substance use researchers as a simple method of screening for at-risk or hazardous use, substance abuse or harmful use as well as dependent use of alcohol, tobacco and other psychoactive substances. The questionnaire covers:

- Tobacco
- Alcohol
- Marijuana
- Cocaine
- Prescription Stimulants
- Methamphetamine
- Sedatives or sleeping pills
- Hallucinogens
- Inhalants
- Prescription pain medication
- Heroin
- Other drugs

The ASSIST is especially designed for use by health care providers in a range of health care settings. According to the World Health Organization, primary health care is the first level of contact that individuals, the family and community have with their health care system and constitutes the first part of a continuing health care process.

The ASSIST provides information about:

- The substances people have used at any point in their lifetime
- The substances they have used in the past three months
- Problems related to substance use
- Risk of current or future harm
- Dependence
- Injection drug use

The ASSIST scores are used to caution patients that they may be at risk of developing problems related to their substance use in the future and provides an opportunity to start a discussion with a patient about his or her substance use. It helps in identifying substance use as a contributing factor to the patient’s presenting medical illness. The ASSIST results are linked to a brief intervention to help at-risk substance users to cut down or stop their use of tobacco, alcohol or other drugs to avoid future consequences of substance use.
Health care providers, including trained Health Educators, have the opportunity to screen a broad range of individuals for general lifestyle issues as a routine part of their health care service. Screening at the primary care level increases the likelihood of identifying individuals with a lower level of risky substance use who are more likely to respond well to an intervention. Health care providers are a trusted and credible source of health information and may provide the first point of contact with groups, which are at higher risk of harm from substance use. There is evidence that if health care workers inquire about substance use risk factors, then patients are more willing to talk about substance use problems and to consider the possibility of changing their substance use behaviors. Primary care interventions based on motivational interviewing and cognitive behavioral interventions are effective for a range of lifestyle-related problems including substance use.

The ASSIST is the first screening test which covers all psychoactive substances including alcohol, tobacco and illicit drugs, and can help providers identify patients who may have hazardous, harmful or dependent use of one or more substances. More detailed description of psychoactive substance-related disorders may be found in the DSM Reference Materials section of the CT SBIRT Training Manual.

- **At-risk use, sometimes called hazardous use**, is a pattern of psychoactive substance use which increases the risk of harmful consequences for the user. It is defined primarily by the amount of alcohol an individual is drinking.
- **Substance abuse or harmful use** is a pattern of psychoactive substance use that is damaging to the physical and or mental health of the user.
- **Dependence** on alcohol or other drugs usually develops after repeated use and involves a cluster of symptoms which may include a strong desire to use the substance, impaired control over its use, persistent use of the substance even when it is causing harm, increased tolerance to the effects of the substance and a withdrawal reaction when use is stopped or reduced. Hazardous, harmful or dependent use patterns of psychoactive substances can also cause significant social problems for the user, such as problems with family, friends, the law and finances.

**Problems Related to Substance Use**

In general, people use substances because they have pleasurable or desirable effects for the user. However, substance use problems can arise as a result of acute intoxication, regular use or dependence, and from the way in which substances are used. It is possible for a person to have problems from all of these. Problems relating to acute intoxication can occur as a result of a single episode of drug use and may include:

- Acute toxic effects including ataxia, vomiting, fever, confusion
- Overdose and loss of consciousness
- Accidents and injury
- Aggression and violence
- Unintended sex and unsafe sexual practices
- Reduced work performance
A variety of different problems can occur from using substances regularly, ranging from physical problems to mental health and social problems. There is not always a clear distinction between these effects, and it is worth noting that mental health and social problems can be as debilitating as physical problems for some people. The kinds of problems relating to regular use and dependence develop over a period of time and may include:

- Specific physical and mental health problems
- Decreased immunity to infection
- Anxiety and depression
- Sleep problems
- Withdrawal symptoms when use is reduced or stopped
- Financial difficulties
- Legal problems
- Relationship problems
- Work problems

Withdrawal symptoms vary depending on the drug involved but generally include craving (strong desire for the psychoactive substance or its effects), anxiety, irritability, gastrointestinal upsets and problems sleeping. Symptoms are more severe for some drugs than others. Withdrawal from alcohol, benzodiazepines and opioids may require health care management while uncomplicated withdrawal from other drugs can usually be managed with supportive care.

Substance-related problems can result from the way in which substances are used; for example, much of the harm associated with tobacco and marijuana occurs because these substances are smoked and the smoke is harmful. Using substances by injection can cause serious health problems no matter which substance is injected.

Use of illicit drugs places the user at particularly high risk of legal problems and the consequent social, financial and employment difficulties associated with having a criminal record. These problems cause stress, which is also associated with an increased risk of health and family problems independently of the substances used.

A detailed description of specific problems associated with each category of psychoactive substance is located in the DSM Reference Materials section of the CT SBIRT Training Manual.

The ASSIST was designed specifically for use in health care settings and to identify

- Those whose patterns of substance use put them at risk of problems
- Those who have already developed problems related to their substance use
- Those at risk of developing dependence

**ASSIST Components**

The ASSIST questionnaire consists of eight questions. Questions one to seven ask about use and problems related to tobacco, alcohol, marijuana, cocaine, prescription stimulants, methamphetamine,
inhalants, sedatives or sleeping pills, hallucinogens, prescription pain medication and heroin. Any additional substances not included in this list are specified under the ‘other’ category.

- Question 1 asks about which substances have ever been used in the patient’s lifetime
- Question 2 asks about the frequency of substance use in the past three months, which gives an indication of the substances which are most relevant to the patient’s current health status
- Question 3 asks about the frequency of experiencing a strong desire or urge to use each substance in the last three months
- Question 4 asks about the frequency of health, social, legal or financial problems related to substance use in the last three months
- Question 5 asks about the frequency with which the use of each substance has interfered with role responsibilities in the past three months
- Question 6 refers to substances ever used and asks whether anyone has ever expressed concern about the patient’s use of each substance and how recently that occurred.
- Question 7 asks whether the patient has ever tried and failed to cut down or give up their use of each substance and how recently that occurred.

Taken together these questions provide indications of at-risk use and dependence. Scores in the mid-range on the ASSIST are likely to indicate at-risk or hazardous use; substance abuse or harmful substance use. Substance dependence is particularly indicated by trying and failing to cut down and compulsion to use, and those who have high scores on the ASSIST are likely to be dependent and at high risk of substance-related harm.

- Question 8 is focused on injecting and asks whether the patient has ever injected any drug. Injection is treated separately because it is a particularly high-risk activity associated with increased risk of dependence, blood born viruses such as HIV and hepatitis C and with higher levels of other drug related problems. For the current program, this question is not asked as part of the ASSIST since it is included as part of the GPRA items.

**Screening Introduction**

The ASSIST screening process, which in the CT SBIRT program includes the tobacco questions and AUDIT-C, is introduced with a brief explanation of the reasons for asking and instructions for responding. The ASSIST questionnaire is administered with a response card which includes a list of the drugs covered by the questionnaire as well as a series of response categories for each question. The following is an example of an introduction.

“The following questions I’m going to ask you relate to your experiences with alcohol, cigarettes and other drugs. Some of the substances we’ll talk about can be prescribed by a doctor or dentist (like pain medications). But I am only concerned with those if you have taken them for reasons other than prescribed, or in larger doses than prescribed. This information is an important part of your medical history and will help us in our mission to give you the most appropriate and comprehensive care.”

For patients whose drug use is prohibited by law, culture or religion it may be necessary to acknowledge the prohibition and encourage honest responses about actual behavior. For example:
“I understand that others may think you should not use alcohol or other drugs at all but it is important in assessing your health to know what you actually do.”

The Response Card for Patients

During the introduction and instructions for the ASSIST the HE clarifies which substances are to be covered in the interview and ensures that they are referred to by names which are familiar to the patient.

The Response Card for Patients contains a list of the substance categories covered by the ASSIST together with a range of names associated with each category. It also contains frequency responses for each question. The drug names on the card are those which are most commonly used, but the HE should use the most culturally appropriate names for their location. Check how patients describe particular drugs and use the names that they use.

ASSIST Questions

The ASSIST questionnaire contains prompts and instructions to guide HEs during the interview. While some flexibility is possible in asking the questions, it is important to make sure that all the relevant questions have been asked and that the answers have been recorded. The WITS system follows the skip-out patterns for items not relevant to the patient.

Question 1 asks about lifetime use of substances, that is, those drugs the patient has ever used, even if only once. Every patient is asked this question for all the substances listed. If the patient answers ‘No’ to every substance the HE asks a probing question “Not even when you were in school?” If the response is still ‘No’ to all the substances then the interview is stopped. The exception is for those patients who are not current smokers (via the Tobacco Use pre-screen) or who score negative on the AUDIT-C questions. In those cases, patients who score negative are not asked the ASSIST tobacco or alcohol use questions.

If the patient answers ‘Yes” to Question 1 for any of the substances listed, the HE moves on to Question 2 which asks about substance use in the previous three months. Question 2 is asked for each of the substances ever used. If the response is ‘Never’ to all of the items in Question 2, the HE skips to Question 6. If any substances have been used in the past three months, the HE continues with Questions 3, 4 and 5 for each substance used. Note that Question 5 is not asked for tobacco because it is unlikely that failure to fulfill role obligations would be experienced by tobacco users.

All patients reporting ever having used any substance in their lifetime in Question 1 are also asked Questions 6 and 7 for those substances used in their lifetime.
Question Flow of the ASSIST:

Scoring and Interpretation

Each question on the ASSIST has a set of responses, and each response has a numerical score. The interviewer simply enters the numerical score that corresponds to the patient’s response for each question. At the end of the interview these scores are added together to produce the Specific Substance Involvement Score of responses to Questions 2-7 within each drug category. The score provides a measure of use and problems over the three months prior to the interview for each substance covered by the ASSIST. Each patient may have up to 12 Specific Substance Involvement scores depending on how many different types of substance they have used (e.g., alcohol, tobacco, marijuana, cocaine, etc.).

Patients with ASSIST Specific Substance Involvement scores of three or less (10 for alcohol) are at a lower risk of problems related to the use of the substance involved. While they may use substances occasionally, they are not currently experiencing any problems related to their use and are at low risk of developing health problems related to their substance use in the future if they continue their current pattern of use. Mid-range scores between 4 (11 for alcohol) and 26 for any substance are an indication of at-risk or harmful use of that substance. Patients with scores in this range are at moderate risk of harm from their current pattern of substance use. Included in this risk group would also be patients who score in the lower risk range for alcohol but drink above the recommended guidelines (identified on the AUDIT-C as consuming 5/if male)/4 [if female] or more drinks on one
occasion on a weekly or more frequent basis). Risk is also increased for those with a past history of problems or dependence.

A score of 27 or higher for any substance suggests that the patient is at high risk of dependence on that substance and is probably experiencing health, social, financial, legal and relationship problems as a result of their substance use.

Question 8 on the ASSIST asks about the resent injection of substances. Although not asked for the SBIRT project, patients who score positive for any substance use are asked a similar injection question as part of the GPRA evaluation items. Patients who are injecting more than once a week, or have injected drugs three or more consecutive days in a row are at very high risk of harm, including dependence, infection and blood borne virus contraction, and will require more intensive treatment.

<table>
<thead>
<tr>
<th>Screen Result</th>
<th>HE Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative</strong></td>
<td>Congratulate and provide feedback on lower risk use</td>
</tr>
<tr>
<td>ASSIST score 0-10 for alcohol and 0-3 for other substances</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Positive</strong></th>
<th>Provide Brief Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSIST score 11-19 for alcohol and/or 4-19 for other substances, or ASSIST score 0-10 for alcohol and the AUDIT-C binge question (#3) ≥3.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Positive</strong></th>
<th>Provide Brief Intervention and referral to Brief Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSIST score 20-26 for alcohol and/or other substances, or ASSIST score 20+ for marijuana use*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Positive</strong></th>
<th>Provide Brief Intervention and referral to more intensive substance abuse treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSIST score 27+ for alcohol and/or other substances (except marijuana)</td>
<td></td>
</tr>
</tbody>
</table>

* Note, that for patients who smoke marijuana, those who score 27+ would be referred to Brief Treatment, not to specialized substance abuse treatment. The Brief Treatment modality has been shown to be successful with individuals who may be dependent on marijuana.
GPRA Program Evaluation Questions

The results of the ASSIST screening indicate the services to be provided (“Planned Services”). The planned services category dictates which sections of the GPRA evaluation are to be completed. Answers for all questions in GPRA Section A are required of all screened patients. Additional GPRA sections are required based on the “Planned Services” category.

In the WITS system, the Planned Services are automatically populated based on the ASSIST screening scores. This selection should not be edited by the HEs. If a HE provides additional services (e.g., more intensive than indicated by the screening score), or does not provide any services (e.g., the patient had to leave before the BI could be conducted), those services are recorded as in the Encounters reporting section in the WITS system. The system also reminds HEs whether the patient is potentially eligible for follow-up enrollment.

<table>
<thead>
<tr>
<th>Screen Result</th>
<th>Planned Service</th>
<th>GPRA Sections Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative*</td>
<td>Screening and Feedback</td>
<td>A (no other data required)</td>
</tr>
<tr>
<td>Positive</td>
<td>Not willing to participate in the SBIRT Program (refused service)</td>
<td>A (no other data required)</td>
</tr>
<tr>
<td>Positive</td>
<td>Brief Intervention</td>
<td>A, B</td>
</tr>
<tr>
<td>Positive</td>
<td>Brief Treatment</td>
<td>A, B, C, D, E, F, G</td>
</tr>
<tr>
<td>Positive</td>
<td>Referral to Treatment</td>
<td>A, B, C, D, E, F, G</td>
</tr>
</tbody>
</table>

* Negative refers to screening negative for both alcohol and other substances (with the exception of tobacco). Although the CT SBIRT program provides services for those screening positive for at-risk tobacco use, no GPRA sections are required for a tobacco-positive score if the alcohol and other drug ASSIST scores are negative.
Section 6: Conducting the BI

- The ASSIST-linked Brief Intervention (BI)
- Motivational Interviewing
- FRAMES
- Putting it All Together: Steps for an Effective Brief Intervention
The ASSIST-linked Brief Intervention (BI)

The Brief Intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use is located in the Brief Intervention section of the CT SBIRT Training Manual and on WHO's ASSIST website at:  http://whqlibdoc.who.int/publications/2010/9789241599399_eng.pdf

The ASSIST-linked brief intervention is a short intervention lasting 3 to 15 minutes given to patients who have been administered the ASSIST screening questionnaire. The ASSIST screens for use of all substance types (tobacco products, alcohol, cannabis, cocaine, amphetamine-type stimulants, sedatives, hallucinogens, inhalants, opioids and ‘other’ drugs) and determines a risk score (‘lower’, ‘moderate’ or ‘high’) for each substance. The risk scores are recorded on the ASSIST feedback report card which is used to give personalized feedback to patients by presenting them with the scores that they have obtained, and the associated health problems related to their level of risk.

