



Introduction To SBIRT for Primary Care Settings



Introduction to SBIRT for Primary Care Settings

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Today's Presenter

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Kalamazoo, Michigan, and Seattle, Washington



Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

AGENDA

1	The continuum of substance use
2	What is SBIRT?
3	Rationale for SBIRT in primary care settings
4	How to implement SBIRT in primary care settings
5	Additional resources

OBJECTIVES

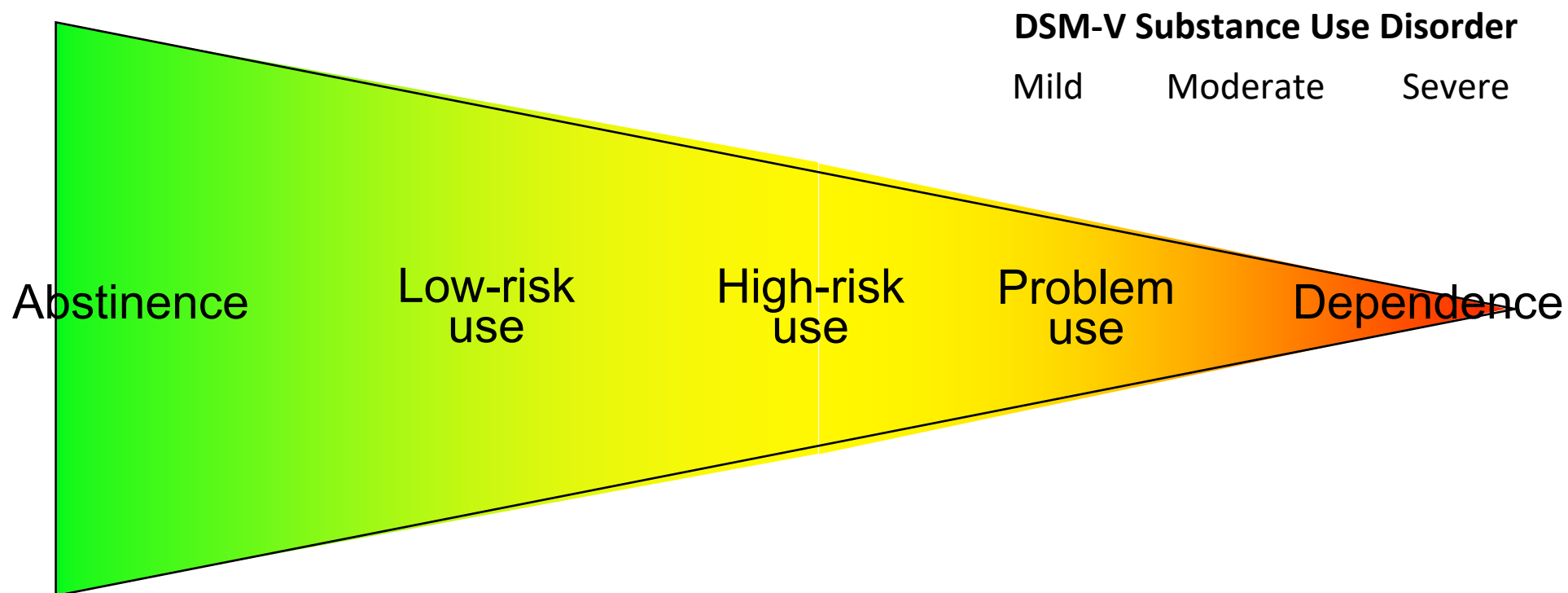
At the conclusion of this presentation, the participant will be able to:

1. Describe the substance use continuum
2. Delineate the process of SBIRT
3. Explain why SBIRT should be implemented in primary care settings
4. Explain how to optimize SBIRT delivery in primary care settings
5. Access additional resources

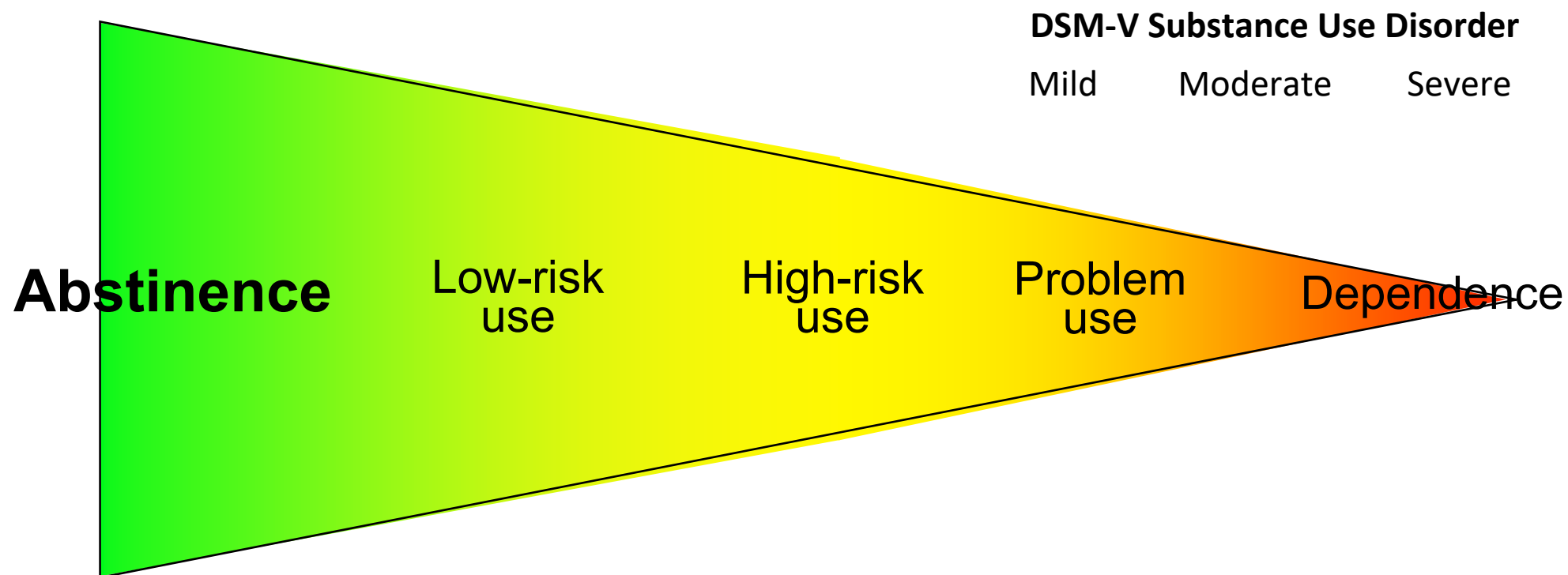
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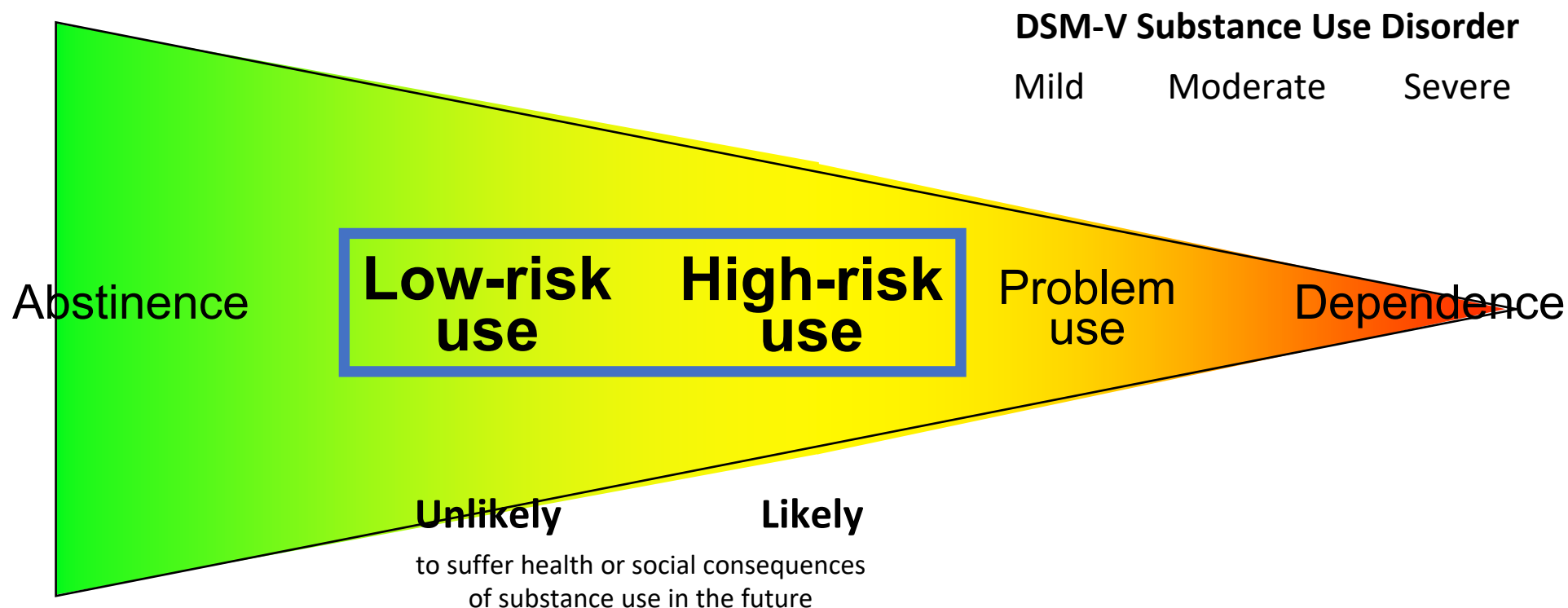
The Substance Use Continuum



The Substance Use Continuum



The Substance Use Continuum



Adults: High-Risk Drinking

	Men	Women
Per week	> 14 standard drinks	> 7 standard drinks
In any occasion	> 4 standard drinks	> 3 standard drinks



