Building Alcohol Intervention Options for NH:

SBIRT: A National Perspective

John C. Higgins-Biddle, Ph.D.

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Main Topics

1. What's the problem?
2. What is SBIRT?
3. How is policy changing?
4. Questions & Discussion

What's the Problem?

Alcohol also . . .

- Kills over 75,000 Americans per year; third leading cause of death
- Annual cost over $180 billion in lost productivity, health costs, legal and justice issues
- Perceived to be a moral, legal, social problem, a failure of individual responsibility

In Medicine Alcohol also . . .

- Causes/exacerbates many physical and mental medical problems
- Unhealthy use is often missed by doctors
- Diagnosis & treatment of many diseases & disorders often neglect its use
- This applies to many levels of use besides alcoholism or dependence
- Understanding requires new perspective

How we address other issues

- Are you a better driver than a typical 16 year-old male?
- Have you had an auto crash?
- So most states require seatbelt use
- Who has more heart attacks: People diagnosed with heart disease; those without heart disease?
- So what?

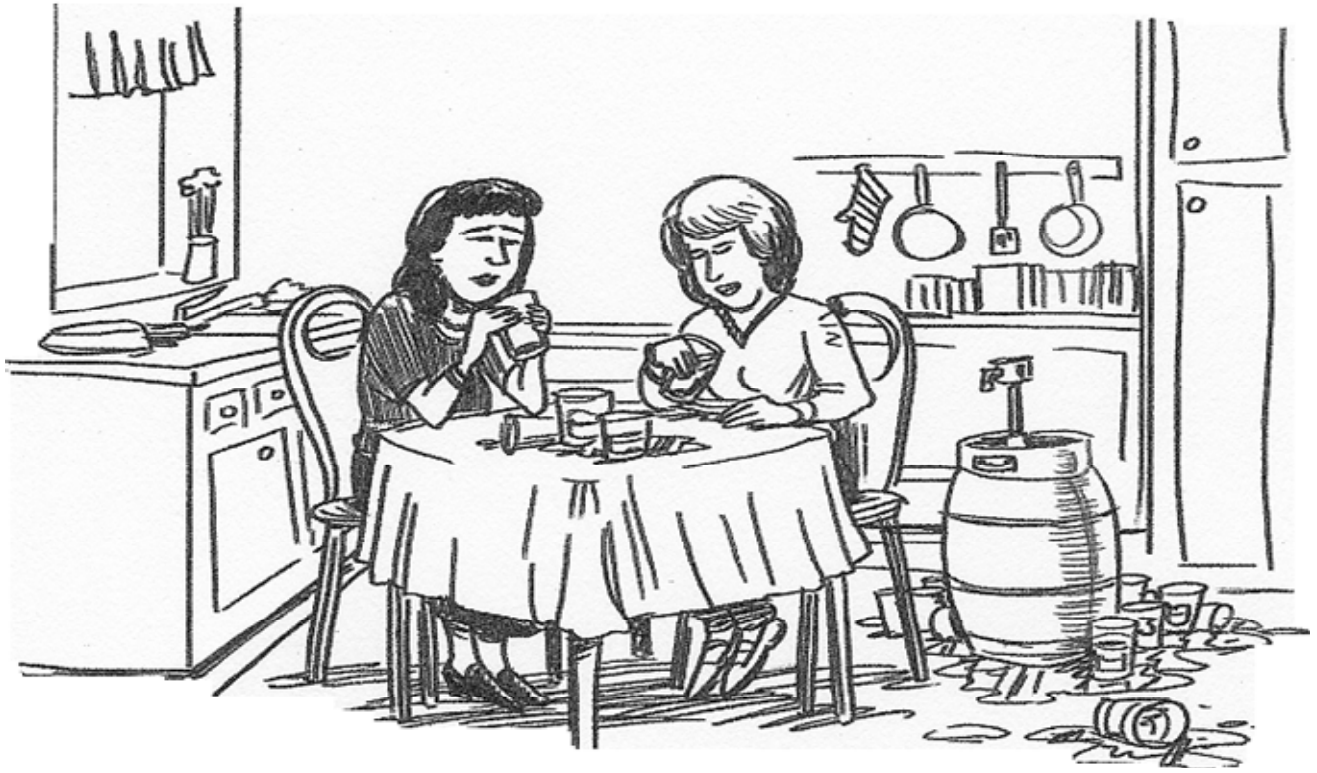
The Preventive Paradox

- Large group (LG) with small problems vs. small group (SG) with big problems
- Good drivers (LG) have more accidents than high-risk drivers (SG)—hence seatbelts for all
- Patients without a diagnosis of heart disease (LG) have more heart attacks than those with a diagnosis (SG) — hence screen all for cholesterol

