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Improving Access to Screening, Brief Intervention, and Referral to Treatment in Primary Care for Adolescents: Implementation Considerations

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IN BRIEF

Adolescence is often a period for risky behavior and experimentation with drugs, alcohol, and illegal substances. As a population, adolescents are more vulnerable than adults are to addiction.[1] Despite these facts, Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based strategy for addressing substance use, is underused with adolescents. The *SBIRT Learning Collaborative*, led by the Center for Health Care Strategies in partnership with the Association for Community Affiliated Plans and with funding from the Conrad N. Hilton Foundation, assisted seven safety net health plans in increasing SBIRT in primary care settings for adolescent Medicaid beneficiaries. Drawing from the experiences of the participating health plans, this brief examines considerations for integrating SBIRT in the primary care setting for adolescents, including: (1) provider engagement; (2) provider training strategies; (3) coding and billing for SBIRT; and (4) measurement.

Adolescence is often a time of experimentation with drugs, including tobacco, alcohol, prescription medications, and illegal substances. While some may feel that this behavior is expected for teens, there are serious risks associated with early exposure to drugs and alcohol.[2] An estimated 70 percent of high school students have tried alcohol and 49 percent of high school seniors have used an illicit drug at least once.[3, 4] Studies show that adolescents are more vulnerable than adults to addiction and are at high risk of experiencing lifelong chronic health issues related to substance abuse.[5] Misuse of drugs and alcohol can be major contributing factors to serious health problems, mental illness, suicide, accidents, and decreased life expectancy.[6]

Understanding adolescents' vulnerability to addiction is especially alarming in the context of the growing opioid epidemic, which is claiming about 130 lives each day across the U.S.[7, 8] Although opioid use among teens is decreasing, overdose deaths for this population have increased, more than half of which are attributed to opioid use.[9] Early identification of risky substance use is critical to prevent addiction and long-term health and social issues.[10] Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based prevention and treatment strategy, is a promising intervention for at-risk adolescents, as well as for people who already suffer from substance use disorder (SUD).

In 2016, the Center for Health Care Strategies (CHCS), in partnership with the Association for Community Affiliated Plans (ACAP) and with funding from the Conrad N. Hilton Foundation, launched a learning collaborative of safety net health plans to increase access to SBIRT for adolescents in the primary care setting. During the three-year initiative, seven participating health

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plans trained primary care provider sites in the SBIRT model with the goal of identifying and meeting the needs of teens around substance use and misuse. This brief examines implementation considerations for implementing SBIRT in a primary care setting for adolescents, including: (1) provider engagement; (2) provider training strategies; (3) coding and billing for SBIRT; and (4) measurement.

Learning Collaborative Health Plans

Participating health plans trained approximately 300 individuals in SBIRT for adolescents at over 40 provider sites over the three year collaborative:

- **Boston Medical Center Health Plan**: 47,000 adolescent members, targeted high-volume adolescent sites – trained 28 individuals at four provider sites.
- **Passport Health Plan**: 54,000 adolescent members, targeted high-volume pediatric practices – trained nine individuals at three provider sites.
- **Prestige Health Choice**: 69,000 adolescent members, targeted practices with high numbers of adolescents – trained 21 individuals at five provider sites.
- **Texas Children's Health Plan**: 115,000 adolescent members, used drug and alcohol poisoning data and targeted sites with a high number of adolescents – trained 64 individuals at 16 provider sites.
- **UPMC *for You*:** 95,000 adolescent members, engaged high-volume sites in two-year-long learning collaborative cohorts – trained 48 individuals at six provider sites.
- **Virginia Premier Health Plan**: 47,000 adolescent members, targeted a mix of rural and urban pediatric and family practices – trained 59 provider staff at five practice sites.
- **YourCare Health Plan**: 10,000 adolescent members, targeted high-volume sites with an interest in SBIRT – trained 39 individuals at four provider sites.

About SBIRT

SBIRT can be applied to various segments of the population to screen for risky substance use and provide early intervention when appropriate. While the approach was developed for adults, it offers promise for use with adolescents. The American Academy of Pediatrics and the Substance Abuse and Mental Health Services Administration (SAMHSA) have endorsed the use of SBIRT with adolescents, and initial research on SBIRT implementation with this population shows promising results.[11] Part of SBIRT's appeal is its flexibility to be used in a multitude of settings, such as primary care offices, emergency departments, schools, and community health centers.[12] SBIRT includes three components:

1. **Screening** – A standardized assessment process to identify either at-risk patients, or those who may already qualify as having SUD, consisting of a set of questions that can be administered in most health care settings. This screening typically takes only a few minutes to complete.
2. **Brief Intervention** – Following a screen, a health care professional, such as a primary care physician or nurse, discusses the results with the patient and provides feedback or a brief intervention (depending on the results of the screen) aimed at reducing or eliminating risky

substance use or reinforcing healthy decision making. This conversation may last from a few minutes to a half hour and uses a motivational interviewing (MI) approach.