Asking patients if they are interested in viewing their scores allows the HE to begin a discussion (brief intervention) with the patient in a non-confrontational way, and has been found to be a successful way of getting patients at moderate risk, in particular, to reduce their substance use.

Screening and brief intervention aim to identify current or potential problems with substance use and motivate those at risk to change their substance use behavior by creating a connection, for the patient, between their current pattern of use and the associated risks and harms. Generally brief interventions are not intended as a stand-alone treatment for people who are dependent or at ‘high risk’ from their substance use. However, a brief intervention is used to encourage such patients to accept a referral to specialized drug and alcohol assessment and treatment, either within the health center setting, or at a specialized alcohol and drug treatment agency.

A Model of Behavior Change

A model of behavior change developed by Prochaska and DiClemente provides a useful framework for understanding the process by which people change their behavior, and for considering how ready they are to change their substance use or other lifestyle behavior. The model proposes that people go through discrete stages of change, and that the processes by which people change seem to be the same with or without treatment. The model includes several stages (Precontemplation, Contemplation, Preparation, Action and Maintenance).

Traditional views of motivation held that it was static and therefore, providers had little or no influence over a patient’s motivation. Patients were viewed as either motivated or not motivated. If a patient was not motivated, it was considered their problem, not the health care provider, and sometime the individual was blamed for not being motivated. It is now known that motivation is influenced by provider style and expectancies as well as patient expectancies. Motivation is positively influenced by providers who listen empathetically but is negatively influenced by providers who are confrontational. Assumptions that motivation lies within the individual leads to viewing those who are stuck as resistant, unmotivated, lazy, manipulative, and difficult.

Ambivalence is a normal component when dealing with behavior change. Individuals generally are not unmotivated to change, but instead tend to have multiple motivations. They may know that using substances is harmful to their health, but are also attached to something that holds them back from making that change (substance-using friends, security, self-medication, etc.). The experience of ambivalence protects the side that does not want to change.
The aim of the ASSIST-linked brief intervention is to support people to move through one or more stages of change commencing with movement from precontemplation to contemplation to preparation (also called determination) to action and maintenance. Movement from the stage of precontemplation to contemplation may not result in a tangible decrease in substance use, however is a positive step that may result in patients moving on to the action stage at some time in the future. It is also worth noting that there is no set amount of time that a person will spend in each stage (may be minutes to months to years), and that people cycle back and forth between stages. Some patients may move directly from precontemplation to action following an ASSIST-linked brief intervention. The model is viewed as cyclical rather than linear with relapse occurring so that the individual may recycle back through the stages several times during their life.

Change is a part of life and occurs all the time as a natural and self-directed event among all people. Change occurs in relation to many behaviors and without professional intervention. There is well documented evidence of natural recovery from substance use disorders and smoking in the natural environment. Some examples of common natural changes are going back to college, getting married/divorced, changing jobs, and taking a vacation. Examples of natural changes in substance use are stopping drinking after an accident, eliminating marijuana use prior to applying for a job, increasing alcohol use during a divorce, and decreasing alcohol use after leaving college or military service.

Most people who try to make changes in their substance use behavior will relapse to their former use patterns, at least for a time. This should be expected and viewed as a learning process rather than failure. Few people change on the first attempt and relapse is a good time to help patients review their action plan. A review should examine timeframes, what strategies did actually work and whether the strategies utilized were over-ambitious and perhaps unrealistic. Smokers, for example, make an average of 6 attempts to quit smoking tobacco before they are successful. Having relapsed, they will return to one of the preceding stages: precontemplation, contemplation, preparation or action. For many people, changing their substance use gets easier each time they try until they are eventually successful. In conclusion, the stages of change model can be used to match interventions with a person’s readiness to take in information and change their substance use. While a patient’s stage of change is not formally measured or assessed during the ASSIST-linked brief intervention, it is important that HEs understand these underlying processes to provide the best care for their patients, and not to be too hard on themselves when patient change is not immediately obvious.
Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based practice useful in helping people to resolve their ambivalence (i.e., conflict) about changing behavior, while not evoking resistance (e.g., confrontational, blame, label) and reducing resistance when encountered. MI is a patient-centered and directive counseling style used to build motivation to elicit behavior change. With MI, patients are assisted to explore and resolve their ambivalence about changing a targeted behavior. Resolving ambivalence is accomplished by increasing the awareness of the discrepancy between the patient’s current behaviors and their desired goals while keeping resistance to a minimum.

In the context of the ASSIST screening and linked brief intervention it is likely that the HEs will have a relatively short time to spend with patients (compared with the amount of time that a counselor, psychologist or drug and alcohol worker has to spend with clients, for example). Therefore, the ASSIST manual focuses predominantly on the practical skills and techniques required to deliver a short brief intervention to those at moderate risk, rather than detailing the underlying theory or providing training on delivering lengthy or on-going sessions with patients. In brief, the take-home message for motivational interviewing is meant to be empathetic, nonjudgmental and objective in the delivery of information pertinent to the patient. The brief intervention approach adopted in this manual is based on the motivational interviewing principles developed by Miller and Rollnick.

There are four principles considered as essential to MI. These are:

1. Develop Discrepancy
2. Reduce or “Roll With” Resistance
3. Express Empathy
4. Support Self-Efficacy

The purpose of developing discrepancy is to create a mismatch between where the person has been or currently is and where they want to be. The goal is to resolve the discrepancy by changing behavior. Resistance is a behavior and as such, it is a state not a “trait” of an individual.

The principle of reducing resistance implies that it takes two to resist. It is interpersonal. Fortunately, resistance is highly responsive to the Health Educator’s style. Resistance can be reduced with MI strategies. Specific suggestions for reducing resistance will be discussed below.

Expressing Empathy is one of the most important elements of motivational interviewing. High levels of empathy during treatment have been shown to be associated with positive treatment outcomes across different types of psychotherapy.

The key to expressing empathy is reflective listening, a specific and learnable skill. By listening in a supportive, reflective manner, Health Educators demonstrate they understand the concerns and feelings of the patient. An Empathetic Style will:

- Communicate respect for and acceptance of patients and their feelings
- Encourage a nonjudgmental, collaborative relationship
- Establish a safe and open environment for the patient that is conducive to examining issues and eliciting personal reasons and methods for change
• Allow clinicians to be supportive and a knowledgeable consultant
• Compliment rather than denigrate
• Gently persuade with the understanding that change is up to the patient

When HEs Support Self-Efficacy the patient’s ability to make decisions and choices is recognized and respected. This implies that the responsibility for a patient’s behavior resides with them. In addition, the Health Educator supports the patient as the only one who can make choices about changing behavior.

**OARS**

When using MI, there are several skills that are essential to minimizing resistance and building motivation to change behaviors. As reflected in the acronym OARS, these skills include the use of open questions, affirmations, reflections and summary reflections. Using OARS provides the basic interaction techniques and skills that are used “early and often” in the motivational interviewing approach.

Open Questions invite others to “tell their story” in their own words without leading them in a specific direction. Of course, when asking open questions, the HE must be willing to listen to the person’s response. Open questions are the opposite of closed questions. Closed questions typically elicit a limited response (“yes” or “no”) or brief specific information (I’m from Farmington). The following example contrasts open vs. closed questions. Note how the topic is the same, but the responses will be very different:

- Did you have a good relationship with your parents?
- What can you tell me about your relationship with your parents?

Open-ended questions allow the HE to probe widely for information and assist to uncover the patient’s priorities and values. Additionally, they draw people out.

- What was it like growing up in Bridgeport?
- What can you tell me about your work situation?
- What brings you here today?

Affirmations are statements and gestures that recognize patient strengths and acknowledge behaviors that lead in the direction of positive change, no matter how big or small. Affirmations build confidence in one’s ability to change. To be effective, affirmations must be genuine and express positive regard and caring. Examples of affirming responses:

- I appreciate that you are willing to meet with me today.
- You are clearly a very resourceful person.
- You handled yourself really well in that situation.
- It takes courage to face such difficult problems.
- You really care a lot about your family.
- Your anger is understandable.
Reflections are statements that let the patient know that you heard the patient’s point by stating your hypothesis, or best guess about what was said. Reflections are a way for the HE to check to see if s/he understood what was said and/or meant by the patient. Reflections are made as statements rather than questions and may be a simple reflection of what was heard. The statement could also be a complex reflection by reflecting what the patient experienced and/or felt about the experience. Note that the reflection is a best guess and may not be accurate. The patient’s response to the reflection will either confirm the accuracy of the reflection or provide further clarification. Developing the ability to listen reflectively will increase the accuracy of reflections.

There are two types of reflections, simple and complex reflections. Simple reflections express exactly what was heard. They rephrase (repeat with new words) the patients’ comments. This communicates that you have heard the patient, and that it is not your intention to get into an argument with him or her. Some examples of simple reflections are:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Health Educator</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t plan to quit smoking anytime soon.</td>
<td>You don’t think that abstinence would work for you right now.</td>
</tr>
<tr>
<td>Last time I quit I started to gain weight immediately, it felt like the very next day.</td>
<td>So, you think smoking helps you to maintain your weight.</td>
</tr>
</tbody>
</table>

Complex reflections paraphrase (makes a guess about unspoken meaning) and/or reflect the feeling. There are several types of complex reflections:

- **Amplified Reflections** amplify or exaggerate what was said to the point where the patient may disavow or disagree with it. It is important that the HE not overdo it, because if the patient feels mocked or patronized, he or she is likely to respond with anger.
- **Double-Sided Reflections** mirror both the current, resistant statement, and a previous, contradictory statement that the patient has made. They present both sides of what the patient is saying which is extremely useful in pointing out ambivalence.
- **Reframing** is like giving the patient a new pair of glasses. It suggests a new way of looking at something that is more consistent with behavior change or change talk of the patient.

<table>
<thead>
<tr>
<th>Reflection Type</th>
<th>Patient</th>
<th>Health Educator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amplified</td>
<td>I don’t know why my wife is worried about this. I don’t drink any more than any of my friends.</td>
<td>So your wife is worrying needlessly.</td>
</tr>
<tr>
<td>Double-sided</td>
<td>I know you want me to give up cigarettes completely because of my health problems, but I’m not going to do that.</td>
<td>You can see that there are some real problems because of your smoking, but you’re not willing to think about quitting altogether.</td>
</tr>
<tr>
<td>Reframing</td>
<td>My husband is always nagging me about my cigarette smoking—calling me an addict. It really bugs me.</td>
<td>It sounds like he really cares about you and is concerned, although he expresses it in a way that makes you angry.</td>
</tr>
</tbody>
</table>
Summaries are special applications of reflections. They are used to keep the conversation focused and to direct the conversation. Summaries are particularly helpful at transition points, for example, after the person has spoken about a particular topic, has recounted a personal experience, or when the encounter is nearing an end. Summarizing helps to ensure that there is clear communication between the patient and HE, and to move the conversation along. Also, it can provide a stepping stone towards change.

- “You mentioned a number of things about your current lifestyle, such as cutbacks at work and the stress you feel. You spoke of having little energy for doing some of the things you use to like to do and did to relax. What do you think might help you get back doing some of the things you once enjoyed?”
- “What I have heard so far is that you enjoy smoking. On the other hand, your boyfriend is not happy about your smoking and is worried you might develop a serious disease.” How would you like to see things different in the future?

Giving Advice

People frequently ask when, in MI, can they give advice or provide information to patients. Giving advice or information at the wrong time or with the wrong approach is one way to encourage resistance from our patients. There are three situations when giving advice is appropriate. Advice can be given:

1. When the patient asks for advice and/or information;
2. When you ask permission to give advice;
   - “May I make a suggestion?”
   - “Would you be interested in some resources?”
   - “Would you like to know what has worked for some other people?”
3. If you qualify the advice to emphasize autonomy.
   - “A lot of people find that _____works well, but I don’t know if that’s something that interests you.”

When the person asks for the advice, it’s important not to jump in if you feel that they are not ready or if you think they are not sincere. In these situations it is better to ask permission to get more information BEFORE giving advice.

- “You know, that’s certainly something I can do, but I’m wondering if I really have enough information about the problem to give you good advice right now. Would you mind telling me a little bit more about the situation?”

When resistance is present, it is predictive of (non) change. Resistance is also a signal of cognitive dissonance. In simple terms, cognitive dissonance is an uncomfortable feeling caused by contradictory ideas such as when beliefs and values contradict one’s behavior. People are motivated to reduce the dissonance by changing attitudes, beliefs, and behaviors or rationalizing attitudes, beliefs, and behaviors. When encountering resistance, it is important to avoid arguments with the patient. Do not push back as this places the individual in the position of defending the opposite side. To reduce resistance or roll with resistance implies that the HE go with the direction of the conversation rather than confronting, preaching, or trying to control the conversation. The use of reflections, particularly complex reflections, is one of the ways a HE can accomplish this. It is also
helpful to remind the person (and yourself) about autonomy and let them know that what they do is ultimately their choice.

**Transition from OARS to Change Talk**

Change talk can flow naturally by simply using OARS. The application of OARS is primarily a patient-centered mode and serves the purpose of expanding the patient’s ambivalence about behavior change. Often through empathic, reflective listening, the patient’s ambivalence shifts toward the “change” side and away from the “status-quo” side of the ambivalence. In addition, during this phase trust and rapport have been established to an extent that the patient is ready to collaborate with resolving the ambivalence.