Types of Alcohol Risk

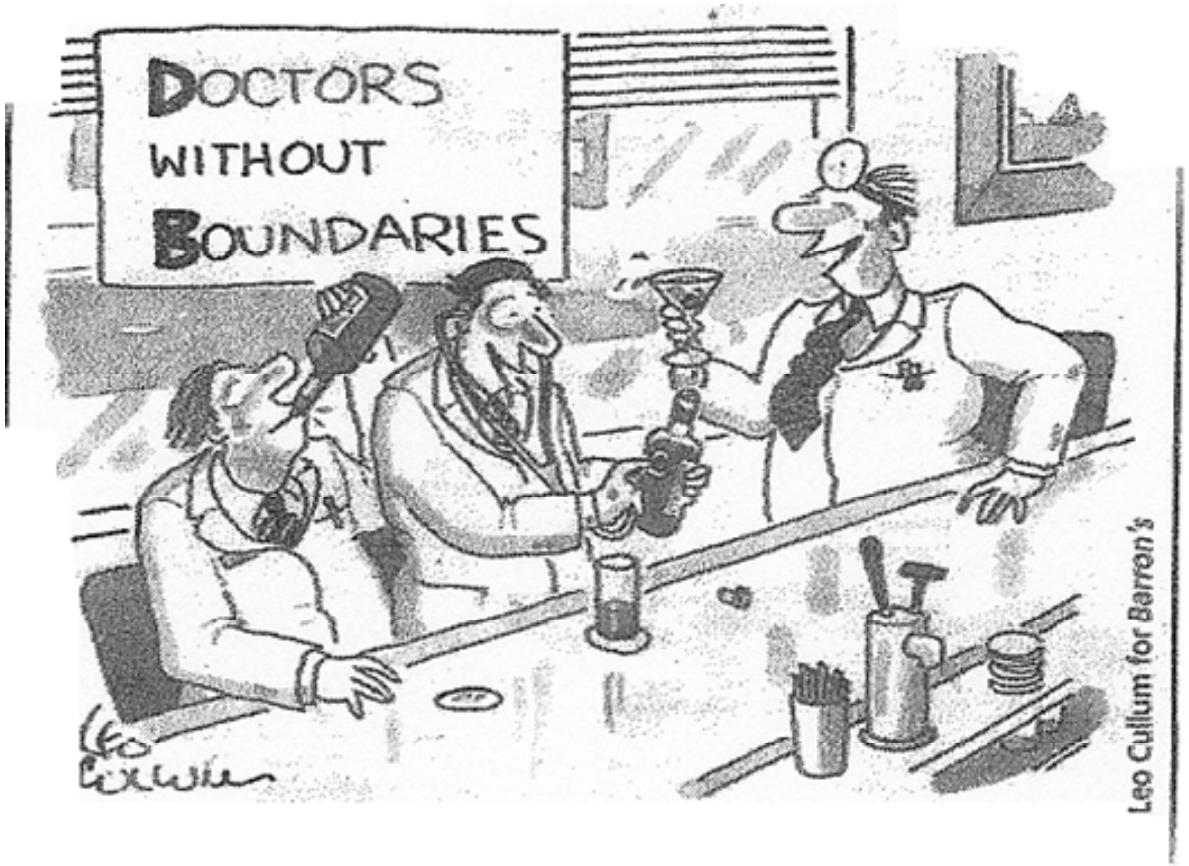
- SG-Dependence—a cluster of behavioral, cognitive, and physiological phenomena that may develop after repeated use
- LG-Harmful Use—consumption causing physical, mental, or social harm
- LLG-Hazardous Use—consumption causing elevated risk without presence of physical or mental harm (yet)

Unexpected Hazardous Use



"Honestly, Paula, I don't know what I'd do without our daily keggers."