Adolescents: All Drinking is High-Risk

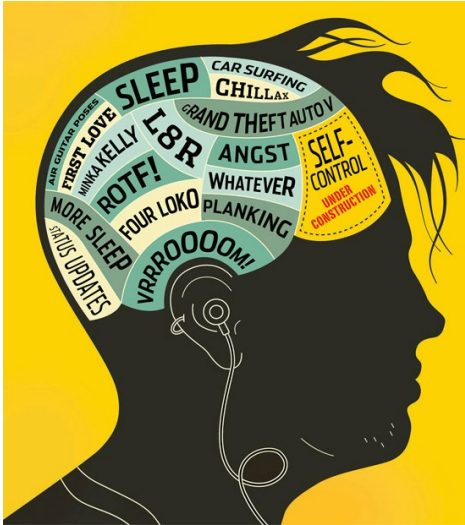
Common negative consequences of drinking suffered by teens:

- School problems: lower grades or absences
- Social problems: fighting, lack of participation in activities
- Disciplinary and legal problems
- Hangovers
- Unwanted, unplanned, and unprotected sexual activity
- Physical and sexual violence
- Increased risk of suicide and homicide
- Motor vehicle crashes and other injuries
- Overdoses



Adolescent Neurobiology

The part of the frontal lobe that inhibits risky behaviors, is not yet mature in teens



ARTICLE

Age at Drinking Onset and Alcohol Dependence

Age at Onset, Duration, and Severity

Ralph W. Hingson, ScD, MPH, Timothy Herren, PhD, Michael R. Winter, MPH

Objective: To examine whether starting to drink at an early age is associated with developing alcohol dependence at a younger age and chronic relapsing dependence, controlling for important demographic, social, and clinical risk factors, including childhood antisocial behavior and depression, and family alcoholism history.

Design: Cross-sectional survey.

Setting: Nationwide face-to-face survey with a multi-stage probability sample.

Participants: A total of 43 093 adults were surveyed in 2001-2002.

Main Outcome Measures: Based on Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, criteria, lifetime alcohol dependence, dependence within 10 years of starting drinking, multiple episodes, an alcohol dependence episode in the past year, episodes exceeding 1 year, and meeting 6 or 7 dependence criteria.

Results: Relative to respondents who began drinking at 21 years or older, those who began drinking before age 14 years were more likely to experience alcohol dependence ever and within 10 years of first drinking (adjusted hazard ratios and 95% confidence intervals [CIs], 1.70 [1.52-2.11] and 1.69 [1.38-2.07], respectively). They also more often experienced past-year dependence and multiple dependence episodes (adjusted odds ratios, 1.93 [95% CI, 1.40-2.64] and 3.09 [95% CI, 2.10-4.50], respectively). Among alcohol-dependent persons, the odds were 2.62 (95% CI, 1.78-3.89) for having at least 1 episode exceeding 1 year and 2.89 (95% CI, 1.97-4.25) for meeting 6 or 7 dependence diagnostic criteria.

Conclusions: There is a need to screen and counsel adolescents about alcohol use and to implement policies and programs that delay alcohol consumption.

Arch Pediatr Adolesc Med. 2006;160:739-746

MORE THAN 75 000 DEATHS annually are attributable to excessive alcohol consumption, the third leading preventable cause of death in the United States.¹ Although alcohol use is found in 7% to 20% of outpatients, 30% to 40% of emergency department patients, and 50% of trauma patients.²

The Centers for Disease Control and Prevention's 2003 Youth Risk Behavior Survey of high school students nationwide revealed that 28% drank alcohol other than a few sips before age 13 years. By age 17 years they were 7 times more likely to consume 5 or more drinks or more times per month than those who waited until they were 17 years or older to begin drinking. The National Institute on Alcohol Abuse and Alcoholism has defined binge drinking as males consuming 5 or more and females 4 or more drinks in 2 hours.³ Binge drinking for the average person on an empty stomach produces a blood alcohol level of 0.08% or higher, the legal level of intoxication in every state.⁴ Thus, those who begin drinking before age 13 years are much more likely even in high school to frequently drink to intoxication. Compared with other students, the approximately 1 million frequent heavy drinkers who often exhibit behaviors that pose risk to themselves and others, such as riding with drinking drivers, driving after drinking, never wearing safety belts, carrying guns and other weapons, becoming injured in fights and outside attempts, having unwanted and unprotected sex, becoming or making someone else pregnant, using tobacco, marijuana, and other illicit drugs, drinking and smoking marijuana at school, and earning money low grades (D's and F's) in school.⁵

Starting to drink at an early age is also associated with alcohol dependence and related problems during adult life. Accord-

Author Affiliations: Youth Alcohol Prevention Center, Boston University School of Public Health, Boston, Mass.

(REPRINTED) ARCH PEDIATR ADOLESC MED. JULY 2006
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Early initiation of drinking is associated with higher lifetime risk of severe alcohol use disorder



High Risk Substance Use

Low-risk use vs. **High-risk use**

High Risk Drinking

<u>ADULTS</u>	Men	Women
Per week	> 14 standard drinks	> 7 standard drinks
In any occasion	> 4 standard drinks	> 3 standard drinks

TEENS - Any drinking



High Risk Substance Use

Low-risk use vs. **High-risk use**

High Risk Drinking

<u>ADULTS</u>	Men	Women
Per week	> 14 standard drinks	> 7 standard drinks
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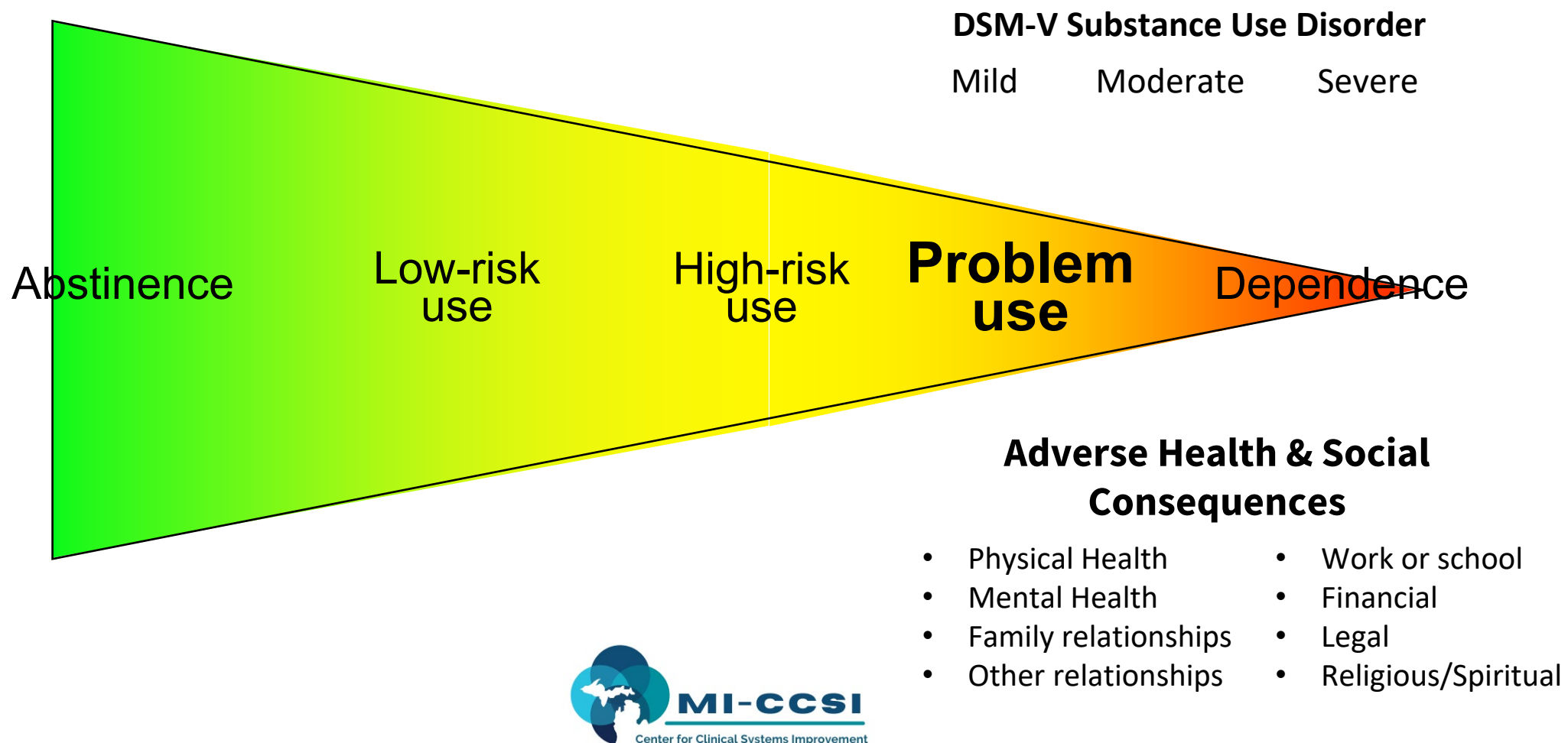
TEENS - Any drinking

High Risk Drug Use

- Daily marijuana use
- Any use of other illegal drugs



The Substance Use Continuum



Adverse Health Consequences

Alcohol & Drug Cause ...

