NWX-OS-OGC-RKVL

Moderator: Marilyn Keefe
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Coordinator: Welcome and thank you for standing by. At this time your lines have been placed on listen only until we open for question and answers.

Please be advised today's conference is being recorded. If you have any objections you may disconnect at this time.

I would now like to turn today's conference over to Marilyn Keefe. Please go ahead.

Marilyn Keefe: Hi everyone. This is Marilyn Keefe. I'm the Deputy Assistant Secretary for Population Affairs here at HHS. Thanks so much for tuning into this call today.

We're delighted to have Joan Dilonardo with us today as our featured speaker on this important topic, which today is Screening Brief Intervention and Referral to Treatment for Substance Abuse.

Doctor Dilonardo is a nurse with more than 30 years of administrative policy, research and clinical experience in the mental health and substance abuse

treatment field, with a special focus on public sector - on the public sector and financing.

As an independent consultant her focus as continued to be on financing in the organization and services, most recently the integration of substance abuse services in other healthcare settings.

Doctor Dilonardo previously held leadership positions in the Substance Abuse and Mental Health Administration. And was instrumental in the implementation of the initial SBIRT program.

Doctor Dilonardo also has held faculty appointments at the University of Maryland School of Nursing and the Georgetown University Medical School.

Doctor Dilonardo received her PhD from the University of Maryland in 1997 with a focus on clients and families adaptation to mental and substance abuse disorders.

She has made numerous presentations and contributions to peer review, mental health and substance abuse literature.

I also wanted to mention that Sarah Wattenberg is also with us today. She's a Senior Advisor for Substance Abuse Policy in the Office of the Assistant Secretary for Health.

There's also quite a good turnout from the Office of Population Affairs Staff, the Deputy Director, (Steve Mesasaki), (Shenay Oakman), (Nancy Matony-Smith), (Christine Brazel), (David Johnson) and Vanessa White.

I think we're still trying to deal with a few technical difficulties. We've actually sent out the slides. Hopefully you were able to access those from via your email.

And we're hoping in the not to distance future those slides will actually be available online as well. But I think Doctor Dilonardo is just going to begin her presentation, and hopefully the slides will magically appear.

Joan Dilonardo: Hi, good afternoon everybody. I have to tell you that although I've done a lot of things, I have so far up until today avoided doing a Webinar. So I will expect...

Marilyn Keefe: And you know why now.

Joan Dilonardo: And I now understand why as I, you know, was called in the car to be told about those lovely corrupted files. But experts are working on fixing that. So hopefully that will work.

I also do want to say that I'm really thrilled to be here. OBGYN was my second love after mental health. So I did go into mental health. But OBGYN has always been an interest of mine.

And I'm really rusty on what you all are doing out there in the family planning clinics. So I'm looking forward to the end of this. Maybe we'll have some discussion, and I can learn some things from you all.

So I'm going to go ahead and start. And I'm not going to spend a lot of time on all of these slides because of course I made too many. But if there are particular ones that you want to go back to and talk about more, we can do that at the end if we have time for questions and discussions okay.

So basically SBIRT stands for Screening, you know, in the government we always have to have some little thing that we actually that we have to call things that make no sense. So SBIRT stands for screening, brief intervention and referral for treatment.

Although in its initial introduction into a variety of places we also focused a little bit on brief treatment. But I'm not going to talk about that today. So what I'm going to be talking about today is screening.

Screening is a preliminary procedure to see if you think somebody has a problem with drugs or alcohol or if they're at risk for developing a problem.

I'll also be talking a little bit about some pre-screening, shorter version questions and if you don't want to get into a whole screening procedure.

Brief intervention is something that you do with a patient who is at risk for problems with their substance abuse. And the purpose of brief intervention is to try to increase the patient's motivation to avoid substance use. Assist the patient in learning behavior change skills and setting some goals.

And this sounds like a lot to do. And when I go through it in the presentation you'll say oh my God, we could never do all this. But in actuality once you get these skills down pat, screening and brief intervention should take between five and seven minutes for most at risk patients at the most. So you're not talking about a whole other thing.

And referral to treatment are for patients who actually have an - qualify sort of for an abuse or addiction diagnosis who may need specialty treatment or some

kind of other longer-term treatment. So that's sort of what we're going to be talking about today.

Most of the time in the past when we have focused on substance abuse, we have focused on dependence and abuse. Those are the things that are in the diagnostic manual.

This means a patient already has symptoms of significant severity from their use alcohol or drugs. And that those symptoms are likely to be unremitting unless there's some intervention.

What screening and brief intervention really focuses on is a different group of patients. Patients who are using alcohol or other illicit substances in a way that can cause some harm. But they're not yet at a point which would qualify them for an actual diagnosis.

And hazardous use which means that they're using it in a way which causes them some elevated risk, there's not necessarily any harm yet.

And really the patients we want to target with screening and brief intervention are the patients with hazardous use who are not really creating a tremendous amount of harm to themselves, but will if something doesn't intervene.