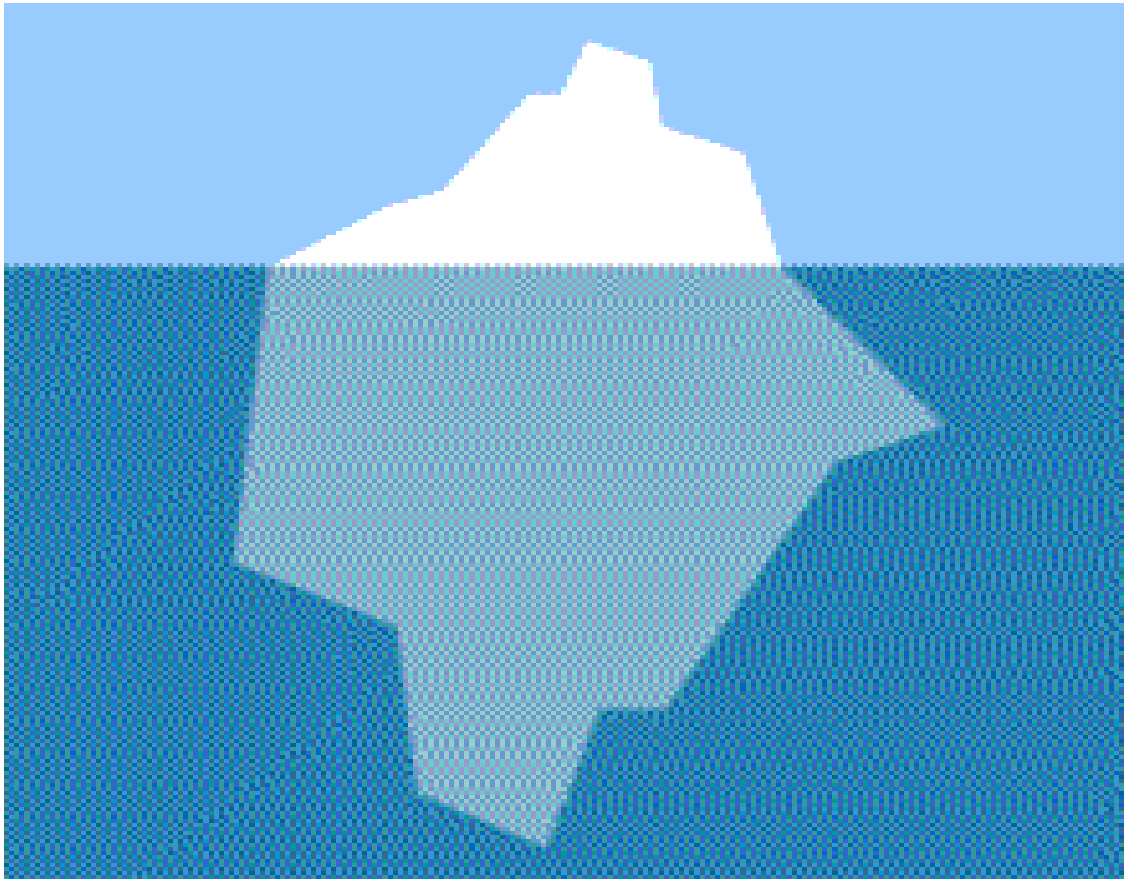
Or More Unexpected

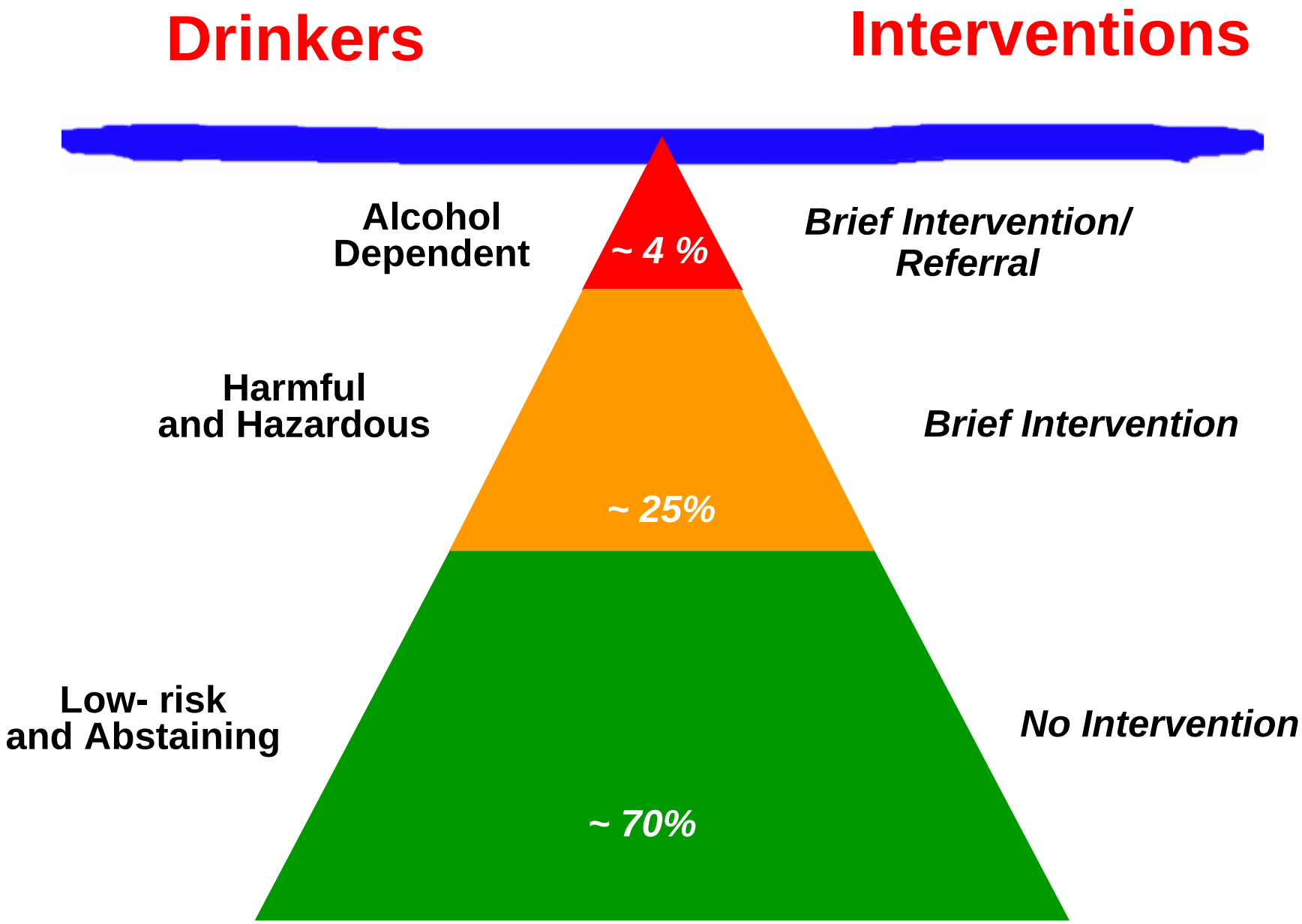


Who Causes Alcohol Harm?

- Small group with Dependence experience & cause the most harm--individually
- But there are far more Hazardous and Harmful users
- So together Hazardous & Harmful drinkers cause at least half of alcohol/drug harm
- Two ways—high-level regular use and occasions of intoxication leading to work, health, social, legal problems

What we don't see can hurt!





Summary of the Problem

- ~30% use too much at least once/year; intoxication is the #1 alcohol use disorder
- <5% are dependent—need treatment; ~25% are not—need brief intervention
- Reducing problems requires finding and helping both groups
- How can we find them and help the hazardous, harmful, and dependent—each needs somewhat different kinds of help?

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SBIRT Provides a Way

- Screening identifies degree of risk and likelihood of a condition
- Brief Intervention helps patients reduce hazardous and harmful use
- Referral typically sends dependent patients to specialized Treatment

