

**Department of Vermont Health Access  
Vermont Blueprint for Health**

# SBINS

**TABLE OF CONTENTS**

ONE-PAGE MODEL OVERVIEW	1
ENHANCED COMMUNITY HEALTH TEAM PAYMENT	2
SCHEDULE OF EVENTS	4
PLANNING GUIDANCE	5
SBINS ATTESTATION FORM	7
SBINS IMPLEMENTATION CHECKLIST	9
SYSTEMATIC, EVIDENCE-BASED SCREENING	11
BRIEF INTERVENTION	11
BRIEF TREATMENT OR NAVIGATION TO SERVICES	11
FORMAL REFERRAL RELATIONSHIPS	12
CONTINUOUS QUALITY IMPROVEMENT	13
EVALUATING IF VERMONTERS ARE BETTER OFF	17
APPENDIX I: SAMPLE CLINICAL WORKFLOWS	18
APPENDIX II: SAMPLE INTERORGANIZATIONAL AGREEMENTS	21
APPENDIX III: SAMPLE SCREENING TOOL	22
APPENDIX IV: RESEARCH-BASED RECOMMENDATIONS FOR SCREENING AND FROM THE SBIRT EVALUATION	25

**Department of Vermont Health Access  
Vermont Blueprint for Health**

# SBINS

## MODEL OVERVIEW

[Deaths of despair](#), defined as the mortality increases driven by suicide and opioid- and alcohol-related fatalities, are indicative of a grave decline in American well-being and remain a core public health problem. The Screening, Brief Intervention, Brief Treatment and Navigation to Services (SBINS) model ensures that Vermonters have timely access to care for mental health and substance use disorders and health-related social needs. Designed to produce a positive impact on well-being, the SBINS model is comprised of **5 core components**:

- **systematic screening** for risk factors that impact health in Patient Centered Medical Homes and Emergency Department settings;
- **same-visit brief interventions** that enhance relationships between patients and providers while promoting behavioral or environmental changes for improved health and well-being;
- **brief treatment and navigation services**, provided in-house for mental health and substance use disorders, social and other determinants of health, and trauma, assure that identified needs are met with timely connection to specialty treatment and social services;
- **formalized referral relationships**, at the local level, support navigation between health care and social services;
- **continuous quality improvement**, incorporating health information technology, reporting of data, and contribution to program evaluation, that drives effective programmatic implementation.

SBINS builds upon the clinically meaningful improvements demonstrated by SBIRT (Screening, Brief Intervention, and Referral to Treatment) by broadening the screening approach beyond screening for just depression or substance use while emphasizing the responsibility of integrated care teams to actively assure that identified needs are met with connection.

## IMPROVING HEALTH AND WELL-BEING OF VERMONTERS

[Vermonters are dying by suicide](#) at a rate that far outpaces the national average and mental health conditions are one of several factors contributing to suicide. [Opioid-related fatalities](#) increased approximately 30% from 2015-2016, and 5% from 2016-2017. Finally, just [3 behaviors](#) (tobacco use, poor nutrition and no physical activity) lead to the onset of 4 diseases that result in more than 50 percent of deaths in Vermont. Evidence-based screening and [brief, motivational conversations](#) can promote clinically meaningful behavioral and environmental changes and create opportunities for connection.

## VERMONT MEDICAID'S NEW INVESTMENTS IN THE COMMUNITY HEALTH TEAM EMPOWER VERMONTERS TO BE PARTNERS IN THEIR CARE AND SUPPORT AN INTEGRATED HEALTH SYSTEM

Each participating practice and emergency department commits to enhancing clinical-community linkages, to integrating additional Community Health Team staff within the setting, and to implementing [universal screening](#) for depression, suicidality, substance use disorder, social determinants of health (e.g. interpersonal violence, housing instability, food insecurity) and patient perception of health. Furthermore, participating settings commit to providing same-visit brief interventions for both negative and positive screening results, offering in-house brief treatment and navigation services (which may include [telemedicine](#)), formalizing referral relationships and implementing continuous quality improvement for an improved experience of care for both patients and providers. Community organizations and agencies support SBINS implementation by improved access to services and through the local Community Collaborative/Accountable Community for Health work directed towards improving well-being by [aligning community services and building service capacity](#) to address the social determinants of health.

**Department of Vermont Health Access  
Vermont Blueprint for Health**

# SBINS

## VERMONT MEDICAID'S ENHANCED COMMUNITY HEALTH TEAM PAYMENT SUPPORTS PATIENT ENGAGEMENT AND INTEGRATED CARE

The Department of Vermont Health Access is responsible for managing Vermont's publicly-funded health plan (Vermont Medicaid). Vermont Medicaid has a long history of commitment to preventing the progression of chronic conditions and to prioritizing improved health outcomes for Vermonters, as evidenced by the Spoke program and Women's Health Initiative. As a part of the Department of Vermont Health Access, the Blueprint for Health supports Patient Centered Medical Home practices in successfully assessing and addressing health priorities, enhancing clinical-community linkages and ensuring Vermonters are connected with whole-person health care that is evidence-based, person- and family-centered, and cost-effective. The Community Health Team (CHT) program has demonstrated effectiveness in providing population health services such as panel management, care management, care coordination, etc. Despite increased demands for the services provided by the Community Health Team program, the payment level has remained the same since the program's inception in 2008. The current CHT per patient per month payment of \$2.77 (Medicaid, Commercial), or \$2.45 (Medicare), supports a staff to patient ratio of [1:4000](#). This funding level, and associated staffing, is not sufficient to provide integrated mental health and substance use disorder treatment services systematically across every health service area of the State and has not supported additional services necessary for creating the clinical-community linkages that allow for assessing and addressing the social determinants of health (e.g. interpersonal violence, housing instability and food insecurity).

The Screening, Brief Intervention, Brief Treatment and Navigation to Services (SBINS) model, implemented under the Community Health Team program, helps ensure that primary care practices, emergency departments, and communities can systematically identify, and provide effective interventions for, depression, suicidality, substance use disorder, and social determinants of health. The enhanced community health team payment is intended to provide additional resources to each health service area for increasing community health team services for, and patient engagement with, integrated care in the Patient Centered Medical Home and Emergency Department settings that attest to implementing the 5 core components of SBINS. The planned enhancement to the existing community health team program is consistent with national and statewide goals to improve integration of mental health and substance use disorder services with health care. In addition, the proposed services will link clinical care and community service partners in recognition of the need to broaden the definition of factors that impact health (e.g. social determinants).

The table below describes, in detail, the expected financial impact of supporting statewide implementation of the SBINS model across approximately 140 Patient Centered Medical Homes and 14 Emergency Departments. This includes a differential payment rate for federally-qualified health centers, as these settings have higher encounter rates than either hospital-owned or independent primary care practices. When fully implemented, the enhanced Community Health Team program payment would fund an additional 90 full-time equivalent CHT staff across Patient Centered Medical Home and Emergency Department settings throughout the State of Vermont.

**Department of Vermont Health Access  
Vermont Blueprint for Health**
**TABLE 1: EXPECTED TOTAL ANNUAL BUDGET AND STAFFING FOR SBINS**

			TOTAL
<b>EMERGENCY DEPARTMENTS</b>			
SMALLER HOSPITALS (10)	MIDSIZE HOSPITALS (3)	TERTIARY MEDICAL CENTER (1)	14 HOSPITAL EMERGENCY DEPARTMENTS
1 FTE \$78,000	2 FTE \$156,000	3 FTE \$234,000	<b>\$1,482,000.00 (19 FTES)</b>
<b>PRIMARY CARE (FEDERALLY QUALIFIED HEALTH CENTERS)</b>			
#ATTRIBUTED MEDICAID MEMBERS	39,389	RATE \$2.65	<b>\$1,252,570.20 (16 FTES)</b>
<b>PRIMARY CARE (INDEPENDENT &amp; HOSPITAL-OWNED)</b>			
#ATTRIBUTED MEDICAID MEMBERS	66,931	RATE \$5.42	<b>\$4,353,192.24 (55 FTES)</b>
<b>QI FACILITATION AND TRAINING</b>			
#ATTRIBUTED MEDICAID MEMBERS	106,320	RATE \$0.46	<b>\$586,886.40</b>
<b>HEALTH INFORMATION TECHNOLOGY</b>			
#PCMHS AND EDS	<b>140 PCMHS 14 EDS</b>	RATE TBD	<b>TBD</b>

**Department of Vermont Health Access  
Vermont Blueprint for Health**

# SBINS

## SCHEDULE OF EVENTS

The Vermont Department of Health Access / Blueprint for Health anticipates that statewide implementation of SBINS in Patient Centered Medical Homes and Emergency Department settings will take place over 18 months, with a preliminary start date of January 1, 2019. New primary care practices and emergency department settings will be enrolled at the beginning of each quarter, based on demonstrated readiness to implement the model.

**TABLE 2: PROPOSED SCHEDULE OF SBINS EVENTS**

22 OCTOBER 2018	SBINS PLANNING GUIDANCE ISSUED
29 NOVEMBER 2018	READINESS PACKAGE (PATIENT CENTERED MEDICAL HOME OR EMERGENCY DEPARTMENT ATTESTATION FORM AND SUPPORTING DOCUMENTATION) SUBMITTED TO THE BLUEPRINT FOR HEALTH BY THE PROGRAM MANAGER OF EACH HEALTH SERVICE AREA
13 DECEMBER 2018	READINESS PACKAGE APPROVED BY THE BLUEPRINT
14 DECEMBER 2018 - ONGOING	STAFFING RECRUITMENT BY HEALTH SERVICE AREA ADMINISTRATIVE ENTITIES (INCLUDING HIRING ARRANGEMENTS FINALIZED AND TRAINING RECRUITMENT)
01 JANUARY 2019	PROGRAM AND FUNDING BEGINS (PHASE I) – STAFF HIRED, TRAINED, SBINS IMPLEMENTED
01 APRIL 2019	PROGRAM AND FUNDING BEGINS (PHASE II) – STAFF HIRED, TRAINED, SBINS IMPLEMENTED
01 JULY 2019	PROGRAM AND FUNDING BEGINS (PHASE III) –STAFF HIRED, TRAINED, SBINS IMPLEMENTED
01 OCTOBER 2019	PROGRAM AND FUNDING BEGINS (PHASE IV) – STAFF HIRED, TRAINED, SBINS IMPLEMENTED
01 JANUARY 2020	PROGRAM AND FUNDING BEGINS (PHASE V) – STAFF HIRED, TRAINED, SBINS IMPLEMENTED
01 APRIL 2020	PROGRAM AND FUNDING BEGINS (PHASE VI) – STAFF HIRED, TRAINED, SBINS IMPLEMENTED
01 JULY 2020	FINAL PROGRAM ENROLLMENT (PHASE VII) – STAFF HIRED, TRAINED, SBINS IMPLEMENTED IN FINAL PCMH AND ED SETTINGS

