

**ALCOHOL SCREENING and BRIEF  
INTERVENTION (ASBI)  
PROGRAM IMPLEMENTATION and  
OPERATIONS MANUAL**

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## **ASBI Frequently Asked Questions (FAQ'S)**

**The IHS Office of Clinical and Preventive Services has developed an active injury and alcohol control program called ASBI. It targets young, non-dependent alcohol/drugs users who present to IHS –Tribal Hospitals and Clinics with an injury related to alcohol and drug misuse. Via ASBI, reductions in repeat injury (recidivism) and lower alcohol consumption may reach up to 50%. Listed below are some frequently asked questions about ASBI.**

### **What is the Problem?**

Injury is the number one cause of death for people between 15 and 44 years of age. Traumatic injury caused by alcohol misuse is an unresolved major clinical problem for Native Americans and Alaskan Natives causing immense personal, family and community suffering. The sheer number and the magnitude of traumatic injuries cause stress on our emergency personnel and can overwhelm our facilities, with inordinate costs and impacts on operating budgets and contract care funds.

- ∞ Alcohol related deaths are seven times higher in Native Americans/Alaskan Natives than in the remainder of the U.S. population.
- ∞ The fatality rate from motor vehicle collisions is two times higher in Native Americans/Alaskan Natives than in the remainder of the of U.S. population.
- ∞ Native Americans/Alaskan Natives have the highest percentage of alcohol-related collisions.
- ∞ Alcohol-related injury is typically not a one-time event but rather an escalating series of recurring events. Patients seen in a trauma center with an alcohol-related injury are twice as likely to die from a subsequent injury.

### **How much is too much to drink?**

The National Institute of Alcohol Abuse and Alcoholism offers specific guidelines for men and women regarding the maximal thresholds for low-risk drinking:

1. Men should not drink more than fourteen drinks in any week and not more than four drinks in any given day.
2. Women should not drink more than seven drinks in any week and not more than three drinks in any given day.

People who drink below these levels may still be at risk for alcohol-related injuries, medical and/or other alcohol-related problems. However, drinking above these amounts is known to place individuals at high risk.

### **What is a standard drink?**

A standard drink is 12 oz of beer, 1.5 oz of spirits or 5 oz of wine.

### **What is ASBI?**

ASBI stands for Alcohol Screening and Brief Intervention. It is a targeted prevention program incorporating alcohol screening, brief feedback, and motivational interviewing to assist patients in connecting their drinking behavior with their current injury or medical problem. Patients are then encouraged to take action to reduce their risks.

### **What is a Targeted Prevention Program?**

Instead of providing a program to every person who presents to a medical provider, a targeted prevention program focuses on the subset of individuals who are at particular risk for a problem based on their membership in a designated population segment. This concentration on a specific group maximizes intervention impact by directing services to those who will specifically benefit from them. The ASBI program is such a program, targeting young adults with risky alcohol or drug behaviors.

### **Who does ASBI target?**

ASBI targets the young, non-dependent but Harmful or Hazardous Drinker. This is the person whose alcohol consumption places him or her at high-risk for injury or other related harm but who does not have a physical dependence on alcohol and who as of yet has not had major problems related to his or her drinking. The Harmful or Hazardous Drinker is capable of changing alcohol consumption behavior but needs motivation to do so. In addition, because most young adults have few, if any, preventive visits to a medical provider, targeting a program to an acute care visit for injury may be the only opportunity to capture those in need of assistance for their drinking.

### **Why “Target” the Emergency Department, Primary Care and Behavioral Health Clinics?**

This is where the Hazardous Drinkers present with their resulting injuries and where “The Window of Opportunity” presents itself. Providers should be tuned to this and provide the ASBI in these “Opportunistic” situations. High risk patients are most easily recognized in these initial and acute care settings. These patients need to be “screened” for alcohol and drugs during these initial encounters. They may receive their Brief Intervention at some later stage according to local ASBI protocol.

### **Is there a Standard ASBI Protocol?**

No, each hospital and clinic will establish its own. It is important to screen initially and follow through with the Brief Negotiated Interview (BNI) within the “Teachable Moment,” which may be up to several days. The BNI, therefore, can be done in a follow-up clinic or on the ward for hospitalized patients.

### **When do the more seriously injured patients get an ASBI?**

Trauma Patients transferred to Regional Trauma Centers will receive an ASBI there. The IHS-Tribal providers need to recognize this and provide follow-up “Booster” ASBI according to protocol.

### **What can ASBI achieve?**

ASBI has been demonstrated to reduce alcohol consumption and related injuries in targeted patients:

- ∞ 32% reduction in drinking and driving at six months
- ∞ 47% reduction in repeat injuries requiring an Emergency Department visit or hospital admission at one year
- ∞ Significant, prolonged reductions in alcohol consumption

**How long does ASBI take?**

ASBI only takes a few minutes to provide. Screening tools, such as the AUDIT-C questionnaire can be offered in written or verbal form. The brief negotiated interview may take as little as five to ten minutes.

**Who can perform ASBI?**

ASBI is performed by any trained health care provider. A variety of different provider backgrounds have been used for ASBI programs ranging from trauma surgeons and nurses to social workers and community health educators. The key to being a successful provider is compassionate, non-judgmental listening and the ability to guide patients to the connection between their alcohol consumption and their injury. ASBI providers need to be trained to understand the stages of change and how to negotiate a patient through the pathway.

**What is the IHS ASBI Implementation Goal?**

The goal is to introduce ASBI to all hospitals in 2007 and to all primary care clinics and behavioral health clinics in 2008. Primary Care clinics and Behavioral Health clinics will be crucial additions to the program because many people with lesser injuries do not seek medical attention in an acute or emergent care setting. Moreover, it has been shown that a brief booster session in which a health care provider reviews the patient's progress with his or her drinking goals is extremely helpful and such session could be performed at any health care visit.

**Are there other drugs or "Dys-behaviors" that ASBI could impact?**

The core intervention that ASBI is based on, motivational interviewing, was initially developed as a technique to help with smoking cessation and has proven very successful. At present, initial studies suggest that approaches similar to ASBI are effective in reducing the use of other drugs such as marijuana, cocaine and heroin at six months of follow up. Larger and longer term studies are underway. Additional research is in process involving the use of screening and brief intervention for domestic violence.

**Who supports ASBI?**

Alcohol Screening and Brief Intervention has been recommended for adults in primary care settings by the United States Preventive Services Task Force and in emergency departments and trauma centers by the Society for Academic Emergency Medicine as well as by the American College of Surgeons Committee on Trauma. Implementation of the IHS-Tribal ASBI Program is fully endorsed by the IHS-Tribal Health System as well as all the Area Office Chief Medical Officers and Behavioral Health Consultants. The program aligns with former IHS Director, Dr. Charles Grim's three Health Initiatives: Behavioral Health, Chronic Care, and Health Promotion/Disease Prevention. In addition, a number of federal agencies are in full support of the program such as Substance Abuse and Mental Health Services Administration, the White House Office of National Drug Control Policy, the Centers for Disease Control and Prevention and the National Highway Traffic Safety Administration.

**What is the ASBI Manual?**

This IHS ASBI Manual provides the concept, scientific and programmatic background, basic steps, important infrastructure information and key implementation steps. It is a soup to nuts, one-stop-shopping experience for you to develop your ASBI program.

