SBIRT

Implementation

Implementation Site Visit Report

Cohort IV State Grantee: Connecticut SBIRT

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Implementation Site Visit: State of Connecticut

Grantee Name	State of Connecticut
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Grant TI Number	TI023459
Date of Site Visit	May 10–11, 2012
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Site Visit Team Members	Joe Hyde, Jan Armstrong, Janice Pringle

Grantee Project Team Members Visited
AnneMarie Fitzpatrick, Department of Mental Health and Addiction Services (DMHAS) Project Manager
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Janice Vendetti, M.P.H., Data Manager/Data Analyst, UCHC
Robin Odell, Followup Specialist, UCHC
Bonnie McRee, Ph.D., M.P.H., Connecticut SBIRT Training Institute Director, UCHC
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Karen Steinberg, Ph.D., Brief Treatment (BT) Supervisor, UCHC

Introduction

On May 10 and 11, 2012, the SBIRT site visit team met with State of Connecticut SBIRT implementation team. The purpose of the site visit was to engage the State grantee in a discussion to identify the current status of their SBIRT program implementation, its strengths, and possible challenges. An additional purpose was to engage the grantee in identifying any potential enhancements that might be supported by technical assistance, as approved by SAMHSA. The site visit process included several components:

- Meeting onsite with the principal investigator/project director, core senior faculty, key partners, project evaluator, project coordinator, and State agency senior leadership
- Reviewing curriculum components and materials
- Visiting SBIRT implementation sites and site interviewing staff
- Reviewing materials
- Meeting with key implementation partners
- Meeting with the Policy Steering Committee co-chair

On May 10, 2012, the site visit team met first with the Connecticut implementation team. After introductions, the team received a project overview, discussed project implementation to date, and discussed their service delivery model. Commissioner Patricia Rehmer of the Department of Mental Health and Addiction Services (DMHAS), who is also the Connecticut Alcohol and Drug Policy Council/Policy Steering Committee co-chair, met with the team to discuss the Policy Steering Committee's role and operations as well as the State's commitment to SBIRT. In the afternoon, the team traveled to United Community/Family Services in Norwich, Connecticut, one of the implementation sites. The team toured the facilities and discussed SBIRT implementation, including successes and challenges, with health center staff.

On May 11, 2012, the team met with the evaluation team from the University of Connecticut Health Center to discuss the evaluation plan. Topics included GPRA and other data collection, implementation of the Web-based reporting system (WITS), and quality improvement activities. Following this discussion, the team traveled to Community Health Services of Hartford to tour the facility, meet with staff, and discuss program implementation, including successes and challenges. In the afternoon, the site visit team engaged in discussion with the implementation team, addressing key program areas including: grantee organization and leadership; grantee program implementation; the Policy Steering Committee; practice site implementation; sustainability; evaluation; training/workforce development; and cultural competence. The afternoon concluded with debriefing the SAMHSA/CSAT project officer via teleconference.

Overview

The Connecticut DMHAS administers the SBIRT grant and is the Single State Authority (SSA) for substance abuse. DMHAS was formed in 1995 by a merger of the Addiction Services Division of the Department of Public Health with the Department of Mental Health. The SSA director is commissioner of DMHAS and reports directly to the Office of the Governor.

The Connecticut Alcohol and Drug Policy Council (ADPC), created in 1996, functions as the Policy Steering Committee for this grant. The ADPC is responsible for reviewing State agency and judicial branch policies and practices concerning substance abuse prevention and treatment programs, referring individuals to such programs, and responding to criminal justice sanctions. This public–private partnership comprises State agency representatives, treatment providers, university researchers, persons in recovery, and other stakeholders. Among its tasks, ADPC issues statewide interagency substance abuse priorities and plans that provide policy and budgetary guidance for prevention and treatment. The council is co-chaired by DMHAS and the Department of Children and Families, the State's child welfare authority.

Grantee and Key Partners

DMHAS has two key partners in managing and implementing this initiative: the University of Connecticut Health Center, and the Community Health Center Association of Connecticut. DMHAS performs overall program management and reporting. The University of Connecticut Health Center is responsible for program evaluation, including GPRA reporting, and for conducting the Connecticut SBIRT Training Institute. The Community Health Center Association of Connecticut has helped recruit 10 community health centers that are Federally Qualified Health Centers (FQHCs); and it has screened, hired, and outplaced 10 full-time health educators (HEs) at each of these sites. Association staff monitor and supervise the HEs and are liaisons to the health centers in this initiative. The Connecticut SBIRT team provided the organizational chart below, illustrating the relationships among the key partners and their relationships to the Governor's Office and the Policy Steering Committee.