**Recognizing Change Talk VS Sustain (Status-quo) Talk**

Change talk and sustain talk are opposites of the same coin. Sustain talk is an expression that supports keeping things the same. Change talk expresses movement in the direction of change.

- **Sustain talk:** “Marijuana has never really affected how well I do my job.”
- **Change talk:** “If I were to quit smoking, I would be better at my job.”

Understanding how to listen for and generate “change talk” is an essential component of motivational interviewing. HEs should listen for DARN-C and then utilize two forms of strategies to help motivate change: passive –reflective listening strategies and more active self motivation strategies. Commitment talk is thought to be necessary and lead to the most immediate change. There are five types of change talk (DARN-C):

- **D** - Desire to change – “I want to; I would like to; I wish I could…”
- **A** - Ability to change – “I can; I could…”
- **R** – Reasons to change – “I should because; If - then…”
- **N** - Need – “I need to; I have to; I've got to…”
- **C** - Commitment – “I will…”

Our goal with MI in is to increase the change talk and decrease the sustain talk.

**Eliciting Change Talk**

Sometimes, change talk does not occur naturally, and there are tools to use that elicit change talk. The HE should not elicit change talk too early, that is, before the patient has sufficiently explored the ambivalence about the behavior and is now ready to explore and resolve ambivalence about change. It is only at this point that the more semi-directive techniques can be employed. The following list provides some of the strategies for eliciting change talk.

- Ask evocative questions: What help will you need? What is next for you? Any new insights?
- Explore the decisional balance (weighing costs/benefits or pros/cons)
- Ask for elaboration or examples
- Ask “looking back” question: Think back to a time when things were OK, what was different then?
• Ask “looking forward” question: How do you want your life to be different?
• Imagine extreme outcomes: What is going to happen if this gets worse? What is the best thing that could happen if you were to quit?
• Identify “motivation hooks:” What would have to happen to make quitting smoking more important to you?
• Use change rulers/confidence rulers: On a scale of one to ten, how important is it for you to change right now? If you did decide to change, how confident are you that you could do it, on a scale of zero to ten? Why did you choose a 6 and not a 4? What would it take to move you from a 6 to an 8?
• Explore goals and values

Commitment Talk

Commitment talk is the language that confirms something different will happen. The difference between change talk and commitment talk lies in the strength of the statement. During change talk, the idea of change is explored; with commitment talk, the intention is expressed to make the change. A good question to use for eliciting commitment talk is “Will you do it?”

• Change talk: “I know my kids want me to.”
• Commitment talk: “I’ll definitely give it a go.”

A Change Plan

Once commitment is solidified, it is important to move on and help the patient create a plan for making the changes they have committed to make. The change plan should be expressed verbally at minimum but can also be in writing. Ideally, the patient should actually write the plan or complete the form. Responses to the following questions will create a simple but powerful plan for change.

1. The changes I want to make are: (specifics)
2. The most important reasons I want to make these changes are:
3. The steps I plan to make in changing are:
4. The ways people can help me are: Person   Possible Ways to Help
5. I will know that my plan is working if:
6. The things that could interfere with my plan are:
Clinical experience and research into brief interventions for substance use have found that effective brief interventions comprise a number of consistent and recurring features. These features have been summarized using the acronym FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy. A number of the features of FRAMES are associated with Motivational Interviewing. Although HEs do not have to be expert in MI and FRAMES techniques, it is important to have a good working knowledge of these practices, particularly as related to providing an ASSIST-linked brief intervention.

The features of FRAMES most relevant include Feedback, Responsibility and Advice. A description of each of these is given below along with examples of using these techniques within the confines of the ASSIST-linked brief intervention.

**Feedback**

The provision of personally relevant feedback (as opposed to general feedback) is a key component of a brief intervention. This may comprise information about the individual’s substance use obtained from an assessment or screening – in this case an individual’s ASSIST scores – and the level of risk associated with those scores. It is worth noting that many patients are interested in knowing their questionnaire scores and what they mean. Further, information about personal risks associated with a patient’s current drug use patterns that have been reported during the screening (e.g. depression, anxiety, etc.) combined with general information about substance related risks, also comprises powerful feedback.

The ASSIST feedback report card, completed after the ASSIST is scored, is designed to match personal risk (i.e. ‘lower’, ‘moderate’ or ‘high’) with the most commonly experienced problems. In short, feedback is the provision of personally relevant information which is pertinent to the patient, and is delivered by the HE in an objective way. Much of the feedback given in an ASSIST-linked brief intervention can be delivered by reading directly from the ASSIST feedback report card.

**Responsibility**

A key principle of intervention with substance users is to acknowledge and accept that they alone are responsible for their own behavior and will make choices about their substance use and about the course of the brief intervention given by the HE. Communicating with patients in terms such as, “Are you interested in seeing how you scored on this questionnaire?”, “What you do with this information I’m giving you is up to you” and “How concerned are you by your score?” enables the patient to retain personal control over their behavior and its consequences, and the direction of the intervention. This sense of control has been found to be an important element in motivation for change and in decreasing resistance. Using language with patients such as, “I think you should… ”, or “I'm concerned about your (substance) use” is likely to create resistance in patients and causes them to maintain and defend their current substance use patterns.

**Advice**

A central component of effective brief interventions is the provision of clear objective advice regarding how to reduce the harms associated with continued use. This needs to be delivered in a
non-judgmental manner. Patients may be unaware that their current pattern of substance use could lead to health or other problems or make existing problems worse. Providing clear advice that cutting down or stopping substance use will reduce their risk of future problems will increase their awareness of their personal risk and provide reasons to consider changing their behavior. Advice can be summed up by delivering a simple statement such as, “The best way you can reduce your risk of (e.g. depression, anxiety, etc.) is to cut down or stop using”. Once again, the language used to deliver this message is an important feature. Comments such as, “I think you should stop using (substance)” or “I’m concerned about your use of (substance)” do not comprise clear objective advice.

All patients screened using the ASSIST should receive feedback regarding their scores and level of risk and be offered information about the substances they use. For patients whose ASSIST score indicates that they are at low risk of substance related harm for all substances this level of intervention is sufficient. Patients who are at low risk or abstainers should be congratulated and encouraged to remain that way.

Patients whose ASSIST score indicates that they are at moderate risk of harm (Specific Substance Involvement score between 11 and 26 for alcohol, and 4 and 26 for other substances) should be offered a brief intervention. People who are injecting less than once a week, and have not injected drugs three or more times in a row during the last three months also could be given a brief intervention by the health care professional including the "Risks of Injecting" card. A brief intervention suitable for use with these patients is described in detail in the companion document “Brief Intervention for Problematic Substance Use. A Manual for Use in Primary Care.” Patients whose Specific Substance Involvement score is 27 or more for any substance, and/or have regularly injected drugs in the last three months are likely to be at high risk and substance dependent and require more than just a brief intervention. These people require further assessment and more intensive treatment. This may be provided by the health care professional(s) within that primary care setting, or, by a specialist drug and alcohol treatment service if these agencies exist and are accessible for the patient within a reasonable period of time.
Putting it All Together: Steps for an Effective Brief Intervention

The following are steps to an effective BI adapted from the WHO ASSIST Brief Intervention manual that are specific to CT SBIRT.

1. Ask patient if s/he would like to see their questionnaire score
2. Provide personalized feedback using the ASSIST Feedback Report Card and other handouts
3. Give advice about how to reduce risk associated with substance use
4. Allow patient to take the ultimate responsibility for his/her choice
5. Ask patient about his/her thoughts on the score and cutting back (or stopping)
6. If patient is resistant to change or ambivalent about changing, utilize pros and cons exercise or readiness ruler to develop discrepancy and elicit change talk. Link information to the patient’s ASSIST responses.
   If patient is in agreement about wanting to quit or cut back, develop change plan by using brochures or hand-outs
7. Summarize and reflect on patient’s concerns. Reinforce change plan, if one has been made. For those not ready to change, vow to assist them when they are ready
8. Provide take-home information

Asking Permission to Show ASSIST Score.

HEs always ask permission to provide feedback, suggestions or advice: Are you interested in seeing the results of the questionnaire we just completed?

Providing Personalized Feedback

The ASSIST Feedback Report Card is populated with data from the ASSIST questionnaire and is used to provide personalized feedback to the patient about their level of substance related risk (see sample in the ASSIST Brief Intervention manual in the Brief Intervention section of the CT SBIRT Training Manual). The patient may view the report card on the HEs computer, or a hard copy may be provided to the patient to take home as a reminder of what has been discussed. The report card shows each substance category with the associated score. At the bottom of the report card is an indication of what the scores mean. The HE reads this information to the patient before describing the risks associated with the patient’s use.

What do your scores mean?

- **Low:** You are at low risk of health and other problems from your current pattern of use. *When a person scores in this range, their risk level is very low and we rarely mention it*
- **Moderate:** You are at moderate risk of health and other problems from your current pattern of substance use. *When a person scores in this range, they are often beginning to develop some unseen health risks — their lungs may be getting black from smoking or their blood pressure may be going up because of alcohol use but they are usually unaware of it. They are also at greater risk from car accidents, from drunk driving, falls and other accidents or drug related fights or injuries*
• **High**: You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent. *When individuals score in this range, they are often dependent on the substance and it is beginning to control many areas of their life.*

At this point, the HE might ask the patient: *What do you make of your scores?* This is frequently a serious moment for the patient. He or she may say something like: “I need to quit or cut back or make some changes.” This is an important time for the HE to reflect back to the patient what he or she is saying. “So it’s important to you to make some changes like cutting back or quitting.” When the patient is at high risk for more than one substance, the HE asks: *Which of these substances concerns you the most?* It is important to allow the patient to direct the session, even if he or she chooses tobacco and is at a very high risk for another substance. After doing a BI on the substance that concerns the patient the most, if the patient has mentioned being concerned about any of the other substances, it is fine to say, “You mentioned when you saw your risk number for (other substance) that you were concerned. Would it be OK if we talk about that for a few minutes?” A second BI should be done on another substance as well, and even a third if the patient expresses an interest or desire.

The HE then reviews the most pertinent risks from the ASSIST materials by showing the patient the laminated card for the substance of discussion (there is a risk card for each category of psychoactive substance with risks ranked from least to most serious). The HE links the risks on the card to the patient’s presenting medical problem when possible. Using alcohol as an example, card follows:

<table>
<thead>
<tr>
<th>Alcohol</th>
<th>Regular excessive alcohol use is associated with:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hangovers, aggressive and violent behavior, accidents and injury, nausea and vomiting</td>
</tr>
<tr>
<td></td>
<td>Reduced sexual performance, premature aging</td>
</tr>
<tr>
<td></td>
<td>Digestive problems, ulcers, inflammation of the pancreas, high blood pressure</td>
</tr>
<tr>
<td></td>
<td>Anxiety and depression, relationship difficulties, financial and work problems</td>
</tr>
<tr>
<td></td>
<td>Difficulty remembering things and solving problems</td>
</tr>
<tr>
<td></td>
<td>Birth defects and brain damage in babies of pregnant women</td>
</tr>
<tr>
<td></td>
<td>Permanent brain damage leading to memory loss, cognitive deficits and disorientation</td>
</tr>
<tr>
<td></td>
<td>Stroke, muscle and nerve damage</td>
</tr>
<tr>
<td></td>
<td>Liver disease, pancreas disease</td>
</tr>
<tr>
<td></td>
<td>Cancers of the mouth, throat and breast</td>
</tr>
<tr>
<td></td>
<td>Suicide</td>
</tr>
</tbody>
</table>
“This card shows some of the risks associated with heavy alcohol use. As you can see it includes not only accidents and injuries, but also digestive problems and high blood pressure, both of which are issues you have discussed with your provider today.”

Giving Advice to Reduce Risks Associated with Use

The HE then provides advice about moving from the higher risk category to the lower risk category. The HE always asks permission to provide feedback, advice or other suggestions: “May I provide you some advice for reducing these risks? Once the patient assents: Our best advice to move into this lower risk category (point to lower risk category) is to stop using altogether or cut down on your drinking. To avoid these risks and other risks in the future, our best medical information shows that (Show card to patient),

- For men, the recommended limit is no more than 2 drinks a day or 14 drinks per week. We also suggest that you don’t drink more than four drinks on any one occasion.
- For women, the recommended limit is no more than 1 drink per day or 7 drinks per week. We also suggest that you don’t drink more than three drinks on any one occasion.
- A standard drink is a regular 12-oz bottle or can of beer, a 5 oz glass of wine or a 1 ½ shot of hard liquor (gin, vodka, rum, whiskey, etc.).”

Allowing Patient to Own Responsibility

The HE then allows the patient to take the responsibility for his or her choice: “I’m here to provide you with some education and advice, but what you do with the information is very much up to you!”

Eliciting Patient Thoughts on ASSIST Score and Cutting Back (or Stopping Use):

The HE asks for the patient’s thoughts about the conversation thus far: So what are your thoughts about your scores and about cutting back on your use? OR, “You seem surprised about your score?”

For Patients Resistant to Change or Ambivalent About Changing

As described earlier, HEs may explore the decisional balance exercises (weighing costs and benefits; pros and cons), utilize “looking back” questions (to a time when things were ok), use change rulers, etc. to keep resistant or ambivalent patients engaged in the conversation. The decisional balance is a good way to help the patient verbalize ambivalence: “On a positive note, what are the good things about drinking alcohol?” Allow the patient to be honest. Help the patient to think by asking, “What else?” When the patient can’t think of anything else, ask, “What, if any, are the not so good things about it?” Each time the patient states a not so good quality, it is important to reflect the patient’s response so that s/he has heard himself/herself say it, and then heard you repeat it. In summarizing the decisional balance, it is important to always use the word “AND” instead of “BUT.” For example, “So the good things are that it relaxes you, it tastes good with a meal and is something that connects you with friends. And at the same time, some of the not so good things are that you have had an automobile accident related to your drinking, and your doctor says that your blood pressure is too high.”