**Who do I call for additional help?**

**There is expertise in each IHS Area Office. Both the Chief Medical Officer (CMO) and the Behavioral Health Consultant (BHC) are experienced with this IHS-Tribal ASBI program.**

**Likewise the Office of Clinical and Preventive Services (OCPS) in Rockville can help. The lead person at the OCPS is David R. Boyd MDCM.**



## ***Preface***

### **Origin of the Alcohol Screening and Brief Intervention (ASBI) Program**

Injuries and premature deaths due to trauma remain an ever-present source of concern in many Native American and Alaska Native communities. Targeting high risk drinkers using the Alcohol Screening and Brief Intervention (ASBI) to reduce recurrent trauma offers health care providers an opportunity to significantly decrease such events. Endorsed by the Indian Health Service (IHS) Office of Clinical and Preventive Services, the ASBI program takes advantage of the already significant integration of clinical programs in AI/AN health programs to provide a concrete and empirically based approach to trauma reduction. It bridges the IHS disciplines of trauma, emergency care, behavioral health, alcohol and substance abuse and injury prevention.

The program directly addresses former Director Dr. Charles Grim's three key initiatives of Behavioral Health, Chronic Care, and Health Promotion/Disease Prevention to reduce health disparities. American Indians and Alaska Natives suffer higher rates of alcohol-related injuries, especially motor vehicle fatalities, and higher rates of alcohol-related illnesses than any other racial or ethnic group. The first of Dr. Grim's initiatives, Behavioral Health, aims to "apply methods of behavior change, prevention counseling and interview methods"<sup>1</sup> towards treatment and prevention. The other initiatives both target enhancing and improving disease prevention and health promotion as well as protecting against chronic disease. ASBI uses motivational interviewing to target critical change opportunities in at risk alcohol users and reduce risk for future trauma.

Dr. Charles Grim said at the April 2007 ASBI Telemedicine Conference:

"The success of this ASBI program will require the understanding and cooperation of many key leaders of IHS and Tribal Clinical, Behavioral, Emergency, Medical, and Administrative programs. We can, within our existing resources, effectively develop and deliver on this ASBI program concept. I believe we can implement and evaluate ASBI as we have in other areas like diabetes. This program can be another IHS "Model for the Nation."

"We have all experienced the frustration and futility of trying to control and diminish the Trauma, Injury-Alcohol Cycle. Alcohol and trauma remain two of the most prominent causes of morbidity and mortality in Indian Country. We will be saving lives, limbs, and health-care dollars as well as diminishing the unnecessary family and community grief caused by accidental death in young American Indians."<sup>2</sup>

The IHS-Tribal ASBI Program was developed by Dr. David Boyd, Dr. Anthony Dekker, and Dr. Jim Flaherty. Administrative and professional support comes from Dr. Rick Olsen, Dr. Jon Perez, Mr. Jim Stone, and Dr. Peter Stuart. The program is fully endorsed by the Area Office Chief Medical Officers and Behavioral Health Consultants and widely by clinicians throughout the Service Unit Clinics. It has also been supported with consultations and program assistance from national leaders in the field such as Dr.

Larry Gentilello, Dr. Carl Soderstrom, Dr. Daniel Hungerford, Dr. Janet Selway, Dr. Carol Schumer, Dr. Gail D'Onofrio, Dr. Linda Degutis, Dr. Susan Boyd, and Ms. Carol Rottenbiller. The scientific review and technical writing for the manual was by Dr. Karen Milman, a resident from Johns Hopkins University.

## **The Alcohol Screening and Brief Negotiated Intervention Program**

Injury is the number one cause of death for people ages 15 to 44 and, in the Native American and Alaskan Native populations, motor vehicle collisions are the leading cause of injury death, twice the rate of the rest of the U.S. population.<sup>3</sup> Across all other racial and ethnic groups, Native Americans and Alaskan Natives have the highest percentage of motor vehicle collisions related to alcohol.<sup>4</sup> Trauma and alcohol-related death and disability in the Native American and Alaskan Native population have reached immense proportions, with enormous personal, family and community consequences. The Indian Health Service is working to provide leadership to expand practices for trauma control both by improving Trauma and Emergency Medical Services (EMS) Systems and through increasing injury prevention methods. The purpose of this manual is to introduce a new approach of “targeted” injury prevention technology into acute care settings with the Alcohol Screening and Brief Intervention (ASBI) program.

### **The Current Indian Health Service/Tribal Trauma and EMS System**

Throughout the United States, considerable progress has been made in the utilization of Trauma and EMS Systems concepts and operations, including the designation of Trauma Centers and the upgrading of trauma care capabilities in community hospitals. IHS and Tribal Trauma Care programs are patterned after and integrated into their respective regional trauma and EMS systems. As a result, obvious improvements in the quality of pre-hospital care, transportation, “protocol-driven” hospital resuscitation, definitive care, and transfer to regional trauma centers have occurred. Unfortunately, limitations in the IHS and Tribal Trauma Care and EMS systems remain, such as those due to shortages of professionals and lack of advanced equipment. Perhaps the largest of these disadvantages affecting the injured patient is the remoteness of many AI/AN healthcare sites because all trauma care is affected by time delay prior to resuscitation, stabilization and definite surgery. Current consensus thinking among the nation’s trauma surgeon community is that the existing trauma system is operating at a maximal level and that it is the nature of location and type of injury occurring that limits patient survival. As succinctly put by Dr. Ronald Maier in the September 2005 Journal of Trauma, “Improvements in care have not reduced the incidence of trauma-related deaths that occur at the scene (approximately 50%). These numbers will only change when prevention efforts are increased.”<sup>5</sup> This particular journal issue focused on the conference proceedings of multiple trauma associations as they discussed the issue of trauma and alcohol/drug misuse and how to control complications, mortality and recidivism. One conclusion from the conference was the next step for significant trauma care gains, the next trauma frontier, is the field of injury prevention.

### **An Ounce of Prevention?**

Not unlike Trauma Centers in the rest of the United States, in the Indian Health Service/Tribal Trauma Care System, the typical patient tends to be a young, 18-35 year

old, male, alcohol misusing but not dependent drinker, who likely has not made the connection between his alcohol consumption and present injury. He is at high risk of repeating the alcohol-injury event and killing or harming himself or others as the events escalate. In fact, evaluation of alcohol-related injuries seen across acute care settings reveals that these are not one-time events but tend to be a pattern of recurring injury. One critical study showed that patients intoxicated on admission to a trauma center were two and a half times more likely to be readmitted for a second injury than those who were sober.<sup>6</sup> In addition, the National Highway Traffic Safety Administration reports that fatally injured American Indians have the highest percentage of previous DWI and license suspensions compared to all other groups.<sup>3</sup> Overall, studies demonstrate that “compared with other trauma patients, patients who test positive for alcohol or other drugs at the time of admission to a trauma center are more likely to die from a subsequent injury,” a finding “most apparent for trauma patients who are younger than 45 years of age.”<sup>7</sup> Specifically in the IHS setting, analysis of six years of records from the Billings Area Health Service showed that 38% of people who died due to alcohol-related injury had been seen in the health care system for a previous alcohol-related injury within six months prior to death.<sup>8</sup>

### Striking Statistics

- **25-55% test positive for alcohol in the Trauma Center or Emergency Department**
- **25-50% have a diagnosable “Alcohol Use” problem**
- **The above patients are 3.5 times more likely to be re -admitted for another trauma episode**
- **Death from repeat trauma is 6 times greater than for the general population**

—Carl Soderstrom MD, FACS<sup>9</sup>

This tragically high number of repeat visits illustrates the opportunity for prevention. Each presentation of a patient with an alcohol-related injury to a medical provider offers a potential for divergence in a patient’s path. Developed in high volume trauma centers and busy emergency facilities, ASBI capitalizes on this chance to intervene in the alcohol-injury cycle. By providing a positive environment and empathetic communication during Alcohol Screening (AS) the health care provider connects with the patient and is then able to progress through a pre-scripted Brief Motivational Interview (BI). Most patients who are targeted by ASBI have never received alcohol screening or counseling, as they rightfully consider themselves to be neither alcoholics nor in need of counseling. Yet they are in need of an intervention. ASBI has demonstrated meaningful effects of decreased substance use and repeat injuries in young, non-dependent hazardous alcohol users.