So basically when you look at the population and you look at alcohol use. So let's take alcohol use first. We have the largest group of patients who are either non-users or they're very low-risk users. And I'll talk about those definitions in a minute okay.

But then we have about - we have at the other end of the spectrum about 6% of the population who either qualify for an abuse or dependence diagnosis. And then in between we have about 20% of patients who are at risk users.

For drug use we have about 14% of patients who are at risk users. So what we want to do here is we want to try to screen patients. And we want to try to identify the patients who are at risk before they perhaps progress to harmful use or to dependence.

So about 9% of everybody in the United States population uses some kind of illicit drug. Slightly more than 50% of the United States population drinks alcohol, 23% report at least one episode of binge drinking in the past year.

And about 7% report heavy drinking in the last 30 days. Heavy drinking is five or more drinks on five or more days in the last 30 days.

Okay, so why do we want to try and find these people? We want to try and find them before they get worse. But we also want to try and find them because we want to save some money and create a care system which is more efficient.

In the United States we've estimated that we have spent $181 billion for the economic productivity health and crime related costs related to illicit drugs. And 235 billion for the productivity health and crime related costs for alcohol.

Those costs don't take into account everything, even all illnesses. But they - and they also don't take into account all the costs related and associated with family disintegration, employment loss, (unintelligible) or domestic violence, or the emotional impact on patients and their families.

So there is something called a prevention paradox, which John Higgins-Biddle talks about a lot. He's one of the leading SBIRT experts. And what this, what we're talking about when we're talking about the prevention paradox is that we have a much larger group of patients who have a less severe problem then we do patients who are addicted or dependent.

And even though the problems of addicted and dependent patients may be more severe, because there are more patients who are at the earlier stage of just being at risk, they're really costing us a lot of money in driving under the influence.

People have more accidents even if they're blood level is up but they are not - they don't qualify for a DUI yet. But they still have more accidents. So there are lots of costs that come with these folks who are all at risk users.

Okay, I'm going to switch gears a little bit. I spent a little bit of time trying to find something about the prevalence of alcohol and drug use in patients in your family planning clinics. But I wasn't at all successful with that.

So what I did come up with are some statistics related to alcohol and drug use in STD clinics. Is the conference coordinator on the phone? Excuse me?

Coordinator: Yes I'm here ma'am.

Joan Dilonardo: We got the slides up, but they're horizontal. They're the wrong direction. Is there any chance that you can fix that from your end?

Coordinator: I can call out to our tech support group to see if there's any way they can fix that.

Joan Dilonardo: Okay great.

Coordinator: Okay and I'll do that behind the scenes.

Joan Dilonardo: Okay thanks. I appreciate that.

Coordinator: Thank you.

Joan Dilonardo: Okay. So otherwise we can all maybe lie down and I'll try to keep us all awake or something. I don't know if you guys slides are going in the wrong direction, but ours are.

Anyway, so one study looked at the prevalence of binge drinking in a clinic for the treatment of sexually transmitted diseases. Adolescences and young adults who were 15 to 24 go into this clinic, 39.6% of the woman reported an episode of binge drinking and 48% of men.

And 23.6% of folks in this clinic who were women also qualified for abuse or dependency diagnosis and 33% of men. So you see it's a pretty significant proportion of these patients.

Some other folks in an STD clinic sound very similar, our results, high rates of binge drinking among women, 30%, men, 42%. And for women there was a relationship between binge drinking, risky sexual behavior and gonorrhea.

So now some of these results are also mediated in high-risk taking women. The relationships remain, but they weren't as strong as just everybody, okay.

So again, why are we going to wait until these people qualify for diagnosis? Substance abuse is often treated as very different than other medical conditions.

We don't wait until patients develop diabetes at the end stage. We usually try to screen blood sugar and treat people earlier. We don't want until patients end up with congestive heart failure.

But we do wait in substance abuse. That's been the paradigm of care. Wait until people are really, seriously at the end and then treat them. It makes no sense whatsoever.

Okay, the other reason why it's really important to screen in other medical care settings is - I don't know if you can see this graph. But what this represents is that is all of the people who according to a drug use and health survey. These are all people who qualified for some level of drug or alcohol treatment okay.

They all, from reporting their use, they all qualified for treatment. However, only a few of them got treated. There were a few who got - who thought they needed treatment, but couldn't get it.

But the largest group, the red circle are the 84% of people who qualified for a diagnosis of a drug or alcohol problem. But who didn't think they needed treatment.

So if we wait for all these people who actually already need treatment to go to substance abuse treatment, they're never going to go. They don't think they need it. So trying to find them elsewhere is something that's really important to do.

So we need to be able to reach patients with a range of substance abuse conditions. And we need to be able to provide an appropriate level of care.

Unrecognized substance abuse can compromise a patient's self-care ability and lead to an increase in non-compliance and poor outcomes across a myriad of disorders.