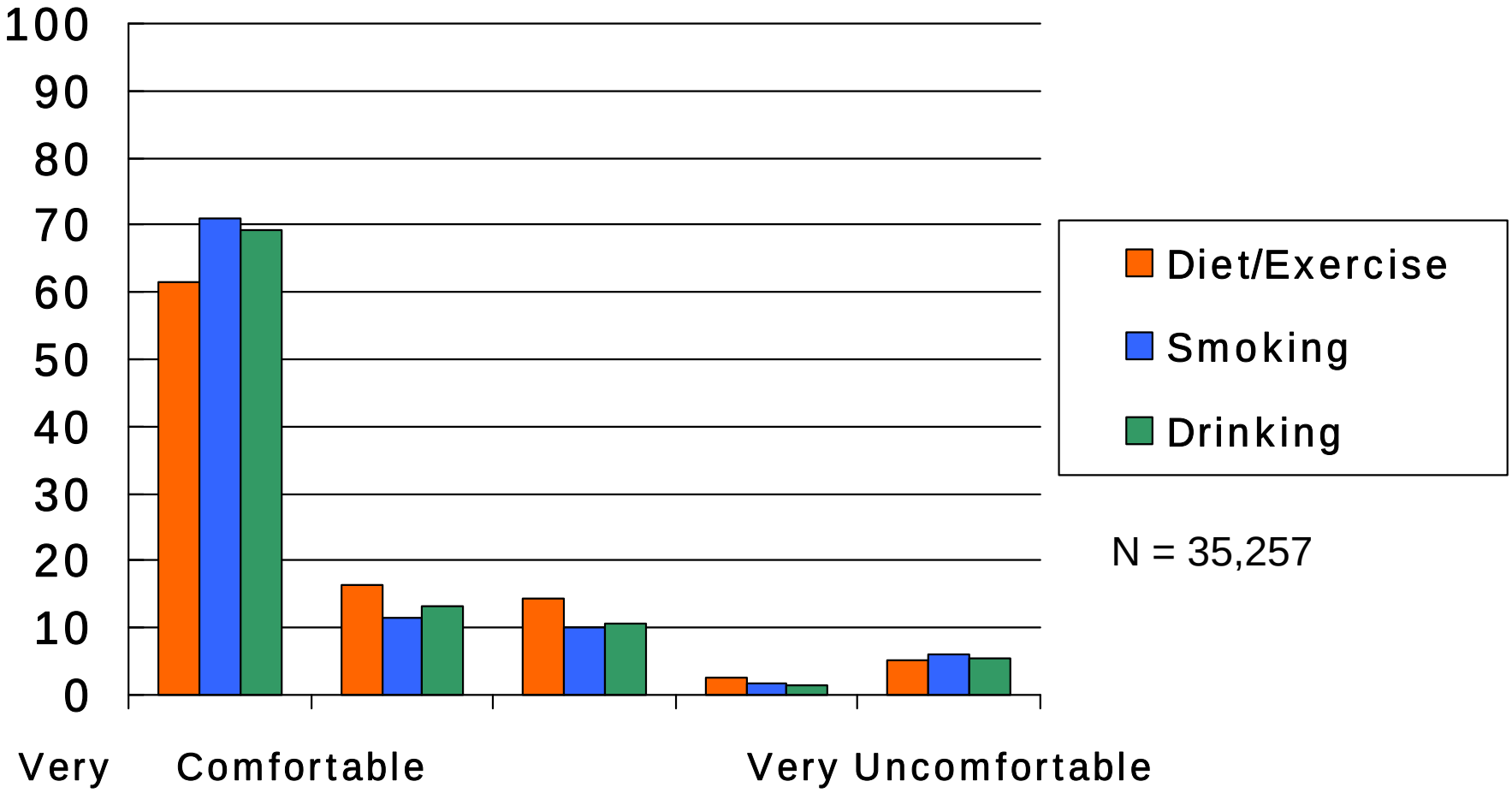
Why Screen?

- Rough estimates of excessive use by setting:
  - ✓ Primary Care—10-25%
  - ✓ Ob-Gyn—10-20%
  - ✓ Emergency—20-40%
  - ✓ Trauma—40-60%
- Research shows providers cannot identify hazardous & harmful drinkers without screening
- So everyone should be screened annually
- Drinking patterns change over time