## **IHS ASBI PROGRAM GOAL**

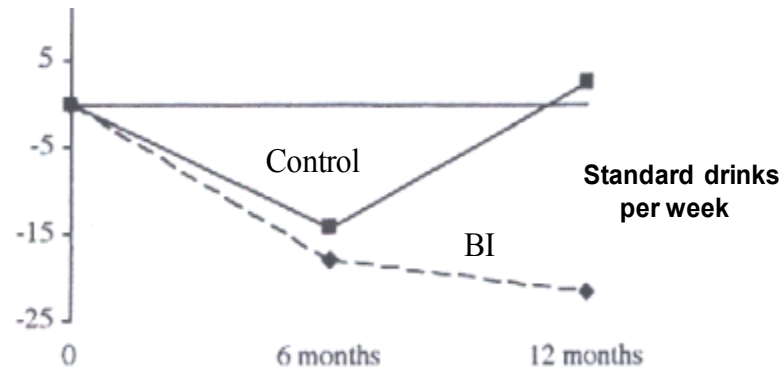
***“ALCOHOL SCREENING AND A BRIEF NEGOTIATED INTERVIEW, DURING THE TEACHABLE MOMENT, AFTER INJURY, CAN BE EFFECTIVE IN REDUCING RE-INJURIES (RECIDIVISM) UP TO 50% FOR SEVERAL YEARS”***

---David Boyd MDCM, FACS<sup>10</sup>

### **ASBI, Worth a Pound of Cure**

There are numerous studies demonstrating the reduction of both alcohol consumption and alcohol-related injuries after receiving Alcohol Screenings and Brief Negotiated Interviews in a variety of settings. Due to difficulty of execution, there are the fewest number of trials in trauma centers and emergency department settings. In a randomized controlled trial of ASBI in young adults seen for alcohol-related injuries in an emergency department, at a follow-up point of six months, Monti et al. demonstrated a 32% reduction in drinking and driving along with half the occurrence of alcohol-related injuries in the patients who received ASBI compared to the standard care group. These young adults also had significantly fewer traffic violations and alcohol-related social problems.<sup>11</sup> At twelve months, another trial showed a reduction in alcohol intake by four drinks per week as well as a 47% reduction in repeat injuries, which lasted up to several years.<sup>12</sup> Figure 1 demonstrates the reduction in alcohol consumption in this trial. Traffic problems were also reviewed in a randomized control study led by Schermer, who followed participants receiving a motivational interview in the emergency department for three years. This study revealed that there were significantly lower rates of DUI arrests in people who received ASBI than in those who did not.<sup>13</sup> ASBI offered in the trauma or emergency department setting appears to decrease alcohol consumption and alcohol-related injuries.

**Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence**  
 Gentilello LM (Dunn CW) et al: Ann Surg 1999;230:473 -483



**Figure 1. Large randomized controlled trial reveals that alcohol consumption reduces in both groups at six months but remains reduced in the Brief Intervention group whereas the control group returns to pre-injury alcohol consumption levels at one year.<sup>12</sup>**

ASBI studies in primary care settings consistently shows reductions in alcohol consumption. A meta-analysis of the literature with pooled outcome results found drinkers who received a brief intervention to be twice as likely to decrease drinking as those who did not receive the intervention.<sup>14</sup> A study in primary care centers in seven countries demonstrated that men who received ASBI reduced their drinking intensity by 15% and significantly more than those who did not.<sup>15</sup> Moreover, in other trials, these results have been demonstrated to last up to four years.<sup>16</sup>

Reductions in alcohol consumption indicate an alteration in behavior, which also suggests the potential for changes in other risky behaviors such as those predisposing a person to injury. Across a variety of settings, it is clear that ASBI significantly reduces alcohol consumption.<sup>15, 17-20</sup> Although not all studies have evaluated the effect of Brief Interventions on injury reductions, the trend is clearly implicated. During the four year follow-up of young adults in a primary care based randomized clinical trial, those receiving the brief intervention not only significantly reduced their drinking but also had significantly fewer emergency department visits, motor vehicle crashes, motor vehicle events and arrests for controlled substances or liquor violations than those who did not receive the intervention.<sup>21</sup> In addition, the Cochrane Library's Systematic Review found that brief counseling interventions reduced the relative risk of injury death by 35%, although this reduction was not statistically significant.<sup>22</sup> Furthermore, if alcohol is the attributable cause in up to 45% of injuries, then it follows that reducing alcohol consumption will reduce the frequency of injuries.<sup>23</sup>

## **Implementation: Championing a New Paradigm**

The introduction of ASBI into acute care settings throughout the IHS/Tribal Health System's acute care settings is expected to reduce recidivism in patients with alcohol-related injuries. The plan is to introduce ASBI to all hospitals in 2007 and in all Primary Care and Behavioral Health clinics in 2008; this represents a system-wide implementation policy. The ASBI program is consistent with former IHS Director Charles Grim's Health Initiatives to decrease health disparities in behavioral health, chronic diseases, and health promotion/disease prevention.<sup>1</sup> Implementation is also fully supported not only by the IHS Director and Headquarters but also by Area Office Chief Medical Officers and Behavioral Health Consultants. During 2007, there were five ASBI train-the-trainer conferences, several hospital service unit train-the-trainer sessions, and four national ASBI introductory presentations, resulting in the introduction of ASBI to over 500 IHS professionals. There were neither negative reviews nor negative responses to the program. ASBI was found to be consistent with current IHS clinical practices and treatment methodologies.

### **Strategic Approach of ASBI**

- **A Targeted Injury Control Initiative**
- **Alcohol Screening in Acute Care Settings: Trauma, ED and Primary Care Clinics**
- **Utilizes Multiple Providers**
- **Low Cost Implementation**
- **Cost Effective Intervention**
- **Offers Universal Screening of Other Substance Abuse and "Injurious" Behaviors**

In addition, Alcohol Screening and Brief Intervention has been endorsed both by the Society for Academic Emergency Medicine with an "alpha rating" for use in the Emergency Department<sup>24,25</sup> as well as by the United States Preventive Services Task Force, who find good evidence for use in primary care settings.<sup>26,27</sup> The planned use of ASBI in the IHS-Tribal settings is consistent with other government, professional screening and intervention activities such as The Substance Abuse and Mental Health Services Administration's similar Screening, Brief Intervention, Referral and Treatment Program (SBIRT)<sup>28</sup>; furthermore, the American College of Surgeon's Committee on Trauma endorses SBIRT and works cooperatively with IHS ASBI program on several levels.