Let me just, there are a couple of things with you from a couple - one study at least. So one study look at the association between the duration of illicit drug use and health conditions.

And they adjusted for all kinds of confounding variables that you would expect with relate to patient's health. But they did find positive association between the duration of marijuana misuse and anxiety, depression, sexually transmitted diseases, bronchitis and lung cancer. This isn't on your slide.

They also found a positive association between cocaine use and pancreatitis, between heroin use and hepatitis and TB, between hallucinogen use, tinnitus and sexually transmitted diseases and between inhalent use and depression, HIV/AIDS, TB, bronchitis, asthma, sinusitis and tinnitus. It's not on your slide. So if you want the reference I'll be glad to give it you.

So what this next graph tries to say is that for all of these types of users, for non-users and low-risk users, when you screen, you can provide those patients with education and information.

That will often lead you into a conversation about somebody they know, their husband or somebody else who has a drug or alcohol problem. So I'm just warning you.

For at risk users, you would want to provide them with feedback about their risk. And you want to provide a brief intervention. And then for people who have an abuse disorder or dependence disorder, you probably want to motivate them and refer them on to an appropriate treatment setting.

Okay so let me just talk a little bit about substance use and family planning. Twenty-five percent of sexually active 9th to 12th grade students reported using alcohol or drugs during their last sexual encounter. For males it was 31% and females 19%.

Adults age 18 to 30, with those folks there's a relationship between heavy drinking and having sex. Thirty-five percent of men were drinking heavily, five to eight drinks when having sex and 39% of women.

Substance use and unintended pregnancies may often occur within the same population. Fifty-five percent of teenagers say that while having sex they were drinking or using drugs. And that that - and teenagers report that that's a reason for unplanned teen pregnancies.

And the use of some illicit drugs can suppress menstruation. So women may not know if they're pregnant or able to get pregnant.

Crack cocaine or injecting drug use is also associated with inconsistent condom use among women who were both HIV positive and HIV negative. Actually the HIV positive women did better, were more compliant than the women who tested negative for HIV.

And there's a mixture in the studies about female substance users and how they do. Female substance users, one study, many of the studies say that they don't use contraception as much as non-substance abusing women.

But there were some reports, at least one, that said substance abusing women with HIV were more compliant with condom use.

So now obviously we wouldn't be talking about SBIRT if it was an ineffective treatment. But there are a number of studies that have shown that screening and brief intervention and referral to treatment are effective.

(Witlock) did a huge review for the presented as services task force. And reviewed more than 50 studies and said that the recipients of brief intervention, these are at risk folks, reduced their alcohol consumption an average of 13 to 34% when compared with controlled.

There are not as many studies or strong evidence for using screening and brief intervention with illicit drug use. And the findings are not universal. But they do show some promise.

For example, some people have found positive findings for reducing cocaine and heroin use after brief intervention, some people methamphetamine use and some people marijuana.

There was also another study that had a very strong design which looked at disabled the effect of brief intervention on disabled Medicaid patients. And those patients who received the brief intervention compared a comparison group had a reduction in per member, per month Medicaid costs of $542, which approached significance.

Okay, also with use there have been some findings looking at decreasing marijuana use and reporting fewer friends who use marijuana in use in underserved clinic populations.

So all this evidence has actually led to the OBGYN committees taking a position that obstetricians and gynecologists have an ethical obligation to learn. And use a protocol of universal screening questions, brief intervention and referral to treatment in order to provide patients with medical care that's state of the art comprehensive and effective.

Screening and brief intervention for alcohol use has also been endorsed by the US Preventative Services Task Force as high priority and cost effective. It's listed in the Top 5 of all prevention activities. And it's as effective as flu shots for the elderly and cholesterol reduction.

It's also now a required activity for Level 1-trauma centers. SBIRT has been successfully implemented in a wide variety of medical care and other settings. It's been implemented in primary care settings, trauma centers, emergency departments, urgent care centers, pharma in-patient, medical, surgical and other in-patient units.

Obstetrical outpatient services, sexually transmitted disease clinics, dental services, breast exam clinics, adolescent clinics, social service agencies and some in-school (big) health centers.

Okay so if you're still awake out there, and you're - I hope your slides are right up because ours are not yet. So, you know, that's a lot of - a long-winded way of saying look, substance use problems occur like every other disease in the world along a continuum of severity.

And we need an efficient treatment system which matches people to the most appropriate and lowest level of care needed at the lowest cost.

And the only way we're going to get there for alcohol and drug use problems is to improve identification in healthcare settings. If we don’t do that then I don't know that we're ever going to lick this problem.

Okay, I'm now going to move on, and I'm going to go through this quickly because I have a sense. I'm not trying to teach you how to do this in this Webinar.

I just want you to get a little better feel for what screening and brief intervention is actually like because one of the things people often ask is oh, you mean you really talk directly to patients. And how do the patients respond?

So I want to go through some of the kinds of things that I would say to patients. And then we'll, we can talk about it later.