The confidence and readiness rulers may also be helpful in eliciting change-talk. The HE starts by asking, “Could I get your thoughts on something?” If patient assents, the HE shows the ruler card. For the confidence ruler, the question is “If 0 is not confident at all, and 10 is I am very confident that I can cut down, where do you put yourself?” “There is no right or wrong answer to this question - it is purely a personal choice based
on your thoughts and feelings.” If the patients says a number like 6, the HE asks “Why not a 4 or a 5?” and then, “What, if anything might help you get to an 8?” If the patient is stumped, the HE may respond by saying, “Would you be interested to know some of the things that have helped other people gain confidence?”

For the readiness ruler, the question is the same: “If 0 is not ready at all, and 10 is I am very ready to cut down, where do you put yourself?” If the patient scores himself low, such as a 3, the HE responds, “Why 3 and not 1?” If the patient scores low in all areas and is not interested in change, it is important for the HE to recognize that the patient is in the precontemplation or contemplation stage of change and is not ready to prepare for action. It is important for the interviewer to recognize that good work has been done regardless of the patient’s motivation, simply because the patient has begun to identify some significant personal needs and has spent time thinking about them with the HE. The interviewer should not feel a need to push, pull or convince the patient to move toward change. Thank the patient for his or her honesty. Thank them for taking the time to look at their health risks. Say something like, "In conclusion," then reflect their scores for them and important statements that they have made during the interview. Ask if you might give them some take-home materials related to the things that they were just discussing and select the appropriate handouts. If, however, the patient scores himself or herself at a high number for readiness or has indicated earlier in the conversation that s/he is ready to change, it is time to work with the patient to develop a plan.

Developing Change Plan for Patients Ready to Change

Before starting the change plan phase, it is important to stop and collect important statements from the interview: The HE will begin with responses such as, "So you are ready to move forward in your life." “What is your plan? or, What will be your target date to stop?” The HE will allow the patient to make his own statements before offering any prompts. While the patient is the one who knows his home life and personality best, the interviewer may have more information about options. The goal is to create a plan together, while at the same time allowing the patient to be in the driver’s seat.

If the patient lacks confidence in making a plan, the HE asks questions such as, “What big changes have you made in the past? What gave you the greatest support to make a change? Where would you like to see yourself in a year from now? What would your life look like? What will it take to realize those goals?” If the patient is uncertain or draws a blank, the HE may ask, “May I share with you a few support options that other people have found helpful?” The HE should utilize the project-specific change-plan booklets, pamphlets and hand-outs with the patients for the particular drug: “What if we take a look at this pamphlet – How to Cut Down on Your Drinking (smoking or drug use) and go through it together to develop a change plan for you.” Successful change-plan components will include:

- the patient’s important reasons for change;
- his or her steps to make in changing;
- who can help the patient change and how these people may help; and
- Identification of high risk situations that could interfere with the patient’s plan and ways to avoid those situations.

If the patient is fairly confident about making a change plan, the HE should ask “What will be your target date to make this happen?” and negotiate a date with the patient.
Summarizing

Once completed, HEs summarize the interview, reflect on the patient’s concerns, reinforce the change plan, if one has been made, and vow to assist those not ready to change. At the end of the conversation and before leaving the room, the HE should thank the patient for taking the time to think and talk about these issues together. It is important to leave on a positive note, expressing confidence in the patient's ability to move forward. Even in the most resistant of circumstances, the interviewer may say something like, "Thank you for your time, your honesty and the thought you have put into our talk today. I am very confident that when the time is right and it becomes important to you, you will be ready to move forward. Should you want or need any extra support from me or anyone else on our team, this is a phone number that you can call for assistance. Again my name is _____________; Health Educator with ________________. It's been a pleasure talking with you."

Provide take-home information

At the end of the interview, the HE should ask the patient if it would be okay to give some additional resource materials. If the patient agrees, the interviewer should select materials that are appropriate for the patient.
Section 7: Referring a Patient to Treatment

- Making a Referral to Treatment (BT or RT)
- Medication Referrals for Tobacco Cessation
- Helpful Scripts for the Referral Process
- CT Defined Levels of Care
- Locating Substance Abuse or Mental Health Services in CT
Making a Referral to Treatment (BT or RT)

RT provides those identified as needing more intensive treatment with access to specialty care. The effectiveness of the referral process to specialty treatment is a strong measure of SBIRT success. The referral process involves a proactive and collaborative effort between SBIRT providers and those providing specialty treatment to ensure access to the appropriate level of care. Patients will be referred to either Brief Treatment (BT) or more intensive treatment based on a diagnostic assessment completed by a licensed substance abuse therapist. High risk patients who are not willing to participate in more intensive treatment or who are wait-listed for treatment will be offered BT as an alternative.

BT consists of 6-8 sessions of manual-guided therapy aimed at substance use disorders such as alcohol abuse or marijuana dependence. The services will be offered through the health center’s behavioral health department if licensed to provide substance abuse treatment or through partnering substance abuse treatment agencies. Substance abuse counselors at the health centers and at the treatment agencies will be trained and certified by UCHC staff to provide SBIRT BT services. CT SBIRT BT is available to all patients whether or not they are insured or Medicaid eligible. A key aspect of CT SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community’s substance abuse (SA) treatment programs with a network of early intervention and referral activities conducted in medical service settings.

Referrals to BT and to more intensive services will be conducted as per each health center’s specific protocol, but general procedures are as follows:

**The Health Educator will make a referral to BT when:**

- Patient scores 20-26 on the ASSIST for alcohol and/or other substances
- Patient scores 20 or higher for marijuana (i.e., all patients scoring in the moderate to high risk category for marijuana use are referred to Brief Treatment)
- Patient scores 27 or higher on the ASSIST (is in need of more intensive services) but refuses or is wait-listed for more traditional SA treatment.

**The Health Educator will make a referral to more intensive substance abuse treatment when:**

- Patient scores 27 or higher on the ASSIST for alcohol and/or other substances
- Patient requests an alcohol or other drug service referral
- Patient answered yes to the injection question on the GRPA
- Patient scores in a lower risk category (e.g., BI or BT) but the HE feels it is appropriate to make a discretionary referral. This may be due to inconsistent answers on the ASSIST, because the patient has had issues with substance abuse in the past, or simply because the conversation during the brief intervention determines the need for more intensive services.
Process for Making a Referral:

- HE screens the patient
- HE provides a brief intervention to the patient
- HE identifies patient in need of BT or more intensive treatment based on ASSIST score and brief intervention conversation
- HE asks for patient’s consent for a referral and completes (site-specific) authorization to disclose health information as applicable. HEs should use the appropriate site-specific Release of Information (ROI) form when making a referral to an outside agency.
- HE contacts the SBIRT-affiliated in-house or off-site behavioral specialist to set up an appointment. Whenever possible, HE attempts a “warm” hand-off of the patient. Ask if the behavioral specialist is available and introduce the patient in-person or over the telephone. If not possible, assist the patient in making an appointment through the usual reception staff. If the referral is in-house, walk the patient to the office location so that he or she knows where to come for their appointment.
- HE provides the BT clinician with a copy of the Patient Feedback Report and when applicable, a copy of the signed ROI.
- HE provides the patient with the referral information as well as the HE’s card if the patient prefers to make the appointment him/herself.
- HE telephones patient at home to assist in making the referral if patient does not have time during the medical visit appointment and requests to be phoned at home.
- HE follows up with the patient over the phone to ensure that patient has made the appointment or if they were able to attend their first session, if the appointment was made at the time of the medical visit. HEs also determine if patients need additional assistance with the referral.
- For BT referrals, HE maintains contact with the behavioral specialist to monitor treatment compliance and completion. Once the patient has completed treatment, or if the patient drops out of treatment, the HE conducts a discharge interview with the patient and obtains the necessary documentation from BT counselors (see next bullet).
- See Section 8, Tracking Referrals to Treatment (BT or RT) for detailed instructions on maintaining and recording contact with patients, obtaining the necessary documentation from BT counselors (Brief Treatment Evaluation Reporting Form), and recording patient referrals in WITS.

Medication Referrals for Tobacco Cessation

Although technically not a component of the SAMHSA/CSAT SBIRT program, CT SBIRT is screening for tobacco use and providing BIs for tobacco cessation. It is likely that HEs, after conducting a tobacco-related BI, might motivate a patient to request nicotine replacement therapy (NRT) or other smoking cessation medication from their provider. As of January 1, 2012, NRT (patch, gum, lozenge, etc.) and other non-NRT pharmacological treatments (Chantix, Zyban) are covered under Medicaid insurance (HUSKY A, HUSKY C, HUSKY D). Providers may also be reimbursed for smoking cessation counseling visits as of January 1st.
Note: The health centers cannot bill for the HE’s services, the provider must prescribe the product and also provide the tobacco cessation counseling for billing purposes. Because this is a new program to the State, many providers may be unaware of tobacco cessation products and counseling reimbursement codes and may not have the codes incorporated in their billing systems. HEs must be sensitive to this issue and work with staff at the Health Centers to institute the new procedures.

If a patient decides after receiving a BI that s/he would like to have a prescription for NRT or other pharmacologic therapy, HEs should advise the patient to make another appointment with their provider for smoking cessation (the HE can help facilitate this appointment). In order for the provider to be reimbursed for tobacco cessation counseling services, the patient will need to come back for another medical appointment. Providers cannot bill for smoking cessation counseling AND the medical visit (occurring on the same day). When the patient returns, the provider can bill for the encounter and write the prescription at the same time. The HE should work with the provider in integrating these procedures with the SBIRT program.

**Helpful Scripts for the Referral Process**

Following are several HIPAA-compliant scripts that HEs may find helpful in communicating with patients about the alcohol or other drug use treatment referral process. HE's should record all communications with the patient in the Notes section of WITS.

HEs should refer to Section 8, Tracking Referrals to Treatment (BT or RT) for detailed instructions on maintaining and recording contact with patients, obtaining the necessary documentation from BT counselors (Brief Treatment Evaluation Reporting Form), and recording patient referrals in WITS.

**Voicemail Script**

Hello, this message is for [first and last name of patient]. This is [HE first and last name] and I'm a Health Educator calling from [FQHC site] about your visit on [date of screen].

I'd like to take a few minutes to follow-up with you. Please call me at [HE work number]. You can reach me between [__hours__].

I look forward to hearing from you. Thank you!

**Someone Answers Script**

Hello, my name is [HE first and last name] calling from [FQHC site]. May I please speak with [first and last name of patient]?

Follow either the Speaking with the Patient Script or Leaving a Message Script as appropriate.
Speaking with the Patient Script

The person that answers the phone says that s/he is the patient:

*Hi, [first name of patient]. This is [HE first and last name]. I am a Health Educator at [FQHC site] and I am following up on a conversation we had on [date of screen]. This will only take a few minutes. Is this a good time to talk?*

If yes, go to Confirming Patient Identity Script. If no, go to the Scheduling an Appointment Script.

Leaving a Message Script

The person answering says that the patient is not there:

*Okay, I am calling because [first name of patient] visited [FQHC site] and I'd like to follow up with him/her on his/her visit. Would you please tell me when the best time is to call back and talk to him/her?*

HE records the best time to call back if the information is available. *Thank you. Could I please leave a message for him/her?*

**If yes:** My name is [HE first and last name] and I’m a Health Educator calling from [FQHC site]. I’d like to follow-up with [first name of patient] about his/her visit. My phone number is: [HE work number]. Thank you very much for your time. Goodbye.

**If no:** Okay, I will try calling back at another time. Thank you for your time. Goodbye.

Call Back Protocol

If HEs leave a message with someone or schedule an appointment with a patient and do not hear back from the patient after two days, attempt the follow-up process again. HEs should attempt to call the patient up to three times.

Scheduling a Phone Appointment Script

The patient does not have time to talk:

*Okay, that’s not a problem. We can schedule an appointment to talk another time. I am available [day available] at [time available] or [alternative day/time]. Which time would work best for you?*

The patient agrees to a time or s/he suggests another time that works:

*Great, I’ll give you a call on [day] at [time]. It shouldn’t take more than a few minutes. Thank you for your time. Talk to you soon. Goodbye.*

The patient does not agree to a time (s/he is too busy or says s/he will call you back):

*I understand how hard it is to find a good time. Did you have any questions about why we’re calling? If so, HE answers the questions and attempts to schedule an appointment again. If not: Okay, I’ll go*
ahead and leave my number with you. It is [HE work number]. I look forward to talking with you soon. Thank you for your time. Goodbye.

Confirming Patient Identity Script

The patient should provide the HE with information about what s/he recollects about their last meeting together. The HE should not volunteer information because the HE has not yet confirmed that s/he is talking to the correct person. This is important to ensure confidentiality.

The patient has time to talk:

In order to protect confidentiality, I need to verify some information. Would you please tell me your date of birth? (Confirm with records)

If HE is confident that s/he is speaking with the correct person, go to Main Interview Script.

If HE has any suspicion that this is not the person despite answering the birth date question correctly: Would you please tell me a little bit about the conversation we had at the health center?

If the HE is confident that s/he is speaking with the correct person, go to Main Interview Script.

If the HE is unsure whether this is the actual patient, stop the interview and say:

Since I’m only able to speak with an identified patient, I’d like to leave my number so that [first name of patient] can call me. Go to Leaving a Message Script.

Main Interview Script

To determine if patient has attended a scheduled treatment appointment:

Thank you for providing that information. I’d like to follow-up with you about our conversation on [date of screen] and your referral to treatment. I want to see if you were able to attend your first session, if you have any questions about your referral, or if I can assist you in any way. To get started, do you have any questions or concerns about your referral?

Were you able to attend your appointment?

**If yes:** Great? How did that go? When is your next appointment? (Record this information.) Go to Ending the Call Script.

**If no:** If it’s alright with you, I’d like to assist you with in rescheduling and in getting to your first treatment appointment. Go to the Assisting with Referral Guide below.
To determine if patient has scheduled a treatment appointment:

Thank you for providing that information. I’d like to follow-up with you about our conversation on [date of screen] and your referral to treatment. I want to see if you have any questions about your referral or if I can assist you in any way. To get started, do you have any questions or concerns about your referral?

Have you scheduled an appointment with a treatment facility?

If yes: Where? When is your scheduled appointment? (Record this information.) Go to Ending the Call Script.