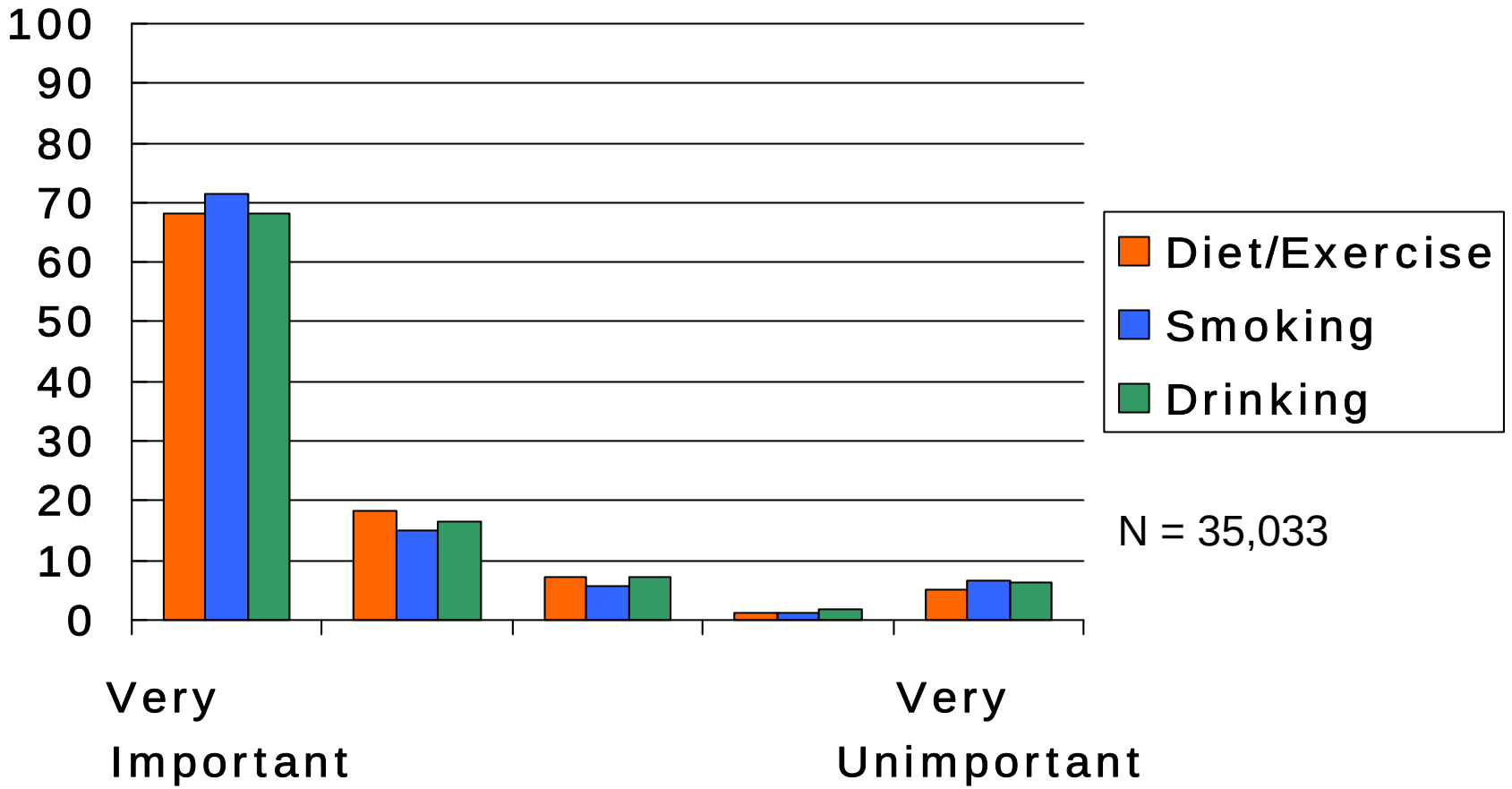
Screening for Alcohol Use

- >25 years of research in medical sites
- Where people go with health issues and expect to be asked questions
- Self-report screening is quick, accurate, and inexpensive
- Can be done via paper, oral, computer
- Good screens distinguish risk levels
- But many think patients will get upset

Patient Comfort—Cutting Back



Patient Sense of Importance



Goals of Screening

- Identify both hazardous/harmful use and those likely to be dependent
- Create a professional, helping atmosphere
- Gain the patient information needed for an appropriate intervention
- Use as little patient/staff time as possible

Screening Instruments

- Validated instruments are easy to use
- Most common ones for adults:
  - Single-Question (S-Q) Screen: intoxication
  - AUDIT-C (US): 3 questions—weekly drinking & intoxication
  - AUDIT: 10 questions--use, dependence signs, problems; provides severity of risk

Screening Systems

- Two Step Process
  - A. S-Q or AUDIT-C (US) for all annually
  - B. Positives only get AUDIT
- A. can be done by M.A./Nurse w/ vitals signs or in a health survey by reception
- Scoring A. and handing out B. can be done by M.A./Nurse
- Time: 5-30 seconds for all; 30 sec. for positives

Does Screening Work?

- No screening for anything is perfect
- Self-report systems rely on patients
- Most patients tell mostly the truth
- They come with a health problem & want help—so it works as well as most
- Those at most severe risk fib most
- Instruments usually catch them!