**Department of Vermont Health Access  
Vermont Blueprint for Health**

# SBINS

## PLANNING GUIDANCE FOR COMMUNITIES, PATIENT CENTERED MEDICAL HOMES, AND EMERGENCY DEPARTMENTS INTENDING TO IMPLEMENT SBINS

The statewide implementation of SBINS in Patient Centered Medical Homes and Emergency Department settings has been planned according to the schedule detailed above in table 2, with an 18-month phased implementation expected for SBINS model adoption. In order for the implementation of SBINS to be successful, each entity has specific responsibilities that will support a successful initial implementation of SBINS. These responsibilities are described below. Together, the responsibilities of the Blueprint for Health central office team, the local Blueprint Program Managers, and community-based Patient Centered Medical Homes (PCMHs) and Emergency Departments (EDs) form the process for collaboratively implementing the SBINS program. It is expected that:

### Blueprint Central Office Responsibilities

1. Issue the planning guidance that supports the Blueprint Program Manager of each health service area in engaging Blueprint-participating primary care practices and emergency departments in the SBINS program;
2. Provide the local Program Manager with the number of Medicaid claims-attributed members by practice type (independent, hospital-owned versus federally-qualified health center) that were used to create an estimated Community Health Team payment for the health service area under the differential per patient per month payment;
3. Review submitted readiness packages within 15 business days;
4. Confirm approval to the local Program Manager (or additional information is requested if approval cannot be granted) by formal letter from the Executive Director of the Blueprint for Health;
5. Schedule the SBINS per patient per month enhanced Community Health Team payment to be sent to the health service area administrative entity of the primary care practice or emergency department, effective on the first day of the next quarter open for program enrollment;
6. Design and communicate program evaluation requirements.

### Blueprint Program Manager Responsibilities

1. Review the number of Medicaid claims-attributed members by practice type (independent, hospital-owned versus federally-qualified health center) that were used to create an estimated Community Health Team payment for the health service area for accuracy and inform the State of any changes;
2. Provide outreach to Blueprint-participating Patient Centered Medical Homes, Emergency Departments, and community-based agencies and organizations to promote engagement in the SBINS program and support a planning process;
3. Develop an initial implementation schedule with a goal of having all PCMH and ED settings in the health service area participating in SBINS by June of 2020;
4. Support interested PCMHs and EDs with completion of the readiness package, including the documentation described in Implementation Checklist and the process for recruiting, training, and integrating new SBINS staff into the Community Health Team and PCMH and ED settings;
5. Review the readiness packages submitted to them by interested PCMHs and EDs for completeness and request additional information as needed;
6. Describe the hiring arrangement and staffing recruitment and training plan in a cover letter that accompanies the readiness package;
7. Submit the completed cover letter and readiness package to the Blueprint for Health central office for review;

**Department of Vermont Health Access  
Vermont Blueprint for Health**

8. Finalize hiring arrangements and begin staffing recruitment with the SBINS-participating PCMH and ED settings once the formal letter approving SBINS implementation is received from the Executive Director of the Blueprint for Health;
9. Coordinate with the local Blueprint for Health Community Health Team Lead to ensure SBINS-hired Community Health Team staff are enrolled in trainings for specialized skill development (offered quarterly by the State) applicable to integrated care;
10. Monitor SBINS implementation in each Patient Centered Medical Home or Emergency Department setting for effective implementation, including ensuring that SBINS staff are fully integrated into the setting.

**Patient Centered Medical Home and Emergency Department Responsibilities**

1. Participate in the local planning process;
2. Request support for readiness package completion as needed from the local Blueprint Program Manager, who may provide additional staff to the setting to support package completion (i.e. Quality Improvement Facilitators);
3. Submit the readiness package to their local Program Manager;
4. Work with the local Program Manager to finalize hiring arrangements and for staffing recruitment;
5. Support SBINS-hired Community Health Team staff, and additional setting staff as necessary per the staffing plan, in enrollment, engagement and completion of trainings for specialized skill development (offered quarterly by the State) applicable to integrated care;
6. Identify a clinical champion and an implementation/quality improvement (QI) team at the setting (responsible for monitoring and improving upon the implementation of team-based care and SBINS workflows);
7. Begin implementation of all 5 core components of the SBINS model once SBINS staff are integrated into the setting.

**Community Organization and Agency Responsibilities**

1. Support SBINS implementation through executing formal referral agreements that allow for enhanced access to services;
2. Participate in the local Community Collaborative/Accountable Community for Health work directed towards improving well-being by aligning community services and building service capacity to address the social determinants of health.

**DEMONSTRATING READINESS: THE ATTESTATION FORM AND IMPLEMENTATION CHECKLIST**

In order to be eligible to participate in the SBINS program, Blueprint-participating Patient Centered Medical Homes and Emergency Departments need to sign a Screening, Brief Intervention, Brief Treatment and Navigation to Services (SBINS) attestation form. The form is submitted to the Blueprint for Health alongside additional documentation, which is described in the implementation checklist. Together, the attestation form and the documents described in the implementation checklist create a readiness package that demonstrate the commitment and readiness of the primary care practice or emergency department to implement the Screening, Brief Intervention, Brief Treatment, and Navigation to Services model.



Department of Vermont Health Access  
Vermont Blueprint for Health

## SBINS

## ATTESTATION FORM

Practice or Emergency Department Name: \_\_\_\_\_

Setting Type: (please check one)

- ☐ Blueprint-participating Patient Centered Medical Home, Hospital-owned or Independent practice.
- ☐ Blueprint-participating Patient Centered Medical Home, Federally-Qualified Health Center.
- ☐ Emergency Department.

Blueprint-Participating Patient Centered Medical Home Provider Billing Information for Attribution (not applicable to Emergency Department settings):

I attest that the list of providers registered ([rostered](#)) for the aforementioned practice with the State of Vermont, Department of Vermont Health Access, Blueprint for Health, Patient Centered Medical Home program is up-to-date with the necessary billing information. If there are any changes to the status of the providers within the aforementioned practice, the changes will be communicated to the local Blueprint Program Manager within 10 business days of the change, and the local Program Manager will communicate the change to the Blueprint for Health central office staff.

Blueprint-participating Patient Centered Medical Home or Emergency Department Commitment:

By signature of an authorized signatory for the setting on this attestation form and subsequent acceptance of funds by the administrative entity for the health service area by the Screening, Brief Intervention, Brief Treatment, and Navigation to Services (SBINS) enhanced Community Health Team payment, the setting commits to implementing the **5 core components of the SBINS model**, demonstrated by:

1. Developing and implementing policies, procedures and clinical workflows for the evidence-based practice of:
  - systematically **screening all patients for depression, suicidality, substance use disorder, social determinants of health (e.g. interpersonal violence, housing instability, food insecurity) and patient perception of health** in order to support patient engagement and promotion of health and well-being;
  - providing **same-visit brief interventions for all patients** for enhanced patient-provider relationships through dedicated time for brief conversations to review screening results, offer affirmation in the absence of identified risk factors or education about any identified risk factors that could impact the patient's health and well-being, and to support patient motivation to change and engagement with establishing the next steps;
  - providing **brief treatment or navigation services** in-house if the brief screen indicates a positive result, and the brief intervention indicates a need for, and patient willingness to accept, treatment or services. Patients are engaged in further assessment and conversations about any concerns identified, and assist the provider with goal-setting and care plan development through a shared-decision making process. Facilitated connections with additional services and supports assure timely transitions and addressment of challenges or barriers that would prevent the patient from accessing treatment or support services. For individuals identified through assessment as having a mental health or substance use disorder, this provides immediate initial treatment and care management while the individual is connected to longer term care. This component may be achieved through the use of telemedicine.

Authorized Signatory Initials: \_\_\_\_\_



**Department of Vermont Health Access  
Vermont Blueprint for Health**

2. Developing and executing agreements for **formalized referral relationships**, an essential element for supporting timely transitions to services and supports (e.g. with Department of Mental Health Designated Agencies (DAs), Division of Alcohol and Drug Abuse (ADAP) Preferred Providers, and local private practitioners for specialty mental health and substance use disorder services, and community-based agencies / organizations for social services);
3. Developing and implementing a **continuous quality improvement** plan that describes the process for using health information technology, reporting of data and contributing to programmatic evaluation, including:
  - A description of how data will be collected in structured fields of the electronic medical record for documentation and reporting of the number and percentage of screens indicated and completed, brief interventions for positive screens and brief interventions for negative screens indicated and completed, brief treatment and navigation to services indicated and completed, the referral type for patients identified as needing additional services and supports (e.g. indicates whether the referral was for mental health, substance use disorder, housing instability, food insecurity, interpersonal violence, etc.) and patient confirmation that the connection was completed;
  - A description of how the setting plans to engage with, and report on, whether their patients report improvement in their symptoms, functioning and in their experience of care.
4. Providing screening, workflow, and outcome data to the State of Vermont, Department of Vermont Health Access, Blueprint for Health, or State-identified vendor, for programmatic evaluation.
5. Participating in a learning health community to ensure best practice adoption and specialized skill development for staff providing integrated care through the SBINS program;
6. Integrating the local Community Health Team and Quality Improvement Facilitator into the setting (Patient Centered Medical Home or Emergency Department);

Name of Authorized Signatory (printed): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title, Position in Organization: \_\_\_\_\_

Setting Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: ☐ Same as Above ☐ Different: \_\_\_\_\_

Setting Best Point of Contact: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**FOR BLUEPRINT CENTRAL OFFICE STAFF ONLY:**

DATE RECEIVED: \_\_\_\_\_ BY WHOM: \_\_\_\_\_

**Department of Vermont Health Access  
Vermont Blueprint for Health**

# SBINS

## IMPLEMENTATION CHECKLIST

The implementation checklist describes the documents that should be developed and submitted with the attestation form, indicating that the Patient Centered Medical Home or Emergency Department is ready to begin implementation of SBINS.