3. **Referral to Treatment** – For patients requiring additional assistance, the health care professional refers the patient to the appropriate treatment or specialty care.[13,14]

Primary care providers (PCPs) are well-positioned to identify and prevent problematic substance use, making their visits with adolescents a good place to utilize SBIRT. Their expertise in preventive medicine and regular interactions with teens with whom they have existing relationships puts them in an effective position for screening youth for risky behavior, intervening, and making referrals to specialty care when necessary.[15] However, PCPs often do not recognize the role they can play in mitigating these adverse outcomes or feel they do not have the training to administer effective prevention practices or address risky adolescent substance use. Medicaid agencies and health plans interested in preventing negative health outcomes related to substance use can work with PCPs in their networks to use SBIRT to encourage healthy behaviors for their adolescent patients. In some cases, SBIRT can be part of a larger shift to better integrate physical and behavioral health care — it can be used as a mechanism for identifying behavioral health and substance use issues in a physical health setting and ensuring individuals are connected to behavioral health care providers when necessary.

Implementation Considerations

During the three-year learning collaborative, participating health plans worked with their PCP networks to embed SBIRT into practice workflows — approximately 300 individuals and practitioners were trained at more than 40 provider sites as a result. Some PCPs who embraced the training felt they were providing better care overall after implementing SBIRT. In particular, MI — the process used to intervene with an individual following a substance use screen — provided participating practitioners with a valuable tool to facilitate conversations about difficult topics with adolescent patients. The biggest challenge for most health plan learning collaborative participants was securing PCPs' commitment to participate, particularly for the training. Following are implementation considerations for provider practices interested in using adolescent SBIRT screening in a PCP setting.

Provider Engagement

Across the country, states and health plans are exploring how health care providers can more effectively address the many health needs of their patients, including behavioral health and other unmet social needs. PCPs in particular are increasingly being asked by states, managed care organizations, and community partners to address the holistic needs that patients face in their daily lives.[16] Implementing SBIRT with adolescents may be perceived as another task requiring time and money — two resources that can be scarce in PCP offices. Health plans seeking to gain provider buy-in for SBIRT implementation should carefully consider how to engage provider practices, tailoring the approach as needed to each office. Clearly articulating how the SBIRT model can be an asset to providers by improving the health of their patients and/or preventing future at-risk behavior can help make the case.

Challenges

For health plans participating in the learning collaborative, provider buy-in was essential to launching the SBIRT project. However, learning collaborative participants identified significant barriers during provider outreach for SBIRT training and implementation. For example, cold calls to provider offices did not garner strong interest, signifying that the health plans needed a more direct, personal approach. For providers who were curious about potentially adopting SBIRT in their practices, there was significant variation in when and how they wanted to receive training, and how much time they could devote to training. Additionally, health plans were not always able to immediately answer provider questions around larger systemic issues, such as potential gaps in billing codes and availability of referral resources. Providers want to know that they can financially support a new activity when allocating scarce time with a patient as well as ensure that they can respond adequately when they encounter a patient who screens positive for risk of substance use, or already displays signs of addiction. It is also important to note that in some jurisdictions, large-scale health care reform efforts impeded health plans' and practitioners' ability to dedicate time and energy to implementing SBIRT.

Lessons

Health plans seeking to engage providers in SBIRT may glean lessons from the *SBIRT Learning Collaborative*. The following are recommendations based on outcomes of the collaborative.

1. Frame SBIRT as a tool and not another task

Using SBIRT in the PCP setting provides an opportunity to encourage conversations around difficult topics for teens. SBIRT training includes motivational interviewing, a patient-centered technique that can help patients feel more comfortable opening up about needs or sensitive topics, such as safe sex and teen pregnancy, and catalyzing meaningful changes in behavior. The techniques used in MI extend beyond substance use and may foster a more trusting environment between the patient and PCP. When needed, the referral to treatment component of SBIRT can also be a launching pad for conversations with behavioral health partners and lead to better integrated physical and behavioral health services, driving better outcomes for children and youth with complex needs.