Brief Intervention (BI)

- Structured brief advice/counseling/ conversation
- Builds upon screening info
- Non-judgmental, interactive, empathic
- Aims: to reduce or stop use; or to refer patient to specialized treatment
- Cognitive info and motivation to change

FLO of an Intervention

1. Feedback from screening and advice to reduce use & risk
2. Ask what patient thinks & Listen to encourage patient thinking & decision-making
3. Provide guidance and negotiate a decision about Options for change— choice of a goal, information on limits, how to make change last, encouragement & motivation

Moderate Drinking Guidelines

Healthy men up to age 65:

- No more than 4 drinks in a day AND
- No more than 14 drinks in a week

Healthy adult women and healthy men over age 65:

- No more than 3 drinks in a day AND
- No more than 7 drinks in a week

Lower limits or abstinence for patients:

- Taking medications that interact with alcohol
- With health condition exacerbated by alcohol
- No consumption if pregnant or trying to get pregnant

Source: National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism

Who can do BI?

- Just about any clinical staff
- Good people skills are most important
- Be non-judgmental, empathic
- Understand the patient's perspective
- Include the essential BI ingredients
- More training is needed for longer sessions, more severe patients

Should you take the time?

- Screening time:
  - 5-30 seconds for all—during current actions
  - 30 sec. for positives; + 2 min. patient time
- BI time: 3-5 min. or 15+ min. if billing
- Is it worth the time & effort?
- How do you choose which services to provide? Which do you now provide?
- There is evidence on how to decide

Preventive Services

- USPSTF: alcohol SBI a “B” rating—like cholesterol screening & elderly flu shots
- USPSTF- ranked recommended services by:
  - Clinically preventable burden (CPB) -How much disease, injury, and death would be prevented if services were delivered to all targeted individuals?
  - Cost-effectiveness (CE) - return on investment - How many dollars would be saved for each dollar spent?

Maciosek, *Am J Prev Med* 2006; Solberg, *Am J Prev Med* 2008; http://www.prevent.org/content/view/43/71

Rankings: Preventive Services

#	Service	CPB	CE
1	Aspirin: Men 40+, Women 50+	5	5
2	Childhood immunizations	5	5
3	Smoking cessation	5	5
4	Alcohol screening & intervention	4	5
5	Colorectal cancer screening	4	4
6	Hypertension screening & TX	5	3

Rankings: Preventive Services

#	Service	CPB	CE
7	Influenza immunization	4	4
8	Vision screening - 65+	3	5
9	Cervical cancer screening	4	3
10	Cholesterol-men 35+, women 45+	5	2
11	Pneumococcal immunization	3	4
12	Breast cancer screening	4	2
13	Chlamydia screening - women <25	2	4

Referral To Treatment

- AUDIT screening can supply a likelihood of dependence—not a diagnosis
- Dependent patients may benefit from a brief intervention but usually need more help
- Early identification may get more patients to treatment earlier; thus increasing effectiveness of therapy, decreasing costs
- Docs can also manage patients do NOT want treatment; 87% who need it don't want it!

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Policy Actions to Date

- USPSTF rating and ranking (2004)
- Many medical societies endorse SBI
- Am. College of Surgeons Com. on Trauma **requires** it in Level I centers; screening in Level II; more to come
- AMA and CMS have issued billing codes
- States are adopting Medicaid codes; Most private payer are paying

More Policy Actions

- IHS including SBIRT in emergency service
- NHTSA encourages SBIRT for reducing impaired driving and traffic injuries
- CDC provides training for trauma and emergency departments
- States repealing alcohol exclusion laws
- Employers beginning to take action
- JCAHO standard now being developed

Codes and Fees for SBI

Payer	Code	Service	Fee
Commercial	CPT 99408	15-30 min.	$33.41
	CPT 99409	>30 min.	$65.51
Medicare	G0396	15-30 min.	$29.42
	G0397	>30 min.	$57.69
Medicaid* *State plan approval required	H0049	Screening	$24.00
	H0050	BI per 15 min.	$48.00

SAMHSA SBIRT Initiative

- 11 state/tribal coop. agreements ave. >$2 mil. per year for 5 years
- See http://sbirt.samhsa.gov/
- 12 campus grants ave. $1.3 mil. over 3 years
- Over 500,000 patients screened since 2004
- Sites in huge urban hospitals to rural clinics
- More grants to come; plus residency training

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