If no: If it’s alright with you, I’d like to assist you with your referral. Go to the Assisting with Referral Guide below.

Assisting with Referral Guide

HEs assist the patient as much as possible to successfully schedule (and attend) an appointment with a treatment provider. This may include calling the treatment provider, offering contact and location information, and problem-solving around logistical issues (e.g., insurance, transportation, child care). HEs should remind the patient that the SBIRT BT therapy is free of charge to those who do not have insurance and are not Medicaid-eligible.

Ending the Call Script

Thank you for speaking with me today. If appropriate: Please feel free to call me at [HE work number] if you have any further questions or concerns. Thank you for speaking with me. Goodbye.

CT Defined Levels of Care.

Because the referral process varies across sites, Health Educators should be familiar with not only the on-site behavioral health services or the partnering treatment providers, but also the mental health and substance abuse providers in their area. In CT, the following are definitions of levels of care:

Ambulatory Detox. Ambulatory Detoxification happens on an outpatient basis as opposed to inpatient. This is generally appropriate for people who are addicted to an opiate, such as heroin, that do not want to be in a methadone maintenance program. They will typically need to go to the clinic multiple times a week for their withdrawal medication.

Inpatient Detox. Inpatient Detoxification happens in a 24/7 residential setting for approximately 3-5 days.

Methadone Maintenance. Methadone maintenance is for individuals who are addicted to heroin or painkillers that want to use methadone on a long term basis for the purpose of getting off and staying off of the other drug(s) to which they are addicted. Patients will need to go the clinic daily for at least 3 months for their methadone dosing.
Outpatient Services

*Standard Outpatient.* Standard Outpatient treatment is a typical once per week service appropriate for people that need minimal support in their recovery.

*Intensive Outpatient.* Intensive Outpatient treatment occurs for 3 hours per day (either day or evening hours), 3 days per week and is appropriate for people that need additional support to remain drug/alcohol free.

*Partial Hospitalization.* Partial hospitalization is an aggressive outpatient service, generally 12-15 hours per week, and is appropriate for individuals needing a great deal of support and who often have other issues such as homelessness or a serious co-occurring mental health disorder.

Residential Services

*Intensive Residential.* Intensive residential treatment is a 21-28 day residential program for someone either coming out of detox and/or who hasn't been in an Intensive program before or who has relapsed and needs an Intensive refresher course on the basics of addiction and maintaining recovery. They may have employment or stable housing upon discharge from the program.

*Intermediate Long-Term Residential.* Intermediate Long-Term residential treatment is a 60-90 day residential program for someone coming out of detox and/or who hasn't been in an Intermediate Long-Term Program before and who needs a longer term length of stay to strengthen their recovery skills, find employment or housing, or stabilize some other major life issue related to their addiction.

*Long-Term Care.* Long-Term Care is the longest type of residential treatment and is appropriate for someone coming out of detox and/or who hasn't been in a Long-Term Care program before and who needs a long term length of stay. These are generally people who have a long history of addiction and relapses and who have never been able to maintain a period of sobriety. The program is generally 6-9 months long.

*Transitional Housing/Halfway House.* Transitional Housing, otherwise known as Halfway Houses, are residential programs for people who have completed some type of residential treatment and who are in need of minimal support for maintaining their recovery. The length of stay is generally 1-3 months and the focus is on finding permanent housing and employment.

Locating Substance Abuse or Mental Health Services in CT

More intensive (than SBIRT) services are best accessed through CT’s Department of Mental Health and Addiction Services (DMHAS). DMHAS promotes and administers comprehensive, recovery-oriented services in the areas of mental health and substance abuse treatment throughout the State. Its mandate is to serve adults (over 18 years of age) with psychiatric or substance use disorders, or
both, who lack the financial means to obtain such services on their own. DMHAS also provides collaborative programs for individuals with special needs, such as persons with HIV/AIDS infection, people in the criminal justice system, those with problem gambling disorders, substance abusing pregnant women, persons with traumatic brain injury or hearing impairment, those with co-occurring substance abuse and mental illness, and special populations transitioning out of the Department of Children and Families. Its website: http://www.ct.gov/dmhas may be accessed via the HE’s laptop. A comprehensive listing of services, by region, may be found in the Referral to Treatment section of the CT SBIRT Training Manual.

CT services are administered through five regional offices directed by regional managers.

HEs are encouraged to telephone the regional managers if difficulties in obtaining appropriate mental health or substance abuse services for patients are encountered.
## Regions and Regional Managers for the State

<table>
<thead>
<tr>
<th>Region</th>
<th>Cities/Towns</th>
<th>Manager</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Westport, Wilton.</td>
<td>Wayne Starkey</td>
<td>860-262-5355 or 860-418-6835&lt;br&gt;<a href="mailto:wayne.starkey@po.state.ct.us">wayne.starkey@po.state.ct.us</a></td>
</tr>
<tr>
<td>2</td>
<td>Ansonia, Bethany, Branford, Chester, Clinton, Cromwell, Deep River, Derby, Durham, East Haddam, East Hampton, East Haven, Essex, Guilford, Haddam, Hamden, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Milford, New Haven, North Branford, North Haven, Old Lyme, Old Saybrook, Orange, Portland, Seymour, Shelton, Wallingford, Westbrook, West Haven, Woodbridge.</td>
<td>Wayne Starkey</td>
<td>860-262-5355 or 860-418-6835&lt;br&gt;<a href="mailto:wayne.starkey@po.state.ct.us">wayne.starkey@po.state.ct.us</a></td>
</tr>
</tbody>
</table>
Section 8: Program Evaluation, Follow-up and Tracking

- SAMHSA-CSAT's Program Evaluation
- Tracking Referrals to Treatment (BT or RT)
- Implementation Phase-in
SAMHSA-CSAT’s Program Evaluation

What is the follow-up program evaluation?

The follow-up evaluation is a voluntary aspect of the CT SBIRT Program that allows the team and the funding agency to assess the effectiveness of SBIRT services for patients over time. The funding agency, SAMHSA-CSAT, requires that SBIRT projects follow a percentage of patients at six months post treatment to measure the effectiveness of the SBIRT program and to see if the CT SBIRT service may have had an impact on their substance use and quality of life factors. At follow-up, staff from UCHC ask the same GPRA questions that were asked during the patient’s initial interaction with SBIRT HE staff. When patients qualify for the follow-up, Health Educators emphasize the following:

- The CT SBIRT Program wants to check-in with them about progress toward their health goals
- As an incentive, patients receive a $20 gift certificate upon completion of the interview
- It is important to have accurate contact information in order to follow-up with them

How many people does CT SBIRT follow?

- SAMHSA requires that all SBIRT grantees ask 10% of patients receiving a brief intervention, referral to brief treatment or referral to more intensive treatment to be contacted for a follow-up interview. CT SBIRT is expected to successfully contact 80% of those people.
- Overall, CT SBIRT anticipates screening approximately 56,700 patients, of which 14,700 are expected to receive a brief intervention or referral to brief treatment or more intensive treatment. All SBIRT grantees are expected to follow 10% of those receiving services (~1,470 for CT SBIRT).
- HEs must collect good contact information from the patient since it is required by the funding agency to complete a minimum of 80% of those asked to be contacted at 6 months.

Who will be followed?

- Every 10th patient whose screening score indicates a “Planned Service” category of BI, BT or RT, and as identified by the WITS application, is asked for permission to be contacted in 6 months for a follow-up interview.
- The WITS application alerts the Health Educators when a patient has been flagged for follow-up.
- Health Educators are responsible for collecting the minimally required contact information so that UCHC evaluation staff can successfully contact the patient at 6 months.
- The patient population receiving SBIRT services is highly mobile and many do not maintain a landline or long-term phone number, making follow-up contact a constant challenge.
Obtaining patient permission to follow

It is the responsibility of the Health Educator (HE) to explain to the patient that they have been randomly selected for program evaluation. If the patient agrees to be contacted, Health Educators will be prompted by the WITS application to obtain locating and collateral contact information.

Asking patients to participate in the follow-up interview is the LAST step of the patient interaction. Patients will receive the necessary intervention (brief intervention, referral) first, to ensure that their clinical needs are met. Evaluation, while important, is secondary to service delivery. Some tips for introducing the follow-up evaluation to patients:

- Thank them, sincerely, for taking the time to speak with you. Reiterate how valuable this conversation has been and that you appreciate them feeling comfortable answering all the questions.
- Let them know that their information will be used to help evaluate whether screening services are beneficial. The information can help secure additional funding and support to help others like themselves.
- In order to evaluate the effectiveness of the program, a random set of patients screened are eligible for what’s called a “follow-up evaluation.” This means that in approximately six months, an evaluator from the SBIRT team, who keeps all information confidential, will call them to ask some of the same questions and just check to see how they are doing. This individual will be calling from the University of Connecticut Health Center.
- For their time, if they agree this is something they would like to do, they will receive a $20 gift card upon completion of the follow-up interview.
- If they show interest, let them know that the only real requirement is that they have several points of reliable or stable contact information. This is important because the follow-up team needs to be able to locate the patient (there cannot be a follow-up interview without correct contact information).
  - Be sensitive to homeless patients. Although CT SBIRT does not want to exclude patients from the follow-up evaluation, there is a limited budget for tracking patients. If a HE’s patient cannot provide at least two stable contacts (including phone number), the patient cannot be included in the follow-up.
- Obtain the patient’s written permission to be contacted by having him or her sign the site-specific consent form. File this signed consent form with the patient’s health center record.

Sample Script to be used after the SBIRT services have been completed; when asking patients to participate in the follow-up evaluation.

Thank you for the time you have spent with me today. As part of our program, we follow up with some of our patients to see how our services are making a difference.

You have been randomly selected to be part of our follow-up evaluation. Agreeing to be contacted gives you a chance to provide us feedback about how our program is working. We want to know whether a brief
conversation with a Health Educator can have a positive effect on individuals who use tobacco, alcohol or other substances that may put them at risk for various health problems.

By participating in this follow-up interview, you help us to support these services in the future. You will be given the opportunity to provide feedback about our program and we will also check in with you about your health goals.

Your participation in this evaluation is completely voluntary, and you may choose to skip any questions that make you uncomfortable.

Your decision whether or not to be contacted for an interview will not affect your patient care with ______________(FQHC). You are being asked to be contacted because you were randomly selected by the computer and you are a ______________(FQHC) patient.

You will receive a $20 gift card once the interview is complete. If you agree to participate in this follow-up interview, you will be asked to sign a consent form giving us permission to contact you. If you have any questions about participating in this evaluation you may contact Thomas Babor, the Evaluation Director at 860-679-5459.

If the patient agrees to participate, give the patient the Follow-up Reminder card (with the approximate follow-up date entered) and be sure to continue saying:

My co-worker, named Robin at the University of Connecticut Health Center, will be calling you in the next month to introduce herself and update your contact information. She will be the one responsible for conducting the interview in 6 months. The only thing we ask of you is that you provide us with accurate contact and locating information and are available to answer the questions in 6 months. Robin will be the one mailing the $20 gift card, so it’s important that she have your correct information.

Thank you for helping us in this important evaluation of our work.

Collecting patient locating information

If the patient is identified as a member of the 10% sampling pool, the WITS application will prompt the HE to obtain the necessary patient locating information. A patient record cannot be saved without the completion of certain required fields (highlighted in bright yellow). HEs inform patients that this information will help us reach you when it’s time for your follow-up interview. It will only be used to locate you for your follow-up and will not be given to anyone except the follow-up specialist at the University of Connecticut Health Center, who will be contacting you.

- HEs may need to remind the patient that the contact information is kept in a secured location and is only used to follow patients over time to see how they are doing. It will not be used for billing purposes or placed in their health center medical record.
- Required fields are highlighted in bright yellow and must be complete before the record can be saved. Fields with a white background are encouraged, but not required by the system.
- Required patient information includes: First and last name, gender, date of birth and social security number. Patients who do not have, or do not wish to share their social security
number are assigned a number starting at 000-00-0000, and can be increased by one every time the instance occurs (e.g., 000-00-0001, 000-00-0002, etc.). 000-00-0000 is the only number that can be used more than once. The program flags all other duplicate social security numbers, so this procedure must be followed at each Health Center.

- HEs are encouraged to collect any alternate names (nicknames, alias’, etc.) that the patient uses; however this information is not required.

- Patient contact information, including at least one Phone number and Address are required to save the record. The CT SBIRT Program strongly encourages HEs to obtain at least one additional work or mobile phone number.

- If a patient reports being homeless, HEs will indicate “Homeless” in Address Line 1. City, State and Zip will still be entered. Alternatively, Health Educators can use Address Line 1 to indicate specifically where the homeless patient typically stays, for example, 5th Street Bridge.

- Additional information to be collected on homeless patients includes:
  - A brief list of places the patient usually hangs out (street corner, park, bridge, etc.)
- Shelters, single-room-occupancy (SRO) hotels: which ones does s/he tend to use?
- What soup kitchen, restaurant, etc. does s/he like to use?
- Does he/she shop at a nearby liquor store? Where does s/he buy necessities? (Store owners who give credit may know where the patient tends to hang out)
- Where does s/he cash checks?
- Does s/he know any service workers in the area where s/he usually hangs out? Get agency and names.
- Does s/he stay in different places in the winter vs. summer? Get list.

Collecting collateral contacts

The WITS application will prompt the Health Educator to obtain the necessary collateral contacts for patients who agree to be followed in 6 months.

- Required fields are highlighted in bright yellow and must be complete before the record can be saved. Fields with a white background are encouraged, but not required.
- Required collateral contact information includes: **First and last name, relation to the patient, and two phone numbers.** Female collateral contacts are preferred (mother, sister, daughter, cousin). And collateral contacts **should not** live at the same address as the patient.

![Collateral Contacts](image)

Good rapport & communication about the project and follow-up with patients

Patients are more likely to be followed-up if they have a good experience with the SBIRT staff & understand that their participation will help us improve services and continue providing services to patients. A good understanding of the project will help keep communication with patients clear. HEs will:
• Explain to patients that they have been randomly selected to participate in a follow-up interview to help improve services at _____________FQHC.
• If needed, briefly explain that the services provided are new, funded by the federal government, and require follow-up with patients to continue to receive funding.
• Be clear that the information is confidential and used only to locate them.
• Let the patient know that someone from the University of Connecticut Health Center will be conducting the follow-up interviews and will contact him/her to verify locator information and complete the follow-up interview. Having a good hand-off between the HE and UCHC evaluation staff will support continuity for the patient.