In addition to helping patients participate in difficult or sensitive conversations, providers who were already talking to adolescents about substance use found that SBIRT enhanced many of the conversations they were having with their patients. By completing a formal SBIRT screen, most providers are able to bill for a service that they may already be providing, but had not previously been reimbursed for completing. Highlighting potential "lost revenue" for the practice is an opportunity to encourage the adoption of a routine SBIRT screening process for adolescents.

2. Identify a champion within the practice

During the learning collaborative, practices were more successful in increasing screenings and adopting SBIRT if there was a champion onsite. Champion practice staff members, especially if they are a primary care provider, are effective in building the will necessary to embed SBIRT into the practice workflow and sustaining momentum. They also serve as effective models for other

providers in the practice. Dr. Hillary Whonder-Genus, medical director at Virginia Premier Health Plan and practicing pediatrician, became a champion for SBIRT through the *SBIRT Learning Collaborative*. She makes it a priority to engage other providers and help them understand that "the motivational interviewing aspect of SBIRT has made me a better communicator and pediatrician, period."[17]

3. Use existing relationships and have a flexible approach

Health plans often have staff who regularly interface with the PCP offices in their network. Creating a cross-departmental SBIRT project team within the health plan, which includes staff members who regularly engage practices, can help increase provider uptake of SBIRT. Leveraging existing relationships provides an opportunity to engage physicians more personally, and ideally, more successfully. Capitalizing on the existing relationship between health plan staff and the practice allows for personalization and support to that physician and staff. It also negates the need for cold calls, which generally have low success rates. Additionally, if there is an opportunity to engage SBIRT practice champions in outreach to potential new provider sites, having a peer who can speak to their SBIRT experience is helpful. Texas Children's Health Plan noted that "providers with a clear connection to [the health plan] appeared more willing to participate."[18]

4. Ensure communications and messaging strategies are aligned with what works

The FrameWorks Institute analyzed the public's understanding of adolescent substance use and created a *Communications Playbook* to help individuals promoting early interventions effectively frame their message.[19] The *Communications Playbook* describes ways to better explain the role of health care professionals in addressing adolescent substance use. The health plans in the learning collaborative found it particularly valuable to spend time fine-tuning their messaging strategies to more effectively reach providers and necessary stakeholders.

5. Let the data speak

Data can be a powerful tool for engaging physicians in SBIRT. Providing a practice with information on the number of adolescents they serve, coupled with the potential increased billing opportunities to offset the time spent screening, can help make the case for SBIRT. Prestige Health Plan created a data dashboard (Exhibit 1) that includes screening and brief intervention rates and associated revenue. They share this information during their regular meetings with practices, highlighting how an increase in the number of SBIRT screenings and interventions done by the practice would avoid missed opportunities, clinically and financially. Sharing this data regularly can set the context for important conversations about the nature of screenings and the quality of interventions.

Exhibit 1. Prestige Provider Data Dashboard

Provider	Screenings H0049 ($24)	Interventions H0050 ($48)	Total Adolescent Claims	Percentage Rate H0049	Percentage Rate H0050
Provider 1	15 ($360)	3 ($144)	205	7.3%	1.4%
Provider 2	17 ($408)	3 ($144)	211	8.0%	1.4%
Provider 3	25 ($600)	6 ($288)	638	3.9%	0.9%
Provider 4	61 ($1,464)	11 ($528)	3,647	1.6%	0.3%
Provider 5	0 ($0)	0 ($0)	1,108	0%	0%
Overall	118 (2,832)	23 ($1,104)	5,809	2.0%	0.4%

Training Strategies

Health plans in the learning collaborative developed a variety of approaches for SBIRT training. Participating plans chose to: (1) create their own SBIRT training; (2) use an existing training platform, such as Kognito, which uses virtual simulations to practice patient scenarios; or (3) use a combination of the two.[20] Health plans chose one of three general approaches to implement the training: (1) a multi-hour full SBIRT training, conducted either in-person or virtually; (2) an SBIRT introductory overview followed by access to Kognito; or (3) a yearlong, multi-practice learning collaborative.

Challenges

Some of the health plans in the learning collaborative faced several challenges around provider training, ranging from difficulty addressing providers' concerns about the training time-commitment, to a lack of data on screening or brief intervention rates following the SBIRT training as a mechanism to assess training effectiveness. With regard to prioritizing training, some health plans struggled to get providers to carve out time for training in their schedules. In-person trainings ranged from two hours to a full-day, while virtual trainings were limited to under two hours.