- ☐ Staffing and Clinical Supervision Plans that demonstrate the ability of the setting to provide systematic screening for depression, suicidality, substance use disorder, social determinants of health (e.g. interpersonal violence, housing instability, food insecurity) and patient perception of health, brief intervention, brief treatment and navigation services and connections to additional treatment and support services;
- ☐ Clinical Workflows that describe how providers and patients will experience the consent process, systematic screening, brief intervention, brief treatment and navigation services and connections to additional treatment and support services during a visit, including:
  - Who will be screened (define the patient population, e.g. everyone);
  - Which age-appropriate, evidence-based screening tools will be used;
  - How often will the screenings occur (e.g. annually or at each visit);
  - The method by which screenings occur (e.g. self-administration, oral interview)
  - When and where will the patients be screened during the visit (e.g. in the waiting room or examination room) as the model chosen for administration impacts workflow development and continuous quality improvement (e.g. screening results being entered into the electronic medical record);
  - The process for addressing the results of the screen (e.g. by whom and when will a brief intervention, brief treatment and navigation to services be provided);
  - How in-house brief treatment and navigation to services will be provided, including describing the use of telemedicine if planned.
- ☐ Consents to Coordinate Care, which will be essential for assisting and arranging additional treatment and support services with the patient and communicating with other agencies and organizations with shared responsibility for care with the patient;
- ☐ Intra- and Interorganizational Agreements that support timely transitions to additional treatment or support services (e.g. MOUs, Co-Management Agreements), including connection to primary care for those individuals who may be identified in the emergency department as not having a primary care provider and clinical-community connections for social determinants of health (such as interpersonal violence, housing instability, food insecurity).
- ☐ Continuous Quality Improvement Plan, that describes:
  - The team dedicated to continuous quality improvement, identifying who is responsible for running and reviewing the SBINS data reports, the roles and responsibilities of each team member, the overarching goal the team desires to accomplish, and the frequency with which the team will meet to review new reports to continually inform effective SBINS implementation;
  - Electronic medical record template development to incorporate developed workflows into the electronic medical record in order to improve effectiveness, efficiency, and patient and provider satisfaction;
  - How the electronic medical record will be used to document the screening, brief intervention, brief treatment and navigation to services that were indicated and completed (e.g. in structured fields that indicate the screening results and completed connections to additional services and supports),

**Department of Vermont Health Access  
Vermont Blueprint for Health**

and patient confirmation that any connection was completed, such that the results are able to be extracted in the form of reports to direct continuous quality improvement;

- The electronic medical record report for aggregation of the number and percentage of screens indicated and completed, brief interventions for positive screens and brief interventions for negative screens indicated and completed, brief treatment and navigation to services indicated and completed, and the referral type for patients identified as needing additional services and supports (e.g. indicates whether the referral was for mental health, substance use disorder, housing instability, food insecurity, interpersonal violence, etc.) and patient confirmation that the connection was completed;
- How the setting plans to engage with, and report on, whether their patients report [improvement in their symptoms, functioning and satisfaction with the services they received.](#)

**Department of Vermont Health Access  
Vermont Blueprint for Health**

# SBINS

## BRIEF SCREENING – ASKING ABOUT RISK FACTORS, INVOLVING VERMONTERS AS FULLY-INFORMED PARTNERS IN THEIR CARE

The first component of this process is a [brief initial screen](#) that utilizes validated tools to provide an easy, and quick, method for identifying risk factors in individuals in your care setting (as well an opportunity for identifying those individuals who may already be experiencing issues related to mental health or substance use disorders or other determinants of health). Screening tools typically utilize information reported by the individual, and the results can be scored by any health care professional. The guiding principles to successfully implementing systematic brief screening are that evidence-based, age-appropriate screening should be completed at moments of greatest clinical utility, and at a minimum of each individual's annual preventative visit, and be used to engage patients as partners in promoting their own health and wellness. Implementing a screening tool requires a plan for who will be screened (e.g. universal), how often the screenings will occur (e.g. annually), when the screening will occur (e.g. in the waiting room or examination room), the method by which screenings will occur (e.g. self-administration versus oral interview), and what the process will be for addressing the results of the screenings (e.g. by whom will the brief intervention, brief treatment or navigation to services occur). Systematic screening for depression, suicidality, substance use disorder, social determinants of health (e.g. interpersonal violence, housing instability, food insecurity) and patient perception of health is required under the SBINS program, but settings may propose additional factors to screen for, or request modifications or substitutions, provided the setting can demonstrate a research-based rationale that includes a proposal for an alternative leading indicator of health. It is imperative that the results of the screen are integrated into the electronic medical record to assure that results may be reported in a standardized format.

## BRIEF INTERVENTION – CREATING CONNECTION, MOTIVATING CHANGES IN BEHAVIOR AND CIRCUMSTANCE TO IMPROVE HEALTH AND WELL-BEING

The second component of this process is a same-visit [brief intervention](#), which is an evidence-based practice designed to motivate individuals to change their behavior or environment by engaging in a conversation that provides an opportunity to acknowledge a problem, provide education pertaining to health risks, develop a relationship, and assess an individual's readiness to change. Effective brief interventions require specialized skill development, such as proficiency in motivational interviewing to support healthy behaviors and the principles of integrated care, as this component, when skillfully conducted, can encourage individuals to accept treatment and connections to support services that will improve their health and well-being. Brief interventions should be provided for both positive and negative results on the brief screen and begin by reviewing screening results, should serve to engage patients in obtaining more information about the risk factors they encounter and provide person-centered education, determine a patient's readiness to initiate and engage with services, support goal setting, and establish the ability of the setting to triage urgent issues appropriate for the scope of practice. For example, when suicidality is identified during the brief intervention, appropriate interventions and connections must be provided to ensure that an evidence-based approach (e.g. engaging at-risk individuals in an immediate suicide care management plan) is used to address this life-threatening, but preventable, condition.

## BRIEF TREATMENT AND NAVIGATION TO SERVICES – ASSISTING AND ARRANGING ADDITIONAL CARE, WHEN AND WHERE VERMONTERS NEED IT MOST

The third component of this process serves as a bridge to additional treatment or support services, which may take the form of in-house brief treatment or navigation services, depending on the need(s) of the individual in your care. After an individual has been identified as having a need(s) and expresses a willingness to accept additional care,

**Department of Vermont Health Access  
Vermont Blueprint for Health**

whether for mental health or substance use disorders or other determinants of health, this component involves engagement with the individual for further screening, assessment (e.g. secondary screen, assessment of trauma and additional psychosocial factors that are impacting health, etc.) and diagnosis, discussion of the health risks related to conditions, behaviors or environmental concerns identified in the assessment, assisting the individual with goal-setting and care plan development through shared-decision making, communicating with other care team members, arranging timely transitions to additional treatment or services with the individual, and addressing any challenges or barriers to accessing treatment or support services. The services are expected to be provided in-house, but settings are encouraged to consider the use of telemedicine for meeting this component.

[Brief treatment](#) is a systematic process that encompasses assessment, individual engagement, and rapid implementation of change strategies in order to provide individuals with effective therapeutic tools that increase positive outcomes by addressing larger scale attitudes and behaviors. Brief treatment typically requires a duration of 6-20 sessions. **Under the SBINS program, brief treatment should be appropriate to the scope of practice in primary care and emergency department settings (e.g. short-term and not specialized), limited to approximately 3 sessions,** should serve to provide immediate initial treatment and care management while connecting the individual with a timely transition to longer term care, and support patients in becoming empowered to be partners in their care. Brief treatment should be provided by appropriately credentialed and licensed staff, with clinical supervision plans submitted for those staff that are licensure track but not yet licensed. Licensed mental health and substance use disorder clinicians include licensed clinical social workers, licensed psychologists, licensed clinical mental health counselors, licensed alcohol and drug abuse counselors, and licensed marriage and family therapists.

For individuals who require [navigation services](#), the additional care begins with same day support to start the process of identifying the other health care or human service providers individuals are currently connected with, assisting individuals with identifying and enrolling in health care and human service programs if individuals are not already engaged with these services, coordinating follow-up services, advocating for individuals, empowering individuals to communicate effectively with health care and human service providers, providing health or nutrition education, etc.

**FORMALIZED REFERRAL RELATIONSHIPS**

The Patient-Centered Primary Care Collaborative has established that it is essential to have clinical-community partnerships (referred to as "[medical neighborhood](#)") in order to support Patient Centered Medical Homes, as the primary site for delivery and coordination of health care services, in providing the medical and social supports necessary for enhancing health. By working together, clinical and community care organizations can focus on meeting the needs of individual patients for whole-person care, but can also incorporate aspects of population health and community health needs in order to promote health and wellness for all. As risk factors identified under SBINS implementation will require individuals to be connected to other providers within an organization and with providers outside the organizational setting, both intra- and interorganizational agreements will need to be developed and executed for SBINS implementation to be successful. Once executed, intra- and interorganizational agreements (e.g. MOUs, Co-Management Agreements) can support [the flow of information across and between providers and organizations](#) and support timely transitions to additional treatment or support services, **including connection to primary care for those individuals who may be identified in the emergency department as not having a primary care provider and clinical-community connections for social determinants of health** (such as interpersonal violence, housing instability, food insecurity).

Formalized referral relationships will help with addressing current service gaps that often prevent Vermonters from accessing the services they need through allowing each entity to understand the roles and responsibilities inherent

**Department of Vermont Health Access  
Vermont Blueprint for Health**

to the referral arrangement, identifying the information that must be shared for successful care transitions, and establishing a process that remains in effect even when staff transitions occur. In order to ensure that appropriate connections to treatment and support services are completed, **Consents to Coordinate Care** will also need to be developed and implemented, which will allow for patients to provide consent for the sharing of information that will support coordination of care. Promoting a culture of shared responsibility between primary care, the emergency department, crisis response, in-patient units, and community-based organizations (e.g. recovery support services) is critical.

