Advancing Screening Brief Intervention and Referral to Treatment (SBIRT) to a Supported Designation

Omni Institute Lessons Learned Memo

REPORT HIGHLIGHTS:

- **This memo captures lessons learned** from Omni Institute's efforts to recruit school-based healthcare clinics (SBHCs) for an adolescent SBIRT study seeking to strengthen SBIRT's evidence designation to *supported*.
- **Providing SBHCs with financial support** that realistically offsets staff time and operational costs is critical for effective evidence-building partnerships.

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Background

As part of the Family First Hub's role in evidence-building for programs/services in Colorado's Prevention Plan, the Colorado Lab selected Omni Institute (Omni) to lead a rigorous evaluation of Screening Brief Intervention and Referral to Treatment (SBIRT) with an adolescent population, with the goal of building evidence from its current *promising* designation toward a *supported* designation. Omni proposed a quasi-experimental design (QED) that met criteria outlined in Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures, Version 2.0 for a moderate design and execution rating with assessment of outcomes of youth at 6 and 12 months beyond intervention at school-based healthcare clinics.

Prior to implementing the full study, Omni worked to conduct a feasibility study that tested two distinct approaches to retaining youth in the study: Omni-led outreach vs. participating health clinic-led outreach. From April 2024 to August 2025, the Omni team invested significant efforts to recruit school-based health clinics (SBHCs) as intervention and control sites. After extensive efforts to recruit the two sites, we were unable to secure participation for SBHC or pediatric clinics more generally and have, in collaboration with the Colorado Evaluation and Action Lab, decided to discontinue the study. This memo summarizes the barriers encountered and provides recommendations based on the activities and adjustments that increased interest but ultimately did not secure firm commitments from clinics.

Lessons Learned

Study site recruitment efforts revealed key insights into clinics' capacity to participate. While some strategies generated interest, external factors such as competing program implementation demands and constrained budgets (particularly in 2025 when clinics faced severe budget cuts) ultimately limited their ability to commit to participate. The following lessons synthesize the barriers encountered and the approaches that showed promise, offering guidance for future efforts to evaluate SBIRT in similar contexts.

Clinic Onboarding and Needed Lead Time

Allow 6–9 months to identify suitable clinics and obtaining official approvals.

Conducting research in SBHC settings involves navigating multiple administrative layers (e.g., SBHC specific providers, school administrators, and, in some cases, school district-level review). Early outreach and persistent follow-up are critical. In our experience, interest secured at one level of approval was sometimes overturned at another within the same site.

Compensation & Incentives

Clinic-level support is essential.

SBHC's operate with limited staff and budgets. Modest gift cards ($250) to individual staff were not sufficiently persuasive to clinic leadership.

Future studies should consider providing an honorarium directly to the clinics sufficient to offset staffing costs for training, informed consent (if not done digitally), data pulls, and other study-related activities.

Acknowledge staff contributions.

Staff who work directly to recruit participants, support research logistics or data pulls, should also receive recognition whether through gift cards or other forms of appreciation approved by the clinic.

Communicating Study Requirements

Use concise materials to communicate study requirements to clinics.

Leadership and staff are stretched thin. A concise one-page research brief, written in plain language, that outlines the study purpose, expected clinic-specific activities, and time commitments is a useful tool to share during initial outreach or before discussions.

Broaden outreach.

Outreach to a broad audience that goes beyond SBHC staff and leadership such as family liaisons at schools or local organizations and agencies (e.g., Adolescent Workgroup Meeting hosted by Peer Assistance Services).

Reduce administrative burden.

Study design should integrate informed consent process and data collection into existing EMR systems, to the degree possible. Limit staff involvement to essential tasks.

Adapt protocols to local workflows and specific patient population.

Not all clinics can integrate study materials into their existing EMR. Materials need to be available in Spanish, and other languages may need to also be supported dependent on population of the clinic. Flexibility will be necessary to adopt study protocols to each clinic's unique workflow and technology.

Timing and SBHC Realities

School year-start and -end workload pressures.

The beginning and end of the school year are especially demanding. Even year-round clinics face increased demand during the academic year. Timing of study onboarding and training need to be carefully coordinated with clinic leadership and staff.

Academic year vs. year-round operations.

Many SBHCs close or scale back during summer months. If academic-year sites are onboarded to a future study, data collection tools should be integrated into existing EMR platforms or

alternative data collection means before the school year ends in preparation for a fall launch. If staff training cannot occur in the fall due to time demands at the beginning of the school year, plan for a brief orientation before classes resume, followed by technical training as soon as staff return. Ensure these trainings are on the clinic staff's calendars before they leave for summer.

Conclusion

Our experience was that while SBHC leadership recognized the importance of advancing SBIRT's evidence designation to *supported* for adolescent populations, most SBHCs lacked the capacity to engage in a study, even with limited requested involvement. Without substantive, clinic-level compensation to offset staffing and resource constraints, SBHCs could not commit to participation. Although we developed streamlined study protocols, offered to tailor workflows to minimize staff burden, provided culturally and linguistically appropriate materials (e.g., study materials), and committed to ongoing technical support for data sharing and study implementation, these strategies, though positively received, were insufficient in light of severe resource limitations at SBHCs.

Future studies should prioritize direct honoraria or other forms of financial support at levels that realistically account for staff time and operational costs. Without this investment, even well-designed protocols and persistent outreach are unlikely to secure firm commitments from SBHCs. By pairing rigorous study design that aligns with Title IV-E Prevention Services Clearinghouse standards with adequate financial and operational supports, future evidence-building efforts will be better positioned to engage SBHCs as partners and advance SBIRT's designation to *supported* for adolescent populations.