For providers willing to do a truncated training either in-person or virtually, a new challenge arose: how to fit the robust content into a shorter timeframe and provide enough opportunity for skill building and practice around MI – a key component to brief interventions. Outside of the training commitment, there was inconsistency in the availability and quality of data on screening and brief intervention rates, which made it difficult for the health plans to assess the success of training efforts. Not only was there a time lag in seeing screening and brief intervention rates in claims data, the billing codes used were not always specific enough to provide a clear indication of what service was provided, i.e., screening, brief intervention, or some combination of the two. Plans seemed to be more confident in their approach at driving practice improvement if they had robust data on screening and brief intervention rates.

Lessons

There are a multitude of options for SBIRT training, all of which can be tailored to meet the specific needs of the PCP. Below are training recommendations based on outcomes of the collaborative.

1. Provide an array of training options for providers

A menu of options is an effective strategy for designing PCP training session(s) that accommodate provider office schedules. While some practitioners preferred early mornings, others appreciated the multi-tasking nature of "lunch and learns." On the other hand, with adequate planning, some opted for a single day off to tackle key topics requiring focused time and attention, such as motivational interviewing. The MI skill set requires practice and role-playing opportunities, which can take time. YourCare Health Plan noted that "no consistent pattern emerged for what works in engagement — both in success and failure — [and that the] best approach was to try multiple things at once."[21] Their strategies ranged from working directly with the practice to schedule trainings at convenient times, to offering trainings open to multiple practices at specified times, or at local conferences.

2. Plan for multiple touchpoints and ongoing technical assistance

Since SBIRT is often a new approach for PCPs, it can take time before they feel comfortable using it with patients. Offering training in small chunks can allow for a more natural progression of both learning and getting comfortable with the material — something that may not be feasible when trying to condense the training into a single day. Further, PCP offices can benefit from ongoing technical assistance (TA) around workflow management in adopting this new practice and billing for SBIRT. Regularly scheduled skill-building sessions after the initial training offer an opportunity to strengthen the use of MI to inform high-quality brief interventions — a skill set that transfers well to other health care topic areas.

SBIRT Provider Practice Learning Collaborative at UPMC

University of Pittsburgh Medical Center (UPMC) Health Plan created a learning collaborative framework for engaging provider practices to participate in their SBIRT initiative. Based on "The Model for Improvement" developed by Associates in Process Improvement,* their learning collaborative incorporated Plan-Do-Study-Act principles, which is a tool for documenting change. Practices established process aims that were reviewed during monthly webinars. Two separate cohorts of practices participated in an initial training session, a mid-point, and a final convening. These were comprised of a half-day training and involved MI skills and role-plays. There were also opportunities to learn about substance use from experts in the field of addiction medicine and engage with peers.

At the end of each cohort, UPMC saw screening rates of more than 95 percent in most practices and high rates of brief interventions for youth who screened positively for high-risk. Providers reported positive feedback on the process and welcomed the support in developing their SBIRT workflow and reinforcing the use of MI.

*G.L. Langley, R. Moen, K.M. Nolan, T.W. Nolan, C.L. Norman, and L.P. Provost. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco, CA: Jossey-Bass Publishers, 2009.

3. Provide peer skill-building opportunities after SBIRT training

Creating a compendium of resources for providers post-training can build goodwill and momentum toward positive outcomes of SBIRT implementation. Time and space for providers to come together and role-play brief interventions may help them feel more comfortable working with adolescents around their substance use and develop new strategies to more effectively engage patients.

4. Provide continuing medical education and/or maintenance of certification credits

Health plans should consider offering SBIRT training that provides practitioners with continuing medical education and/or maintenance of certification (MOC) credits as a way to encourage provider participation.[22, 23] By addressing these professional requirements, providers may be better able to justify the time out of the office. UPMC offered MOCs for their training, which requires a more intensive set-up process, and they determined that it added value beyond the more easily obtainable CMEs for their providers. MOCs are often burdensome for providers to obtain, so providing an opportunity to meet this requirement is a powerful incentive. While offering MOC credits may be unfamiliar territory for health plans, providing these credits may create additional opportunities for training their provider network.