**CONTINUOUS QUALITY IMPROVEMENT**

Finally, a plan for continuous quality improvement must be developed in order to support reporting that allows for frequent review of data, rapid cycle change strategy implementation for enhanced program effectiveness, contribution to programmatic evaluation, and supports sustained practice transformation. The Continuous Quality Improvement Plan will include descriptions of:

- Electronic medical record template(s), and decision trees (as applicable), development to incorporate developed workflows into the electronic medical record;
- How the electronic medical record will be used to document the screening, brief intervention, brief treatment and navigation to services that were indicated and completed (e.g. in structured fields that indicate the screening results and completed connections to additional services and supports), such that the results are able to be extracted in the form of reports to direct continuous quality improvement;
- How the electronic medical record will report aggregated number and percentage of screens indicated and completed, brief interventions for positive screens and brief interventions for negative screens indicated and completed, brief treatment and navigation to services indicated and completed, the referral type for patients identified as needing additional services and supports (e.g. indicates whether the referral was for mental health, substance use disorder, housing instability, food insecurity, interpersonal violence, etc.) and patient confirmation that the referral was completed;
- The team dedicated to continuous quality improvement, identifying who is responsible for running and reviewing the SBINS data reports, the roles and responsibilities of each team member, the overarching goal the team desires to accomplish, and the frequency with which the team will meet to review new reports to continually inform effective SBINS implementation.
- Selected process and outcome measures to evaluate SBINS effectiveness and impact on the patient and provider experience of care.

The Blueprint for Health will provide quality improvement facilitation support<sup>3</sup> to Patient Centered Medical Homes and Emergency Departments participating in SBINS implementation through its network of Quality Improvement Facilitators. Quality Improvement Facilitators will work with providers to assess the current state of the setting and provide time-limited facilitation services that support successful programmatic implementation. The services that may be provided include facilitation support for:

- the provision of effective, patient-centered, team-based and integrated care;
- the development of clinical workflows for systematic screening, brief interventions, brief treatment and navigation services;
- the development of formal referral agreements that will enhance connections to treatment and support services;
- the establishment of processes for monitoring and follow-up that may include improvements in information sharing or improvements in care plan accessibility by primary and specialty providers for continuity of care;

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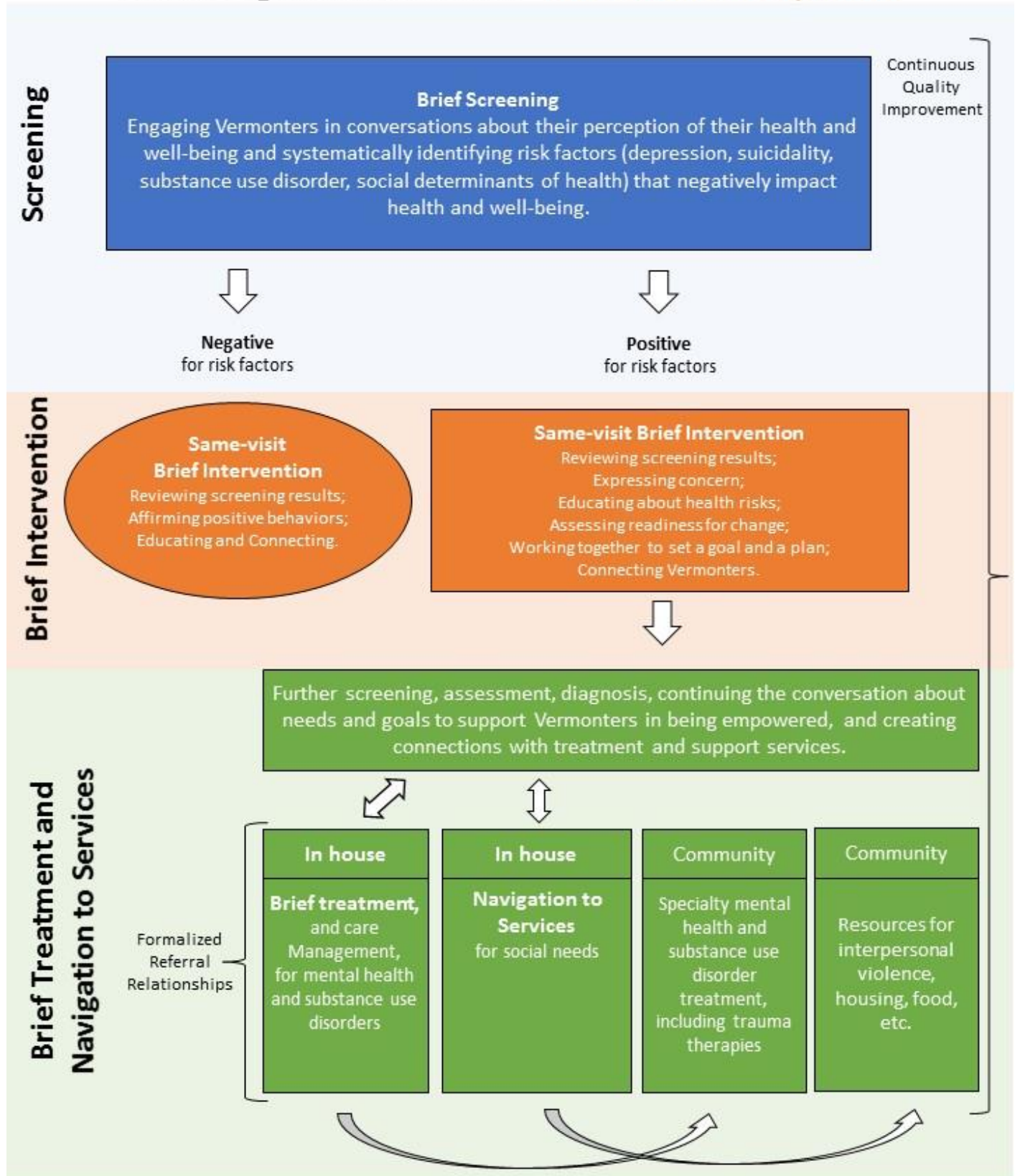
- the appropriate use of determined measures to monitor and evaluate program quality and effectiveness.

<sup>§</sup> It is important to note that in order for quality improvement facilitation services to be provided, the setting must have committed to providing an interdisciplinary team to support sustained practice transformation (including a clinical champion), with dedicated time and space to meet no less than monthly during the active programmatic implementation period.



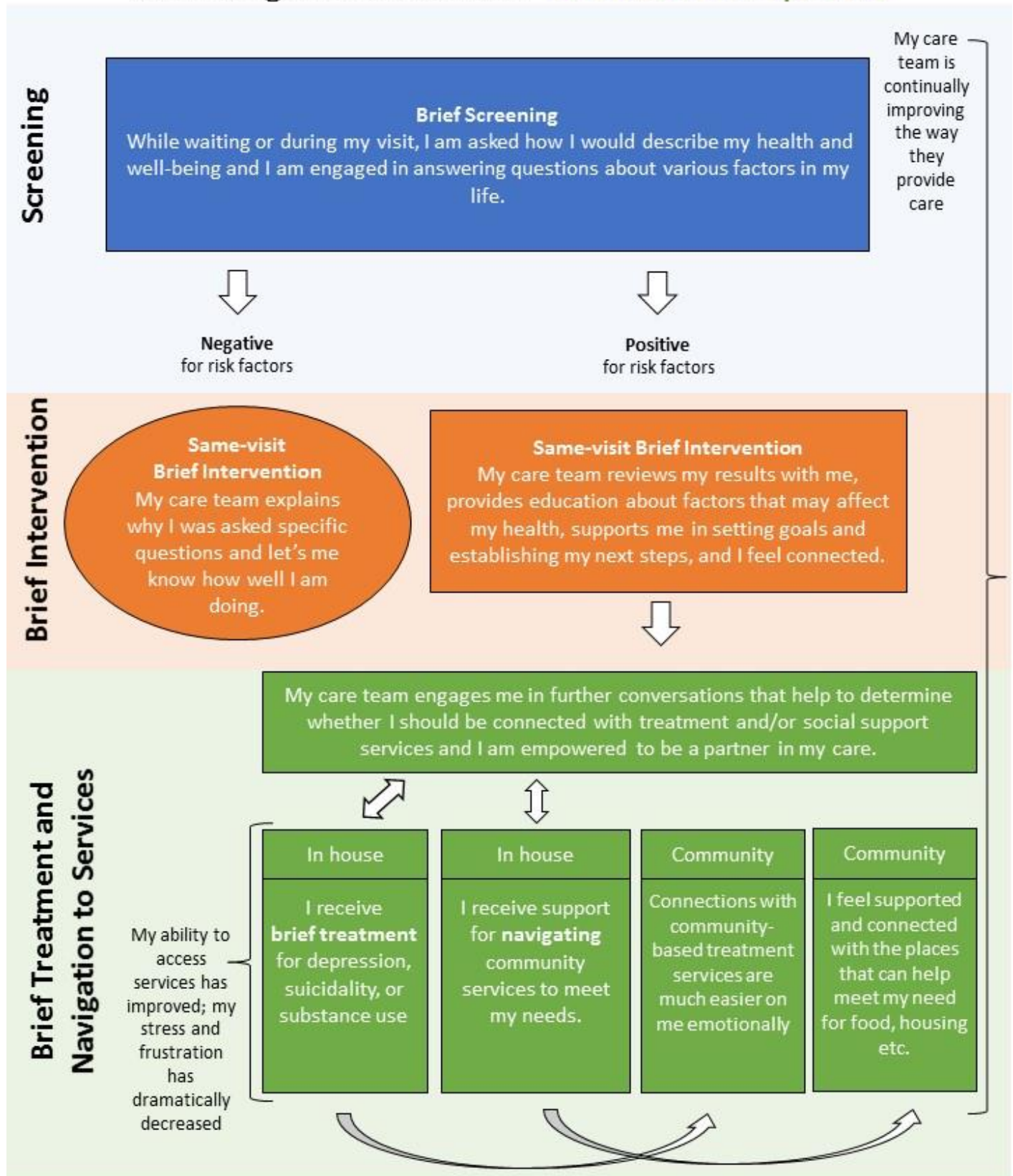
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## The SBINS Model: Screening, Brief Intervention, Brief Treatment, and Navigation to Services – A Provider's Perspective



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## The SBINS Model: Screening, Brief Intervention, Brief Treatment, and Navigation to Services – A Patient’s Perspective



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# SBINS

## EVALUATING IF VERMONTERS ARE BETTER OFF

At its core, SBINS has been designed to create connections between Vermonters receiving care and health care providers by dedicating time for engagement, education and conversations that empower Vermonters to promote their own health and wellness. To that end, it is essential that SBINS implementation include programmatic evaluation so that the State of Vermont, its partners, and providers can answer the question of whether or not the Vermonters touched by the SBINS model are truly better off. [The International Consortium for Health Outcomes Measurement](#) brought together patients, leading physicians and measurement experts from all over the world to recommend methods for measuring patient-centered outcomes. Recommended measure sets include indicators of improved symptom burden, improved functioning (physical, social and employment-related), and health sustainability (i.e. overall success of treatment). Blueprint-participating Patient Centered Medical Homes and Emergency Departments that attest to participating in the Screening, Brief Intervention, Brief Treatment and Navigation to Services program should describe how they plan to engage with, and report on, whether their patients report improvement in their symptoms, functioning and their experience of care.