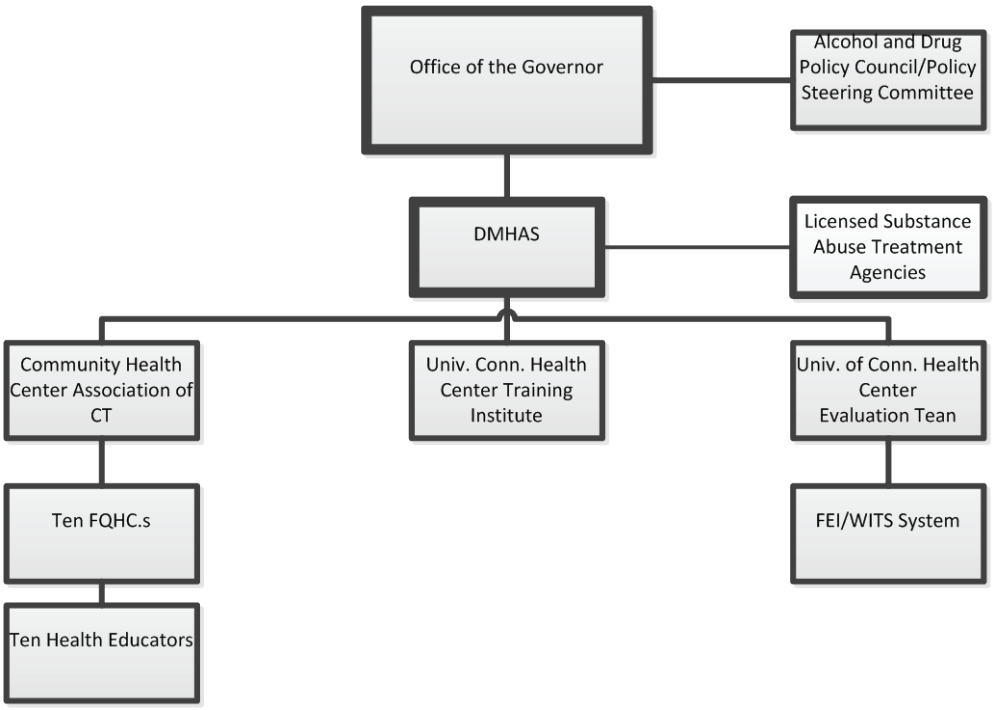
SBIRT Implementation Plan

The Connecticut team approaches implementation using a defined model informed by the work of Greenlagh, et al. (2004), in implementation science. The grantee implementation model has as a series of essential elements:

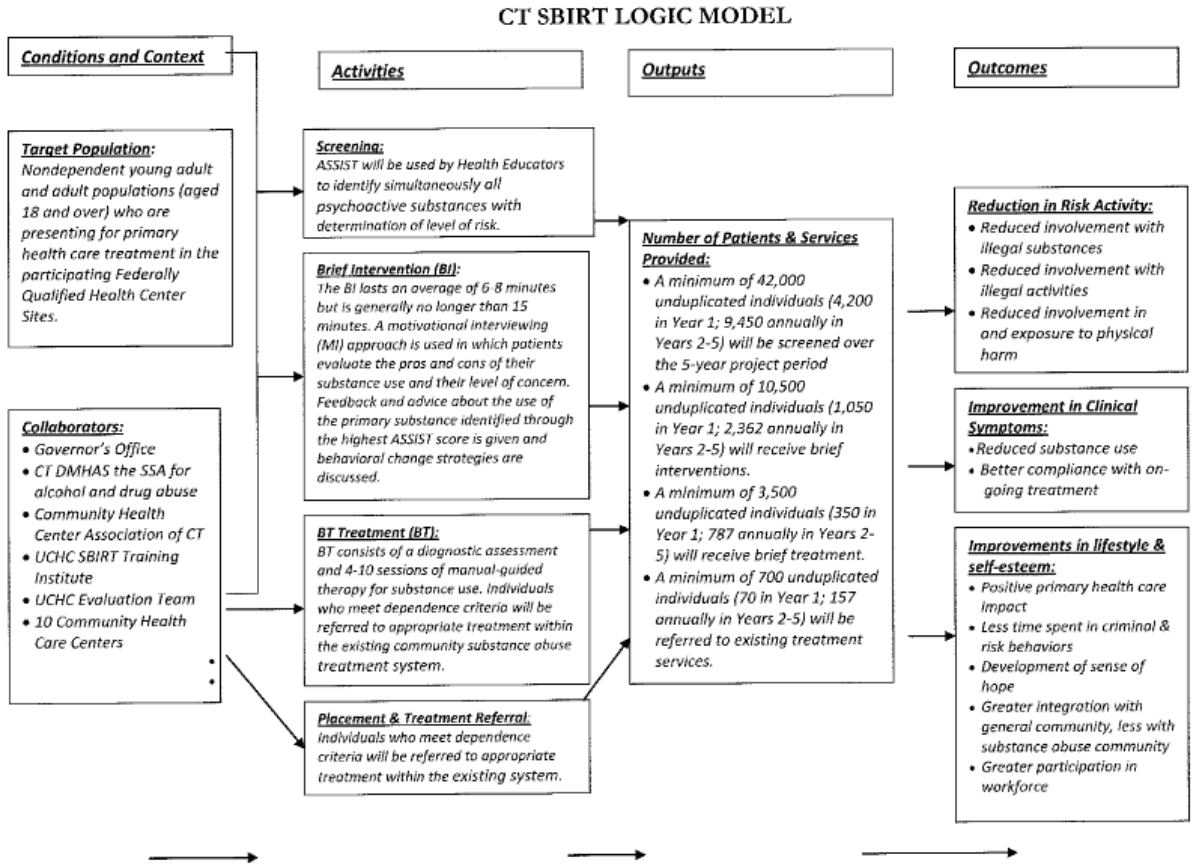
- Clearly defined partners and associated roles
- Leadership buy-in supporting program readiness, including policymakers and practice site champions
- Defined systems for regular communication among partners, as well easy access for ad hoc communication
- A defined plan with action steps to achieve the plan
- Protocols for program operations, including use of technology, common sets of tools, and processes
- Participatory decisionmaking