- Injury & disability
- Viral hepatitis
- HIV/AIDS
- Other STIs
- Unplanned pregnancies
- Poor birth outcomes
- Psychiatric disorders



Adverse Health Consequences

Alcohol & Drug Cause ...	Alcohol Cause ...
• Injury & disability • Viral hepatitis • HIV/AIDS • Other STIs • Unplanned pregnancies • Poor birth outcomes • Psychiatric disorders	• Hypertension • Hepatitis • Heart disease • Dyslipidemia • Neuropathy • Stroke • Cancers • Dementia - Oropharynx • Pancreatitis - Esophagus - Breast - Liver - Colon



Adverse Health Consequences

Alcohol & Drug Cause ...	Alcohol Cause ...	Alcohol Impedes Tx for ...
• Injury & disability • Viral hepatitis • HIV/AIDS • Other STIs • Unplanned pregnancies • Poor birth outcomes • Psychiatric disorders	• Hypertension • Heart disease • Neuropathy • Cancers - Oropharynx - Esophagus - Breast - Liver - Colon • Hepatitis • Dyslipidemia • Stroke • Dementia • Pancreatitis	• Hypertension • Dyslipidemia • Diabetes • GERD & other GI disorders • Sleep problems • Mental health disorders • All chronic diseases



Adverse Mental Health Consequences

- Dysphoria, depressed mood, anxious mood
- Full-fledged depressive and anxiety disorders
- Irritability, mood swings, hostility
- Paranoia, psychosis
- Any psychiatric symptom can stem from intoxication, overdose or withdrawal



Adverse Family Consequences

- Marital and family dysfunction
- Behavioral and school problems among children
- Mental health problems and somatic symptoms among family members



Adverse Social Consequences

- Alienation from or loss of old friends
- Gravitation toward others with similar substance use



Adverse Work & School Consequences

- Lateness and absences
- Requests for excuses
- Declines in performance
- Frequent job changes
- Flat career trajectory



Adverse Legal Consequences

- DWI
- Disturbing the peace
- Domestic and other violence
- Drug possession and dealing
- Burglary and robbery



Adverse Financial Consequences

- Spending more than one can afford on substances and related activities
- Financial strain
- Indebtedness
- Selling possessions

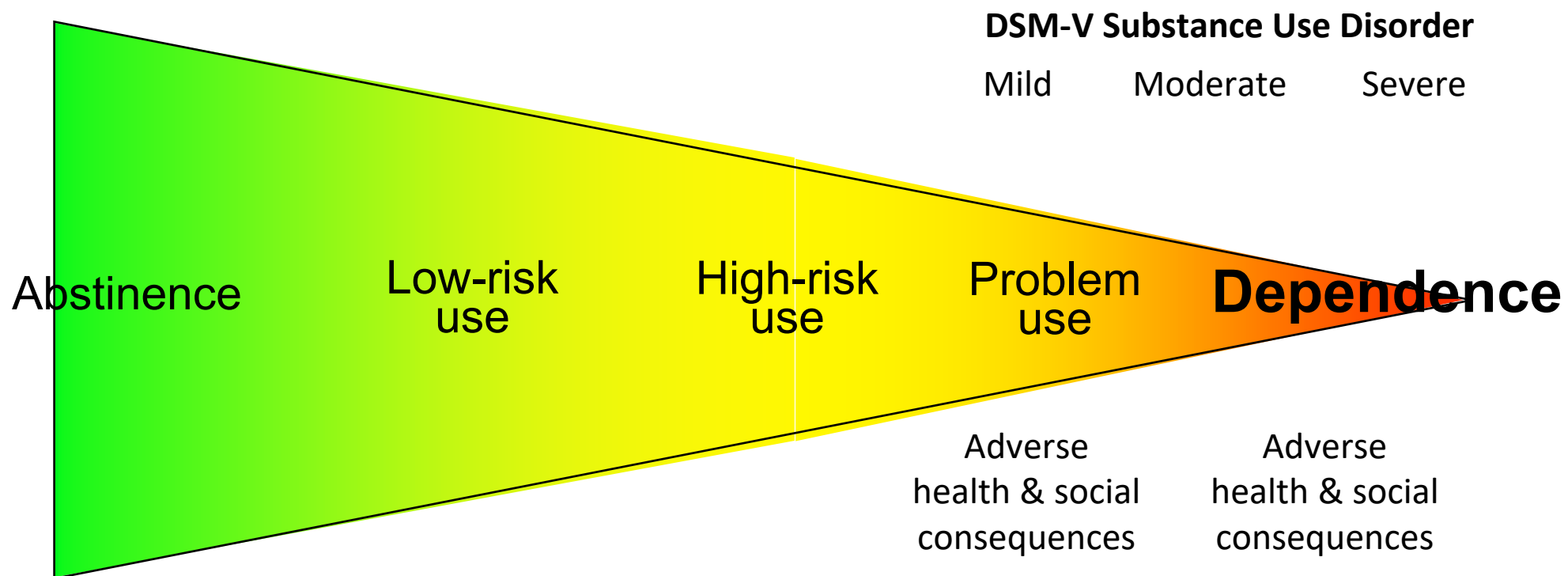


Adverse Religious and Spiritual Consequences

- Disconnection
- Alienation
- Shame
- Disgrace



The Substance Use Continuum



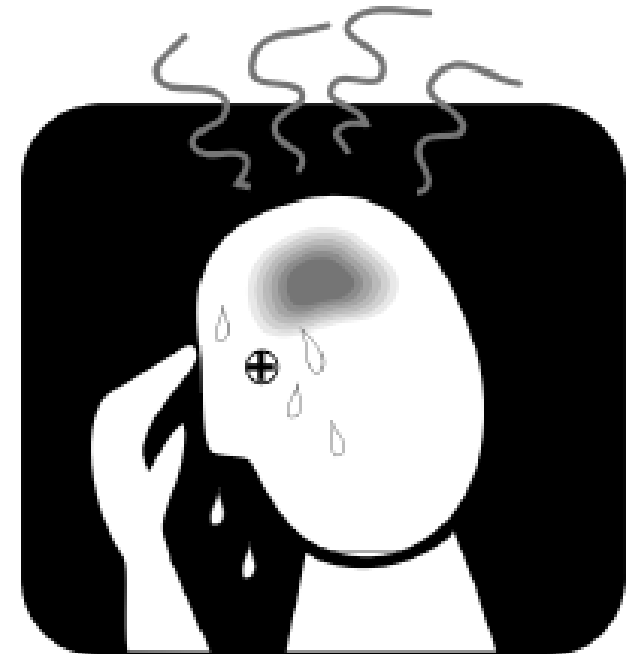
Physical Dependence

- Propensity to withdrawal after sudden cessation of or reduction in substance use
- Most dangerous: alcohol & other sedatives
- Occurs in a different part of the brain than where true addiction occurs

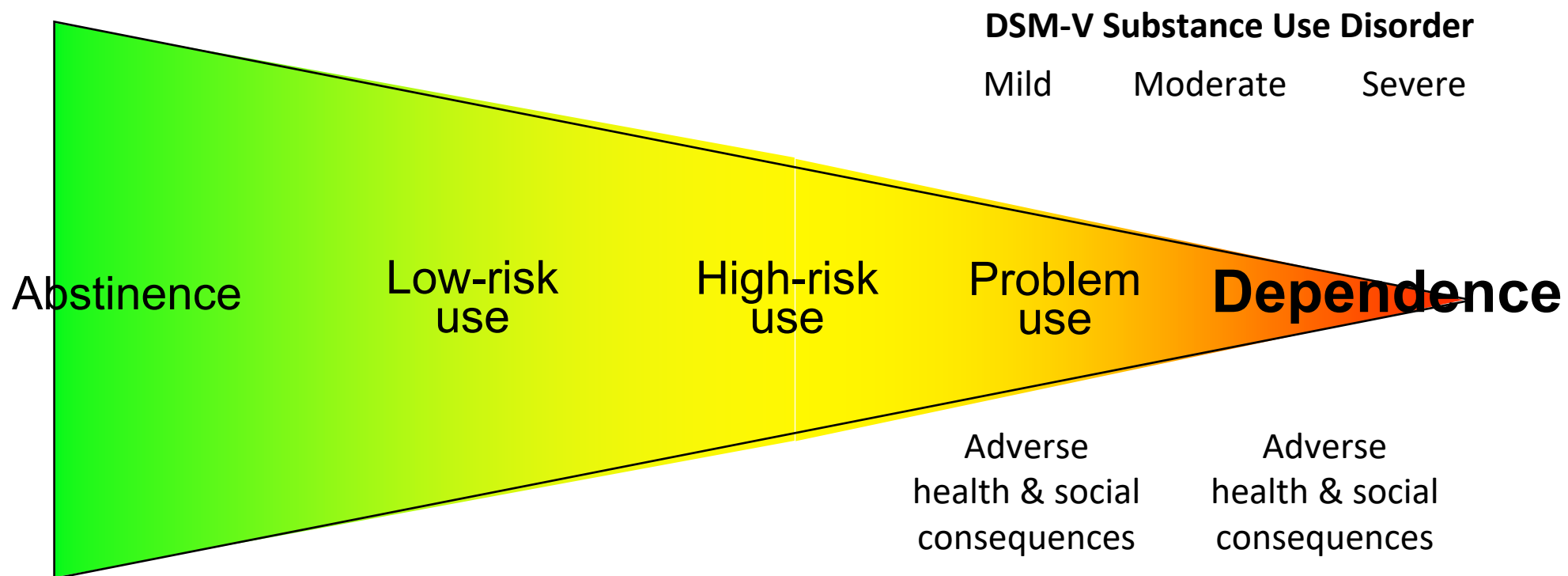


Physical Dependence

- May occur without other symptoms of addiction, as in sudden discontinuation of potentially addictive medications
- NOT the key symptom of dependence