Okay, I want to start first with what do we use as the guidelines for screening? What's unhealthy use or at risk use?

And I'm not going to be surprised if you all are surprised that these are the guidelines. Or if some of you think, especially for alcohol, they're too strict because that's often what people will say back.

But these guidelines were developed through a lot of research with - by the National Institute for Alcoholism and Alcohol Abuse. So they come from the experts. I give them to you for what they are.

So at risk drinking for me, it's more than 14 drinks a week or more than four drinks per occasion, because remember if you get into five drinks per occasion, you're starting to look like it's binge drinking.

For women, because women are smaller, they have less, typically less body weight, less place for the alcohol to go. The guidelines are significantly lower. For women it is seven drinks per week, or three drinks per occasion.

And for anybody whose over 65, it's the same as for women, seven drinks per week or three drinks per occasion. For pregnant women, we all know it's no drinks. And for illicit drug use in terms of a screening criterion it's any illicit drug use.

So we want to be asking these questions about drugs and alcohol in medical settings. Why? Because ask and answering questions is always normal and expected.

You got to the doctors, you get asked a lot of questions by a lot of people. Adding questions on alcohol and drug use within that context normalizes that conversation.

So you're not being asked by a policeman. You're not being asked by a teacher. You're not being asked by your spouse. You're being asked because your alcohol and drug use is related to your health, can affect your health. And your healthcare provider needs that information.

There's lots of ways to do this kind of self-report screening okay. You can do it using a written instrument. You can do it, have patients do it in the waiting room and hand it in before you see them.

It can be done on a computer. In fact, if you go online you'll find lots of, you can do lots of screening of yourself. There's lots of sites online that will provide you with alcohol and drug screening, especially alcohol.

And in many healthcare settings as the SBIRT projects developed, some of the folks combined drug and alcohol screening along with tobacco screening. Some of them also moved to the direction of including depression screening, exercise and diet so that they really started to move in the direction of general kind of screening.

So I'm not going to go through the screening tools. There's a ton of them. I will tell you where to go look at a list of them at the end of the presentation.

There are some one question pre-screen, says screens. They are screens. But they're pre-screens. So if you can't ask, if you feel like in your setting you can't ask two questions, NIDA has developed the one question screen for drug abuse. And NIAAA has developed a one-question screen for alcohol use.

They're not as good as some of the longer screens. But they're a lot better than nothing. So I'll go through those.

A variety of clinic staff can do this. In some of the SBIRT projects receptionists gave patients the screens. And they scored them and then put them on the chart for whoever was seeing the patient.

Sometimes the medical assistant did it. Sometimes nurses. But some physicians and nurses and other providers preferred to do the screens as part of the intake or the interview.

I just want to say good screens distinguish risk levels. But all SBIRT is not equal. And by that I mean you have to really ask these questions in a certain way.

At my emergency room in my local community hospital, here is how I get asked this question. The Joint Commission on Hospital Accreditation requires us to ask you do you use alcohol in a risky way, which is (unintelligible), not the question.

And, you know, most patients, I know who the Joint Commission is. Most patients won't. And what it clearly communicates to the triage nurse who's asking me this question, or communicates to me is that the triage nurse doesn't really think it's anything he or she needs to know.

So that kind of a screening procedure I think won't work. And patients won't respond to it. So you need to look at also how are you going to do this if you're going to do it?

It's tolerated very well by patients if patients - if it's asked in a sincere and helpful way. It actually scares me a little bit that there are people coming into our emergency room, our local emergency room who do have alcohol and drugs onboard. And the question is asked in a way that's very unlikely to elicit an honest response from the patient.

Okay, so one screening tool that actually has ten items and has been used internationally and validated with all kinds of populations of patients is called the audit.

There's a three-question version of the audit (see) which I'm not, I don't know if you got or not. But that's something you could certainly look at. The one

question screen for alcohol use is how many times in the past year have you had either five drinks for men or four for women or more in a day?

So if anybody says oh, I did that once. That's considered a positive screen if you want to use this okay.

And for drug use is how many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? Any drug use is in this context considered a positive screen.

Okay, because what you want to do then is you want to go on and probably learn a little bit more about how much this patient is using. And you want to really talk to them about healthy guidelines.

Okay, so after you do some kind of screening, what you're going to do with the patient is bring up the subject. And provide screening feedback.

So one thing that's helpful is to say to a patient, you know, I'd like to spend a few minutes with you talking about your alcohol and drug use and how it relates to your health. Is that okay?

Most patients will say yes. You do get an occasional patient who will say no, I don't want to talk about that. In which case you can say to the patient okay, well I see you're not ready to talk about it today.

But I hope maybe the next time we get together or the next time you're in we could have a little conversation about that because I'm concerned about how it's affecting your health. And you let it go okay.

Here are things you - you're using a technique known as motivational interviewing, which you may all be familiar with. But basically what you really want to do is you really want to let the patient be as much of the driver of this as possible.