Tracking patients for follow-up

• UCHC evaluation staff are ultimately responsible for the follow-up interview, however, Health Educators are expected to contribute to all efforts to keep contact with patients, including updating of patient locating and collateral contact information as necessary.
• If patients return to the Health Center for care, Health Educators confirm and update all patient locating information, including collateral contact information.
• Once patients are identified for a follow-up interview (and within 7 days), UCHC evaluation staff send a welcome letter to the patient with forwarding request to verify the address is correct and remind them of that UCHC staff will be contacting them in about 6 months to schedule an interview time.
• Calls will be made to participants every 45 days to ensure that the contact information shared with the HE is valid and accurate. To further aid the assurance of contacting the participants at follow-up, the participants will be asked to allow the evaluation staff to contact individuals whose names and addresses are provided by the patient on the CT SBIRT Follow-up Locator form in order to obtain locating information about the participant, including addresses and telephone numbers.
• Starting at six weeks before the follow-up due date, UCHC staff begin calling the patient to schedule the follow-up interview. If the patient is difficult to reach and the time-window for completing the follow-up is open, the evaluation staff forego efforts to schedule the interview and attempt to complete the interview at the time of the call. The follow-up window opens one month prior to the follow-up due date and closes two months after the due date.
• Upon completion of the interview, a $20 gift card will be mailed to the address provided by the patient as compensation for completing the follow-up interview.
Tracking Referrals to Treatment (BT or RT)

An important part of the CT SBIRT program is tracking the individuals to whom we provide treatment referrals. While a unique component of the CT SBIRT program is the Brief Treatment component, we are interested in knowing the status of patients referred to all levels of care.

For Brief Treatment Referrals, Health Educators are required to collect the Brief Treatment Evaluation Reporting Form from the BT Counselor to whom the patient was referred. This form is to be completed by the BT Counselor for each patient referred to Brief Treatment. However, it is the responsibility of the Health Educator to be proactive in obtaining that form. Health Educators that refer to outside agencies must obtain a Release of Information signed by the patient for the patient chart in order to do this. The Health Educator should keep up with the following required elements:

- the WITS ID’s of patients referred
- the agency and/or name of the BT Counselor to whom the patient was referred
- the date of the referral and the date treatment was started (if applicable)
- whether or not the patient initiated (went to) treatment (e.g., did not call, did not show, etc.)
- whether or not the patient was subsequently referred to a higher level of care
- the discharge date and the discharge status

The best way to track patients who have been referred to treatment is to use a combination of “The Encounter” and “Miscellaneous Notes” sections in WITS. Staff at UCHC will periodically provide, to each Health Educator, a list of patients who have been given a referral. HE’s can use this list as a means to track the status of each referral. For confidentiality reasons, only the WITS ID will be used. Under no circumstances should an HE keep a list of patient names on their computer or on paper.
Entering the Encounter

The initial Referral (BT or RT) will be captured in the “The Encounter.” Here the Health Educator will enter the type of Service provided and the Start Date (which should be the day of the interaction with the patient). The Signed Note should indicate as much information as possible, including, but not limited to, the Agency and/or Counselor’s name, the proposed start date of treatment, and any other information helpful for tracking the patient. It is important to remember to click on the button so that the information is transferred to the gray Signed Notes area of the screen. HE’s do not need to Release these notes.
Entering Miscellaneous Notes

Once a referral is made to Brief or more intensive treatment, the patient’s progress should be tracked via the “Miscellaneous Notes” section.

This can be found by clicking on the Notes tab on the Navigation Pane. From here, Health Educators can Add New Misc. Note. Notice, that any previously entered “Encounters” (identified as Progress Notes) appear in this list as well.

“Miscellaneous Notes” should be used to track any communication a Health Educator has with either a patient or a counselor regarding a patient about the treatment referral. Required fields are highlighted in bright yellow and must be complete before the record can be saved.
Referral to Treatment Notes and Contact Notes

The *Note Type* should reflect the reason for communication with the Patient. There are 3 *Note Types*, however, Health Educators will primarily make use of the following:

- **“Referral to Treatment Note”** should be used for *any* communication about a referral to either BT or more intensive treatment.
- **“Contact Note”** should be used to record other communication with patients, such as the patient calling to inform the Health Educator that they quit smoking or contacting the patient to update his or her locating information.
- **“Contact Notes”** mainly serve as the Health Educator’s own personal records while “Referral to Treatment Notes” will be used by UCHC staff to track referrals. *Therefore, it is important that any communication with a patient or a counselor about a patient’s referral to either BT or more intensive treatment should be recorded as a “Referral to Treatment Note.”*
- **“Contact Notes”** will also be used by the evaluation team to track and record communication with the patient regarding the follow-up evaluation.
The *Program* field will default to the Health Educator’s Agency/Facility; the *Service Date* will default to the current date. These fields do not require editing.

For *Frequency*, “Not Applicable” should be selected.
The Summary should be a short, but clear summary of the purpose of the communication, and the Signed Note should be a longer description of the communication.

Here are some examples of “Miscellaneous Notes”.

Contact Note
Referral to Treatment Note

[Image of a computer screen showing a software interface for creating notes, with the title "Miscellaneous Notes for TEST, TEST" and a summary note indicating a patient called to say they couldn't get an appointment at Liberations, and they don't want to go there, and would like a referral to another agency.]
Using the WITS Scheduler to Track Patient Referred to BT

On the Home Page screen of WITS is a Scheduler that can be used to set reminders to track patients referred to treatment (Brief of otherwise).

Once a treatment referral has been made, Health Educators should use the Scheduler to add a reminder to follow-up with the patient. To do this, select Edit/Add Schedule. The Scheduler will pop up with the current day/time displayed.
To enter a reminder, use the Scheduler options at the top of the screen to advance to the date on which the reminder should occur. For example, if a patient is scheduled to start treatment on 11/8, advance to that date to enter a reminder to check with the counselor to see if the patient came to treatment (didn’t show, rescheduled, etc.).

Double click on the time of day for the reminder. A pop-up screen for which to enter the event’s details will appear.
In the **Summary**, type a brief summary of the purpose of the reminder.

Enter the start and end time parameters for when the reminder will occur.

In the **Description**, type a longer description of the purpose of the reminder.

For the **Event Type**, select the category that best describes the reason for the reminder.
For the **Appointment Type**, choose the blue option marked “Scheduled.” This will prompt you to enter the **Service** and will also allow you to automatically link to a client.

* If you are scheduling an appointment that is NOT linked to a client (e.g., a staff meeting), you may choose “Normal.” (You will not be required to enter anything further in the **Service** or **Client** fields.) *

Always leave the **Status** as “Scheduled.”

For the **Service**, select the category that best describes the event.
Type the patient’s name in to the Client field. As you begin typing the name, several similar options will begin to appear. Choose the correct client name to link the client with the scheduled appointment.

Click Save & Close to return to the Scheduler.
The new Event will appear in the Scheduler.

The event, along with summary details, will appear on the Home screen on the day it is scheduled.

The Review link shows the event details. From there, it is possible to move the event to a future date for another reminder.

The Start and End Dates can be modified to view scheduled events within a specific time period.

Once a patient/counselor has been followed up with, click on the Create Encounter link to go directly to the Encounter page to enter a Misc. Note about the status of the patient.
Section 9: Post Training Activities: Certification, Ongoing Monitoring and Technical Assistance

- Post Training Activities
- Sample Health Educator Competencies Checklist
Post Training Activities

A number of post-training activities will occur following the completion of the classroom training and on-site mentorship. HEs will work under the close supervision of UCHC and CHC ACT staff as they begin health center SBIRT service delivery. Once the program is underway, HEs will audio-tape sessions to be evaluated by UCHC training staff for compliance with SBIRT protocols. UCHC and CHC ACT staff members will also conduct routine on-site supervision to assess HE performance. Quarterly technical assistance meetings will also be held to provide continuity and additional training exercises.

Certification

Upon completion of a written exam and a successful 3- to 6-month period in the field in which high quality services are maintained, HEs will be granted certification as an SBIRT Health Educator. Annual re-certification is required for which HEs will demonstrate their competency in delivering services to each patient group, integrating SBIRT services into the clinic, following operational procedures and protocols, responding to inquiries about SBIRT services, maintaining good relationships with patients and clinic staff, assisting with patient follow-up and protecting patient confidentiality.

On-going Performance Monitoring

On-going performance monitoring will be conducted through 1) quality assurance (QA) activities to assess fidelity to SBIRT protocols; and 2) productivity reporting to monitor compliance with program requirements regarding the number of patients screened and the proportion of eligible patients receiving BI, BT and RT services.

**QA Feedback.** QA feedback will be provided by UCHC staff through the use of standardized proficiency checklists via audio-taped interactions with patients. Each health educator will receive feedback weekly for the first month of the project, every other week for months 2-4 and monthly thereafter. The objective components of key screening and brief intervention elements as well as the more stylistic MI elements of the encounter will be rated for a random selection of taped interactions. The tapes will be used to monitor compliance with service protocols for individual patient screening and operational procedures by monitoring the accuracy of the screening score, interpretation of risk levels and advice and intervention provided.

**Shadowing of HEs.** On regular occasions, program supervisors will also conduct on-site shadowing of health educators for QA monitoring. During on-site visits HEs will be observed providing SBIRT services to eligible patient groups. The observations will be guided by a series of performance evaluation forms that delineate the items required for a positive evaluation; these objective criteria help ensure standardized services. CHC ACT and UCHC staff will also converse with the medical staff at the health centers to ascertain whether the health educators are meeting the expectations of being helpful to agency staff, courteous to patients, respectful of patient privacy and industrious during on-duty hours.

**Productivity Reporting.** Productivity reporting will be computed from the data-entered GPRA information and will be provided to HEs on the same schedule as the QA feedback.
reporting. The reports will track HE efficiency regarding the maintenance of program quotas for screened patients and the proportion of eligible patients receiving appropriate services.

**On-going Technical Assistance**

Educational exercises will be conducted monthly during the scheduled HE meetings. Quarterly activities through in-service training activities will focus on areas of service delivery deemed most important by the HEs and program staff. Examples might include reinforcement of existing procedures, instruction in new services and protocols and education related to substance use issues.

**Sample Health Educator Competencies Checklist**

Following is a sample HE Competencies Checklist. Together with the HEs, monitoring staff will create a competencies checklist similar to the sample provided below. The checklist will be used during shadowing visits and in routine communication with the HEs and health center staff to provide feedback to HEs about SBIRT performance. A proficiency score scale will be used to rate each of the items (e.g., 1=poor/2=average/3=excellent)

**Sample Health Educator Competencies Checklist***

Health Educator:
Evaluator:
SBIRT Site:
Date:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Concepts</th>
</tr>
</thead>
</table>
| **SBIRT Fluency and Implementation** | • Has a clear understanding of why SBIRT services should be provided in community health care settings in Connecticut  
• Is able to describe the continuum of substance use and understands the physiology of addiction as a disease  
• Is able to explain SBIRT to health care providers and describe the components of a successful SBIRT program  
• Works with medical staff well to identify strategies for incorporating SBIRT practices into regular clinic flow |
| **Proficiency with WITS application and tablet computer** | • Understands how to navigate the database seamlessly  
• Is able to explain each section of the application and explain its function  
• Completes each required section without errors  
• Incorporates use of the tablet computer into interview without hindering rapport |
| **Pre-Screen & Screen Administration** | • Understands the concept of universal screening and its importance  
• Administers screens and collaborates with staff to screen patients  
• Works with clinic staff to destroy or save paper screens or enter screens electronically |
<table>
<thead>
<tr>
<th>Goal</th>
<th>Concepts</th>
</tr>
</thead>
</table>
| **GPRA A Information** | • Accesses charts or EMR to complete GPRA A demographic information  
• Incorporates demographic information with negative screens and submits to WITS |
| **ASSIST Administration** | • Understands the purpose of assessment  
• Understands strengths and limitations of ASSIST  
• Understands what type of feedback to provide to patients based on ASSIST scores |
| **Health Information Feedback** | • Identifies level of risk for each substance on health feedback scorecard  
• Provides health information accurately according to level of risk  
• Incorporates MI skills into delivery of health information by staying non-judgmental |
| **Brief Intervention** | • Uses MI techniques to begin motivational interview after screen assessment  
• Actively listens to patients and use reflections to keep them engaged  
• Asks open-ended questions  
• Is genuine and personable  
• Demonstrates good judgment in tone and body language  
• Uses affirmations to develop a positive relationship  
• Avoids confrontation and rolls with resistance  
• Knows when to guide, follow, and direct using MI principles and skills |
| **GPRA B-G Administration** | • Understands importance of GPRA and why it is crucial to the success of CT SBIRT  
• Utilizes skip patterns to administer questions efficiently  
• Maintains rapport with patients while administering questions  
• Asks follow-up questions as needed or clarification purposes |
| **Referral to Brief Treatment and More Intensive Treatment** | • Understands the high-risk population in relationship to the majority of patients that are at low to moderate risk  
• Presents treatment options to patients in need of further assessment and is familiar with resources available in the local area |
| **Follow-Up** | • Understands the SAMSHA follow-up evaluation requirement and how it is crucial to maintaining CT SBIRT  
• Recognizes when a patient is eligible for follow-up  
• Is able to answer questions about the follow-up evaluation  
• Completes all required paperwork accurately, including locator information  
• Encourages patient to stay in contact with clinic staff and offers incentives |
| **Documentation** | • Informs the health care team of SBIRT services that are provided to patients  
• Accurately enters patient encounter information in the WITS system  
• Accurately tracks patient communications and referrals (BT or RT) in the WITS system |
| **Adapting to the Health Center Setting** | • Interacts as part of the team with the health care providers  
• Understands the roles of the health care team  
• Integrates SBIRT into the clinic flow |

*Comments & Proficiency Score (1=poor/5=average/10=excellent)
Section 10: FQHC Site Profiles

1. Community Health Services, Inc., Hartford
2. CT Institute for Communities, Community Health Center of Greater Danbury
3. Fair Haven Community Health Center, Inc., New Haven
4. Generations Family Health Center, Inc., Willimantic
6. Optimus Health Care, Inc., Bridgeport/Stamford
7. StayWell Health Center, Inc., Waterbury
8. Southwest Community Health Center, Inc., Bridgeport
9. United Community and Family Services, Inc., Norwich/Jewett City
1. Community Health Services, Inc., Hartford

**Health Educator**
Traci Norman

**Key Health Center Staff**
Ken Green, CEO
David Gossman, Director of Behavioral Health
Dr. Johvonne Claybourne, Medical Director
Vidya Ganesan, Director of Grants and Programs
Judy Tollman, Grant Writer

**SBIRT Champion**
Dr. Johvonne Claybourne, Medical Director

**Address**
500 Albany Avenue,
Harford CT 06120
Parking: On-site, gated (not locked) front and back lots.

**About Community Health Services, Inc.**

Community Health Services, Inc. (CHS) is a private nonprofit federally qualified health center located in Hartford’s North End community. The largest community health center in Hartford, CHS is also the second oldest health center in the State. CHS serves a patient-base of almost 16,000 individuals and accommodates over 90,000 patient visits a year. While the majority of those CHS serves live in the primary service area of Hartford’s North End community, CHS is the medical home of residents throughout the Greater Hartford area. CHS offers primary and preventive services in Adult Internal Medicine, Adolescent Medicine, Behavioral Health, Dental Care, Optometry, Pediatrics, Podiatry and Women’s Health.

