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Implementing adolescent SBIRT in an urban federally qualified health center: generalist vs. specialist service delivery models

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Background

Little is known about how best to implement SBIRT services in pediatric health care settings or who, optimally, should provide brief interventions when on-site behavioral health is available. The objective of this presentation is to present results from a cluster randomized trial examining implementation of adolescent SBIRT services for substance use within a US federally qualified healthcare system. Two different implementation models for conducting brief interventions (BIs) were compared using randomization at the clinic level to either: the Generalist Model (BI provided by primary care provider) or the Specialist Model (BI provided by behavioral health specialist).

Material and methods

Multilevel logistic regression modeling was used to examine differences by Condition in rates of successful delivery and documentation of the following services: (a) screening (of all adolescent patients ages 12-17), (b) brief advice (for patients reporting alcohol or drug use but scoring ≥2 on the CRAFFT), and (c) brief intervention (patients scoring <2 on CRAFFT, delivered using either the Specialist or Generalist models). Due to the organization transitioning to a new electronic medical record (EMR) in month 6 of the study, data on BA and BI are currently limited to extractions from the new EMR.

Results

Multilevel logistic regression analyses taking into account the cluster-randomized design showed no significant differences between Generalist and Specialist conditions in rates of screening (OR=1.27; p=.55), with significant volatility over time (<.001) and variation by sites. In the post-EMR transition, Generalist sites were not significantly more likely to deliver appropriate BA (OR=1.34; p=.70) or BI (OR=1.53; p=.36) than Specialist sites. Site-level intraclass correlations were higher than anticipated. Future analyses will examine practices for the full implementation period and subsequent to the removal of implementation support resources.

Conclusions

Both service delivery models showed promise for delivering BIs but the high rates of variability within sites demonstrate a need for further examination.

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