- Ongoing training, technical assistance, monitoring and coaching to support implementation, and fidelity to the model
- Sensitivity to unique contextual conditions at the practice sites and the associated need for adaptation

SBIRT Implementation Organizational Chart



To help organize their implementation processes, Connecticut developed an implementation logic model.



Grantee Goals and Objectives

According to the application submitted by the State of Connecticut, this initiative has several proposed goals and objectives:

1. Develop an expanded and trained workforce with SBIRT competencies through state-of-the-art SBIRT training/technical assistance to targeted CHC sites, general hospitals, and the Military Support Program to sustain these practices.
    - Establish an SBIRT Training Institute, comprised of UCHC staff, to ensure fidelity in implementation and promote proven effective SBIRT practices.
    - Recruit, hire, and train HEs as SBIRT specialists across the CHC sites statewide.
    - Provide SBIRT training/ongoing TA to other settings, including general hospitals and the military support program, to further support SBIRT implementation and sustainment.
2. Identify systems and policy changes that will ensure continuity of SBIRT in Connecticut.
    - Develop a strategic plan that identifies long-term sustainability of the Connecticut SBIRT Program, including a practical strategy for quality, continuity of care, and leveraging of resources to sustain the model program.

- Convene the SBIRT Steering Committee, composed of representatives from the Governor's Office, DMHAS, ADPC, academia, CHCACT, CHCs, hospitals, treatment providers, individuals in recovery, and other key stakeholders.
- Have the Steering Committee oversee project development, implementation, and evaluation.
- Have the Steering Committee support systems and policy changes to sustain SBIRT in Connecticut.

3. Conduct a comprehensive evaluation of the Connecticut SBIRT Program.
   - Conduct ongoing process and outcomes evaluations related to SBIRT implantation across the targeted community health center sites and communities.
   - Evaluate fidelity measures and methods for ongoing quality assurance assessments that allow providers to utilize data to inform and modify practices.
   - Evaluate outcome measures and methods to develop, implement, and plan for ongoing outcome assessments that allow providers to utilize data to inform quality improvement.
   - Translate the implementation evaluations into lessons learned for communities attempting to implement SBIRT beyond those targeted by this project.
   - Disseminate findings through presentations and reports statewide to inform the Governor, General Assembly, and ADPC.

The grantee proposes to provide SBIRT services to more than 56,700 individuals during the 5-year project period.

Population(s) Served

The Connecticut SBIRT Program targets adults, ages 18 and older, at risk for substance misuse or diagnosed with a substance use disorder. Services will be implemented in 10 community health center sites statewide. At least 85 percent of the population served in these clinics are Medicaid or Medicare recipients, and a high percentage of these patients are of racial and linguistic minorities.

At a future date, the grantee proposes to integrate SBIRT into the DMHAS's Military Support Program (MSP), which includes statewide behavioral health services to National Guard members, Reserve members, and their families.

Contextual Conditions

With approximately 3.5 million residents, Connecticut is the fourth most densely populated State. Most of its population is concentrated along the coast in Bridgeport, New Haven, and Stamford, and in the center of the State in Hartford (the capital) and Waterbury. Each of these cities has a population of 100,000–150,000. These urban areas are racially and ethnically diverse. Connecticut's population is older than the national average: the median age is 37.4 years, compared with a national median of 35.3 years. Connecticut's adult population (25 years and older) makes up 67.3 percent of the total State population; children (17 years and younger) compose 24.7 percent of the population.

DMHAS has a program to assist military personnel and their families with the transition and stress that accompany deployment. The DMHAS Prevention and Health Unit assists and directs the military support program management team through its relationship with the Connecticut National Guard. The two entities collaborate on various initiatives, including assignment of a National Guardsman to help manage statewide resources for community providers who work to reduce substance abuse and related risk factors among Connecticut residents.