You want to help patients understand the discrepancy between their behavior and their goals. You want to use personalized feedback. So you don't necessarily - you want to take their screening score, hang on.

And you want to go ahead and talk to them about their screening score. You want to use empathy. And you want to really see what they think they want to do about the problem.

So you're going to introduce the subject. Can we take a few minutes? I'd like to take a few minutes. Is that okay? You want to explain how their use of alcohol might relate to what their visit is about if you can see the connection.

You guys will have to tell me that for family planning. I mean one connection is maybe they're not so good at using their contraception if they have to use it at a time if it involves things that they use before sex. Then it's something they have to do. And they're drinking or using drugs.

So lots of places use some handout like this, which puts the guidelines and definitions of what's a drink in front of the patient. You say okay, here are the guidelines for healthy drinking.

From what I understand about your drinking, you're drinking more than three drinks. Or you're drinking more than four drinks per occasion. You're telling me lots of times you drink, you know, on Friday night you might have six drinks.

Okay, that's probably not something that we would consider good for your health. So now I'm going to segway for a minute. What do you do with patients who screen negative?

Patients who screen negative, it's really good to say to them, you know, we asked you to do this alcohol, this screening. And I just want to say you're really doing a good job with how you're using your alcohol.

You're only having two drinks an occasion. You're not drinking that much. It's a really good thing to continue because it's important for your health. So you want to provide feedback for all screens.

Okay, once a patient's at an unhealthy level of alcohol or drug use, you say here are the guidelines. So you were saying you drank how much? Where does that fall on this chart?

You want to help them talk about the pros and cons. What is it that alcohol does for you? What negatives? Do you ever have any negative experiences from your alcohol or drug use? Does your partner object to your alcohol or drug use? Are you more likely to use your alcohol or drugs in a particular situation?

And basically you can - if there's a connection to why the patient's visiting, you can help the patient make that connection. If they don't make that connection, you can try to make that connection for them.

A lot of people have trouble using protection when they're drinking or using drugs. Alcohol may make you make different decisions about your sexual - what you want to do sexually then if you weren't drinking.

So basically you really want to have a short conversation. I'm not talking about saying all of these things to one patient. I'm simply saying depending on where the patient is, you want to basically talk to them.

And then you want to say, well what do you think? The next thing, enhance their motivation. Do you think you could do something to change your drinking pattern? Where are you on a scale of 1 to 10 in terms of being motivated to change that? Do you think that's something you could consider changing?

Okay, if the patient says they're ready for change, anything more than 2 on a scale of 1 to 10 you can ask them if they're really drinking a lot. And you really want them to cut back a lot, why did you choose that number and not a lower one if you'd like to see them say that they're more motivated.

If the patient says they're not ready for change, just say well what would have to happen for you to be ready? What would make you ready?

So you then help the patient develop discrepancies between what they say they want to do. Yes, they'd like to be healthy. But not so much that they really want to cut down on their alcohol.

Or yes, they'd like - they wish they had said no to anal sex. But not enough - it doesn't happen enough that it's a problem. So you help the patient look at what they're doing. Develop the discrepancy and ask the patient to see what they could do about fixing that problem in themselves.

So you can encourage patients to name their own solutions, choose a course of action in how to do it. For the patient who is not ready to change, you can present the feedback and leave it alone.

Sometimes patients say they don't know. They have to think about it. You could say well, you know, you could think about it. And when you come back we could talk about it some more.

So you're going to reinforce what the patient says. So if the patient's drinking six drinks a week or, you know, let's say the patient's drinking, when he drinks he drinks six drinks on occasion.

And he says okay, I'll cut back to five. Yes, five is still binge drinking. But five is better than six right. And if the patient is drinking five and he goes to four.

So my point here is you don't have to fix this all in one fall swoop. The patient needs to change. Actually if the patient sets a goal like that and the patient does make it and is able to do that, the patient is much more likely to actually go beyond that and cut down.

And the next time you see the patient, the patient will be drinking three or four. So well it wasn't that hard to cut to five. So I actually got to four.

So, you know, this is not a (temper) and (union), stamp it all at all costs and go to zero. This is help the patient move incrementally to a more healthy pattern.

Sometimes people provide patients with written contracts like okay, you said you were drinking this much now. And you're going to, you know, you want to make a contract with yourself to cut down to five drinks.

Then the patient signs it. It's a contract with the pat - the patient has with themselves. And they take it out of the room. So practices, depending on their flow and how they see patients, they might schedule a follow up booster with the patient and say okay, well come in in a month and let's see how you're doing with this.

Or other focus on when they'll see the patient again and how they'll talk then about how the patient met the goal. Some people also provide follow up by telephone.

So let me briefly go to a referral to treatment. So obviously for patients who have more serious problems, treatment - a brief intervention may reduce their use some. But it's unlikely to provide enough treatment for all patients.

So those patients may need some additional services. They could either, you could either suggest they see their primary care physician and discuss this with their primary care physician.