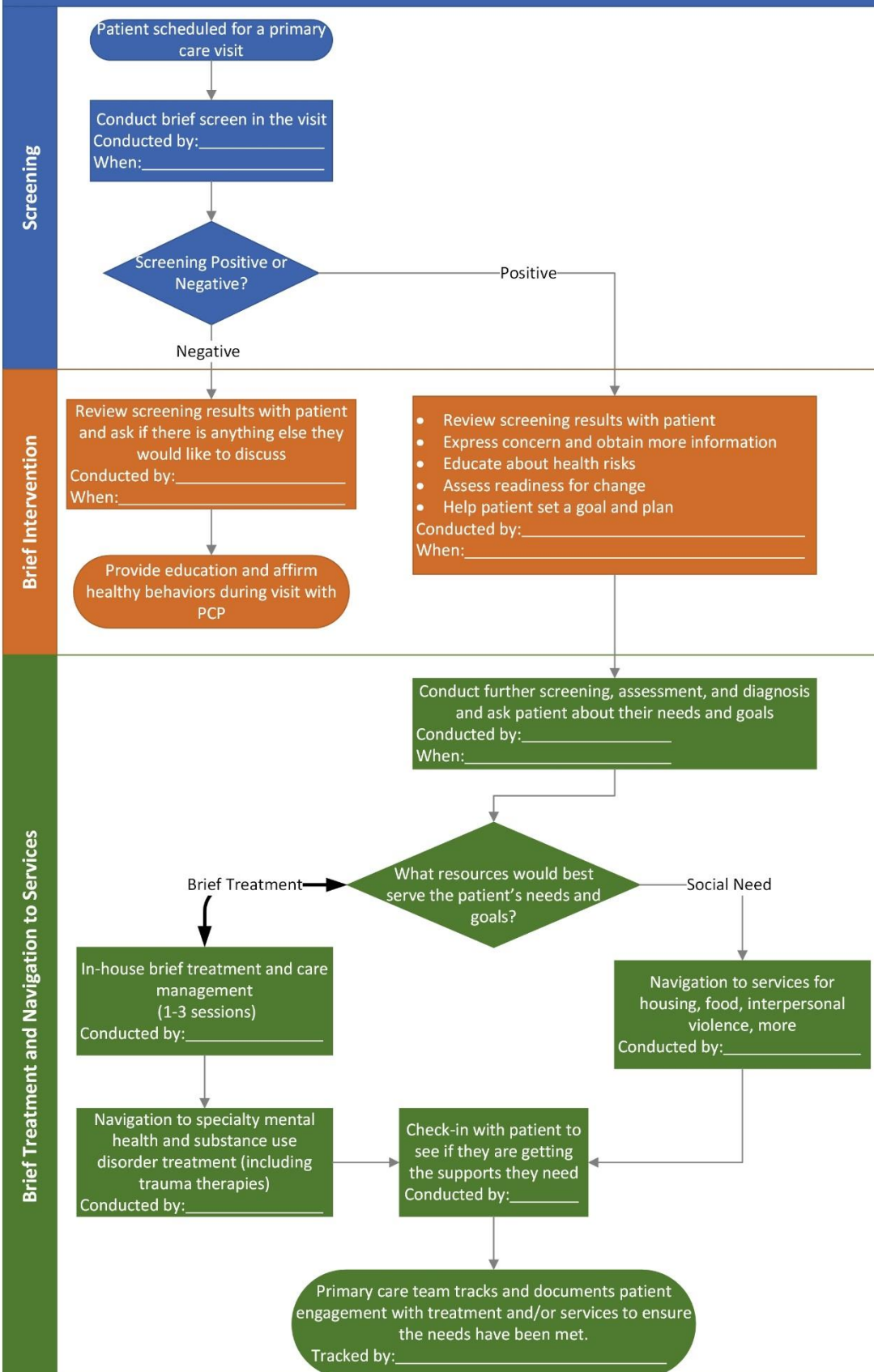
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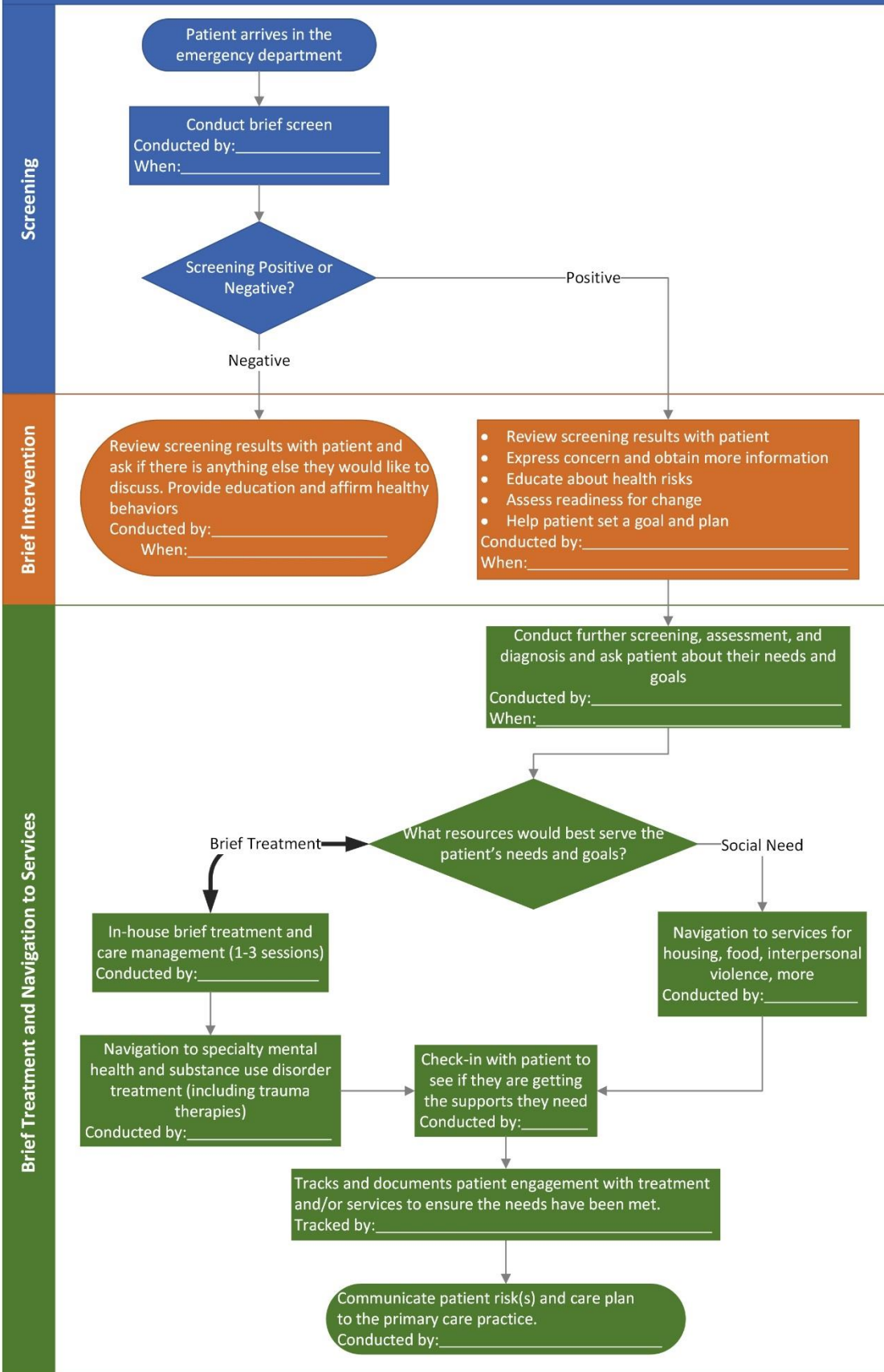
# SBINS

## APPENDIX I: SAMPLE CLINICAL WORKFLOWS

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**SBINS Sample Workflow – Patient-Centered Medical Home**


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**SBINS Sample Workflow – Emergency Department**


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# SBINS

**APPENDIX II: SAMPLE INTERORGANIZATIONAL AGREEMENTS****Practice Letter Head or Name (DRAFT)**

This Collaborative (or Co-Management) Agreement is between <Practice Name> and <Mental Health Provider> for the management of patients with mental health and/or substance use disorders. As unaffiliated providers, we enter into this agreement to benefit the care of our mutual patients, to promote clear communication, to reduce duplication of resources, to streamline care and to provide high quality care.

<Practice Name> will do the following:

- A physician/provider or the Community Health Team member can refer a patient to <Mental Health Provider>;
- Inform the patient to call the <Mental Health Provider> directly to schedule an appointment or assist the patients in scheduling an appointment with the <Mental Health Provider>;
- At the time of the referral, the practice or Community Health Team member will tell, mail or fax the following information: reason for the referral; medical problem list; medication list; any expectations of treatment or other concerns; and the best way to communicate with the practice or physicians;
- If the practice has a HIPAA compliant release of information signed by the patient, it should be mailed or faxed to <Mental Health Provider>;
- Notify <Mental Health Provider> in a timely manner any important changes in medical status or medications, as appropriate;
- Communicate to the <Mental Health Provider> any concerns about the patient or the patient's treatment.

<Mental Health Provider> will do the following:

- Accept as many appropriate referrals as possible from the practices;
- Will schedule an appointment with non-emergent patients within 2 weeks of the referral;
- Notify the <Practice Name> of the acceptance of the patient and the date of the appointment if the practice did not assist in scheduling the appointment;
- Following the initial assessment/interview, provide a note including the diagnosis, treatment plan, goals and level of engagement;
- For on-going visits, provide a treatment/progress note including the next scheduled appointment and any change in diagnosis, treatment plans and/or goals or utilize a customized fax form after each visit;
- Communicate directly with the referring physician at <Practice Name> if there are any concerns or recommendations related to medications;
- Notify <Practice Name> if the patient does not show for the appointment or cancels the appointment without rescheduling the appointment;
- When therapy ends, the final treatment/progress note, or discharge summary should include the diagnosis, treatment outcomes, and any recommendations.
- May refer to the practice's Community Health Team (a multi-disciplinary team, providing support to Patient Centered Medical Home practices, that may include licensed mental health clinicians, health coaches, community health workers, dieticians, etc.) by contacting the nurse case manager.