Another DMHAS service initiative involves college alcohol issues by working to reduce the incidents and consequences of underage and young adult binge drinking. At one time, Connecticut was a State grantee for the College SBIRT initiative.

Medicaid has created an incentive program for providers to screen patients for tobacco use. This program has provided additional incentive for health centers to adopt SBIRT and screen for tobacco.

Project Management

Staffing

The Connecticut SBIRT initiative involves a successful collaboration among DMHAS, the University of Connecticut Health Center, and the Community Health Center Association of Connecticut. Each partner provides staff according to its role in the project.

DMHAS provides administrative and fiscal oversight for the program and coordinates efforts with other State and community agencies.

The Community Health Center Association of Connecticut is the organization that hired and placed the 10 HEs at the participating health center sites. Association staff members directly supervise the HEs and coordinate training and technical assistance in cooperation with the University of Connecticut Health Center. The Association facilitates collaboration among the participating sites and the initiative for planning, program implementation, and sustainability.

The HEs provide several services: direct patient contact, including prescreening and full screening of patients using ASSIST; brief intervention using motivational interviewing strategies based on the ASSIST (BI) model; referrals to treatment when indicated; participation in evaluation activities, including GPRA; and support for SBIRT adoption within the clinic sites.

The University of Connecticut Health Center supports planning and delivery of the SBIRT intervention through its SBIRT Training Institute. The Institute trains HEs, brief treatment specialists, and others. Institute staff members conduct routine performance monitoring and coaching to support program fidelity. The University also manages the SBIRT program evaluation and GPRA activities. The Training Institute eventually plans to provide SBIRT training-of-trainers activities to support further dissemination and sustainability.

Licensed chemical dependency treatment specialists have been recruited and designated as brief treatment specialists. These specialists are located within those health centers with embedded behavioral health programs and in the surrounding community.

Curriculum and Training

Curricula Elements

SBIRT Training: Initial HE classroom training lasts 10 days. It includes several components and topics: an orientation to the program, staff roles, and duties; background and evidence supporting SBIRT; use of the AUDIT C and ASSIST screening tools; a brief intervention model; motivational interviewing skills; an introduction to the continuum of alcohol, tobacco, and other drug use; cultural competence; ethics; an orientation to the SBIRT workflow process; and State and Federal regulations governing patient privacy (HIPPA).

Brief Treatment Training: An initial cadre of 30 brief treatment specialists have been recruited and trained to provide a specific brief treatment model developed for the program. This model has been developed for use in primary care settings.

The Connecticut SBIRT brief treatment model, "LET'S PLAY," is based upon a previous research- and evidence-based treatment model for treating substance use disorders, mood disorders, and enhancing motivation for behavior change. LET'S PLAY incorporates elements from a previously (CSAT) funded clinical trial, "The Marijuana Treatment Project," and from the Missouri SBIRT project's "MET/CBT-5." Additional interventions include use of mindfulness and mediation based on a review of treatment literature.

LET'S PLAY includes a series of 12 interventions based on motivational interviewing, cognitive behavioral therapy, and mindfulness. These sessions can be delivered individually or in groups. As part of the training, counselors are encouraged to incorporate these interventions in ways that are consistent with their style and responsive to the patient's stage of change.

Approach to Training

The training approach for HEs includes a variety of didactic and skills-oriented learning strategies followed by a period of shadowing at a practice site. Once HEs begin providing direct services, they are routinely supervised and coached to support transfer of learning and fidelity to the model. The Training Institute has developed a proficiency checklist as a supervision tool to support fidelity and model adherence. Quarterly booster training sessions will be provided.

After the brief treatment training is completed, a clinical psychologist supervises the brief treatment specialists. Use of taped sessions is being explored as a possible future enhancement.

Budget and Funding Allocations

Subrecipient Funding and Contracting

DMHAS makes contractual agreements with the University of Connecticut, the Community Health Center Association of Connecticut, and FEI, Inc. for the WITS system

Policy Steering Committee

The Governor's Alcohol and Drug Policy Council serves as the Policy Steering Committee for the Connecticut SBIRT. The Council is established through statute and is co-chaired by the DMHAS Commissioner and the Commissioner from the Department for Children and Families. Statute-established members include representatives from State agencies and legislators; non-statutory members include universities, community based agencies, advocacy groups, a community hospital, and persons in recovery. The Council/PSC meets quarterly and has met once since the grant's startup.

Voting members representing primary care are currently not reflected in the Council. The Community Health Center Association of Connecticut is now an invited, but nonvoting participant. To further the State commitment toward behavioral health and primary care integration, site visit team members encouraged inclusion of primary care representatives as full members.

The Policy Steering Committee has publicly endorsed SBIRT adoption since 2005 and will play an active role in dissemination and sustainability planning.