Or they could speak with a social worker or go to some clinic that provides psychiatric services. Some places provide a discharge sheet of possible centers and program or information.

That's kind of important. I mean going to substance abuse treatment, what people have in their heads is they're going to go to some place. And they're going to get locked up. And, you know, with all these other people who are really more severely troubled than themselves.

And they don't want to do it. But in actuality most substance abuse treatment is outpatient. It's not in-patient. And people actually do quite well.

Well-developed programs try to do things like warm hand off. Or they try to do something like calling ahead and saying, you know, that this pa - I'm sending this patient over. He's coming to talk to you, just so the patient has some sense that they're expected or whatever.

Okay, again there are a tremendous number of training modules for learning to do screening and briefing intervention and motivational interviewing. There are tons of them on the Web.

Many of which are free. So I just wanted you to sort of get a flavor for this is screening. This is a brief intervention. In the emergency rooms where they do it with patients, really after people who are doing it get up to speed with what they're doing, typically they're not spending more than five to seven minutes with a patient around this content.

And they do it in between other things. So I just want to - it sounds like a much more long-winded process here than it actually is.

I wanted to talk for just a minute about reimbursement for SBIRT because that's always, you know, one of the big questions. So if we did this, it's going to take some time.

And if we did this how would we pay for it? So I want to just be clear that there are some codes, some billing codes that you can use to charge for SBIRT.

There are Medicaid codes for alcohol and drug screening and for alcohol - and alcohol or drug service brief intervention. But they are not turned on in all 50 states. You would need to check and make sure that those codes are included in your state plans.

Some states only pay for SBI, screening and brief intervention. And some states will pay for screening, brief intervention and referral to treatment. So you need to check in your own state and see what's - what will be paid for.

Now, obviously the whole issue of codes relates to a fee for service environment. There isn't an issue with doing SBIRT in any HMO. There isn't an issue with doing SBIRT in most managed care plans. In fact many of those would include that as a service.

Okay, and as we move in health reform to accountable care organizations, health homes and other forms of broadly integrated care, I would expect that given the cost savings that you see in the cost of medical care when you treat people who have substance use disorders and conditions.

That most of those plans over time will include screening and brief intervention and referral to treatment services.

There are also approved Medicare codes. They are alcohol or substance abuse structured screening and brief intervention services, 15 to 30 minutes. And alcohol and/or substance abuse structured screening and brief intervention services for greater than 30 minutes.

And there are also codes for commercial insurance CPT codes. So private insurers may also pay for SBIRT.

That's not to say because there are codes there's a river of money. The early studies that have been done looking at so how much are these codes being used show that some of them are being used some places but that there are some issues.

I learned more about billing in this process then I ever wanted to know. It's like when I gave my mother a nail dryer for Christmas one year. She said oh, I didn't know I wanted one of these. That's the same kind of response I had to all the things I learned about medical billing that I never really wanted to know.

So there are a thousand tiny little issues with any new code. From the fact that hospitals, you know, or healthcare systems already have their own existing software. And getting new codes into the software is not that easy.

And figuring out what to do if the insurer doesn't pay. Then the system typically bills the patient. So the question is do we want to be billing patients for this screening service?

Okay, there are also some issues in Medicaid in some states around same day billing for physical health and behavioral health services. HHS is aware of that and CMS is aware of that. And they are theoretically trying to work that out.

And they're obviously going to have to work it out if they're going to implement the new models of healthcare.

There are also issues about, excuse me, who performs the service. So obviously you need to meet the requirements of the payer in terms of who provides the services.

Now there are - there's a reimbursement manual that I put the Website, the Web directions to get to it developed by Wisconsin. They actually have done the most in the coding and billing and reimbursement end.

And I would suggest that you could look in there and at least it will give you a sense of some of the particular issues that you're likely to get into.

There are barriers other than reimbursement to SBIRT okay. And I didn't get into a whole long list of these. But understand that, you know, everybody has different sets of attitudes towards alcohol and drug use and alcohol and drug users.

A lot of times when we talk about using these self-report screens people will say well patients lie. I'm going to tell you yes, patients do lie sometimes. You can get however a really adequate screen if you do it correctly.

That's not to say there won't be - it won't be without error. But there's nothing that you do or anybody does in a practice that's totally without error. So I wouldn't go there saying just because there will be some error, I won't do it at all.

Some people still think that treatment isn't effective. So since treatment isn't effective, why would we want to know? That it takes too much time when in reality it's really not so much time.

The things that have - that we've seen in successful sites is people who believe that alcohol and drug use is a health issue. And that's it's an important health issue. And we'll champion that to other staff in the clinic is a really good predictor of who will be successful in implementing SBIRT.

You do however need to have good training in motivational interviewing and screening. You need a way to track how it's being delivered. And there's a lot of people out there who have gone from no SBIRT to implementing SBIRT.

So there's a lot of information on the Web and a lot of people to talk to about almost any implementation problem that comes up.