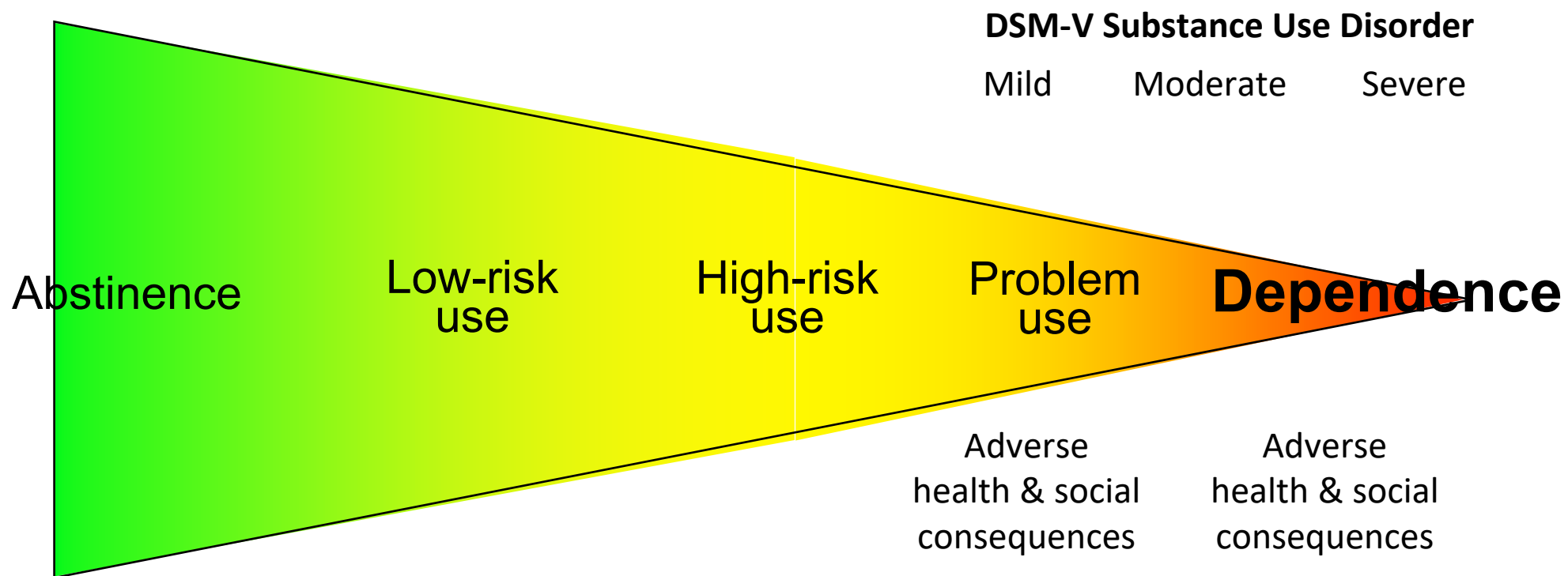


The Substance Use Continuum



?

The Substance Use Continuum



**Loss of
control over
substance use**



Loss of Control Over Substance Use

Loss of Control Over Substance Use



Preoccupation

- Using
- Obtaining



Loss of Control Over Substance Use

Loss of Control Over Substance Use

Preoccupation

- Using
- Obtaining

Urges and
cravings



Loss of Control Over Substance Use

Loss of Control Over Substance Use

Preoccupation

- Using
- Obtaining

Urges and
cravings

Compulsive
use



Loss of Control Over Substance Use

Loss of Control Over Substance Use

Preoccupation

- Using
- Obtaining

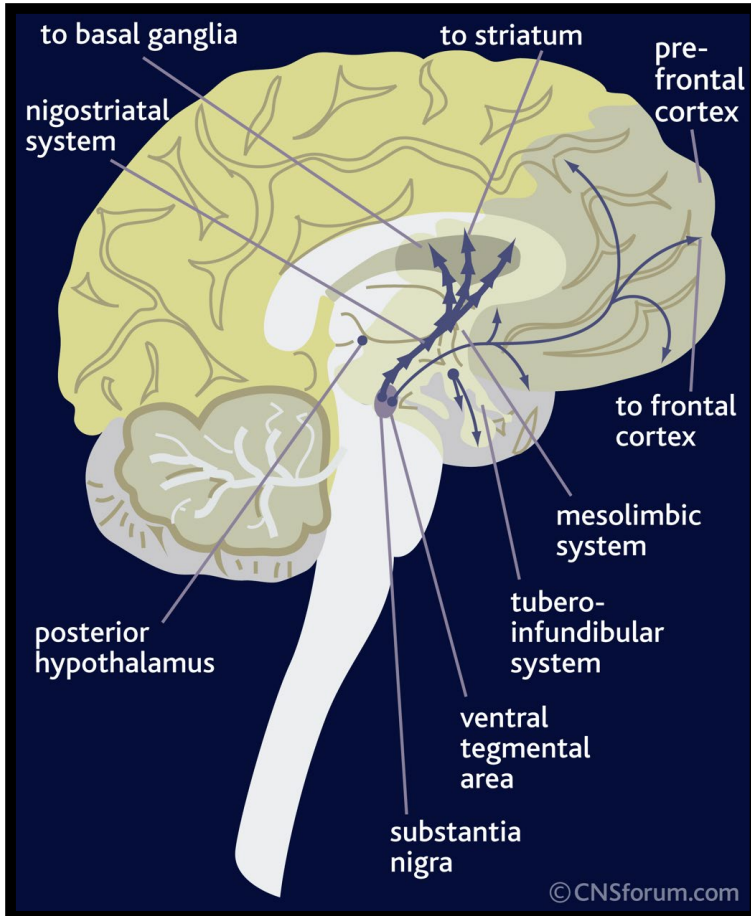
Urges and
cravings

Compulsive
use

Physical
dependence



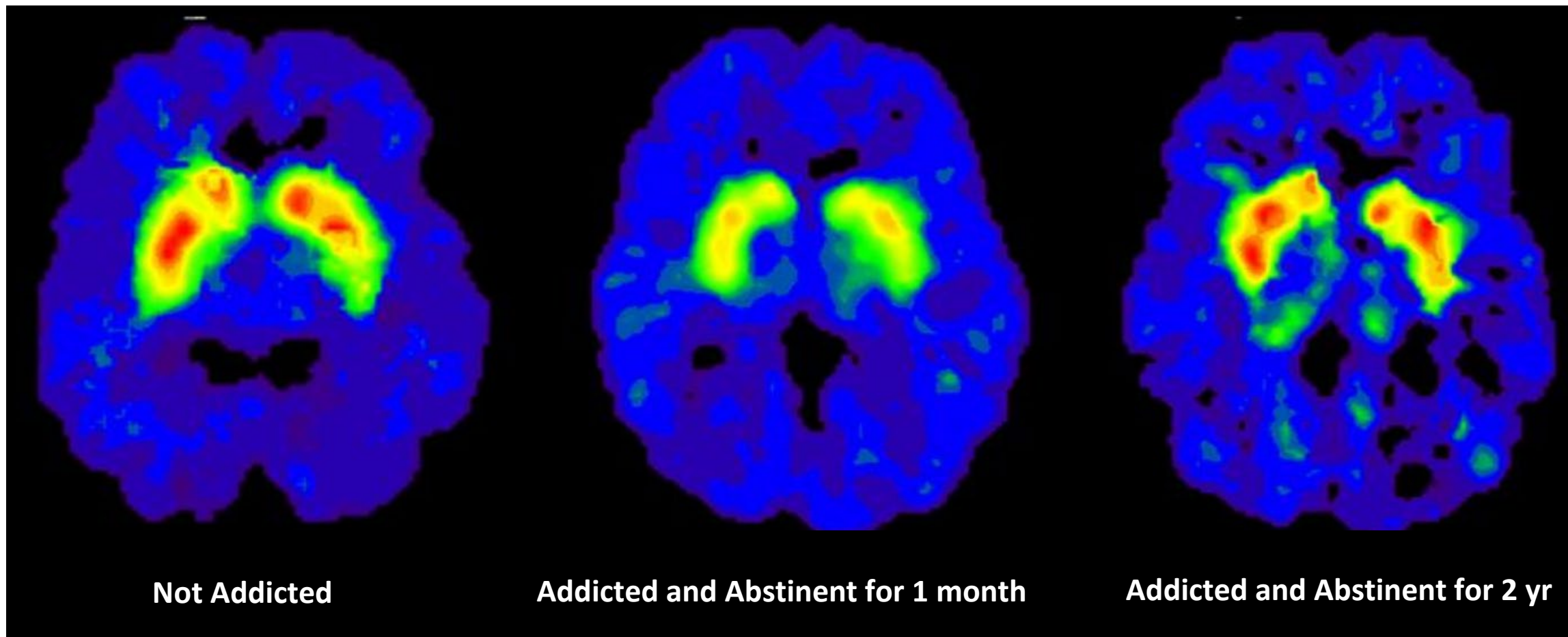
Loss of Control Over Substance Use



- Hijacking of the pleasure-reward system
- System's function is to drive survival and procreation
- Addiction: the system drives substance use