**Mission**

The mission of CHS is to improve health care access and eliminate health disparities within the community by providing quality, comprehensive, culturally-proficient, primary and preventive healthcare services with respect and dignity, regardless of socio-economic status, with emphasis on the underserved and the uninsured.
Behavioral Health Services (Region 4)/Provision of SBIRT BT Services

The Behavioral Health Department is staffed by licensed, certified and certification-eligible mental health and substance abuse clinicians, peer support counselors and outreach staff. In addition, two Board-certified, bilingual psychiatrists are on staff. Services include biopsychosocial assessment; psychiatric evaluation; medication management; crisis intervention, individual and group psychotherapy; psychoeducation on topics such as anger management, parenting and depression; drug screening; peer based support; treatment for co-occurring disorders, and relapse prevention.

CHS is licensed for substance abuse treatment and will serve as the BT treatment site for referred SBIRT patients. Two counselors have been trained in the BT protocol.

Site-specific SBIRT Integration

The HE has a private office located in the Walk-in Clinic area, where SBIRT screening activities will initially take place. CHS suggested that the HE conduct SBIRT screening procedures after the MA and provider have completed the patient visit so as not interfere with provider service productivity. The HE will screen patients in her private office so as not to interrupt patient flow in the exam room area, unless the provider prefers to integrate the screen into the medical visit. The HE may begin by following one provider a day so as not to interrupt workflow. The HE and MA will work together to queue patients for SBIRT according to individual provider preference. Tobacco cessation is a large selling point of the program because they have reported a 60% prevalence rate of patient smoking. It is imperative that the HE have access to the EMR to monitor patient scheduling and to document SBIRT activities for provider reference.

2. CT Institute for Communities, Community Health Center of Greater Danbury

Health Educator
Vinny Barreto

Key Health Center Staff
James H. Maloney, JD, President/CEO
Dr. Tom Draper, Medical Director
Diana Trumbley, Deputy Finance Director and Practice Administrator

SBIRT Champion
Diana Trumbley

Address
57 North Street,
Danbury CT 06810
About CT Institute for Communities, Community Health Center of Greater Danbury

CIFC (CIFC-CHCGD) is a federally qualified community health center organized in collaboration between CIFC and the long-standing medical practice of Drs. Koepke, Mauks & Mauks in Danbury. It was organized in response to the growing number of children and adults in the region who have little or no health insurance and no medical home. As a result, they go without preventive care, and/or treatment of chronic conditions that would help to keep them well.

CIFC-CHCGD offers a comprehensive range of primary care, including medical, contractual dental and mental health services, on a sliding fee basis, to people of all ages: children, adolescents, adults and seniors, especially those who are medically underserved. CIFC serves a patient-base of over 4,400 individuals and accommodates over 11,000 patient visits a year. The service area includes Danbury, Bethel, Brookfield, Bridgewater, New Fairfield, New Milford, Newtown, Redding, Ridgefield and Sherman.

CIFC-CHCGD offers primary and preventive services in for adult, pediatric, adolescent and geriatric patients which include screening, family planning, gynecology, pregnancy screenings, acute care, and referrals for specialty services, home visits, and nursing home care.

Mission

The mission of CIFC-CHCGD is to ensure affordable, accessible, comprehensive, high quality health care to the residents of the Greater Danbury area, regardless of their ability to pay or their insurance status.

Behavioral Health Services (Region 5)/Provision of SBIRT BT Services

MCCA, Midwestern Connecticut Council on Alcoholism, Inc., is the primary provider of substance abuse prevention, evaluation and treatment services in the greater Danbury area. MCCA was established in 1972 in response to regional needs for high quality professional services for individuals and their families suffering from alcohol and substance abuse.

MCCA offers a wide variety of services including outpatient, as well as short and long-term residential inpatient treatment. Various programs service seniors, Latinos, women, family members, and others affected by alcohol and drug dependence; they also have an Employee Assistance Program (EAP), pre-employment drug testing, substance abuse prevention services, and run the impaired driver (DWI) program for the Western Connecticut region. In addition, MCCA has two female adolescent residential programs, ART and New Dawn.

MCCA is licensed for substance abuse treatment and will serve as the BT treatment site for referred SBIRT patients. Two substance abuse counselors have been trained in the BT protocol.

Site-specific SBIRT Protocol

CIFC-CHCGD suggested that the SBIRT screening procedures take place after the MA rooms the patient and prior to the medical provider services. The HE and MAs work together so as not to
interrupt the provider’s workflow. The providers are invested in the program; due to the team approach the HE has been assured that he will see the patient during or immediately following the provider services. SBIRT screening information is available for reinforcement by the medical provider. The Medical Director envisions this as an opportunity for the MAs to learn and eventually uptake the SBIRT procedures. The HE uses a private office area two-three days a week.

3. Fair Haven Community Health Center, Inc., New Haven

Health Educator
Hana Koniuta

Key Health Center Staff
Katrina Clark, Executive Director
Laurie Bridger, M.D, Medical Director
Abigail Paine, Grants Coordinator

SBIRT Champion
Rose Stimson
Mark Austin

Address
374 Grand Ave.,
New Haven CT 06513
Parking: On street and behind clinic

About Fair Haven Community Health Center, Inc.

The Fair Haven Community Health Center (FHCHC) is a not-for-profit primary health care organization that has been dedicated to serving the greater Fair Haven Community since 1971. FHCHC provides comprehensive health care – from prenatal to pediatric, adolescent to adult and geriatric – including behavioral health, social services and school based clinics.

FHCHC provides comprehensive primary care from newborn through adult and elderly services. FHCHC is a true community health center; patient must be a resident of Fair Haven (zip code 06513) to be a patient. FHCHC’s goal is to serve the community in a manner that respects their patients’ culture, language and ethnic beliefs. FHCHC accommodates over 35,000 patient visits per year, providing care to more than 7,000 patients. Patients often are without insurance or under-insured. Staffing includes physicians, nurse practitioners, mid-wives, physician assistants, as well as
certain specialists, such as endocrinologists, hematologists, gynecologists, and infectious disease physicians at Fair Haven.

Mission

The mission of FHCHC is to provide excellent, accessible health care to the residents of the Fair Haven community, regardless of their ability to pay. A consumer and community-based board of directors, the majority of whom are patients, gives guidance and direction to this mission.

Behavioral Health Services (Region 2)/Provision of SBIRT BT Services

In addition to two consulting psychiatrists, four full time and one part time master level behavioral health clinicians provide a range social services, therapeutic counseling and assessments on site. They coordinate services with other mental health providers and provide outreach and referrals to mental health practitioners and programs when it is necessary for patients.

FHCHC is not licensed for substance abuse treatment, however; the health center is pursuing state licensure in order to serve as the BT treatment site for referred SBIRT patients. Two clinicians were trained in the BT protocol offered through DMHAS and SBIRT.

Site-specific SBIRT Protocol

As suggested by FHCHC the SBIRT screening procedures will take place after the clinical assistant rooms the patient and prior to the medical provider services. The HE is situated in a pod for integration into the team workflow; office space is available for follow-up or referral processing with patients. The HE remains flexible and sensitive to the providers’ time constraints, and works closely with clinical assistants so as not interrupt workflow.

4. Generations Family Health Center, Inc., Willimantic

Health Educator
Raisa Negrón

Key Health Center Staff
Arvind Shaw, CEO
Missy Bonsall, COO
Morton Glasser, M.D, Chief Medical Officer
Irma Ross, Chief Behavioral Health Officer
Heather Hintz, Behavioral Health Operations Director

SBIRT Champion
Fran Boulay
Address
40 Mansfield Ave
Willimantic CT 06226
Parking: Lot adjacent to health center

About Generations Family Health Center, Inc.

Generations Family Health Center of Willimantic is located in the Willimantic section of the Town of Windham, a semi-rural town with a population of 22,770 (2005 Census) located 35 miles from Hartford. The Willimantic site, home of the main office, is the original Generations Family Health Center site, which opened in 1983 as a free clinic on a part-time basis. With the infusion of state and federal funding in the mid-1990’s, Generations Family Health Center expanded to a full service, family practice based health center. In 1994, Generations Family Health Center moved into a newly renovated 9,000 square foot space at 1315 Main Street, the site of a former grocery store, where it is collocated with the ACCESS Agency, Inc. to provide “one-stop shopping” for health and human services.

The Dental suite opened in January 1996. Comprehensive preventive and restorative dental care is provided to all ages. The Willimantic site currently has 16 exam rooms and 5 equipped dental operatories.

The Willimantic site currently possesses the highest patient volume of the Generations sites, providing 16,037 medical and 8,721 dental visits in FY2007. The site’s minority user profile is 50% Hispanic, 41% White, 6% Black and 3% Other mix.

Mission

The mission of Generations Family Health Center, Inc. is to provide quality, compassionate and professional health care that is affordable, easily accessible and without discrimination to all members of the communities served. Their vision is to strive to provide access to quality health care that is patient-focused in delivery and maximizes all available resources. The values behind Generations efforts to achieve this vision include 1) every individual has the right to quality health care that is respectful and considerate; 2) commitment to providing continuous care through the entire health care team; 3) creating an atmosphere, for patients and staff, that is safe, accessible and free of discrimination; and 4) an emphasis on training staff and in the continuous improvement of their health center systems to provide the highest quality of care to patients.

Behavioral Health (Region 3)/Provision of SBIRT BT Services

In August, 2009 the Behavioral Health Department began providing comprehensive mental health services for individuals, couples and family therapy; medication evaluation/management; groups; and evaluations at Windham Mills, 322 Main Street, 2nd Floor.

Patients requiring substance abuse services are referred out to Perceptions Programs, Inc., a state licensed substance abuse treatment agency. Three staff members from Perceptions received training in the BT protocol.
Site-specific SBIRT Protocol

SBIRT services were implemented at Generations in September 2012. There is tremendous provider buy-in at Generations. The HE is well-integrated within the health center, attending staff meetings, providing regular SBIRT program updates and working creatively on SBIRT integration. The champion has suggested that the HE only screen after the patient has been seen by the provider. A number of strategies have been tested and refines to accomplish this in the various departments where screening occurs.


Health Educator
Desiree White

Key Health Center Staff
Michael Taylor, CEO (Interim)/COO
Thomas McNamee, M.D, Chief Wellness Officer
Daena Murphy, Program Director – Adult Mental Health and Counseling Services
Jennifer Brackett, Health Promotion Director

SBIRT Champion
Thomas McNamee, M.D.

Address
400-428 Columbus Ave,
New Haven CT 06519
Parking: on street and small lot across from health center

About Cornell Scott-Hill Health Corporation Health Center, Inc.

Cornell Scott-Hill Health Center is a federally qualified community health center established in 1968 in collaboration between the community and Yale School of Medicine. The first community health center in Connecticut, the Cornell Scott-Hill Health Center has a long history of serving New Haven neighborhoods, which are among the most disadvantaged in the State. Cornell Scott-Hill Health Center also provides health care services to those from the City of West Haven and towns in the Lower Naugatuck Valley, Ansonia, Derby, Seymour, Shelton, Naugatuck and Oxford.

Services provided at the Columbus Avenue clinics include: Cardiology, Dental, Family Planning, Health Promotion, HIV/AIDS, Homeless Healthcare, Internal Medicine, Nutrition Services,
OB/GYN, Pediatrics, Pharmacy, Specialty Medical Services, Walk-in Clinic (Convenient Care). Also available are outpatient mental health evaluation and treatment, and outpatient substance abuse evaluation and treatment.

The number of unduplicated persons who used the Center in 2010 was 33,022, for a total of 203,095 patient encounters. The patient demographics are: Latino 29%, African American 28%, Other/Multicultural 47%, White 22%, Asian 2%, Native American >1%; more females (55%) are seen here than males (45%).

Mission

The Cornell Scott-Hill Health Center mission is to provide compassionate, quality, accessible and culturally appropriate healthcare that integrates medical, behavioral health, dental, and prevention services to eliminate health disparities and improve the health status of patients and the community at large. The Health Center especially seeks to make a difference in the healthcare and health outcomes served by the current healthcare system

Behavioral Health (Region 2)/Provision of SBIRT BT Services

The Adult Psychiatric Clinic provides outpatient Mental Health and Substance assessment and treatment to adults age 18 and over. Staff consists of a multi-disciplinary team including a psychiatrist, nurse-practitioners, psychologists, and licensed and Master level therapists.