It is the belief that all IHS and Tribal facilities can implement the program now. The prime issue will be the identification of local ASBI "Champions" to accomplish it. The program is applicable in a variety of settings from emergency departments to behavioral health clinics and can utilize a variety of health care providers from

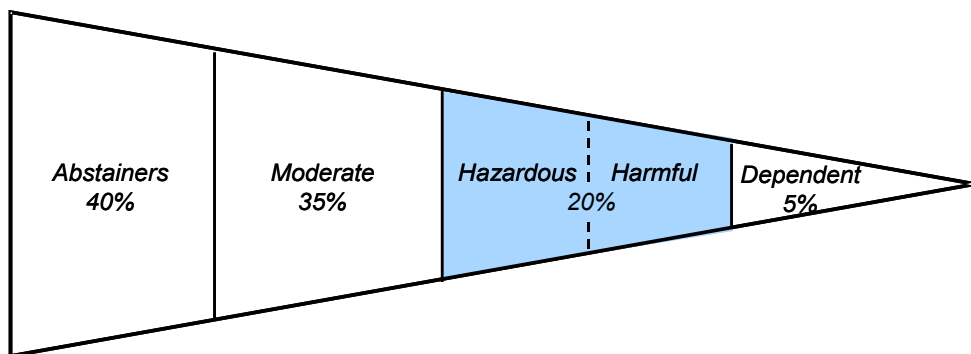
physicians to nurses, social workers and community health educators. Local implementation will require individual skill, creativity and cultural understanding. A new outlook may be required, as often health care providers have developed negative stereotypes and/or attitudes towards the alcohol-using trauma patient and will need to be encouraged towards creating a more optimistic environment and positive interactions with these potentially challenging patients. Application of the program should follow the ASBI methodology described in the literature and outlined in this manual. It is understood and expected that each healthcare setting will maintain the key components of the program, such as utilizing the AUDIT-C for screening and the Yale BNI, but adapt to their own unique strengths and resources. As with the IHS diabetes program, IHS is in the position to lead the path in models of care. When fully implemented, the ASBI program will be the largest, targeted alcohol-injury intervention to date.

### A Targeted Approach: Alcohol Screening

The ASBI program is targeted at a specific subset of injured people who present for medical care: The Hazardous or Harmful Drinker. Screening, with a tool such as AUDIT-C will reveal who fits into this category because it may not be evident based on clinical presentation alone.

Alcohol use occurs on a continuum, ranging from people who abstain from alcohol altogether or drink only on rare occasions to those who are physical dependent or have severe alcohol-related problems. This continuum is shown in Figure 2 and a detailed description of each category along the continuum is provided in Table 1. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) provides guidelines that state men should not consume more than fourteen alcoholic beverages in a given week or more than four in a given day and women should not consume more than seven alcoholic beverages in a given week or three drinks in a given day.<sup>29</sup> Nonetheless, it is estimated that 20% of the U.S. population consumes over these guidelines and therefore falls into the categories of Hazardous or Harmful Drinker.<sup>29-31</sup>

**Figure 2. The Spectrum of Alcohol Consumption by User Type. Categories are based on NIAAA description.**<sup>29-31</sup>





**Table 1. Types of Drinkers**<sup>29-31</sup>

Category of Drinker	Description
Abstainer	Drinks no alcohol
Moderate	Drinks within NIAAA guidelines, alcohol use does not affect health or result in problems
Hazardous/At Risk	Drinks at greater than NIAAA guidelines and alcohol use puts them at risk for injury, illness or other social problems
Harmful/Problem	Currently experiencing problems (medical and/or social) related to alcohol use and has a high likelihood of drinking greater than NIAAA guidelines
Dependent	Drinking has lead to physical dependence (i.e. withdraw symptoms) and/or severe problems. Meets criteria for dependence based on assessment criteria such as DSM-IV

In the U.S. heavy alcohol consumption appears to peak in young adulthood. In the 2006 National Survey on Drug Use and Health (NSDUH), current alcohol use was the highest in people aged 21-25, as was binge drinking, referring to the consumption of more than five alcoholic beverages in a single occasion.<sup>32</sup> Overall, 42% of young adults aged 18-25 surveyed reported episodes of binge drinking in the previous thirty days. Moreover, not only was binge-drinking reported in 31% of American Indians of all ages, but also that number was consistent in adolescents aged 12 to 20.<sup>32</sup> These statistics place the percentage of adolescent American Indians who are binge drinkers as the highest across all ethnic and racial groups. Given this information, it is expected there will be a high number of young adults presenting to the IHS clinics in the Hazardous or Harmful Drinker categories.

### **The ASBI TARGET Patient**

- **Acute Injury initiated medical encounter**
- **Clinical Assessment**
- **Injury Related to Risky Behavior**
- **Risky Behavior has an Alcohol Basis**
- **Not a Diagnosis on “Alcoholism”**
- **Not an Assessment of “Intoxication.”**
- **Blood Alcohol (BAC) Not Required**

## **Addressing the Prevention Paradox**

In the U.S., it is estimated that for every one dependent drinker, there are more than six hazardous or harmful drinkers.<sup>33</sup> Even so, most alcohol programs focus on the dependent drinker, the “alcoholic.” The assumption has been that we should focus our efforts on the patients with the most severe problems. Although this might make sense on an individual level, on a population level, a different picture emerges. As Gregory Rose explains, the concept of the Prevention Paradox describes the situation in which “a large number of people at a small risk may give rise to more cases of disease than the small number who are at a high risk.”<sup>34</sup> It is true that the average Hazardous and Harmful Drinker has a lower risk of injury and less severe alcohol-related problems than the average Dependent Drinkers. However, the situation changes when we look at the number of alcohol-related problems in each group. Because there are so few Dependent drinkers and there are so many more Hazardous and Harmful Drinkers, this latter group actually accounts for a majority of alcohol-related problems. Therefore, even if we were able to “cure” 100% of Dependent Drinkers, we would still not have addressed the biggest part of society’s “alcohol problem.”

A study in emergency departments in Boone County, Missouri evaluated this concept by calculating the “population attributable fraction” associated with drinking before an injury. It calculated how many alcohol-related injuries occurred in each category of drinkers. The results showed that “alcohol-related problems in a population come more from moderate drinkers than from heavy drinkers because there are so many more moderate drinkers.”<sup>35</sup>

It follows that we can maximize the impact of an intervention, by focusing on the part of the population that has most problems. There is another advantage to this strategy: patients with less severe alcohol problems are more likely to get better because as individuals they have fewer barriers to overcome to make changes in their lives.<sup>36</sup> Screening young, injured patients to identify Hazardous and Harmful Drinkers will have the largest impact, resulting in the greatest decrease of alcohol-related injuries.

## **The Teachable Moment: Brief Negotiated Intervention**

The event of an injury that brings a young person to medical attention creates a “teachable moment” during which the person is motivated to re-evaluate his or her actions in connection with recent events. Performance of ASBI in the acute care setting takes advantage of the short window of opportunity to ensure the Brief Negotiated Intervention coincides with the natural tendency for self-assessment that is the “teachable moment,” thereby maximizing its effectiveness.<sup>37</sup> The exact time frame for maximum impact is unknown; however, it is thought ASBI should be provided prior to discharge from the acute care setting or at least within one week of the visit.

Over just a few minutes, the Brief Negotiated Interview compassionately guides patients to make the association between their hazardous or harmful drinking and their injury as well as assisting them in the decision to reduce risky alcohol consumption. Using a pre-set framework, such as the Yale Brief Negotiated Intervention Training Manual,<sup>30</sup> a healthcare provider offers feedback regarding the patient's drinking habits, the injury event, and national drinking norms; enhances motivation via assessment of the patient's readiness to change; and negotiates a patient-oriented drinking behavior goal.