Coding and Billing

Billing codes serve multiple purposes in the Medicaid environment. While codes are primarily a mechanism to pay providers, they also offer a way for health plans to incentivize providers to deliver services or perform desired behaviors, and to assess the extent to which those activities are being performed. As health plans considered the available billing codes for SBIRT-related activities, their experiences, challenges, and opportunities varied widely. Exhibit 2 summarizes the various codes available in Medicaid to support different parts of SBIRT implementation and how learning collaborative participants used these codes. Not all plans used SBIRT billing codes, leaving potential gaps between the activities they were asking providers to perform and what those providers could bill for using available codes.

Exhibit 2. SBIRT Related Reimbursement Codes[24]

Payer	Code	Description	Reimbursement	Collaborative Plans Using Code *(not mutually exclusive)*
Commercial, Medicaid	99408 (CPT)	Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 mins	$33.41	3
Commercial, Medicaid	99409 (CPT)	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 mins	$65.51	2
Medicaid	H0049 (HCPCS)	Alcohol and/or drug screening	$24.00	5
Medicaid	H0050 (HCPCS)	Alcohol and/or drug service, brief intervention; per 15 mins	$48.00	2

Challenges

Coding and billing for SBIRT poses several challenges. The available codes vary dramatically by state, and in the case of SBIRT, this variation meant that some providers were not able to bill for the brief intervention portion of SBIRT. Without additional guidance, no billing code clearly allows for billing a brief intervention under 15 minutes, a generally accepted amount of time for this activity. When asked, some practitioners reported they were doing brief interventions, but not billing due to this issue. This lack of clarity created a significant barrier to provider uptake of SBIRT. Additionally, some plans had screening codes that were also used for something else, such as depression or child development. For example, Boston Medical Center Health Plan's pilot provider sites agreed to only use their screening code for SBIRT screens. However, providers outside of the SBIRT project were using that code for other screens, so Boston Medical Center Health Plan was unable to assess SBIRT uptake across their provider network.

Lessons

While challenges around coding and billing for SBIRT persist, *SBIRT learning collaborative* participants found the following considerations helpful.

1. Collaborate with state Medicaid agencies on SBIRT codes

Health plans can collaborate with their state Medicaid agency to maximize the use of SBIRT-related billing codes to support enhancements in care for adolescent populations. This includes using billing codes to help incentivize provider uptake of SBIRT and allowing health plans to interpret claims data to support quality improvement initiatives. The Substance Abuse and Mental Health Services Administration is invested in SBIRT and is working with the Centers for Medicare & Medicaid Services to educate practitioners regarding the billing rules.[25] However, states have the autonomy to "turn on" individual codes. Health plans can educate their state Medicaid agencies about SBIRT implementation issues related to provider billing and can collaborate to devise a strategy that provides coverage for all SBIRT components. Passport Health Plan worked with their state partners to "turn on" H0049 after receiving feedback from their providers that there were significant limitations in only having 99408 and 99409 available. H0049 offers providers the ability to bill for the substance use screen in addition to any brief intervention that might be implemented.

2. Consider capitated payment arrangements

Some learning collaborative health plans did not allow providers to bill for SBIRT in addition to capitated payments, while in other instances they did. Allowing providers to bill for SBIRT related activities beyond their capitated payment may potentially incentivize provider uptake of SBIRT and allow the health plan to have data about SBIRT provision. Whenever possible, initial SBIRT initiatives should provide financial incentive to providers to encourage implementation of the practice and cover any additional associated costs.

Measurement

Health plans in the *SBIRT Learning Collaborative*, in collaboration with CHCS and ACAP, developed a set of common measures to monitor and assess the progress of their initiatives. These measures included:

- Number and type of practices and providers trained;
- Number of practices implementing screening;
- Screening rates for both their trained providers and their entire provider networks;
- Screening numbers for youth receiving substance use treatment; and
- Pre- and post-test scores for providers and other staff trained.

Measurement proved difficult for some plans, as their main data source was Medicaid claims data. Given the issues with billing codes described above, there was great variation in the codes used. In the end, plans found value in using the measurement process to gain insight into the progress of their initiatives, even if there were only a few measures that they were able to confidently report. UPMC Health Plan had regular access to electronic health record data and was able to assess screening rates, rates of brief intervention, and, for those individuals who screened high-risk, referrals to treatment. This clear picture of how providers are implementing SBIRT was key to the plan's ability to provide ongoing targeted TA and training to PCPs.