SBIRT Implementation in Practice Setting

Startup

Following the notice of award, the grantee initiated multiple activities in order to meet tight program implementation timelines. They hosted a kickoff meeting to provide an introduction and overview; recruited 10 HEs and practice site champions; developed and disseminated program operations protocols; initiated weekly meetings; adopted Web-based reporting systems (FEI/WITS) for GPRA and other data collection; trained HEs in the SBIRT intervention; trained 30 clinicians in the LET'S PLAY SBIRT brief treatment model; launched an informational Web site; and launched the SBIRT Training Institute.

Practice Site Locations

Connecticut SBIRT, working through the Community Health Center Association of Connecticut, has recruited the following 10 FQHC community health centers, spanning the State, as practice sites:

- Community Health Services of Hartford
- Connecticut Institute for Communities (Danbury)
- East Hartford Community Health Center
- Fair Haven Health Center (New Haven)
- Generation Health Center (Willimantic)
- Hill Health Center (New Haven)
- Optimus Health Centers (Bridgeport and Stamford)

- Stay Well Heath Center (Waterbury)
- Southwest Community health Center (Bridgeport)
- United Community/ Family Services (Norwich)

The site visit team toured and interviewed staff at two sites: the Community Health Services of Hartford and United Community/ Family Services. The two clinics serve a diverse population of urban and rural poor. Both clinics have integrated behavioral health capacity.

United Community/ Family Services

Community Health Services of Hartford

Staffing Profile/Model

The grantee has chosen to use a health educator staffing model. These bachelor-level positions require backgrounds in behavioral health or social services and bilingual capacity. The grantee successfully recruited a 100 percent bilingual HE staff. The HEs are employed by the health center association and placed at each of the 10 sites. Each clinic has an onsite identified SBIRT champion who supports the HE and SBIRT implementation. The HE's work is further supported with ongoing supervision provided by the health center association.

The roles that primary care clinicians and allied staff will play in delivering SBIRT are still emerging.

How is SBIRT Implemented?

The HEs situated at the participating clinics are provided with office space for seeing patients. In addition to delivering the SBIRT interventions, the HEs collect and report GPRA data. HEs have also been building relationships with the clinic staff and learning about clinic operations and workflow. Preliminary reports indicate that, overall, physicians and clinic staff respond positively to the HEs and to the added support they provide in addressing patient needs.

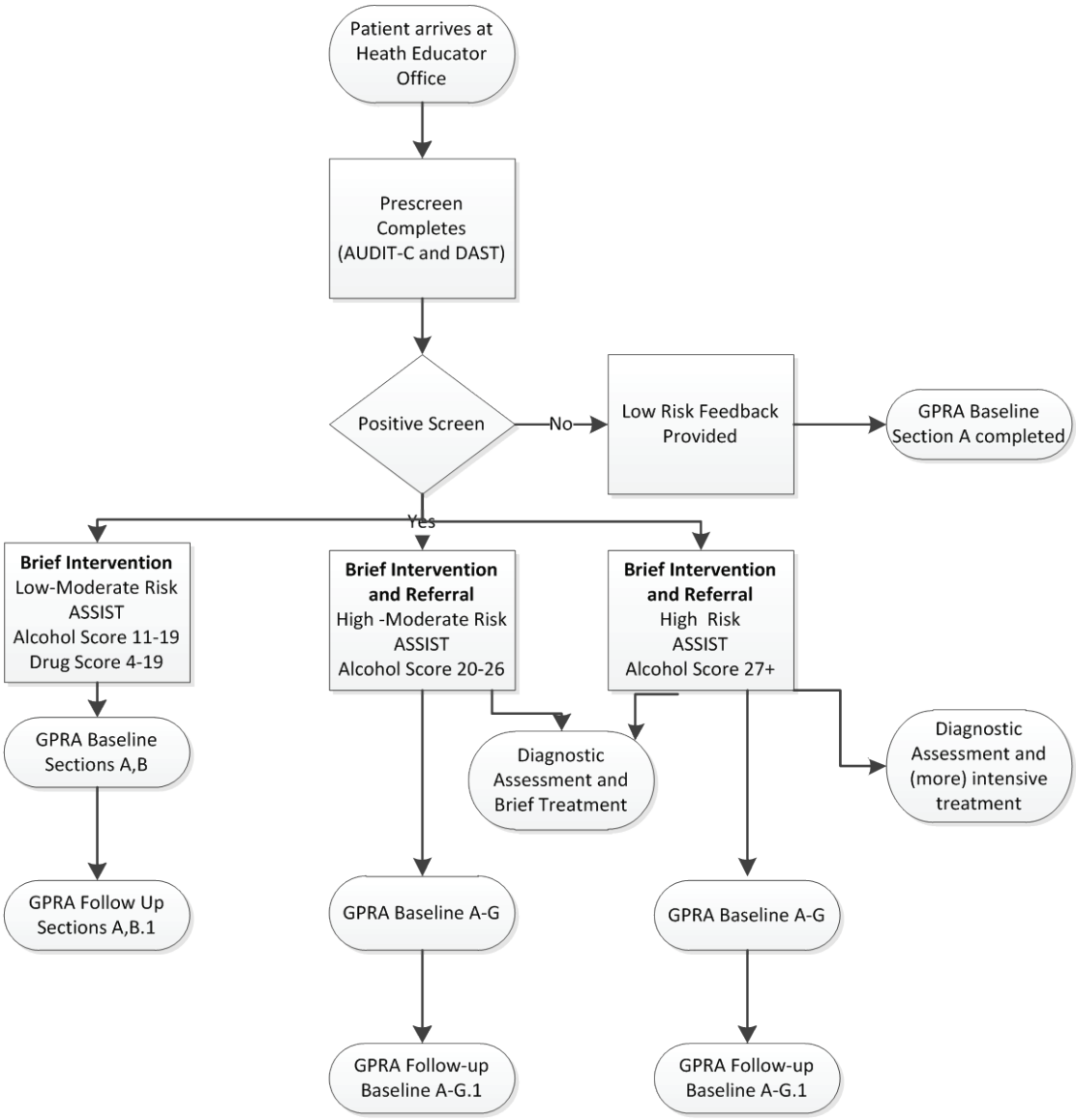
Currently, the HE confers with clinic staff to identify a schedule of patients to be screened each day. Once they have been identified, patients are referred to the HE either before or after their scheduled doctor's appointment. The HE meets with the patient and follows an interview algorithm of prescreening, screening, and brief intervention, as illustrated in the workflow chart below.