Loss of Control Over Substance Use



AGENDA

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SBIRT

Screening,

Brief

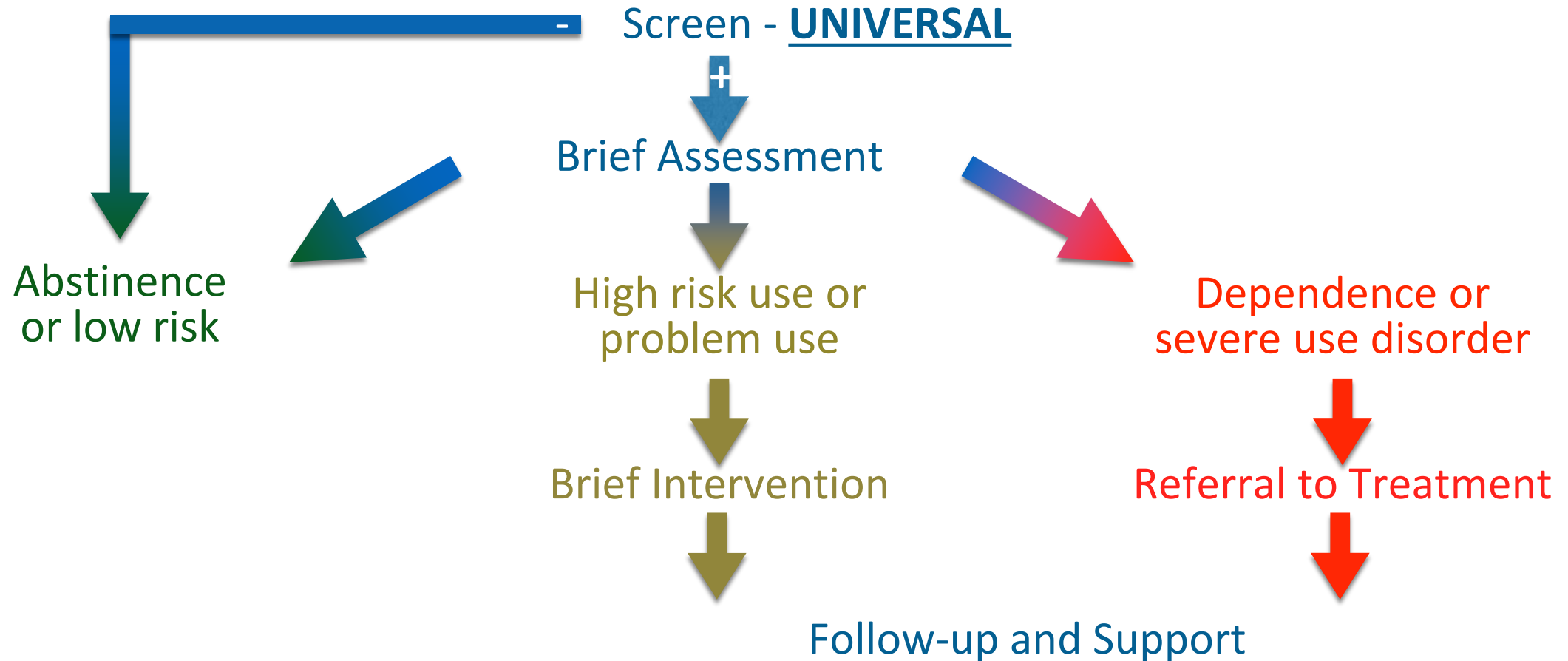
Intervention, and

Referral to

Treatment



SBIRT



Brief Intervention

High-risk use Problem use

What is it?

- 5- to 15-minute discussion on substance use
- 1 to 3 brief follow-ups
- Goal
 - NOT: the patient will recognize a problem
 - the patient will commit to cutting down or quitting



Brief Intervention

High-risk use **Problem use**

Method 1 – Motivational Interviewing

- Respectful, empathic, partnering approach to promoting healthier behaviors
- Avoids giving unwanted advice & information → defensiveness
- Guide patients in weighing the positives and negatives of change in light of their goals, values, resources, and constraints
- Help patients amplify the benefits of change
- Guide patients in constructing a change plan and refining it over time



Brief Intervention

Method 2 – FERNSS

High-risk use **Problem use**

- Feedback - category of use, risks, consequences
- Education - category meaning, explanation of risks and consequences
- Recommendation - quit or cut down on substance use
- Negotiation - identify maximal change patient is willing to make
- Secure concrete agreement - confirm the change in concrete terms
- Set follow-up



Brief Intervention

High-risk use **Problem use**

Motivational
Interviewing

FERNSS



Brief Intervention

High-risk use Problem use

Menu of Elements for Behavior Change Plans

- Limits/targets – substance use
- Triggers
- How to avoid/manage triggers
- Alternate behaviors
- Environmental change
- Social supports
- Medications
- Rewards
- Contingency plans
- Follow-up



Referral to Treatment



Method:

- FERNSS with MI principles
- Recommendation = obtain specialty-based treatment
- If patient declines, offer primary care-based assistance
 - Pharmacotherapy for alcohol or opioid-dependence
 - Behavior change planning
 - Mutual support program: AA/NA/CA/SMART Recovery
- If primary care-based assistance fails, re-attempt referral to treatment



Follow-Up

- Conduct reassessment
- Assess progress
- Review patient's goals and elicit recommitment or modification
- If patient commitment to change is wavering, attempt to strengthen commitment
- Review each element of the change plan
 - Was it implemented?
 - If so, to what extent did it help the patient meet their goals?
 - Keep, delete, or modify the element?
- Review and ensure commitment to the new change plan
- Set next appointment



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Rationale for Implementing SBIRT in Primary Care

- Risky and problem substance use is common
- It frequently leads to negative consequences
 - Patients
 - Families
 - Communities
 - The nation
- SBIRT is effective
- SBIRT reduces healthcare costs



Rationale for Implementing SBIRT in Primary Care

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Substance Use in Michigan

Binge Drinking

26%

Age ≥12, 2018-2019, Past month

Illicit Drug Use

15%

Age ≥12, 2018-2019, Past month

Marijuana Use

14%

Age ≥12, 2018-2019, Past month

Other Illicit Drug Use

4%

Age ≥12, 2018-2019, Past month



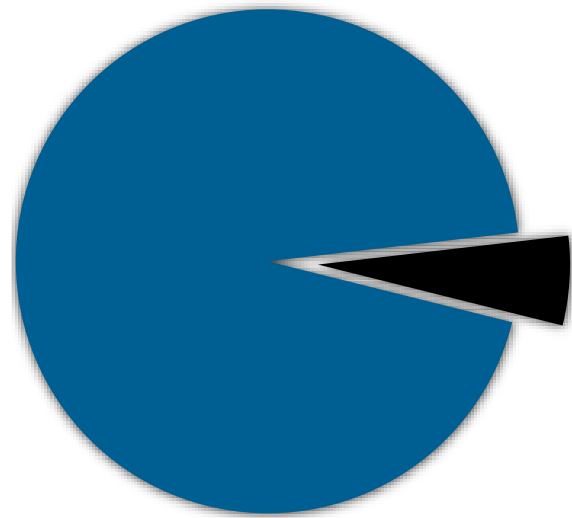
Substance Use Disorders in Michigan

PAST YEAR

Alcohol

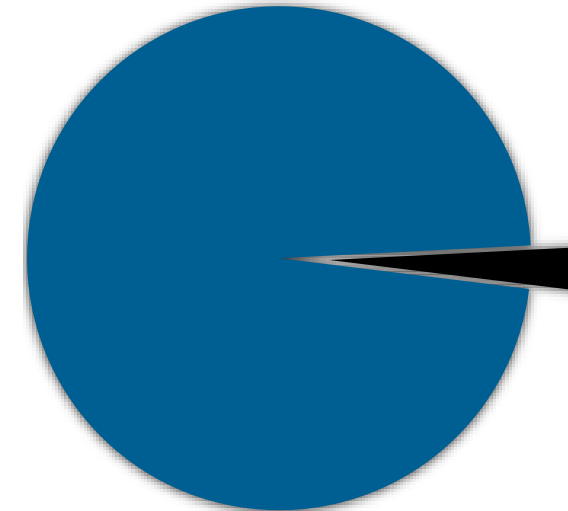
Alcohol and/or Drugs

7.25%



5.72%

Drugs



2.76%



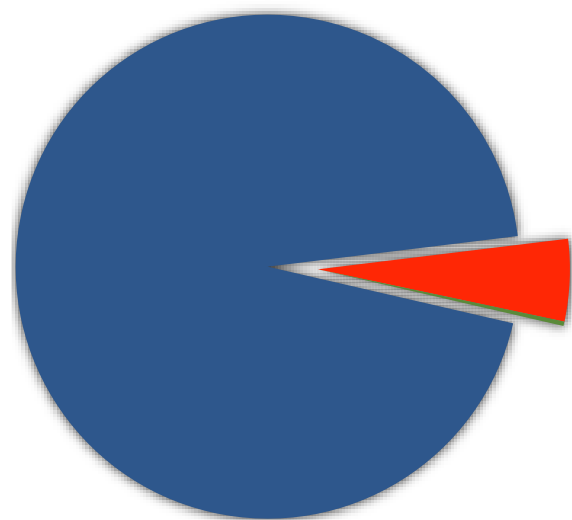
Receipt of SUD Treatment in Michigan

PAST YEAR

Alcohol

Alcohol and/or Drugs

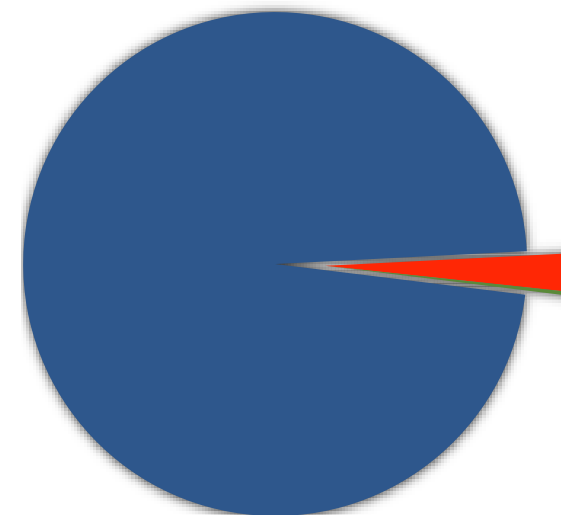
7.25%



Untreated
95%

Treated
5%

Drugs



Untreated
90%

Treated
10%



Rationale for Implementing SBIRT in Primary Care

- Risky and problem substance use is common
- **It frequently leads to negative consequences**
 - Patients
 - Families
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 - The nation
- SBIRT is effective
- SBIRT reduces healthcare costs