Challenges

Health plans need access to data, either through claims or an electronic medical record, to gain insight into the success of SBIRT implementation. Ideally, those data can show exactly how many screenings, brief interventions, and referrals to treatment occur following the training of each practice. Without this information, it is difficult to assess the effectiveness of training. Since the *SBIRT Learning Collaborative* participants relied heavily on Medicaid claims data, most measures focused on process, not the quality of provider interventions. Health plans could only see whether screenings and brief interventions were performed, not if they were performed well. In most instances, referrals to treatment were the most difficult to assess given that there were no available billing codes for this activity. Finally, health plans struggled with internal reliability and validity of data reports since the SBIRT measures were new to them and their information technology staff.

Lessons

Health pans seeking to measure the progress of SBIRT implementation across their network of providers may glean lessons from the *SBIRT Learning Collaborative*. Below are considerations based on the outcomes of the collaborative.

1. Identify measures that provide actionable information

Depending on how an SBIRT implementation initiative is structured, the key to identifying meaningful measures is to ensure that the information gleaned from the data is useful and can directly inform any necessary adjustments to the implementation plan. Depending on the data source, this can be challenging, but there may be innovative approaches to accessing actionable

information, such as surveying participating providers or conducting focus groups of adolescents screened for SUD about their SBIRT experiences.

2. Use data to drive quality improvement

Looking at data at regular intervals is key to driving quality improvement. Health plans should use data gathered through quantitative measures as well as qualitative approaches to plan, test, and adjust their SBIRT implementation initiatives. Data can be used in a variety of ways — sharing data with leadership can increase investment in SBIRT training for providers. Data can also be used with practices to encourage investment in the approach and catalyze conversations around quality brief interventions and timely referrals. YourCare Health Plan uses treatment related data on other interventions and procedures regularly with their provider network and is planning to do the same with SBIRT claims.

Additional Consideration for the Field

The *SBIRT Learning Collaborative* tested the premise that screening and brief intervention has the potential to be more than just a substance use prevention strategy — it can be a tool to bridge the gap between physical and behavioral health. Engaging in a process to embed SBIRT into primary care practices provides a mechanism for evaluating the adequacy of available behavioral health services that health plans make available to beneficiaries and is an opportunity for providers to identify behavioral health needs upstream. In order for physicians and primary care practices to refer patients when necessary to substance use or other needed behavioral health treatment following a screening and brief intervention, there needs to be a process of identifying services for individuals to be referred. Doing this can help primary care practitioners ensure that youth and young adults in need of behavioral health services are supported and connected with the appropriate services. Following are additional considerations for health plans pursuing SBIRT implementation within their network:

1. **Referral Services and Network Adequacy**: If a referral to treatment is needed, are treatment services available? What is the network adequacy for both outpatient and inpatient resources, as needed? How do providers or families access those resources? Do they need a referral through the health plan?
2. **Connection to Behavioral Health Services**: Are there innovative strategies that can be used to ensure youth are connected with additional services if a need is identified? Is there a way to leverage telehealth in PCP offices in this arena? Does the practice have in-house behavioral health services that may improve treatment referral follow through?
3. **Patient Engagement and Confidentiality**: How do practices and providers engage with youth and their families? Do they understand the confidentiality laws as they relate to youth and how to support families in their comfort level around this discussion?
4. **Alternative Screening Locations**: SBIRT screening is generally most easily integrated into the provider workflow during a well-visit. However, while two out of three adolescents visit a PCP once a year, only one in 15 visits are for preventive care.[26] The goal of SBIRT is to ensure that youth are screened at regular intervals, regardless of the reason for their visit to the PCP, so

this should be a consideration for health plans as they set provider expectations.[27] Are there other ways for primary care to screen youth, especially at-risk youth who may not go to well-child visits? Are there school or public health clinics, or other screening events that could be held to reach more youth?

Conclusion

Adolescence is a particularly vulnerable developmental stage — it is critical that the support systems and professionals who interact with youth regularly are aware of and prepared to handle the issues that a young person may be experiencing on a regular basis. Public and private systems have a collective responsibility to ask the right questions to identify any risky behavior or serious needs, especially substance use, and provide effective early interventions to address problematic behavior. Doing so will help ensure that youth have the opportunity to achieve their educational goals, participate in the workforce, and experience good health. SBIRT provides a framework for PCPs to engage youth in difficult conversations around substance use, giving them the tools and language to be successful. CHCS' *SBIRT Learning Collaborative* showed that health plans can play a key role in preparing primary care practices to implement SBIRT into their workflow. Given their regular interactions with their provider networks, health plans are well-positioned to provide ongoing support to providers and practice staff as they work to embed SBIRT into primary care for adolescents.

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