Patients are prescreened using the three-question AUDIT C, the first question of the ASSIST, and a question for tobacco use. Patients who prescreen positive are then fully screened using the ASSIST. The brief intervention provided to at-risk patients is based on the ASSIST model.

HEs document their activities in the FEI/WITS system. They do not currently document within the patient medical record. The HEs do not yet have formal systems for communication and coordination of care with the primary care clinicians and allied staff within the sites. The grantee anticipates developing these systems after staff are further trained later in the fall.

This current workflow process, as described by the grantee, provides the HEs with a starting point to begin services at the practice sites and to become more knowledgeable about clinic operations. All sites are currently operational, the full intervention is being conducted, and GPRA data are being collected through the Web-based data system. This workflow model required minimal accommodations on the part of the clinics and allowed for a quick startup.

Patient Process Flowchart



This site implementation and workflow model has certain limitations. It does not (at this time) afford the HE access to document within the patient records. The grantee recognizes that documenting within the patient record would have multiple benefits, including improved communication within the primary care team, coordination, scheduling, and followup. The grantee also recognizes that integrating SBIRT activities into the record is an important task and plans to integrate SBIRT into the patient record in the future. This task will be complicated by the significant flux of recordkeeping systems within the 10 clinics.

Screening **all** clinic patients will be difficult, as the patient volume exceeds what one person alone can do. The grantee is considering having other staff members complete prescreening by embedding the prescreening questions into other routine activities. This practice would maximize the HEs' time and skills. The grantee will revisit workflow and staffing process changes after training the primary care clinicians and allied staff later in the year.

The grantee supports and supervises the HE's work in three ways: each site has an identified champion who also supports program; the health center association has a designated staff member who monitors and coaches their work; and the evaluator is readily accessible to address any data collection issues that arise.

Each HE has a laptop that allows direct access to upload data and is equipped with helpful reference information to support the staff members' work.

Referral/Relationship With ATOD Treatment

Five of the participating clinics have onsite behavioral health treatment capacity; the remaining clinics use community-based providers. For the clinics with embedded services, the HE escorts the patient to the behavioral health admissions office and supports the treatment referral. For offsite referrals, the HE works with the patient arranging the referral. If access-to-treatment-service issues emerge, DMHAS can help navigate the treatment system. To date, 30 clinicians have been trained in the brief treatment model developed by the grantee.

Role of Electronic Medical Records (EMR)

Each of the participating clinics appears to be in a different state of capacity regarding use of EMRs. Several clinics are still using paper records and have plans for conversation to EMRs; others have current EMRs; and still others have an EMR and are considering conversion to another vendor. At this time, SBIRT is not integrated within the clinic EMRs, but this integration is recognized as an important goal.

Billing

The participating FQHCs are Medicaid and other insurance providers and are proficient with insurance billing. However, SBIRT services are not currently reimbursed to clinic settings. The grantee recognizes this as a significant issue affecting long-term sustainability and plans to engage the PSC members to help change this situation. They have also voiced interest in technical assistance regarding billing and reimbursement.