Okay, so before I stop I'm just going to say that I think as we move forward into whatever forms of healthcare we have in the future, I think it's clear to all of us that we need to be able to integrate substance use, mental health and physical health.

If we leave these things out in the corner, we're going to end up with bigger costs, less effective care. And it's silly to do it when we have some mechanism as we have in screening and brief intervention which has been so well researched. And proven to be so effective.

Okay so I'm not going to go through the last slides. I'll just tell you I gave you Websites for screening tools and for lots of other training modules. Some information on screening adolescents, particularly the American Academy of Pediatrics, even though there isn't enough scientific information for the preventive task force to recommend screening adolescents.

The Academy of Pediatrics has made that recommendation for pediatricians. And there's also all kinds of other places to get information.

Okay thanks for everybody staying awake, and if you were laying on your side trying to read the slides.

Marilyn Keefe: We appreciate you all being willing to contort yourselves on this incredibly important topic. Thanks so much for that terrific overview.

I think Sarah Wattenberg from the Office of the Assistant Secretary for Health would also like to add a few words.

Sarah Wattenberg: Yes. For those of you who don't know, I have been here at OS for a little more than a year working on the substance abuse portfolio. And I'm just, Marilyn thank you very much for hosting this call. Joan thank you for coming.

For those of you who don't know, I work with Joan at SAMHSA. She was one of my greatest bosses. And really just one of the smartest women I know. And she is, you know, the SBIRT person.

When I came into the government she, SBIRT was a blending initiative with National Institute of Health. And she was working out this whole protocol. So you received probably the best SBIRT presentation that exists.

Joan Dilonardo: Not really. That's okay.

Sarah Wattenberg: She lies. A woman of great humility, she lies. And I'm glad you got a little sense for her sense of humor. A couple of good jokes there today.

So I just want to add a few things. As you can - and I want to kind of give the broader context both in healthcare and for OS.

So as you can see, SBIRT is the standard of care. It is a long-standing standard of care. The uptake has been miserable. About three years ago when I was still at SAMHSA, we just did a little brief research into the CMS codes on SBIRT, just to see how many people across the nation were picking it up.

Yes, I thought it was a typo. There were approximately 56. And I said you mean like 5,600, 56,000, 56 what? No, it was 56 people in a year had billed against the SBIRT code.

So we knew we had a real problem. There's a big push in healthcare to move screening, brief intervention, referral to treatment forward for alcohol, other disorders, also for depression and for tobacco.

US (TS TF) have these as a B rated prevention strategy, which means that under ACA you - patients, and Joan raised this issue about billing patients. That patients will not be charged for the service, charged for a co-pay under the preventive services provision or any co-sharing cost sharing for this service.

But I do believe the, as a provider you would get reimbursed for it. And there are a number of different models that you can use, staffing models for implementing this.

Many of them, you know, sort of divide the labor among paraprofessionals and different professionals in the healthcare practice. Some of the models actually are revenue generating.

We heard in a recent White House conference that some people actually can fund an FTE and then some. So we have sort of ways and approaches of doing that.

Joan Dilonardo: That's Wisconsin.

Sarah Wattenberg: That's Wisconsin. They do a lot of the work in this area, Rich Brown. And we have, I've been working behind the scenes trying to see if we can bring technical assistance to you all through SAMHSA and some other mechanisms.

And I think for those of you who would really want to implement this, that we could get technical assistance available for you. I will just give you a heads up, this is the - a big priority for Doctor Koh, the Assistant Secretary for Health.

He would love to see uptake and implementation of this. But in large part he's concerned about making sure that we all are up to speed on what's going to be coming down just in terms of broader healthcare.

National Quality Forum is right as we speak looking for people to help staff some initiatives to move screening and brief intervention along. The innovation center of proposals that have gone out under the innovation center at CMS, we've received a number of proposals from people across the nation on SBIRT.

And we - those proposals will be demonstrating best practices that will likely come up with some new and innovative payment methodologies. Hopefully we'll see some proposals coming in from the accountable care organizations and some of the new healthcare models that Joan talked about.

So over the next few years I know that, you know, there may be some meaningful use measures for electronic health records that will be including some of the screening stuff.

And a number of the other NCQA has some alcohol measures. So you really are going to be seeing this in your oversight bodies more and more. So the

more quickly you can kind of get onboard with it, I think the better in terms of your own practices of course, but also in terms of your business processes.

And under the Medicaid expansion population, under the Affordable Care Act, I think you will be seeing a large group of uninsured people who all of our estimates indicate a large magnitude of those people are going to be at risk for these disorders. So it's important that you can address that as well.

So thank you. I'm so happy so many of you joined this today.

Marilyn Keefe: This was a really terrific turnout. We have a few minutes for questions, although we're almost out of time. So if any of you want to ask questions of either Joan or Sarah, by all means feel free to do so now.