---

<Physician Name>

---

Date

---

<Mental Health Provider>

---

Date



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# SBINS

## APPENDIX III: SAMPLE SCREENING TOOL

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<b>Screening, Brief Intervention, Brief Treatment and Navigation to Services (SBINS)</b>							
<b>Patient Name:</b>			<b>Date of Birth:</b>		<b>Today's Date:</b>		
Once a year, all of our patients are asked to complete this form, and answer questions about medications currently being taken, because these factors can all affect health.							
Please help us provide you with the best care by answering the questions below.							
<b>Perception of Health</b>							
Would you say that, in general, your health is ...		Excellent	Very Good	Good	Fair	Poor	
<b>Patient Health Questionnaire-2 and item 9</b>							
Over the past 2 weeks, how often have you been bothered by any of the following problems?							
Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day			
Feeling down, depressed or hopeless	Not at all	Several days	More than half the days	Nearly every day			
Thoughts that you would be better off dead or of hurting yourself in some way	Not at all	Several days	More than half the days	Nearly every day			
<b>VT SBIRT</b>							
Do you use tobacco products?	Yes	Sometimes	No				
<b>USAUDIT-C Questionnaire</b>							
Think about your drinking in the past year. A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.							
How often do you have a drink containing alcohol?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-9 drinks	10 or more drinks
How often do you have 4 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
<b>VT SBIRT</b>							
How often have you used marijuana in the past year? (including smoking, vaping, dabbing, or edibles)	Never	Monthly or less	Several days per month	Weekly	Several days per week (2-4 days/wk)	Daily Almost Daily (5-7 days/wk)	
How often in the past year have you used prescription medications that were not prescribed to you?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week		
How often in the past year have you taken your own prescription medication more than the way it was prescribed or for different reasons than its intended purpose?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week		
How often in the past year have you used other drugs (for example, heroin, cocaine, salvia, inhalants)?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week		

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<b>AHC HRSN</b>					
How often does anyone, including family, physically hurt you?	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Fairly often</b>	<b>Frequently</b>
How often does anyone, including family, insult or talk down to you?	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Fairly often</b>	<b>Frequently</b>
How often does anyone, including family, threaten you with harm?	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Fairly often</b>	<b>Frequently</b>
How often does anyone, including family, scream or curse at you?	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Fairly often</b>	<b>Frequently</b>
Within the past 12 months, you worried that your food would run out before you got money to buy more.	<b>Often True</b>		<b>Sometimes True</b>		<b>Never True</b>
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	<b>Often True</b>		<b>Sometimes True</b>		<b>Never True</b>
What is your housing situation today? <input type="checkbox"/> I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park. <input type="checkbox"/> I have housing today, but I am worried about losing housing in the future. <input type="checkbox"/> I have housing.					
Do you have any other issues you would like to discuss today?	<b>Yes</b>	<b>Unsure</b>		<b>No</b>	

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Vermont Blueprint for Health

## SBINS

## APPENDIX IV: RESEARCH-BASED RECOMMENDATIONS FOR SCREENING AND FROM THE SBIRT EVALUATION

Implementing evidence-based, age-appropriate systematic approach to screening for factors that impact health requires a plan that describes which screening tools are appropriate, who will be screened (e.g. universal), how often the screenings will occur (e.g. annually), when the screening will occur (e.g. in the waiting room or examination room), the method by which screenings will occur (e.g. self-administration versus oral interview), and what the process will be for addressing the results of the screenings (e.g. by whom will the brief intervention, brief treatment or navigation to services occur). The Blueprint for Health compiled the following research to support primary care practices and emergency department settings in determining which evidence-based screening tools are appropriate for the patient population the setting serves.

## DEPRESSION, SUICIDALITY AND SUBSTANCE USE

The Patient Health Questionnaire-2 item (PHQ-2), comprised of the first two items of the 9-item Patient Health Questionnaire (PHQ-9), is intended to screen for the frequency of depressed mood and anhedonia over the past 2 weeks, and has been validated in multiple settings, including primary care and obstetrics-gynecology clinics, with sensitivity and specificity established for scores of greater than or equal to 3. The purpose of the PHQ-2 is to establish a brief, initial approach to screening for depression in busy clinical settings. It is important to note that **the PHQ-2 does not screen for suicidality** (see next section). Patients who screen positive should be evaluated with the PHQ-9. A cut-off score of 3 is the optimal point for identifying patients who should be evaluated with the PHQ-9. The validity of the PHQ-2 has been evaluated in the adolescent population; a PHQ-2 score of greater than or equal to 3 demonstrated sensitivity and specificity for detecting depression in adolescents.

Kroenke K et al. 2003. The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Med Care*; 41: 1284-1292. Richardson LP et al. 2010. Evaluation of the PHQ-2 as a brief screen for detecting major depression among adolescents. *Pediatrics*; 125: 1097-1103. Patient Health Questionnaire-2 adapted from [phqscreeners.com](http://phqscreeners.com); terms for the PHQ Screeners indicate the content is expressly exempted from Pfizer's general copyright restrictions and that content on the PHQ Screeners site is free for download and use as stated within the site.

The Patient Health Questionnaire-9 item is a frequently utilized tool for screening patients in a primary care setting. Of the 9 items, one question, item 9, may be used to screen for suicide risk. The question asks, "Over the past two weeks, have you been bothered by ... thoughts that you would be better off dead or of hurting yourself in some way." The response given to item 9 of the PHQ-9 has been shown to be a moderate predictor of subsequent suicide death and may be used to identify individuals at increased risk of suicide attempt or death, with cumulative risk continuing to increase over a period of time. When the Patient Health Questionnaire-2 item is used exclusively, a patient could answer "no" to both questions but still be experiencing suicidality. Simon et al. examined the association between thoughts of death or self-harm, as reported by responses to item 9 of the Patient Health Questionnaire, and the risk of suicide attempt or suicide death in the following 2 years. Rates of suicide attempt and suicide death increased with escalating responses to item 9; however, over 1/3 of suicide attempts and deaths occurred among those responding, "not at all."

The Zero Suicide in Health and Behavioral Health Care toolkit states the wording of item 9 is "somewhat indirect" and advises organizations to consider adding a more direct question about suicide to the PHQ-2 and substituting the more direct question for item 9 in the PHQ-9. The toolkit provides the example of: "Over the past two weeks, have you been bothered by ... thoughts that you want to kill yourself, or have you attempted suicide?" Zero Suicide in Health and Behavioral Health Care provides general guidance for screening and assessment processes in primary care. Under the screening section, additional screening tools, such as the Columbia-Suicide Severity Rating Scale

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Vermont Blueprint for Health**

(C-SSRS) and the SAFE-T are discussed in depth. Additionally, the toolkit includes guidance for introducing a Zero Suicide approach into an organization and describes the overall framework, including the core components of training staff in suicide care, identifying individuals with suicide risk through comprehensive screenings, engaging at-risk individuals in a suicide care management plan, treating individuals with suicidal thoughts or behavior through evidence-based interventions, transitioning individuals through levels of care with warm hand offs and support, and using continuous quality improvement to improve organizational policies and procedures. A full assessment of suicide risk involves gathering complete information regarding past, recent and present suicidal ideation and behavior, gathering information about a patient's history and context, and using this information to create a prevention-oriented suicide risk formulation, anchored in the patient's life. These components are essential for providing the foundation for treatment planning. Evidence-based interventions, designed for targeting suicide risk directly, with demonstrated effectiveness for reducing suicidal thoughts and behaviors are: non-demand "caring contacts," structured, problem-solving therapies, and collaborative assessment and treatment planning. Whichever model is chosen, the intervention should be person-centered, collaborative, and acknowledge the ambivalence often cited by individuals contemplating suicide.

Simon GE et al. 2016. Risk of suicide attempt and suicide death following completion of the Patient Health Questionnaire depression module in community practice. *J Clin Psychiatry*; 77: 221-227. Simon GE et al. 2013. Does response on the PHQ-9 Depression Questionnaire predict subsequent suicide attempt or suicide death? *Psychiatr Serv*; 64: 1195-1202. Patient Health Questionnaire-9 adapted from [phqscreeners.com](http://phqscreeners.com); terms for the PHQ Screeners indicate the content is expressly exempted from Pfizer's general copyright restrictions and that content on the PHQ Screeners site is free for download and use as stated within the site. Zero Suicide in Health and Behavioral Health Care toolkit: Screening for and Assessing Suicide Risk. <https://zerosuicide.sprc.org/toolkit>

The USAUDIT is a brief screening questionnaire used by health care and human service practitioners in clinical settings to identify individuals using alcohol in a harmful way and may be administered as a self-report questionnaire, an oral interview, or a computer-administered survey. Based upon the 10 question-Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organization, the first 3 questions are adjusted for the standard U.S. drink (Centers for Disease Control and Prevention, 2014), recommended drinking limits (National Institute on Alcohol Abuse and Alcoholism, 2007), and definitions of alcohol use disorder (AUD), according to the International Classification of Diseases, 10<sup>th</sup> Revision, and the Diagnostic and Statistical Manual, 5<sup>th</sup> Edition.

Administering the USAUDIT-C (the first 3 questions of the USAUDIT) to all patients will identify those patients whose alcohol consumption exceeds low-risk levels for healthy adults (70-90 percent of primary care patients have negative results to these questions and require no additional time or follow-up) by measuring patients' weekly consumption and occasions of excessive alcohol consumption. Patients who score positive on the USAUDIT-C should complete the remaining 7 questions (completed most efficiently by having the patient use a paper form) for full USAUDIT completion, and the total USAUDIT score calculated and used to guide the practitioner in discussing the patient-reported alcohol use with the patient. For the USAUDIT-C, a total score of 7 or more for women and men over the age of 65, and a total score of 8 or more for males (under the age of 65) is a positive risk indicator.

Despite the guide focus on primary care settings, the authors note that "practitioners in other medical and human service settings, such as obstetrics-gynecology clinics ... may find the content useful as well." Screening for alcohol use allows practitioners to engage in conversations with patients regarding alcohol-related health problems and the adverse effect of alcohol on conditions such as high blood pressure, diabetes, obesity, depression, sleep disorders, etc. In conversations with patients about alcohol-related health problems, providers can discuss the irreversible, lifelong birth and development effects of fetal alcohol spectrum disorders.