Grantee Evaluation

GPRA Plan

The grantee has a well-organized plan for collecting GPRA data at intake and at 6-month followup. Collecting GPRA intake information has been made part of the routine workflow of the HE, who has the capacity to collect and directly enter data into a laptop computer for later uploading. The HE will also follow up on GPRA contacts.

GPRA Followup

The grantee has a well-organized system for GPRA followup that includes collecting multiple points of the patient contact information gathered at the initial session. This step is followed by structured and periodic contact following the brief intervention and concludes with the completion of the 6-month followup GPRA. GPRA completion is further incentivized with a gift card given to all patients completing the 6-month followup.

All GPRA information is uploaded directly into the FEI/WITS data system. The software program checks the information's quality, and the evaluator reviews it a second time, before it is finally uploaded into SAIS.

Process Evaluation

The evaluation team has developed protocols and tools to support implementation fidelity and to document any adaptations made to the intervention over time.

The evaluation team has developed robust tracking processes that document working conditions within the clinics, access to internal health center systems, workflow processes, changes in work processes, changes in departments that deliver services, the role and efforts of the onsite champions, and opportunities for possible changes or improvements. The team also monitors SBIRT intervention, referral to treatment, and use of the FEI/WITS system. The team also surveys confidence of the HE to deliver the SBIRT within the practice setting. A fidelity rubric has been developed to monitor and support intervention fidelity. The rubric covers several steps: initial communication with the patient; prescreening and screening; brief intervention/motivational interviewing skills and technique; referral to treatment; and GPRA completion.

Outcomes Evaluation

Outcome evaluation focuses primarily on GPRA reporting. It also includes data collection on model adaptations over time and on the utility of the LET'S PLAY brief treatment intervention.

Coincidentally, half of the clinics have internal behavioral health capacity, while the other half will rely on community referrals. Although the latter involve a relatively small number of sites, they will provide the grantee with useful information about whether integrated services improve service followthrough.

Grantee Performance: General

Staffing

All grant-funded positions have been recruited at this time.

Training

The University of Connecticut Health Center has initiated the SBIRT Training Institute. An initial kickoff training has been held, and HE and brief treatment specialists have been trained. Primary care clinicians and allied staff are to be trained in fall 2012.

Sites

All practice sites have been engaged, and a site champion has been identified at each site. All sites have initiated the SBIRT intervention.

Patients Served

As of May 7, 2012, 1,449 patients have been screened across the 10 sites.

GPRA

Based on an initial review of GPRA data (*n*=1,278), 71 percent screened at low risk/negative, 17 percent received a brief intervention associated with elevated risk, 3 percent were engaged in brief treatment, and 1 percent was referred to specialty treatment.

Summary Analysis of Grantee Performance

Grantee Organization and Leadership

Strengths

- DMHAS staff members are highly experienced grant administrators who have clearly defined relationships with their partnering organizations: the University of Connecticut and the Community Health Center Association of Connecticut.
- Senior State leadership is highly committed to adopting SBIRT within primary care and other systems and has made SBIRT adoption a written priority since 2005.
- DMHAS collaborates with the State Medicaid Office for managing Medicaid behavioral health services.

Challenges

- The grantee describes a need to further engage and mobilize support from within primary care systems.
- Medicaid reimbursement for SBIRT is partially operational in Connecticut at this time, and the reimbursement rates have been described as significantly below the actual service delivery costs.

Potential Enhancements		Grantee	Will Request TA From CSAT	Information Requested
1.	Recruiting and building champions within primary care will support further adoption of SBIRT. The grantee may wish to (1) look within the health centers to identify and groom potential champions, and (2) confer with other States regarding strategies for developing physician champions.	X		
2.	DMHAS stated interest in technical assistance for framing a strategy for SBIRT Medicaid (and other insurance) financing.		X	

General Grantee Program Implementation

Strengths

- DMHAS uses a defined model for program implementation based on health service program implementation and sustainability research of Greenhalgh, et al. (see footnote.)
- The DMHAS implementation model addresses organizational structure, process, context, and culture. Further, it addresses interorganizational relationships, dissemination of program-specific content knowledge, leadership, and planning.
- The SBIRT program builds upon a foundation of prior successful partnership and collaboration among the participating organizations and in-depth content knowledge among the DMHAS partners.
- DMHAS has well-developed processes for communication among program partners and for carefully monitoring program implementation.

Challenges

None noted

Potential Enhancements		Grantee	Will Request TA From CSAT	Information Requested
1.	None noted at this time.			

Policy Steering Committee

Strengths

- The Policy Steering Committee (PSC) consists of senior State agencies leadership, legislators, and community-based organizations, including funders and policymakers. This committee was established by statute, and membership is appointed by the Governor's Office and the State Legislature.
- The PSC has formally endorsed and supported SBIRT as a State priority since 2005.
- THE DMHAS Director co-chairs the PSC.