Services provided include assessments for psychiatric and substance disorders), individual psychotherapy, group psychotherapy, family/couples therapy, medication evaluation and management, and case management. Depending on the level of service indicated, patients requiring more intensive substance abuse services may be referred to any of several other Cornell Scott Hill Health sites. Hill Health is a state licensed substance abuse treatment agency. Two staff from Cornell Scott Hill Health received training in the BT protocol. Both serve as Behavioral Health liaisons for the medical providers.

Site-specific SBIRT Protocol

CS-Hill HC rolled out a new EMR system in May 2012. SBIRT screening began in Convenient Care and expanded to Internal Medicine. The HE is based in the nurses’ station or in an empty office (when available) in the Internal Medicine department for easy access to the patients; she has a shared office in an administrative area for phone calls and data entry. The HE sees patients in the exams room, either between the MA and provider or after the provider, depending on the workflow. Referrals are made directly to the BH liaisons located in the adult medicine area. The health center administrators see SBIRT an extension of the goal to treat the “whole patient when he or she presents for a medical issue. SBIRT would promote this goal by helping to identify those medical patients with risky behaviors who might not normally be screened or offered services.” The HE does not have access to the EMR.
6. Optimus Health Care, Inc., Bridgeport/Stamford

**Health Educator**
Melissa Martinez - Bridgeport, Barnum Ave.
Vinny Barreto - Bridgeport, Park City
Andres Ariza - Stamford

**Key Health Center Staff (Bridgeport)**
Ludwig Spinelli, CEO
Thomas Hill, COO
Carmen Calder, Director of Behavioral Health
Elba Cintron, Nursing Director
Alix Pose, MD, Clinical Site Coordinator, Quality Assurance

**Key Health Center Staff (Park City)**
Janette Rivera, Practice Manager
Michelle Teixeira-Rodriguez, Practice manager

**Key Health Center Staff (Stamford)**
Eric Stein, Site Administrator
Dr. Norma Kirwan, Behavioral Health Director
Dr. Tess Kryspin, Medical Director

**SBIRT Champion**
Carmen Calder, APRN (Bridgeport Barnum and Park City)
Janette Rivera and Michelle Teixeira-Rodriguez (Park City)
Dr. Tess Kryspin (Stamford)

**Address: Bridgeport**
471 Barnum Ave.
Bridgeport CT 06608
Parking: On street @ Barnum

64 Black Rock Ave.
Bridgeport CT 06605
Parking: in lot @ Park City
Address: Stamford
1351 Washington Blvd
Stamford CT 06902
Parking: Garage around corner on North St., take 4th floor crossover to Health Center.

About Optimus Health Care, Inc.

Optimus Health Care, formerly Bridgeport Community Health Center, Inc., is the largest provider of primary health care services in Southwestern CT. With 12 service delivery sites located in the Cities of Bridgeport and Stamford, and the Town of Stratford, they provide comprehensive health care services to everyone, regardless of race, income and insurance status. Optimus is a private non-profit organization operating 12 JCAHO accredited community health centers, including health care centers for the homeless, a walk-in primary care center, dental clinics, and general family health practice.

Optimus Health Care, Inc. provides comprehensive primary health care services to all, regardless of insurance status. Quality health care services are offered by a group of professional health care workers that is culturally competent, accessible and responsive to the community's needs. Services available include: Obstetrics and Gynecology, Medical, Behavioral/Mental Health, Dental, Healthcare for the Homeless, HIV/AIDS Care Services. Optimus serves over 49,000 patients, with 214,000 patient visits occurring per year.

Mission

The mission of Optimus is to improve the overall health of communities in Bridgeport, Stamford, and Stratford, particularly the medically underserved, by providing preventive, primary care and supplemental health care services along with health education in a culturally sensitive manner regardless of one's ability to pay.

Behavioral Health Services (Region 1)/Provision of SBIRT BT Services

The Optimus Health Care Center provides treatment for a broad spectrum of psychiatric disorders. Our mental health services are an integral part of our medical practice. Our mission is to provide short-term behaviorally oriented treatment. We provide on-site services located at the Barnum Avenue site. The East Main location provides therapeutic services by licensed social workers to including services for family and children. A part-time APRN specialized in Child/Adolescence provides evaluations and psychopharmalogic management for children and adolescence.

The Stamford location has three psychiatrists working closely with members of our behavioral health team to facilitate an integrated approach of community reliance.

The outpatient program provides an array of services for a diverse population.

Clinical services may include: Comprehensive Psychiatric assessment/evaluation and treatment to stabilize psychiatric symptoms, Psychopharmacologic evaluation and management, Clinical Case management services, Individual therapy, Family and couples therapy and psychoeducation with
integration of family systems, Anger management groups that focus on development of coping and problem solving skills.

Optimus in Bridgeport is not licensed to provide substance abuse treatment; in order to serve as the BT treatment site for referred SBIRT patients Optimus will consider the state licensure and BT training offered through DMHAS and SBIRT. Until that decision is made, Bridgeport will refer out to Liberation Programs Inc. Stamford offers substance abuse treatment on site but they will refer BT patients to Liberations trained staff. Staff from Liberations have undergone BT training.

**Site-specific SBIRT Protocol**

Optimus Bridgeport suggested several options for the SBIRT screening procedures, depending on the site and specific department. Private space for screening and brief interventions will need to be negotiated. From the beginning the HE worked closely with Carmen Calder, screening behavioral health patients prior to branching out to screen in other departments. The screening usually takes place after the provider has seen the patient, although at times the HE screens between the MA and provider services.

The Park City HE has private office space available where he screens patients after the provider has seen the patient, though with increased buy-in form providers the HE is seeing more patients in the exam rooms. It is a seamless transition from provider service to SBIRT screening.

At the Stamford site, the HE screens in several departments (Family Medicine, Internal Medicine, etc) and on several different floors. He screens in the exam room prior to MA or provider seeing patient. Buy-in at this site was initially slower than at the other two Optimus sites. The HE has been issued an Optimus cell phone to facilitate communication since he moves between departments on a daily basis.

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**7. StayWell Health Center, Inc., Waterbury**

**Health Educator**
Keyvin Lewis

**Key Health Center Staff**
Donald Thompson, CEO
Sunil D'Cunha, M.D, Chief Medical Officer

**SBIRT Champion**
Dr. Sunil D'Cunha
Address
80 Phoenix Ave.
Waterbury CT 06702
Parking:

About StayWell Health Center, Inc.

StayWell Health Care, Inc. is committed to providing high quality, community health care and social services, including preventive medical, dental, and mental health services to the underserved population of the Greater Waterbury community. StayWell Health Care, Inc. has adopted a comprehensive, community based approach to serving people by providing education, advocacy, and bilingual/bicultural services. All patients are accepted regardless of their ability to pay or insurance status.

StayWell Health Center (SHC) is a Federally Qualified Health Center that has been operating in Waterbury since 1972. It opened as part of the Model Cities Program, a federal effort to bring health services to the Medically Underserved Areas of the city. Originally operated by the City of Waterbury, Department of Health, StayWell Health Center became a non-profit tax-exempt corporation in 1994. Since then, it has seen steady growth in its patient base and its role as a healthcare provider within the community. In September 2000, it was designated as a 330 funded Federally Qualified Health Center. StayWell accommodates over 79,000 patient visits per year, providing care to almost 19,000 patients.

StayWell Health Center participates in the Waterbury Ryan White I Consortium, combined from all locations the Federal Health Disparities Collaborative and implements several community-based programs including the Regional Healthy Start Initiative, and the Nurturing Connections Network. They are one of the only points of access to quality primary care in Waterbury for low-income and uninsured people. All patients are accepted regardless of their ability to pay or insurance status.

Mission

StayWell Health Center is committed to providing high quality community health care and social services to the underserved and underinsured of the Greater Waterbury area, including medical, dental, and mental health with the focus on prevention. StayWell Health Center has adopted a comprehensive, community based approach to serving people by providing education, advocacy, and bilingual/bicultural service.

It is the goal of StayWell Health Center to provide primary health care, dental, mental health, health education, outreach and case management services to all medically underserved citizens in their service area regardless of their ability to pay

Behavioral Health Services (Region 5)/Provision of SBIRT BT Services

The Behavioral Health Department offers services including psychiatry, individual therapy with medication management for adults, group therapy, family therapy and therapy services for Ryan White and Homeless populations of Greater Waterbury. Providers include a Director of Behavioral & Mental Health Services, a Nurse Care Coordinator, a licensed psychiatrist, and three clinicians.
StayWell Health Center receives Title A funding under the Ryan White C.A.R.E. Act and provides Behavioral Health services for patients infected or affected by HIV/AIDS. StayWell Health Center also provides Behavioral Health Services to those individuals who are experiencing homeless through its Open Arms program, a federally funded program under the Health Care for the Homeless Initiative

StayWell is not licensed to provide substance abuse treatment. StayWell will continue to refer patients to Wellmore Behavioral Health; staff from Wellmore have undergone BT training.

**Site-specific SBIRT Protocol**

The HE has a private office area. He has access to the daily patient schedule. The HE initially was allowed to screen only those patients scheduled for physicals but has expanded screening to include patients scheduled for follow-up visits. So as not to interrupt the provider workflow, the HE waits outside the exam room until the provider has finished before entering to complete the SBIRT screening. The system is working well with some of the providers; the HE has encountered some resistance from others. At the request of his champion the HE screens occasionally at a satellite site, South Main Street although patient flow is lower there.

### 8. Southwest Community Health Center, Inc., Bridgeport

**Health Educator**

TBD

**Key Health Center Staff**

Kathy Yacavone, Preident/CEO
Dr. Bashi Chaddha, Chief Medical Officer
Nancy Wiltse, Chief Behavioral Health Officer
Susan Khalil, Director of Nursing

**SBIRT Champion**

Susan Khalil, Director of Nursing

**Address**

968 Fairfield Ave.
Bridgeport CT 06650
Parking: on street or small lots on side or behind health center
About Southwest Community Health Center, Inc.

Southwest Community Health Center, Inc. (SWCHC) strives to improve the scope and quality of services offered to meet the unique needs of the Bridgeport communities served. In addition to the comprehensive range of primary medical, dental and behavioral health services, SWCHC provides community outreach, health education/disease prevention programs, and entitlement enrollment services. The Health Center’s physicians are Board Certified and have privileges at local hospitals, and provide after hours coverage to ensure continuity of care. SWCHC provides services to almost 19,000 patients; in 2010 there were 107,000 patient visits.

Mission

The SWCHC non-profit corporation is dedicated to providing high quality, accessible medical, dental and behavioral health services to individuals and families, in the Greater Bridgeport area, especially the uninsured, who reside in the medically underserved Southwest Bridgeport community.

SWCHC is a leader in the community health field, engaging in cooperative alliances with other agencies dedicated to the total well-being of the people in the community.

Behavioral Health (Region 1)/Provision of SBIRT BT Services

Behavioral Health providers include a full time psychiatrist, APRN, and several part-time psychiatric staff. Mental health services offered include psychiatric evaluation, treatment and therapy for adults and children. Highly qualified clinicians offer individual and family counseling, group therapy and anger management. A wide array of social services, including patient advocacy, entitlement program enrollment and case management are offered.

Southwest is licensed to provide substance abuse treatment. Basic outpatient services, individual and group treatment are offered. An Intensive Outpatient Program (IOP) provides comprehensive treatment for adults wishing to attain a substance free lifestyle. The program’s holistic approach to recovery incorporates mental, emotional, and spiritual aspects of care. IOP is a cost effective alternative to residential treatment. Continuing care is also available. SWCHC staff has been trained in the BT protocol.

Site-specific SBIRT Protocol

After the health center orientation, the HE shadowed medical assistants and providers in the Internal Medicine department for several days. Working closely with the MAs and providers, it was determined that the HE would screen patients after they were roomed by the MA and before they were seen by the provider. This system provides the most efficient work flow for a patient visit in Internal Medicine. If the HE requires additional time with the patient, the MA can walk the patient to the HE (located in a private area) after the medical visit is complete.
9. United Community and Family Services, Inc., Norwich/Jewett City

Health Educator
Sirena Secco

Key Health Center Staff
Chuck Seeman, President/CEO
Jennifer Granger, Chief Operating Officer
Ramindra Walia, M.D., Chief Medical Officer
Susanne Campbell, Vice President of Health Services
Cara Westcott, Vice President of Behavioral Health services
Lily Gil, Director of Behavioral Health Services

SBIRT Champion
Yolanda Bowes

Address
47 Town Street
Norwich CT 06360
Parking: on street or small lots on side or behind health center

About United Community and Family Services, Inc.

United Community and Family Services (UCFS) offers comprehensive outpatient services to residents of the greater Norwich area, including Outpatient Primary Medical Care, Outpatient Behavioral Health Services, Community Based Behavioral Health Services, Women's Health Services, Dental Services, Community Health Services, and Eldercare Services. UCFS provides these services to almost 6,600 patients; in 2010 there were over 44,000 patient visits.

Mission

For individuals and families in Eastern Connecticut, United Community and Family Services improves the health and well-being of the community. UCFS values include: striving to meet the needs of the community and the expectations of clients, providing quality service and pursuing excellence, treating everyone with respect and dignity, providing culturally competent and linguistically appropriate services, working collaboratively with the community, valuing employees and rewarding integrity, teamwork, innovation and excellence, being accountable fiscally and professionally to all stakeholders, and advocating for clients, services and the community

Behavioral Health (Region 3)/Provision of SBIRT BT Services
Behavioral health services offered include individual, family, couple and group therapy to children, youth, and adults. The medical staff provides psychiatric assessment and medication management for children, adolescents, and adults. Referrals to community agencies are made when more intensive treatment services are indicated. Outpatient substance abuse services are offered at two sites, Norwich and Jewett City. Substance abuse providers have been trained in the BT protocol.

**Site-specific SBIRT Protocol**

The HE works closely with the Nurse Care Provider, the MAs and providers in implementing the program. She would screen patients after they were roomed by the MA and before they were seen by the provider whenever possible. This should provide the best flow for a patient visit in Adult Medicine. If the HE requires additional time with the patient, the MA will ask the HE to return to the exam room after the medical visit is complete, or the patient can meet with the HE in a private office area. The HE has access to the electronic schedule and the EMR, screening results will be entered directly into a PFR template. The HE also screens patients at the Jewett City site once a week.