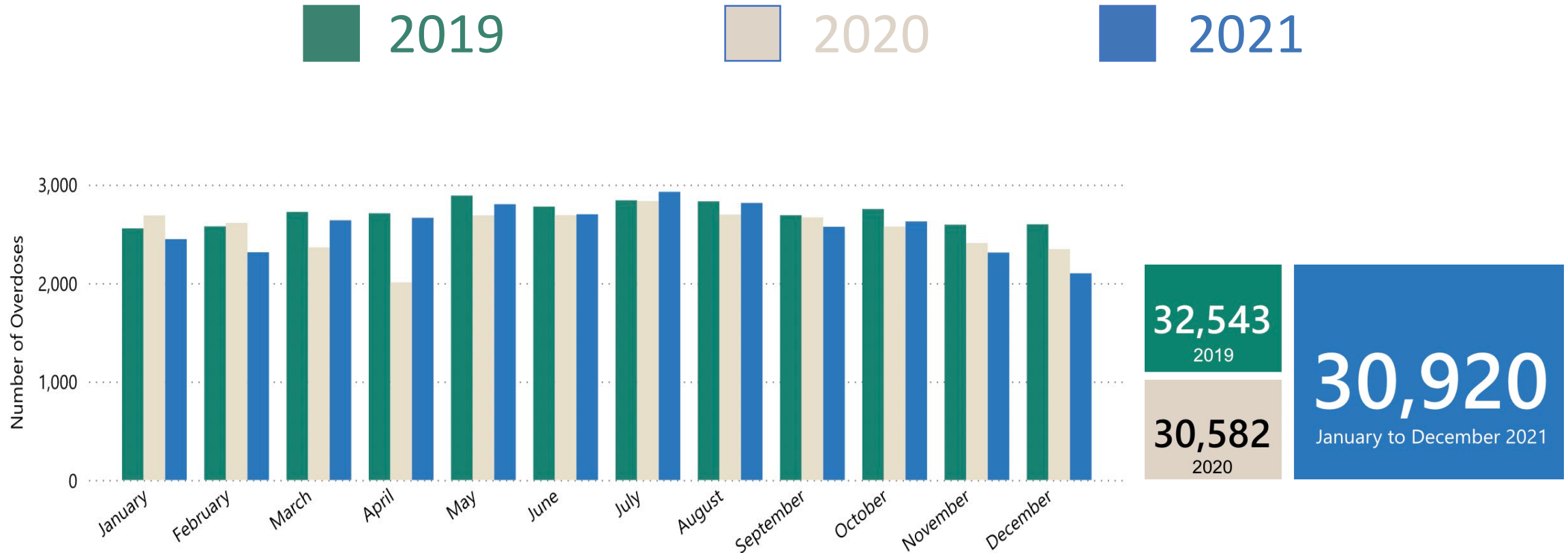


Negative Consequences for Patients

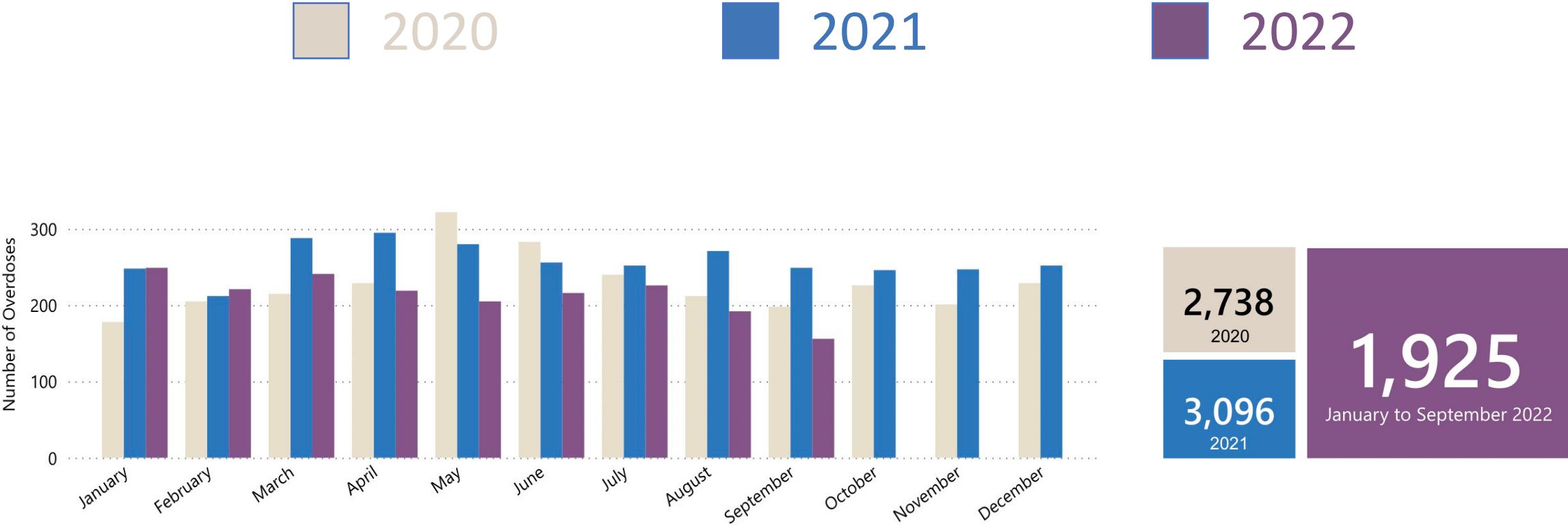
- Physical health
- Mental health
- Family relationships
- Social
- Work/school
- Legal
- Financial
- Religious/Spiritual



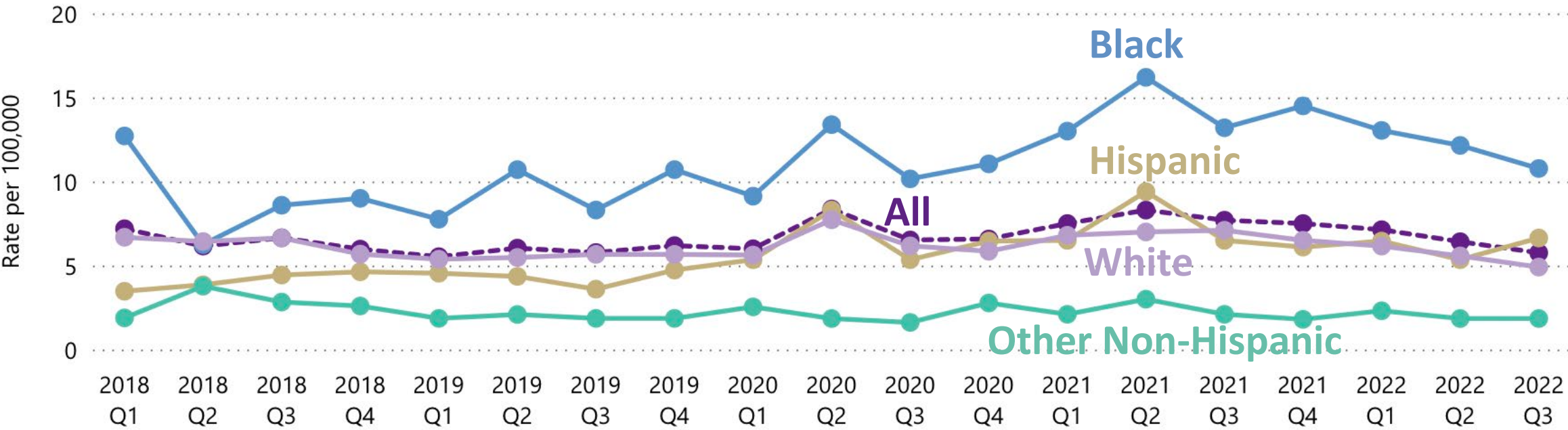
ED Visits for Non-Fatal Overdoses - Michigan



Fatal Overdoses - Michigan



Fatal Overdoses by Race/Ethnicity Group - Michigan



Annual Deaths Attributable to Alcohol - Michigan - 2015-2019

CHRONIC CAUSES						ACUTE CAUSES	
100% Alcohol-Attributable		Cancer		Other			
Alcohol abuse	122	Breast	58	Atrial fibrillation	35	Poisoning	742
Alcoholic cardiomyopathy	21	Colorectal	74	Coronary heart disease	341	Crashes	297
Alcohol dependence	143	Esophageal	43	Hypertension	410	Suicide	343
Alcoholic liver disease	653	Laryngeal	21	Stroke	127	Aspiration	11
Alcoholic psychosis	27	Liver	113	Cirrhosis/GI	358	Drowning	34
Pancreatitis	13	Mouth and throat	71	Pneumonia	10	Fall injuries	61
Other	9	Pancreas	21	Seizures	14	Fire injuries	38
		Prostate	15	Other	12	Hypothermia	18
SUBTOTAL	988	SUBTOTAL	416	SUBTOTAL	1,307	Other	455
TOTAL					2,711	TOTAL	1,838

Total Annual Deaths - 4,549



Negative Consequences for Families

- Discord, divorce, violence
- Children - behavioral and school problems, abuse, neglect
- Mental health problems and somatic symptoms among family members



Negative Consequences for Communities

- Intoxicated driving and related injuries, disability, and death
- Crimes against property and people
- Homelessness
- Overwhelmed social services, law enforcement, courts, and corrections systems
- Negative impacts on workplaces: inadequate workforce, reduced productivity, workplace injuries, absences, and turnover



Adverse Economic Consequences for the U.S. - 2010

	Alcohol	Drugs	Total
Productivity ^[SEP] Loss	\$180 B	\$120 B	\$300 B
Healthcare	\$27 B	\$11 B	\$38 B
Criminal Justice	\$22 B	\$61 B	\$83 B
Total	\$249 B	\$192 B	\$441 B



Adverse Economic Consequences for Michigan - 2010

Total annual costs: \$8.2 billion

Per Michigander: \$826

Per standard drink: \$2.10



Rationale for Implementing SBIRT in Primary Care

- Risky and problem substance use is common
- It frequently leads to negative consequences
 - Patients
 - Families
 - Communities
 - The nation
- **SBIRT is effective**
- SBIRT reduces healthcare costs