Challenges

Primary care systems are not currently voting members of this committee; however, the State's Health Center Association is invited and attends these meetings.

Potential Enhancements		Grantee	Will Request TA From CSAT	Information Requested
1.	In support of SBIRT and primary care/behavioral health integration, the State may wish to reassess membership on the PSC to include primary care representation as full voting members.	X		
2.	The grantee is encouraged to initiate SBIRT sustainability planning discussions early in the work of the PSC .	X		

Practice Site Implementation

Strengths

- Each practice site adapts SBIRT implementation to the clinic's unique workflow and culture.
- Each practice site has an identified SBIRT champion who supports the onsite HE and program implementation.
- The grantee, through its University of Connecticut partner, has developed LET'S PLAY—evidence-based motivational interviewing/cognitive behavioral therapy brief treatment specifically adapted for SBIRT and primary care.

Challenges

- Universal screening is not fully operational at this time as the HE is completing prescreening, full screening, and brief interventions.
- Practice site primary care clinicians and allied health staff have received only an initial SBIRT orientation and have not been fully trained in the model. Training for these staff is to begin in fall 2012.
- All health clinics are either using or preparing for electronic health records. As well, multiple EHRs are used among the 10 sites, creating compatibility challenges.
- Currently, the HE cannot document within the patient health record.

The "start-up" HE model only provides SBIRT to a limited number of patients at each site.

Potential Enhancements		Grantee	Will Request TA From CSAT	Information Requested
1.	The grantee described an interest in technical assistance/training for primary care clinicians.		X	
2.	Once all primary care and allied staff are trained, the grantee may wish to consider having an allied health or support staff member complete the prescreening so as to further embed SBIRT within the practice workflow and to maximize the HE's time and skills and the reach of the program.	X		
3.	Integration of SBIRT activities into the clinic EHRs will support intervention fidelity, intervention effectiveness, and sustainability.	X		

Sustainability

Strengths

- The grantee has the support and commitment from senior State agency leadership through its PSC.
- The grantee is operating from a defined implementation model that supports sustainability. Medicaid codes are already partially activated.

Challenges

The grantee currently uses an HE staffing model for its SBIRT implementation, posing possible challenges within insurance billing and reimbursement because these workers are unlicensed and have diverse training backgrounds.

Potential Enhancements		Grantee	Will Request TA From CSAT	Information Requested
1.	As part of their work addressing insurance billing, the grantee will need to address staffing models and credentials required for SBIRT reimbursement. The grantee may wish to use technical assistance to assist in this process.		X	

Evaluation

Strengths

- The grantee has a clearly defined plan for evaluation, including GPRA collection, GPRA followup, and process evaluation.
- The grantee has comprehensive monitoring tools to assess SBIRT implementation and fidelity.
- The grantee uses a Web-based system for collecting GPRA data with built-in quality controls to check data, minimizing data entry errors.
- The grantee has a comprehensive strategy for client identification to support GPRA followup.

Challenges

None noted

Potential Enhancements		Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1.	None noted at this time.			

Training/Workforce Development

Strengths

- DMHAS has significant training capacity to support SBIRT implementation.
- The grantee has developed a comprehensive SBIRT training curricula and curricula for brief treatment training.
- The grantee has systems in place to monitor fidelity of implementation within the practice site and to provide ongoing coaching to HEs, supporting and strengthening their practice skills.
- All 10 HEs are bilingual.

Challenges

The HE workforce is not credentialed, creating potential future challenges with health insurance reimbursement.

Potential Enhancements		Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1.	Previously described in sustainability section.			

Cultural Competence

Strengths

- The grantee employs a diverse workforce that is reflects the populations served within the health clinics.
- The grantee provides specific cultural competence training as part of SBIRT training.

Challenges

None noted

Potential Enhancements		Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1.	None noted at this time.			

Appendix

Participant List

Participant	Role	Organization
Site Visit Team Members		
Jan Armstrong	Senior Technical Assistance Manager	JBS International, Inc.
Joe Hyde	Technical Expert Lead	JBS International, Inc.
Jan Pringle	Consultant	University of Pittsburgh

Supplemental Sources of Information Reviewed

Sources of Information	
PowerPoint presentation and other handouts	DMHAS
SBIRT Web site	DMHAS
LET'S PLAY Treatment Manual	University of Connecticut Health Center
GPRA Summary Report	University of Connecticut Health Center
Heath Educator Observation Form	University of Connecticut Health Center
HE Integration Tracking Form	University of Connecticut Health Center
Grantee Request for Proposal	DMHAS
Grantee Semi-annual Report	DMHAS
Grantee Implementation Work Plan	DMHAS

Abbreviations

CSAT Center for Substance Abuse Treatment

DMHAS Connecticut Department of Mental Health and Addiction Services

MIS Management Information System

SAMHSA Substance Abuse and Mental Health Services Administration

SSA Single State Authority

TA Technical Assistance