### The Four Key Steps of the Yale Brief Negotiated Interview

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- 1. Raise The Subject**
- 2. Provide Feedback**
- 3. Enhance Motivation**
- 4. Negotiate And Advise**

A key philosophy in the Brief Negotiated Interview is that change is a process, adhering to Prochaska and DiClemente's Transtheoretical Model. This model asserts there are five major stages of change: pre-contemplation, contemplation, preparation, action, and maintenance, each with unique characteristics and obstacles. Interventions should therefore be targeted to an individual's particular stage.<sup>38</sup> Although a successful Brief Negotiated Intervention results in a decrease in alcohol consumption and risk behavior in a patient, inspiring such a patient to transition to the next stage of change and closer to this ideal is also considered a positive outcome. ASBI is not a one-size fits all program; providers must meet the patient at his or her level of readiness, thus allowing for more open discussion about individual motivators and hindrances to behavioral change.

A number of studies have investigated general motivators for change in patients with alcohol-related injuries seen in emergency departments. A survey of minor-injury patients who tested positive for alcohol revealed that how aversive the injury was and perception of degree of alcohol involvement in the injury-event were both positively associated ( $p < 0.008$ ) with motivation to change. Negative consequences attributed to drinking prior to injury strengthened this association.<sup>39</sup> Other studies have reiterated these results, emphasizing the effect of injury severity and the number of anticipated consequences on a person's motivation to change.<sup>40</sup> Astute health care providers will recognize each individual's motivators to change along with their readiness to change and use them as stimuli for thought and incentive to reduce risk. The Brief Negotiated Interview concludes with the provider reviewing the many potential behavioral options and assisting the patient in determining a future goal. Together they work out a written drinking agreement.

Implementation studies to evaluate the feasibility of ASBI in emergency and trauma settings have demonstrated high acceptance by patients. In an implementation evaluation of a busy trauma center in which 26% of the patients were American Indians, survey results indicated that most American Indian patients found it highly acceptable for a medical provider to discuss alcohol use with them. They expressed even greater interest in discussing their own individual alcohol use.<sup>50</sup> This data suggests that ASBI would be a welcome intervention within the IHS-Tribal Health Care System. The ASBI concepts, principles and practices from busy trauma Centers can be effectively transported to IHS and Tribal hospitals and clinics. This is commonly done in everyday and in all medical fields.

### **ASBI INFORMATION TRANSFER**

**The operational concepts of the Opportunistic Intervention, Readiness for Change and the Teachable Moment are transferred from the Trauma Center not the Sophisticated Surgical Care.**

**Patients with lesser injuries have similar statistical risk for Recidivism and Death.**

**David R. Boyd MDCM, FACS**

#### **Boosters: Re-energize**

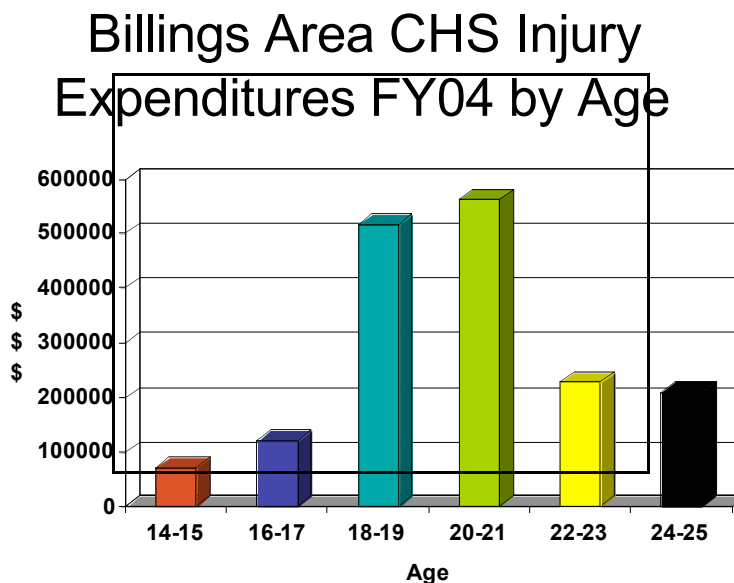
Trials of ASBI suggest that a follow-up, booster session can be very useful to reinforce the details for the patient. This session can take the form of a letter, phone-call or return visit. Gentilello's study, which demonstrated a 47% decrease in trauma center recidivism, sent a hand-written follow-up letter, summarizing the ASBI session to patients one month later.<sup>12</sup> Another trial utilized a telephone booster at one and three months, during which drinking habits were again assessed, initial goals were reviewed and progress on those goals was discussed.<sup>51</sup> Participants in this group had significantly lower levels of alcohol consumption one year later. Yet other study designs opted to have participants return to the clinic seven to ten days after the initial ASBI session to review the content of the initial session, discuss post-discharge experiences and offer the patient feedback as to how to strengthen the plan in light of new experiences.<sup>52, 53</sup> These repeat visits consistently rank as highly effective. The IHS ASBI program intends to utilize existing health-service unit structure to offer booster sessions as the patient comes for primary care and other follow-up visits as described in the following operational manual. Structure of the booster sessions will be locally determined but the chart will have an identifiable marker so that providers at subsequent health encounters will be able to identify patients who have received ASBI and be able to provide a booster discussion.

### A Penny Saved: Trauma and Contract Care Resources Salvaged

As with any new technology, when asked to add it to one's repertoire, two questions arise: How long will it take to perform? And how much does it cost? The answers are far simpler than one might expect. A feasibility study for implementing ASBI for young adults ages 18-39 in an emergency department showed mean times for screening and performing the intervention to be 4 and 14 minutes respectively.<sup>54</sup> This is expected to be on the high end of intervention time frames.

As ASBI requires no new physical technology, this is essentially a low-to-no-cost modality to implement. Estimates of costs vary, but they are immediately overwhelmed when compared to cost-savings. Problem drinkers have a substantially higher rate of injury-related medical care utilization than non-drinkers, with twice the rate of emergency department visits. One study reviewing health insurance claims revealed problem drinkers incur medical costs estimated at three times those of a non-drinker (RR 3.05,  $p < 0.001$ ).<sup>55</sup> Given these high costs of injury-related medical care, a reduction in recidivism results in an enormous cost savings. As an example of the potential trauma costs savings, for the fiscal year 2004, in just a small section of the population targeted by ASBI in the Billings Service Area, Trauma Contract Health Services (CHS) costs for patients 18-21 years of age were greater than one million dollars (Figure 3).<sup>56</sup>

Figure 3. Billings Service Area Fiscal Year 2004 Trauma Contract Health Services (CHS) expenditures by patient age.



In comparison, if ASBI were used, Gentilello estimates of cost savings of \$89 per patient screened and \$330 per patient intervened.<sup>57</sup> Another way to put this is a

savings of \$3.81 per health care dollar spent when examining the costs to implement versus the cost reduction found in the decrease of injuries. Similarly, Flemming found as similar cost benefit with a \$43,000 reduction in future health care cost for every \$10,000 invested.<sup>16</sup> He did not include the cost reductions as a result of fewer motor vehicle collisions or crime in his calculation. Moreover, none of these cost savings estimates account for the potential ability to recoup costs beginning in 2008 as ASBI will become billable via the newly developed CPT and HCPCS codes available. The bottom line is that ASBI is good for both patient care and the bottom line.