Effectiveness of Brief Interventions in RCTs

ALCOHOL



Drinking



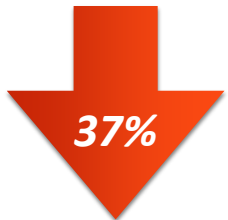
ED Visits



Injuries



Hospitalizations



Arrests



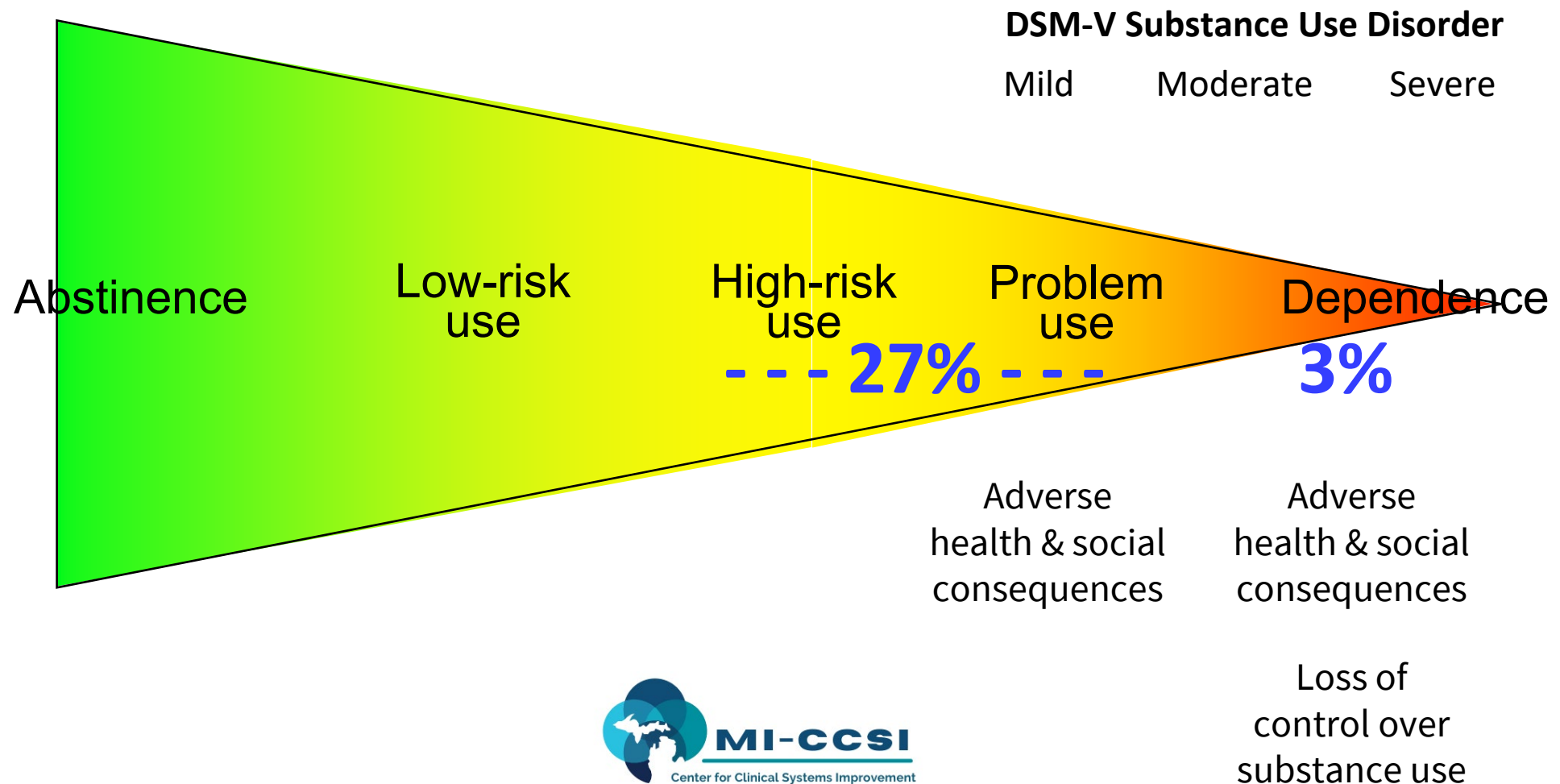
Crashes



DRUGS

Baseline Days of [SEP] Drug Use	Reduction After BI
1 to 4	None
5 to 30	40%

Brief Interventions are the Sweet Spot of SBIRT!



The New York Times

November 21, 2014

NATIONAL | WELL

Most Heavy Drinkers Are Not Alcoholics

By TARA PARKER-POPE

Most people who drink to get drunk are not alcoholics, suggesting that more can be done to help heavy drinkers cut back, a new government report concludes.

The finding, from a government survey of 138,100 adults, counters the conventional wisdom that every “falling-down drunk” must be addicted to alcohol. Instead, the results from the National Survey on Drug Use and Health show that nine out of 10 people who drink too much are not addicts, and can change their behavior with a little — or perhaps a lot of — prompting.

“Many people tend to equate excessive



Key Take Home Lesson

- Poor access to high-quality treatment should not deter primary care clinics from implementing SBIRT.
- 90% of patients who would benefit from SBIRT do not need treatment - just BI.

Effectiveness of Referrals to Treatment

- In Wisconsin's SBIRT project, RT success rate was ~10%
- Common barriers
 - Stigma
 - Wait lists
 - Work
 - Child care
 - Transportation
 - "I don't need treatment."



For Patients Who Will Not or Cannot Get Treatment ...

Offer services in primary care settings!

- Partner with a treatment program to bring in a counselor
- Prescribe medications for alcohol & opioid use disorders
- Help patients design behavior change plans and refine them over time
- Recommend mutual support groups: AA/NA/CA/Smart Recovery
- If primary care-based services fail, re-attempt referral to treatment



Rationale for Implementing SBIRT in Primary Care

- Risky and problem substance use is common
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- SBIRT is effective
- **SBIRT reduces healthcare costs**



Wisconsin's State SBIRT Program: 2006 - 2011

- Supported by a \$12.6 million grant from SAMHSA
- 33 diverse primary care clinics - urban, suburban, and rural; private and public
- >110,000 screens, >23,000 interventions by trained health educators
- High patient satisfaction
- Substantial reductions in drinking and marijuana use at 6 months
- Substantial reductions in inpatient days and ED visits
- ~\$800 savings per Medicaid patient screened over 2 years after screening



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Implementing and Optimizing SBIRT - Best Practices

Prepare

1. Establish an SBIRT Implementation and Improvement Team
2. Design a tentative, high-level workflow, emphasizing who will do what
3. Given the workflow, estimate staff time
4. Identify internal resources needed for success
5. Select screening and assessment questionnaires
6. Plan and implement EHR modifications
7. Design detailed workflows for service delivery, documentation, and billing
8. Determine where current SBIRT workflows and policies will be easily accessible
9. Conduct training for staff involved in all workflows
10. Conduct a launch meeting



Implementing and Optimizing SBIRT - Best Practices

1. Establish an SBIRT Implementation and Improvement Committee

Typical Committee Composition

- Administrator/Manager
- Provider
- Nurse
- Billing staff person
- QI professional
- SBIRT Interventionist
- Medical assistant
- Receptionist
- HER/IT staff person
- Champion (highly respected individual committed to SBIRT work)



Implementing and Optimizing SBIRT - Best Practices

1. Establish an SBIRT Implementation and Improvement Committee

Roles during preparation:

- Make initial decisions on workflows, policies, and procedures
- Convey decisions to peers, elicit feedback, bring feedback to the Committee, and reconsider workflows, policies, and procedures
- Plan and conduct the launch meeting



Implementing and Optimizing SBIRT - Best Practices

2. Design high-level workflows, emphasizing who will do what

Ideal workflow at most primary care clinics:



Receptionists ask patients to complete an annual health screening form



Medical Assistants review patients' responses



Dedicated SBIRT Staff conduct the remainder of the SBIRT session



Implementing and Optimizing SBIRT - Best Practices

2. Design high-level workflows, emphasizing who will do what

Why not have PCPs, nurses, or medical assistants trained to do BI and RT?

A. # unduplicated adult and teen patients		1,500
B. Anticipated positive screen rate		30%
C. # pts expected to screen positive	$A \times B$	450
D. Average # sessions per pt w/ positive [SEP] screen		4
E. Total number of SBIRT sessions per year	$C \times D$	1,800
F. Average length of session (hours)		0.5
G. Time for SBIRT sessions per year (hours)	$E \times F$	900

Current providers and staff cannot simply squeeze BI, RT, and F/U sessions into their current schedules.



Implementing and Optimizing SBIRT - Best Practices

3. Estimate staff time requirements

A. # unduplicated adult and teen patients		_____
B. Anticipated positive screen rate		_____
C. # pts expected to screen positive	A x B	_____
D. Average # sessions per pt w/ positive screen		_____
E. Total number of SBIRT sessions per year	C x D	_____
F. Average length of session (hours)		_____
G. Time for SBIRT sessions per year (hours)	E x F	_____



Implementing and Optimizing SBIRT - Best Practices

4. Identify resources needed for success & sustainability

Expenses	
SBIRT Interventionists' compensation	\$ _____
Supplies and overhead for Interventionists	\$ _____
EMR/IT staff time	\$ _____
Administrative/managerial/QI staff time	\$ _____
Other expenses	\$ _____
TOTAL	\$ _____

Resources	
Reimbursement from payers	\$ _____
Healthcare organization	\$ _____
Subsidies from local hospitals	\$ _____
Other grants, donations, etc	\$ _____
Other resources	\$ _____
TOTAL	\$ _____



Implementing and Optimizing SBIRT - Best Practices

4. Identify resources needed for success & sustainability

If you do not have the resources you need:

- Can you identify additional resources?
- Can you modify workflows - who will do what?
- Can you start out screening a subset of your patients and plan to expand screening in the future?