A team of academic researchers reviewed the literature and concluded that the AUDIT and its abbreviated versions have demonstrated effectiveness in different populations and alcohol consumption ranges, but that little research has focused on detection among adolescents. Cortes-Tomas et al. published a journal article in *Drug and Alcohol Dependence* (2016) that indicated the AUDIT and AUDIT-C were adequate to identify binge drinking, and discussed

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the optimal cutoff scores for the AUDIT and AUDIT-C when used, in an adolescent population, and differences in sensitivity when the sample was divided by gender. For the AUDIT-C, the optimal cutoff score for identification in the adolescent population was the score indicating a positive result for adult women.

Babor T et al. 2016. USAUDIT. The Alcohol Use Disorders Identification Test, adapted for use in the United States: A guide for primary care practitioners. Guide prepared by JBS International, Inc. under contract no. HHSS2832012000021/HHSS28342003T (SAMHSA/CSAT) and grant no. 5P60AA003510-36 (NIAAA). USAUDIT and USAUDIT-C may be reproduced and used without permission or cost by medical and human service practitioners in clinical settings. Cortes-Tomas MT et al. 2016. Different versions of the Alcohol Use Disorders Identification Test (AUDIT) as screening instruments for underage binge drinking. *Drug Alcohol Depend*; 158: 52-59.

The Patient Health Questionnaire-9 item was modified for adolescents and is available as the Patient Health Questionnaire for Adolescents (PHQ-A), a self-administered tool, validated for assessing mood disorders in the adolescent population. The Center for Adolescent Substance Abuse Research (© Children's Hospital Boston, 2009) developed the CRAFFT, a 6-question, self-administered screening tool developed to screen adolescents for high risk alcohol and other substance use. The National Institute on Drug Abuse recently launched 2 evidence-based online screening tools for providers to use to assess substance use disorder risk amongst adolescents aged 12-17, the Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD) and the Screening to Brief Intervention (S2BI). These tools may be self-administered or completed by a clinician in under 2 minutes.

National Institute on Drug Abuse, Accessed October 2017: <https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults> and <https://www.drugabuse.gov/news-events/news-releases/2017/11/nida-launches-two-adolescent-substance-use-screening-tools>. Johnson JG et al. 2002. The Patient Health Questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. *J Adolesc Health*; 30: 196-204.

The Drug Abuse Screening Test (DAST-10) is a 10-item, screening tool that can be self-administered or administered by a clinician and may be completed in less than 8 minutes. The DAST-10 assesses substance use (including cannabis and prescribed or over-the-counter medications, excluding alcohol or tobacco) in the past 12 months. A total score for all the questions indicates a degree of problems related to drug use, and a suggested action of "further investigation" is indicated when the total score is 3-5.

National Institute on Drug Abuse, Accessed October 2017: <https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults> and <https://www.drugabuse.gov/sites/default/files/dast-10.pdf>. Skinner HA. 1982. The Drug Abuse Screening Test. *Addict Behav*; 7: 363-71.

For older adults, there are several age-appropriate screening tools available to help health care providers identify older adults who have symptoms of depression or are at-risk of alcohol use disorder. The Geriatric Depression Scale (GDS), a 15-item screening tool for depression in older adults, and the Short Michigan Alcoholism Screening Test, Geriatric Version (S-MAST-G), a 10-item screening tool for assessing alcohol use, have been validated in the older adult population.

Substance Abuse and Mental Health Services Administration and Administration on Aging. 2013. Older Americans Behavioral Health. Issue Brief 6: Depression and Anxiety. <https://www.ncoa.org/resources/issue-brief-6-depression-and-anxiety-screening-and-intervention/> and Substance Abuse and Mental Health Services Administration and Administration on Aging. 2012. Older Americans Behavioral Health. Issue Brief 3: Screening and Preventive Brief Interventions for Alcohol and Psychoactive Medication Misuse/Abuse. <https://www.ncoa.org/resources/issue-brief-3-screening-and-preventive-brief-interventions-for-alcohol-and-psychoactive-medication-misuseabuse/> Conigliaro J et al. 2000. Screening and identification of older adults with alcohol problems in primary care. *J Geriatr Psychiatry Neurol*; 13: 106-114.

**STANDARDIZED SCREENING FOR HEALTH-RELATED SOCIAL NEEDS**

A team from the Centers for Medicare and Medicaid Services published a discussion paper emphasizing the importance of standardized screening for health-related social needs in clinical settings to address the critical gaps existing between clinical care and community services. Moreover, the published discussion paper provided access to the Accountable Health Communities Health-Related Social Needs (AHC HRSN) screening tool that was developed

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Vermont Blueprint for Health**

by a technical expert panel following review of 50 screening tools, comprising over 200 questions and offering the opportunity for standardization in the screening for health-related social needs. The tool was designed to be readily understandable to the broadest audience, across a variety of settings, and allow for inclusion of routine screening in a busy clinical workflow. Medicare and Medicaid beneficiaries represent a diverse subset of the population; all ages, backgrounds and environments (urban and rural) are represented. As such, the tool had to be accessible to beneficiaries regardless of language, literacy level, or disability status. Self-administration of the screening tool was considered during the development of the tool by the Technical Expert Panel (TEP); the final recommended screening tool was designed to reduce the need for outside assistance. The tool was intended to be completed by the individual respondent or by a parent / caregiver on the individual's behalf.

**INTERPERSONAL SAFETY**

The Hurt, Insult, Threaten, and Scream (HITS) assessment tool, validated in multiple settings around the world for use as a self-report or clinician-administered tool to identify intimate partner violence among women and men, was adapted by the technical expert panel to broaden the scope of the assessment for interpersonal safety beyond intimate partner violence by editing the answer options to say "anyone, including family" instead of "your partner." A total score of greater than 10 indicates the individual is experiencing, or at risk of experiencing, interpersonal violence.

Billieux A et al. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Perspectives; National Academy of Medicine: 1-9.

**HOUSING STABILITY**

The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) assessment tool (developed by the National Association of Community Health Centers) includes questions designed to assess housing insecurity. The technical expert panel adapted the question from the PRAPARE assessment to modify the first answer option, that identifies individuals who are homeless, to be consistent with the federal definition of homeless. The second answer option is intended to identify individuals who are at risk of losing their housing, including inability to afford a mortgage or rent; as a result, selecting either answer option 1 or option 2 would indicate the individual is experiencing, or at risk of experiencing, a housing need (housing insecurity).

Billieux A et al. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Perspectives; National Academy of Medicine: 1-9.

**FOOD SECURITY**

The Hunger Vital Sign™, 2-question screening tool, with established sensitivity, specificity, and validity amongst low-income families with young children and recommended for universal screening by the American Academy of Pediatrics and contained within the 18-question USDA U.S. Household Food Security Survey, was only adapted by the technical expert panel to match the voice of the other questions included within the screening tool. Selection of "often true" or "sometimes true" for either of the 2 questions would indicate the individual is experiencing, or at risk of experiencing, a food need (food insecurity).

Billieux A et al. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Perspectives; National Academy of Medicine: 1-9.

**PREGNANCY INTENTION**

The One Key Question® (OKQ) was developed by the Oregon Foundation for Reproductive Health to embed pregnancy intention screening within primary care practices and ensure that women, aged 18-50, were routinely



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Vermont Blueprint for Health**

offered essential reproductive health services as indicated by the patient's response to the question: yes or ok, either way (preconception care), unsure (comprehensive family planning counseling), or no (comprehensive contraceptive counseling). Improved use of LARC among women aged 15-44 may generate health-care cost savings by reducing inconsistent contraceptive use; if 10% of women aged 20-29 years began using a LARC instead of oral contraception, it is estimated that the total costs of unintended pregnancy in the United States could be reduced by \$288 million per year. Vermont Medicaid's Women's Health Initiative included the One Key Question as an age-appropriate screening tool for identifying pregnancy intention in its recommendations for practices participating in the Initiative.

Bellanca H and Stranger Hunter M. One Key Question® - Oregon Foundation for Reproductive Health; ARHP: December 2013. The Oregon Foundation for Reproductive Health, in partnership with The National Campaign to Prevent Teen and Unplanned Pregnancy. One Key Question® is trademarked and a signed MOU is required before implementation to ensure fidelity of the program. Blueprint for Health, Department of Vermont Health Access, State of Vermont, confirmed with OFRH that all prior agreements with OFRH are being honored by TNC and utilization of the One Key Question within the Women's Health Initiative is still acceptable. Contact: [OneKeyQuestion@TheNC.org](mailto:OneKeyQuestion@TheNC.org) for implementation of the OKQ outside of the State of Oregon; implementation within the State of Oregon, Contact: [info@ORfrh.org](mailto:info@ORfrh.org). Trussell J et al. 2013. Burden of Unintended pregnancy in the United States: Potential savings with increased use of long-acting reversible contraception. *Contraception*; 87: 154-161 and CDC, the 618 Initiative: Prevent Unintended Pregnancy.

The One Key Question® (OKQ) may be adapted to incorporate inclusive language that allows for its use with "men, non-binary, and LGBT individuals" while avoiding assumptions and opening conversations about pregnancy. The adapted question becomes, "Would you, **or your partner**, like to become pregnant in the next year?"

Phanthavong S. 2017. Family Planning Program: Rhode Island Department of Health. ATTC Network One Key Question Presentation.

**ASSESSING PATIENTS' ASSETS, RISKS AND EXPERIENCES (PRAPARE)**

The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) assessment tool was designed by the National Association of Community Health Centers and partners (© 2016) to collect data on the social determinants of health in order to support providers in identifying upstream factors that hold the potential to negatively impact health outcomes and health care expenditures. The PRAPARE tool, version 1.0 (2016), is an 8-page, 21-question tool. For fidelity with the intent of SBINS, the PRAPARE tool's housing questions would count for the housing instability screening component of SBINS, but it is recommended for the food insecurity and interpersonal violence domains that the AHC HRSN tools referenced above are used. The PRAPARE tool does not include questions for the screening of depression, suicidality and substance use disorders that are consistent with the intent of SBINS.

[http://www.nachc.org/wp-content/uploads/2016/09/PRAPARE\\_Paper\\_Form\\_Sept\\_2016.pdf](http://www.nachc.org/wp-content/uploads/2016/09/PRAPARE_Paper_Form_Sept_2016.pdf); the PRAPARE tool and its resources are proprietary information and may not be published, copied or distributed, in part or in whole, without prior written consent.