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## STEP BY STEP GUIDE FOR IMPLEMENTATION

### I. Step One: Champions Needed

- A. Find a Champion. There must be a Leader, an individual who has the inspiration and enthusiasm to take the initiative to start the ASBI program in the service unit or clinic.
1. This person can be a physician, nurse, administrator or other health provider. His or her background is not what matters, but rather, it is the dedication, passion, and ability to gather support and guide others that is critical.
  2. Leadership is an on-going process, not a one time spurt of energy or interest. The Champion should be committed to implementing ASBI and have the endurance to take the program from starting concept to a detailed and finished product.
- B. Form a Leadership Group/Committee. Developing a health service program is not a one person job. Implementing a program requires broad collaboration of all service unit personnel.
1. The first task of the Champion is to get others on-board. This is a group process. He or she needs to energize key personnel in the Emergency Department, Primary Care Clinics, Behavioral Health Clinics, and Surgery and Pediatric Divisions.
  2. Of these individuals, a select group should be chosen to work long-term on developing and implementing the ASBI Program. This group will conceptualize how the program can best fit the service unit or clinic given its specific resources.
- C. Perform a stakeholder analysis. This means take a look at anyone who has the power to affect the implementation of the program both positively and negatively and determine a plan to engage that person. Remember these stakeholders are health care providers, administrators, other staff members, other alcohol treatment providers, community members, patients, and others. The goal is to motivate as many people as possible to sponsor the program.
1. Identify and rally key supporters: In every organization and environment, there are certain key people who hold the power of persuasion and influence, without whose support, no program will succeed.
    - a. Identify which of these individuals support ASBI and enliven their enthusiasm. Unite them towards the goal of accomplishing the ASBI Program.
    - b. Visit them individually; bring them information about the program and how it will benefit them. Answer any questions they may have and listen to their suggestions.

- c. Make a specific “ask” for support; formally get their commitment. Do not be afraid to request a specific action, such as talking to a detractor about the program or making a public statement.
    - d. Do not forget to check in frequently with the supporters, providing them with updates on how the program implementation is proceeding and the successes along the way.
  - 2. Identify and minimize critical detractors: It is important to know who has the power to block the program, at what stage in program development this may occur, and what may be the cause of this interruption. The goal is to prevent or minimize any roadblocks.
    - a. Identify who objects to the program and potential reasons for their opposition. Brainstorm how to respond to these reasons in a manner that answers, diminishes or eliminates them.
    - b. Meet with these individuals to discuss their concerns and identify potential adjustments that can be made to the program to gain their support.
    - c. Reinforce to the individuals the background of the program and the multitude of benefits it will provide.
    - d. Attempt to minimize the power with which these people will object so that the program may proceed.
  - 3. Motivate the disinterested into action: Perhaps the largest number of people will simply show neither support nor objection to the program. The goal with this group is to sway them into action so that they become supporters and not detractors.
    - a. Talk up the benefits of the ASBI Program to everyone. Educate all personnel on the magnitude of the alcohol-injury problem and the effect that this program could have.
    - b. Get community support. Go outside the health care system to garner enthusiasm and interest in the program.
- D. Present the program and process for implementation to the medical staff. Authorization to proceed with full approval by the medical leadership and administration provides the backbone for the program.
  - 1. Have a meeting with full staff, present the program, explain the process that will need to occur, and get full empowerment to implement the program.
  - 2. Discuss with medical staff the complex issues involving implementing a program that focuses on the needs of the alcohol-misusing patient such as addressing the attitudes and beliefs that health care providers might have towards this population.
    - a. Suggest that this may require the difficult step of overhauling status quo as many providers may not recognize the target

population of this program is not the Dependent Drinker but rather the At-risk Hazardous/Harmful drinker, a different population than they are used to thinking about in regards to alcohol.

- b. Remind them that for the program to be successful this must be a full fledged effort.

## II. **Step Two: Create a Time Line**

- A. Outline a time frame for implementation of each stage of the ASBI Program. Successful deployment of any new process requires both big picture planning and managing the details. By breaking the project into smaller tasks, it becomes more achievable. The IHS-Tribal ASBI Program can be initiated almost immediately in all service units; however, to be successful it must be well organized and have full staff support
  1. Implementation is never trouble free. Corrections can be made along the way.
  2. Consideration can be given to staged or incremental implementation.
- B. Stick to these Deadlines. Staying on target for smaller objectives gives a sense of accomplishment to supporters and demonstrates effectiveness to detractors. Small cycles of change that build on each other are often more effective than one major push. It will build momentum and may even attract manpower.
- C. Remember other potential applications. The technique of screening and brief negotiated interviewing will prove invaluable and application to other agents of abuse and “dys-behaviors” will evolve. Allow flexibility in program design for future changes but do not try to force too much at once.
- D. Sell the goals. Enthusiasm is contagious!

## III. **Step Three: Determine the Alcohol Screening Process**

- A. Determine Where and When ASBI is to be offered. The goal for the IHS-Tribal ASBI program is initial introduction into Emergency Departments and Acute Care Settings. The program will later be expanded into all Primary Care and Behavioral Health Clinics.
  1. All injured patients between the ages of 18-35 should be screened. Because such a large proportion of trauma injuries involve alcohol, the IHS-Tribal ASBI Program believes that all injured patients in this age group need to be screened.
  2. Exactly what physical location within the Emergency Department or Acute Care Setting and at what time during the clinical

encounter screening occurs should be determined by the leadership group based on the individual nature of the service unit.

3. Screening should be performed in a clinically appropriate manner with assured confidentiality.

B. Decide who will provide Alcohol Screening.

1. Alcohol Screening can be performed by any trained medical provider. It can be offered by doctors, nurses, other allied health providers, trained health educators or others.
2. The decision as to who will perform screening should be guided by time availability, knowledge and experience, willingness to perform, understanding of change, and interpersonal skills.

C. Choose how Alcohol Screening is to be performed. Upon initiating screening, it is recommended that the health care provider offer an explanation to the patient regarding the content of the upcoming questions and that they are asked of all injured patients.

1. The leadership group may wish to settle on a standardized introductory statement to screening that all providers are required to use.
2. The following are two suggested introductions from the World Health Organization:
  - a. "Now I am going to ask you some questions about your use of alcoholic beverages during the past year. Because alcohol use can affect many areas of health (and may interfere with certain medications), it is important for us to know how much you usually drink and whether you have experienced any problems with your drinking. Please try to be as honest and accurate as you can be."<sup>1</sup>
  - b. "As part of our health service, it is important to examine lifestyle issues likely to affect the health of our patients. This information will assist in giving you the best treatment and highest possible standard of care. Therefore, we ask that you complete this questionnaire that asks about your use of alcoholic beverages during the past year. Please answer as accurately and honestly as possible. Your health worker will discuss this issue with you. All information will be treated in strict confidence."<sup>1</sup>
3. If a provider, other than the one screening, is to perform the Brief Negotiated Interview, it will be useful to explain to patients that an additional provider may be speaking to them.

D. Select the method for Alcohol Screening. For the IHS-Tribal ASBI Program, the **highly** advised alcohol screening method is the AUDIT-C. It is a brief, three question screening tool that has been demonstrated to

have high specificity and sensitivity in identifying patients with hazardous or harmful drinking patterns.<sup>2,3</sup> The AUDIT-C can be offered in either written or verbal format.

1. Health care providers performing the AUDIT-C should be given pocket cue cards with the screening tool printed on them to help assist them.
2. It is important for providers to clarify what is meant by a standard drink: one 12-oz.can of beer, one 5-oz.glass of wine, one shot of spirits (1.5oz). A picture diagram is provided in Appendix C to demonstrate.