Implementing and Optimizing SBIRT - Best Practices

5. Select screening and assessment questionnaires

	Adults	Teens
Screens	• Single Alcohol Screening Question • Alcohol Use Disorders Identification Test - Concise (AUDIT-C) • Single Drug Screening Question • Two-Item Conjoint Screen (TICS)	Pre-CRAFFT Questions
Assessments	• Alcohol Use Disorders Identification Test (AUDIT) and Drug Abuse Screening Test (DAST) • Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) • Short Index of Problems - Alcohol and Drugs (SIP-AD) and Severity of Dependence Scale (SDS)	CRAFFT



Implementing and Optimizing SBIRT - Best Practices

6. Plan and implement EHR modifications

- Add screening and assessment questionnaires, preferably with automatic scoring
- Add templates for routine documentation tasks:
 - Session/procedure for reinforcing healthy behaviors (abstinence, low-risk use)
 - Initial brief intervention session
 - Initial referral-to-treatment session
 - Behavior change plans
 - Follow-up sessions
- Include workflows for provider alerts and sign-offs
- Include procedures and data capture for billing



Implementing and Optimizing SBIRT - Best Practices

7. Design detailed workflows for service delivery, documentation, and billing

- Include scripts for receptionists and medical assistants
- Include “warm hand-offs” to SBIRT interventionists
- Be sure that workflows allow tracking of processes and data capture or quality improvement
- Determine how EHRs and other IT platforms can automate processes and QI as much as possible



Implementing and Optimizing SBIRT - Best Practices

8. Determine where current SBIRT workflows, policies, and procedures will be easily accessible

- Especially during the first several weeks of implementation, workflows, policies, and procedures will usually change often
- Administrators, providers, and staff need to know where they can access the latest information
- An internal webpage and/or a bulletin board are possibilities



Implementing and Optimizing SBIRT - Best Practices

9. Conduct training for staff involved in all workflows

- Include receptionists, who may ask patients to complete screens
- Include medical assistants, who may give initial feedback to patients on their screen results and make internal referrals to SBIRT interventionists
- Ensure that training for SBIRT interventionists includes ample skills practice and feedback from experts



Implementing and Optimizing SBIRT - Best Practices

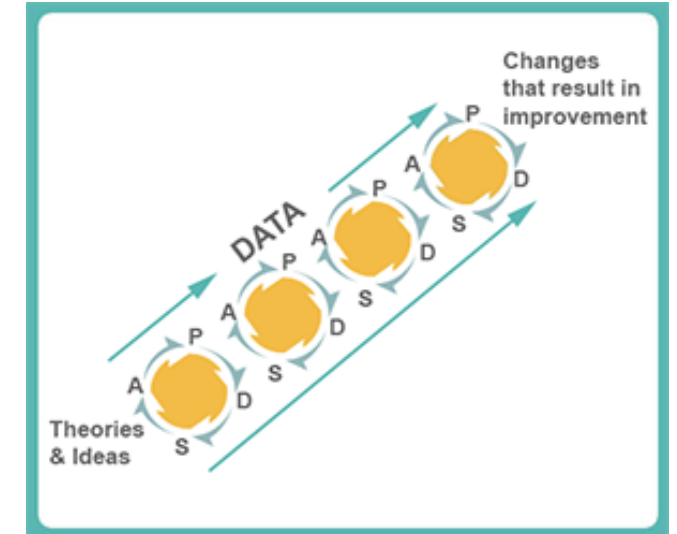
10. Conduct a launch meeting

- Plan a launch meeting immediately before commencing SBIRT
- Goals are to:
 - Generate excitement
 - Make clear strong organizational commitment to a successful SBIRT program
 - Ensure that staff are confident and comfortable with their new roles
 - Open lines of communication so that concerns are conveyed and addressed



Implementing and Optimizing SBIRT

- Conduct rapid-cycle QI.
- SBIRT Implementation and Improvement Committee should meet briefly 3 to 5 times per week to:
 - Review data
 - Identify quality gaps
 - Consider feedback from staff
 - Modify workflows, policies, and procedures as needed to close quality gaps and address staff's concerns.
- Meeting frequency can decline as performance improves.



Recommended Process Quality Metrics

Focus	Description	Denominator	Numerator
Screening	Of all patients eligible to be screened, how many completed a screen?	Patients eligible for screening	Patients who completed screening
Assessment	Of all patients who screened positive, how many completed brief assessment?	Patients with a positive screen	Patients who completed brief assessment
Brief Intervention^[SEP] or Referral-to-Treatment^[SEP]	Of all patients with a positive brief assessment, how many received BI or RT?	Patients with a positive brief assessment (high-risk use, problem use, or dependence)	Patients who received BI or RT



Recommended Outcome Quality Metric

Focus	Description
Substance use	What proportion of the expected decline in substance use was obtained?

This metric should be calculated only for patients who received BI or RT.

- For alcohol, calculate change in risky/binge drinking days in the previous 7 days:
 - Men: On how many of the past 7 days did the patient have more than 4 standard drinks?
 - Women: On how many of the past 7 days did the patient have more than 3 standard drinks?
- For drugs, calculate change in drug use days in the previous 7 days:
 - On how many of the past 7 days did the patient use one or more drugs?

Expected population declines:

- Alcohol: 20%
- Drugs: 15%

Sample calculation:

	Baseline	Follow-up	Decline Obtained	Decline Expected	Proportion Decline Obtained/Expected
Alcohol	7 risky drinking days	5 risky drinking days	29%	20%	29/20 = 145%
Drugs	2 drug use days	2 drug use days	0%	15%	0/15 = 0%

**For patients who use alcohol and drugs, use the average: $(145\% + 0\%)/2 = 72.5\%$*



Recommended Composite Quality Metric

$$Q = \frac{\text{Completed screen}}{\text{Eligible for screen}} \times \frac{\text{Completed assessment}}{\text{Positive screen}} \times \frac{\text{Received BI or RT}}{\text{Positive assessment}} \times \frac{\text{Observed decline in use}}{\text{Expected decline in use}}$$

Example: If a clinic scores 75% for each of the 4 metrics ...

$$Q = .75 \times .75 \times .75 \times .75 = .32$$

... it is eliciting less than one-third of the reduction in substance use possible with SBIRT.

Key Take Home Lesson

- Clinics must score high on all 4 metrics to achieve nearly maximal benefit of SBIRT.
- Aim for $\geq 90\%$ on each metric.



Brown, AJMQ, 2015

AGENDA

1	The continuum of substance use
2	What is SBIRT?
3	Rationale for SBIRT in primary care settings
4	How to implement SBIRT in primary care settings
5	Additional resources

Peer-Reviewed Research:

- Brown RL et al. A team approach to systematic behavioral screening and intervention. American Journal of Managed Care 2014; 20:e113-e119.
- Estee S et al. Evaluation of the Washington State Screening, Brief Intervention, and Referral to Treatment project; cost outcomes for Medicaid patients screened in hospital emergency departments. Medical Care 2010; 48:18-24.
- Fleming MF et al. Brief physician advice for problem alcohol drinkers; a randomized controlled trial in community-based primary care practices. JAMA 1997; 277:1039-1045.
- Fleming MF et al. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. Alcoholism Clinical and Experimental Research 2002; 26:36-43.
- Gelberg L et al. Project QUIT (Quit Using Drugs Intervention Trial): a randomized controlled trial of a primary care-based multi-component brief intervention to reduce risky drug use. Addiction 2015; 110:1777-1790.
- Paltzer J et al. Substance use screening, brief intervention, and referral to treatment among Medicaid patients in Wisconsin: Impacts on healthcare utilization and costs. Journal of Behavioral Health Services & Research 2017; 44:102-112.
- Paltzer J et al. Health care utilization after paraprofessional-administered substance use screening, brief intervention, and referral to treatment: a multi-level cost-offset analysis. Medical Care 2019; 57:673-679.



Other Resources:



Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices. Atlanta, Georgia: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, 2014, <https://tinyurl.com/5br5hyfd>



Implementing Care for Alcohol and Drug Use in Medical Settings; An Extension of SBIRT, <https://tinyurl.com/ysu7hyjk>



Resources for Screening, Brief Intervention, and Referral to Treatment (SBIRT) - <https://www.samhsa.gov/sbirt/resources>



Recommendation Statement: Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care, <https://tinyurl.com/wj7vcyje>

Recommendation Statement: Unhealthy Drug Use Screening, <https://tinyurl.com/8k36hsfw>



Summary - 1 of 2:

- Each patient's substance use pattern fits one of 5 categories
- About 3% are substance dependent, have poor control over their substance use, and should be referred for treatment. If they cannot or will not get treatment, offer services in primary care settings – counseling, pharmacotherapy, behavior change planning, and referrals to self-help groups.
- About 27% have high-risk use or problem use and will often reduce use in response to BIs – the sweet spot of SBIRT. BIs improve health, reduce admissions and ED visits, and save healthcare dollars.
- Those who deliver BI, RT, and F/U sessions should be well-trained in MI or the FERNSS approach, including ample practice and feedback from experts.



Summary - 2 of 2:

- Best practices in implementing SBIRT include establishing a QI committee, estimating staff time requirements, garnering the resources to support and train new SBIRT intervention staff, defining new workflows, modifying EHRs, training all staff with new roles, and conducting a launch meeting.
- When starting SBIRT, implement rapid-cycle QI. Aim for $\geq 90\%$ on each of 4 metrics:
 - Proportion of eligible patients who complete screening
 - Proportion of patients with positive screens who receive brief assessment
 - Proportion of patients with positive brief assessments who receive BI or RT
 - Of patients who receive BI or RT, observed/expected declines in alcohol/drug use
- With a successful SBIRT program, you can help your patients, their families, and your communities avoid ample mortality, morbidity, suffering, and economic loss.





Q & A