**ASSESSING TRAUMA**

The Substance Abuse and Mental Health Services Administration Treatment Improvement Protocol (TIP 57) indicates that exposure to trauma is common, rates of exposure to trauma are higher among clients with mental or substance use disorders, and mental and substance use disorders are often more difficult to treat if trauma-related symptoms are not detected and treated effectively. Screening, early identification, and intervention serves as a prevention strategy as undetected trauma histories and related symptoms may negatively affect factors that impact health outcomes, such as engagement in treatment and relapse rate. Treatment Improvement Protocol (TIP) 57 and SAMHSA provide general guidance for trauma-informed screening and assessment processes in primary care. The guidance includes general rules and methods for introducing trauma-informed screening and assessments, and describes the overall process, including screening, assessment, treatment / referral to more intensive services, and follow-up. There are numerous tools (ACES, PC-PTSD) for screening and assessment of trauma; the purpose of screening and the population to be assessed are essential for determining the appropriate tool to use.

## Department of Vermont Health Access Vermont Blueprint for Health

SAMHSA. 2014. Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series; No. 57. Prins A et al. The Primary Care PTSD Screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry*. 2004; 9:9–14, van Dam D et al. 2010. Validation of the Primary Care Posttraumatic Stress Disorder screening questionnaire (PC-PTSD) in civilian substance use disorder patients. *J Subst Abuse Treat*; 39: 105–113. Felitti VJ et al. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) study. *Am J Prev Med*; 14: 245–258. Clinical assessment tools for children and adolescents available at: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Clinical-Assessment-Tools.aspx>

### EVALUATION OF SBIRT (SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT)

- SBIRT can reach a **broad range of patients**, especially when implemented within high-volume emergency department settings;<sup>1, 2, 15</sup>
- SBIRT is a model capable of **identifying substance use and other conditions, such as intimate partner violence, housing instability and food insecurity, that are likely to present risks to the health of the individual and significant health care costs** to the system if not addressed.<sup>1, 2, 3, 4, 5, 6, 7, 8, 9, 10</sup>
  - A randomized controlled trial of screening, brief intervention, and referral to treatment (SBIRT) to identify and address intimate partner violence was found to be effective for identification and intervention with no significant differences observed between modalities studied (computerized, self-paced versus case manager).<sup>3</sup>
  - A randomized trial of electronic versus face-to-face social screening formats in a pediatric emergency department found that 96.8% of caregivers reported at least 1 social need; rates of reporting on issues perceived to be more sensitive in nature (e.g. household violence and substance use) were higher in the electronic format.<sup>9</sup>
  - A cross-sectional study conducted in an urban young adult clinic with patients aged 15 to 25 years utilized a computerized questionnaire format to screen for health-related social needs; 76% of youth screened positive for at least one social need (34% identified housing, 29% identified food).<sup>10</sup>
- A cross-site evaluation of 11 SBIRT programs in 2 cohorts **screened more than 1 million patients** in general medical and community settings, with the **rate of positive screens ranging from 1 in 5 to a little more than 1 in 10** depending on the cohort;<sup>1, 2</sup>
  - Among those who screened positive, alcohol was the most common type of substance use reported but illicit drug use was still highly prevalent (alcohol [74.4%, 80.0%] and illicit drug use [41.8%, 45.8%] respective to cohort) with almost 1/3 indicating dual use of alcohol and illicit substances. Those served in the cohort study tended to be middle-aged, more likely to be female, and white.<sup>2</sup>
- Increasing screening rates and reducing burden on medical staff involves **integrated staffing models** that allow for the continuum of SBIRT services to be provided successfully for indicated conditions and use of **short, initial screening** instruments that are quickly administered at intake and comprise a **broad screening approach** that assesses multiple risk factors known to impact health.<sup>2, 15</sup>
  - Numerous reviews have been published with results indicating that general practitioners may not be the most appropriate for delivering screening and brief interventions (early intervention), leading to the training of other members of a health care team, including nurses, health educators, etc. and contracted specialists from substance use treatment organizations.<sup>2, 11, 12, 13, 14, 15</sup>
  - Typical challenges associated with implementation may be addressed when leadership is committed, substance use specialists deliver services, and programmatic design includes a start-up phase that is focused on comprehensive education and training to address barriers.<sup>15</sup>

**Department of Vermont Health Access**  
**Vermont Blueprint for Health**

- Maximizing population reach involves **reducing the need for external referrals** through development of the capacity to **provide brief intervention and brief treatment** within the emergency department or medical practice setting.<sup>2, 15</sup>
  - Lower volume settings may experience insufficient patient flow to support SBIRT staffing unless staff are well integrated, a broad screening approach for risk factors is implemented, and staff are able to provide brief intervention and brief treatment onsite and through telemedicine technology (for brief treatment specifically).<sup>2, 15</sup>
  - Factors impacting financial sustainability: Providers spend 40% of their time in support SBIRT activities (e.g. reviewing the patient's chart, locating the patient) and only 13% of their time performing clinical services. The mean time to deliver a pre-screen was 1:19 (minutes: seconds), a full screen was 4:28, and a brief intervention 6:51 with service duration and support time varying by setting.<sup>17</sup>
- SBIRT effectiveness in improving patient outcomes for heavy drinking and illicit drug use showed **clinically meaningful and statistically significant improvements** (declines of 43.4% and 75.8%, respectively), with greater intervention intensity associated with larger decreases in substance use, when pre-post differences were assessed.<sup>16</sup>
- SBIRT effectiveness is impacted by **adherence to evidence-based protocols**, for example, incorporation of **motivational interviewing** elements in brief interventions, so training for health care staff must be available and supervision ongoing to evaluate performance.<sup>2</sup>
- When large scale training programs are combined with clinical guidelines and health policy changes, research suggests that the **training programs change the attitudes, knowledge, and confidence** of the trained health care staff, but also serve to reach large numbers of at-risk individuals.<sup>2, 13, 14, 15</sup>

<sup>1</sup> Babor, TF, Del Boca, F, Bray, JW. Screening, Brief Intervention and Referral to Treatment: Implications of SAMHSA's SBIRT Initiative for Substance Abuse Policy and Practice. *Addiction*. 2017; 112 (Suppl. 2): 110-117.

<sup>2</sup> Bray JW, Del Boca FK, McRee BG, Hayashi SW, Babor TF. Screening, Brief Intervention, and Referral to Treatment (SBIRT): Rationale, Program Overview, and Cross-site Evaluation. *Addiction*. 2017; 112 (Suppl. 2): 3-11.

<sup>3</sup> Gilbert L, Shaw SA, Goddard-Eckrich D, Chang M, Rowe J, McCrimmon T, Almonte M, Goodwin S, Epperson M. Project WINGS (Women Initiating New Goals of Safety): A Randomized, Controlled Trial of a Screening, Brief Intervention, and Referral to Treatment (SBIRT) Service to Identify and Address Intimate Partner Violence Victimization Among Substance-Using Women Receiving Community Supervision. *Criminal Behavior and Mental Health*. 2015; 25(4): 314-329.

<sup>4</sup> Kushel MB, Vittinghoff E, Hass JS. Factors Associated with the Health Care Utilization of Homeless Person. *Journal of the American Medical Association*. 2001; 285(2): 200-206.

<sup>5</sup> Ma CT, Gee L, Kushel MB. Associations between housing instability and food insecurity with health care access in low-income children. *Ambulatory Pediatrics*. 2008; 8(1): 50-57.

<sup>6</sup> Bonomi AE, Anderson ML, Rivara FP, Thompson RS. Health Care Utilization and Costs Associated with Physical and Nonphysical-only Intimate Partner Violence. *Health Services Research*. 2009; 44(3): 1052-1067.

<sup>7</sup> Billioux A, Verlander K, Anthony S, Alley D. Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. Discussion Paper, National Academy of Medicine. 2017; 1-9.

<sup>8</sup> Gottlieb L, Hessler D, Long D, Amaya A, Adler N. A Randomized Trial on Screening for Social Determinants of Health: The iScreen Study. *Pediatrics*. 2014; 134(6): 1611-1618.

<sup>9</sup> Garg A, Toy S, Tripodis Y, Silverstein M, Freeman E. Addressing Social Determinants of Health at Well Child Care Visits: A Cluster RCT. *Pediatrics*. 2015; 135(2): 296-304.

<sup>10</sup> Hassan A, Blood EA, Pikilings A, Krull EG, McNickles L, Marmon G, Wylie S, Woods ER, Fleegler EW. Youths' Health-Related Social Problems: Concerns Often Overlooked During the Medical Visit. *Journal of Adolescent Health*. 2013; 53(2): 265-271.

<sup>11</sup> Funk M, Wutzke S, Kaner E, Anderson P, Pas L, McCormick R, Gual A, Barfod S, Saunders J, World Health Organization Brief Intervention Study Group. A Multi-country, Controlled Trial of Strategies to Promote Dissemination and Implementation of Brief Alcohol Intervention in Primary Health Care: Findings of a World Health Organization Collaborative Study. *Journal of Studies on Alcohol*. 2005; 66(3): 379-388.

<sup>12</sup> Aasland OG, Johannessen A. Screening and Brief Intervention for Alcohol Problems in Norway: Not a Big Hit Among General Practitioners. *Nordic Studies on Alcohol and Drugs*. 2008; 25: 515-521.

<sup>13</sup> Amaral-Sabadini MB, Saitz R, Souza-Formigoni ML. Do Attitudes About Unhealthy Alcohol and Other Drug (AOD) Use Impact Primary Care Professionals' Readiness to Implement AOD-related Preventive Care? *Drug and Alcohol Review*. 2010; 29(6): 655-61.

<sup>14</sup> Carneiro APL, Souza-Formigoni ML. Country-wide Distance Training for Delivery of Screening and Brief Intervention for Problematic Substance Use: A Pilot Evaluation of Participant Experiences and Patient Outcomes. *Substance Abuse*. 2017; 11: 1-8.

<sup>15</sup> Vendetti J, Gmyrek A, Damon D, Singh M, McRee B, Del Boca F. Screening, Brief Intervention, and Referral to Treatment (SBIRT): Implementation Barriers, Facilitators, and Model Migration. *Addiction*. 2017; 112 (Suppl. 2): 23-33.

<sup>16</sup> Aldridge A, Linford R, Bray J. Substance Use Outcomes of Patients Served by Large US Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT). *Addiction*. 2017; 112 (Suppl. 2): 43-53.

<sup>17</sup> Cowell A. et al. A time and motion study of Screening, Brief Intervention, and Referral to Treatment Implementation in Health-Care Settings. *Addiction*. 2017; 112 (Suppl. 2): 65-72.