E. Teach how the AUDIT-C is to be Scored.

1. If a woman's score is  $\geq 4$  or a man's score is  $\geq 5$  than the AUDIT-C is considered positive for hazardous drinking and the patient should receive a Brief Negotiated Interview.
2. If any patient's score is greater than 8, that person should receive both a Brief Negotiated Interview and a referral to treatment.
3. Patient's whose scores are below these levels should receive very brief feedback about the results of their screening tests that reminds them to continue to monitor their drinking levels to remain at low-risk.
4. Additional information regarding scoring is provided in Appendix B.
5. It is important to remember that not all patients who have alcohol misuse problems will present intoxicated; for this, and other reasons described, blood alcohol levels are NOT required for the IHS-Tribal ASBI program.

## AUDIT-C

1. How often do you have a drink containing alcohol?  
Never (0pts), Monthly or less (1pt), Two to four times a month(2 pts)  
Two to three times a week (3pts), Four times or more a week (4pts)
2. How many drinks containing alcohol do you have on a typical day when you are drinking?  
1-2 (0 pts), 3 -4 (1pts), 5 -6 (2pts), 7 -9 (3pts), >10 (4pts)
3. How often do you have six or more drinks on one occasion?  
Never (0pts), Less than monthly (1pt), Monthly (2pts), Weekly(3pts),  
Daily or almost daily (4 pts)

SCORE  $\geq 4$  for women or  $\geq 5$  for men indicates at -risk drinking

- F. Formalize the required documentation for Alcohol Screening. Keeping a record that Alcohol Screening has occurred is a critical step in the ASBI program because it both allows for coordination of follow-up, so that the patient can proceed to the Brief Negotiated Interview and receive appropriate medical care, and it assists with future evaluation of the ASBI program.
1. Alcohol screening and the results of screening can be captured using various codes available in the Resource and Patient Management System (RPMS) Electronic Health Record. See Appendix E for further details on the appropriate use these codes.
  2. If paper records are being used screening activities and screening results should be documented by providers in a consistent manner and Data Entry staff should be trained to recognize and enter these elements into RPMS.
  3. Proper documentation of screening activities and screening results will help ensure that Brief Negotiated Interviews are done when indicated.
  4. There are new CPT/HCPCS that allow for billing of Alcohol Screening and Brief Intervention; however they require that both components be documented in the clinical record. In addition, the duration of the screening and intervention must take at least 15 minutes. For details, see Appendix E.
  5. After removing patient identification information, documentation within the electronic health record may also be used via RPMS to evaluate the success of the program. See Appendix E.
  6. The leadership group may also wish to create other pathways for documentation that facilitate the progress of the patient through the ASBI Program.

#### **IV. Step Four: Determine the Process for the Brief Negotiated Interview**

- A. Ensure appropriate patients receive the Brief Negotiated Interview. Because the Brief Negotiated Interview may occur in a variety of settings, often distinct from the location at which the initial alcohol screening occurred, the leadership group must determine a process by which patients are clearly identified and offered the intervention.
1. The method chosen for documenting alcohol screening and those results should take into account the need for information transfer to providers who will be performing the Brief Negotiated Interview.
  2. The leadership group may need to develop a method to schedule patients for follow-up appointments and/or to track their progress in the program to ensure no attrition from the program.
  3. The patient must be alert at the time of the intervention.
- B. Determine Where and When the Brief Negotiated Interview will occur. At this time there are four recommended pathways for a patient after



presenting to an acute care setting with an alcohol-related injury and screening positive for hazardous or harmful alcohol use.

1. The patient screens positive and receives the Brief Negotiated Interview while still in the acute care setting of initial presentation.
2. The patient screens positive in the acute care setting and receives the Brief Negotiated Interview at a follow-up visit in the Primary Care or Surgical Clinic within **seven** days of the initial presentation.
3. The patient screens positive in the acute care setting and has been admitted to the hospital due to the injury. He receives the Brief Negotiated Interview while an inpatient, up to several days after admission but still prior to discharge from the hospital.
4. The patient screens positive in the acute care setting but is transferred to an outside trauma center due to the severity of injuries. In this pathway, the patient ideally will participate in a Brief Negotiated Interview while an inpatient at the outside trauma center; however, he will also be referred back to either the IHS-Tribal Primary Care or Behavioral Health Clinics immediately upon return to the area for a Brief Negotiated Interview and follow-up.

## Possible Paths for the ASBI Patient

- Presents for acute injury, then receives BI:
  - at the emergency department or primary care clinic visit
  - in the outpatient clinic follow -up for injury within 7 days
  - after hospital admission , on the service unit within several days but prior to discharge
  - if transferred to trauma center, at that location but with back referral to IHS -Tribal Primary Care or Behavioral Health for follow -up
- Primary Care and Behavioral Clinic Surveillance
- During “Universal Screening ” for other substances and injurious behaviors

C. Decide who should provide it? It will be necessary to institute a protocol for who will perform the Brief Negotiated Interview.

1. There may be a different provider type in each setting: Emergency Department, acute care visit at the Primary Care Clinic, Hospital Ward, follow-up visit to the Surgical/Primary Care Clinic, or referral to Behavioral Health Clinic.
2. As with alcohol screening, the same key characteristics of willingness to offer the intervention, excellent interpersonal skills,

nonjudgmental attitude, and understanding of the process of change are required in the provider.

- D. Explain the method to be used for the Brief Negotiated Interview. The IHS-Tribal ASBI program endorses adherence to the procedures outlined in the Yale University, School of Medicine, *Alcohol Screening and Brief Intervention Project: BNI Training Manual*<sup>4</sup> that is attached in Appendix A.
1. Provision of the Brief Negotiated Interview *must* occur at a clinically appropriate time and location.
  2. Both privacy and confidentiality *must* be assured.
  3. The four key steps to the Brief Negotiated Interview are: raise the subject, provide feedback, enhance motivation, and negotiate and advise.
  4. Because the Brief Negotiated Interview *may* entail assisting a patient in outlining a plan for change, providers need to be aware of local treatment options, support groups, traditional healers and other community resources which are available for patients. Leadership groups should make this information easily available for providers in case they should need it.
  5. It is recommended that providers have cue cards to assist them in offering the intervention and patient handouts readily available. See Appendix C.
- E. Formalize the required documentation for the Brief Negotiated Interview. As with alcohol screening, documentation that a Brief Negotiated Interview has occurred is vital to ensure quality health care treatment, continuity of care in the ASBI program, billing, and evaluation of the program itself.
1. As with Alcohol Screening, follow the recording method for the Electronic Health Record or paper chart to document that a Brief Negotiated Interview has been provided
  2. The leadership group will need to create additional documentation pathways to ensure transfer of more detailed information in the patient's record.
  3. Having a clear indication of a patient's status allows for better communication between health care providers and improves the quality of care offered. If it is clear in a patient's chart that he or she has received ASBI and what the patient's drinking goals are, future health care providers will be able to monitor the patient for alcohol-related problems and provide boosters as needed.
  4. Proper documentation will also allow for billing. Alcohol Screening and Brief Intervention has recently received approval for HCPCS codes that result in reimbursement from Medicaid and CPT codes for private insurance. See Appendix E for more details.