Coordinator: Thank you. And on the phone lines, if you would like to ask a question, please press star 1 on your telephone keypad. Once again that's star 1 if you would like to ask a question.

And you will be prompted to record your name for proper registration. One moment for questions to populate.

Marilyn Keefe: Well I know we have one question about how folks can access the PowerPoint slides. I think they were sent out as an email to some people. But we'll make sure post those on the Office of Population Affairs Website. Any other questions?

Coordinator: We do have a question from (Kathy). Your line is open.

(Kathy Desarts): Hi. I'm not sure who this is too. But one of the things, this is (Kathy Desarts) from Region 1. And one of the issues that comes up here is the issue of people who actually do need treatment and want treatment.

And as most people know, treatment is not as readily available as we might hope. And actually seems to be coming less readily available, particularly for woman and for women with children.

And I wonder if there's anything being done to address that issue because I think it's the other end of this. I certainly see the value of the intervention you're describing.

But I think one of the reasons providers are sometimes reluctant is, as is the case with many screenings, is that if you find somebody who really need something and you can't get it for them, it's very frustrating for the provider and the client.

Joan Dilonardo: Yes I mean, this is Joan Dilonardo. I will say that that is a huge problem, a bigger problem in some areas than others. We are hoping a couple of things. We are hoping that as we get to parity for mental health and substance abuse that we will bring more providers sort of into the mix.

And the parity in terms of reimbursement may help some patients who cannot under the current parity - under the current payment structure afford treatment. But might be able to get to treatment if the co-pay wasn't 50%, but was 20%.

Also I think there's a companion initiative going on to try to increase the capacity for brief treatment for patients in medical settings. So the idea would be here that for some patients who have some problem and who either can't get into a specialty treatment or perhaps really don't need it.

That we could provide eventually and develop capacity for providing brief treatment for those patients in the actual medical settings that the patients normally use.

Now I would say that has been the most difficult nut to crack. And has been going the slowest. But yes, I mean I would also say to you that one thing that we do know from the SBIRT, all of the SBIRT sites is there wasn't - there were some patient who needed specialty treatment.

And certainly there were times when the local facilities were not available. But there also weren't a flood of patients. I mean it's not like people found so many people that the specialty sector was just flooded (unintelligible).

(Kathy Desarts): I mean I'm thinking about it more as, actually as a barrier for providers who are worried about those few clients and how do you - and how we can address that because clearly the intervention in and of itself is useful in raising awareness.

Sarah Wattenberg: This is Sarah. Yes, all of the SBIRT folks are very clear that the referral pipeline is a big part of a contributor to why primary care physicians are not picking this up.

And we're trying to work on that. We have a large - we have a big initiative that I'm chairing at the moment through our behavioral coordinating committee at HHS.

I'm trying to recruit and expand the workforce for behavioral health. And a big piece of that is trying to sort of figure out the credentialing and the career ladders to create a pipeline.

And maybe to kind of bring the Department of Labor into it to see if we can't help practices sort of hire people in who have the right skill set to help not just with this, but other kinds of screenings. And other sort of health promotion activities that are now being required under ACA and being promoted as good standards of care.

The other thing I would suggest is, you know, give your local provider association a call. You know, the Substance Abuse Provider Association that's their business.

They know who the local providers are. They probably know which ones are trying to diversify into sort of helping primary care practices who are trying to diversify by increasing their case mix where, you know, they can get Medicaid reimbursement for some people.

I would suggest that you call your county core service agency or your state. However it's organized in your region, and reach out to them. One thing that I'm always trying to push is, you know, getting counties involved in, especially because they're looking for a role now in terms of the substance abuse mental health field because as these services are moving to the private sector through parity.

And now is going to be largely more controlled through Medicaid and Medicare because that's where the funding is going to come from. The counties, the single state agencies for substance abuse and mental health are kind of looking for where do they need to be filling in the gaps.

Personally I think they would be the key people who could really serve as a local referral source.

Joan Dilonardo: And let me tell you one thing. Like for example in Chicago, there was really an issue. So they couldn't get anybody into treatment anywhere. They kept telling me that.

So what they did is they worked with the providers in the Chicago region. And they jointly staffed sort of a holding thing. So they identified patients.

And until those patients got to treatment, there was a group of people from the substance abuse side and from the clinic side who like tracked those patients, met with them, kept them motivated.

Kept them on the hook until there was an appropriate treatment slot. So, you know, you're not talking about an uncommon problem unfortunately.

Marilyn Keefe: I have a feeling we could go on for a whole lot longer. But why don't we take another question or two. And then I think we probably need to wrap up, anyone else?

Coordinator: We have no further questions on the phone lines.

Marilyn Keefe: That's terrific. Well thank you so much. Thank you again Joan for participating. This has been terrific. Sarah, thank you very much as well.

And thank all of you on the phone for participating. And yes we will be posting the slides on our Website. Thanks again.

Coordinator: This does conclude today's conference. We do thank you for your participation. You may now disconnect your lines.

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