## V. Step Five: Set Up a Process for Booster Sessions

- A. Indicate who will receive booster sessions. Because research demonstrates greater effectiveness of ASBI in patients who receive a booster session, the IHS-Tribal ASBI program strongly recommends that all patients be given a booster.
1. The leadership group should establish a process to schedule outpatient follow-ups specifically for ASBI boosters for all patients receiving the intervention. Included in this procedure should be a method to encourage and monitor attendance at these appointments as well as the protocol regarding who will provide the booster.
  2. Patients returning from admission to a trauma center outside of the IHS-Tribal system will have a note in their charts and the above process should also be followed for those who screened positive.
    - a. Direct communication with the regional trauma center's chief medical officer will assist in this arrangement.
    - b. Dr. David Boyd and IHS Headquarters will also assist with this process. The notation will become required as part of the Discharge Planning and Reimbursement Contract for health facilities contracting with IHS.
- B. Create the process for a formal boosters session
1. A formal booster session should include a review of the patient's negotiated drinking goals, the patient's progress towards these goals since the previous visit, any challenges faced, and a motivational discussion as to what the patient plans to do for future change. Additional information regarding alcohol consumption may be offered. Some sessions could be a repeat of the entire ASBI intervention.
  2. At minimal, these formal booster sessions should occur at the first return post-injury medical visit as well as thirty days and six months after the initial alcohol-related injury that brought the patient to medical attention.
  3. It is critical that these sessions maintain the same compassionate approach towards the patient and his or her stage of change as the initial Brief Interview.
- C. Set up a system for subsequent booster sessions.
1. There should be an obvious notation in the chart to serve as a reminder for all health care providers that this patient has screened positive and received a Brief Negotiated Interview.
  2. As with smoking cessation, every subsequent medical encounter will thus turn into an opportunity for health care providers to discuss the patient's drinking patterns and health consequences.

All providers should perform boosters on an as-needed basis and review the patient's drinking goals.

## **VI. Step Six: Build Communication Pathways between Physical and Behavioral Health**

- A. Improve communication between health care divisions. The IHS-Tribal ASBI Program requires the cooperation and consultation across virtually every health care discipline.
1. Ensure Behavioral Health providers in the service unit fully understand the motivation, mission, and methods of the ASBI Program and support the procedures determined above.
  2. Create a system to communicate regularly between divisions. Input will be useful as the ASBI Program expands.
- B. Ensure connections for patient care. Because in many areas where the IHS-Tribal ASBI program is to be implemented, there are community based alcohol treatment programs which are separate from the Behavioral Health Clinics, it is critical that relationships between these entities are established.
1. Set up a system of communications between Behavioral Health Clinics and community resources as well as with other participants in the IHS-Tribal ASBI Program.
  2. Create linkages for referral to such community based alcohol treatment programs.
  3. Investigate other resources available including costs, availability, and services offered.

## **VII. Step Seven: Training**

- A. Decide who will be trained in ASBI. A variety of health care providers can perform ASBI and the decision as to who will offer it and in what setting will depend upon time, availability and each service unit's structure. Nonetheless, to both maximize support for the program and allow for flexibility, it is recommended that all primary care providers and support staff be trained in the procedure.
- B. Use all available ASBI training modalities.
1. Provide everyone with the Yale University, School of Medicine, *Alcohol Screening and Brief Intervention Project: BNI Training Manual*<sup>4</sup> that is attached in Appendix A of this manual. Offer screenings of or access to the corresponding DVD, *The Emergency Practitioner & The Unhealthy Drinker: Motivating Patients for Change*.<sup>5</sup>
  2. Schedule In-Service activities which allow providers to practice the skills they have learned after studying the manual and DVD.

Provide cue cards that assist with screening and interviewing to keep. See Appendix C.

3. Encourage practitioners to attend on-going in-service activities, the National IHS ASBI Train-the-Trainer and other IHS Primary Care Clinic and Behavioral Health Conferences that address ASBI. Also, provide access to on-line lectures and meetings.

C. Educate Medical Staff on the Electronic Health Record and ASBI.

1. Provide hands-on or webex based trainings demonstrating appropriate tracking and documentation procedures.
2. Orient new providers routinely.

D. Educate Medical Coders on the new CPT/HCPCS codes.

1. Providing the service of ASBI to a patient is considered separate and distinct from all other services provided during that same visit thus the effort should not be considered when selecting the level of Evaluation and Management service provided at that session.
2. Instead, an additional CPT code is added, recording the work effort that was offered. The codes are:
  - a. 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (i.e. AUDIT) and brief intervention (SBI) services; 15-30 minutes in duration
  - b. 99409 SBI service greater than 30 minutes in duration
  - c. If an intervention is not required based on the results of the screening, *then* the work effort ought to be included in selection of the appropriate Evaluation and Management service for the session.
3. In addition there are two CPT HCPC Codes:
  - a. H0049 Alcohol and/or Drug Screening
  - b. H0050 Alcohol and/or Drug Services, Brief Intervention, Per 15
4. CMS has created G-codes for reporting comparable services for Medicare FFS clients:
  - a. G0396 Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention services; 15-30 minutes
  - b. G0397 Assessment greater than 30 minutes

## VIII. Step Eight: Full Time Roll-Out

- A. Document the agreed upon procedures. After decisions are finalized, create a formal document for the service unit official ASBI Program Policy. Have it authorized and signed by the Chief Medical Officer, Service Unit Administrator and attendant staff members.
- B. Implement the program. When ready, get the program started. It's show-time! There are always minor adjustments that need to be made during

the first few weeks. The ASBI Champion should be prepared to provide significant on-site support for the first week.

## **IX. Step Nine: Evaluation and Modifications**

- A. Responsibility for the Program. The Champion will help lead the program and ensure functionality as a “chief sponsor” for the Service Unit’s Clinical Director. The Leadership Group may wish to appoint individuals responsibility for various aspects of the program; however, ultimate accountability follows the usual chain of authority.
  
- B. Set up a method to evaluate the process and make improvements. As with all new programs, it will be useful to assess various aspects along the way and make adjustments. Suggestion for items to monitor include:
  - 1. The progression of patients through the program from initial presentation during the acute injury to follow-up for booster sessions.
  - 2. The number of patients involved in the program through time.
  - 3. The quality of care provided and how well it is standardized.
  - 4. How well communications are functioning across the program.
  - 5. The effectiveness of record keeping: documentation of screening, results, provision of Brief Negotiated Interview.
  - 6. Whether or not billing is performed, and if so, is it done correctly?
  - 7. The satisfaction levels of patients and staff.
  
- C. Set up a method to evaluate the outcome of the program. The long-term success of the ASBI Program depends upon both quality of program implementation and ability to achieve the goal of decreasing alcohol misuse and related injuries. After the program becomes operational, evaluating movement towards goal becomes important. A system should be designed to correctly measure:
  - 1. Are there increases over time in the number of patients screened for alcohol misuse?
  - 2. Are there increases in the number of those who screen positive who receive an intervention?
  - 3. Other choices of items to evaluate should be added as desired.
  - 4. In addition, items for research to evaluate program effectiveness may include:
    - a. Are there decreases in alcohol consumption?
    - b. Are there decreases in alcohol-related injuries and illnesses?

## **X. Step Ten: Sharing Success**

- A. Publicize your program. Because Service Units throughout the IHS-Tribal Health System will be implementing the ASBI Program, we will want to hear about your success. Tell others what works well and what challenges you have faced. Attend local and national ASBI conferences.

- B. Assist Others. Again, other areas are undergoing similar processes to yours. Although each area is unique, we can benefit from the experience and success of each other. Talk about it.

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