Building Alcohol Intervention Options for NH:

SBIRT:
A National Perspective

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Main Topics

1. What’s the problem?

2. What is SBI RT?

3. How is policy changing?

4. Questions & Discussion
What’s the Problem?
Alcohol also . . .

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

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

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

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

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

“Honestly, Paula, I don’t know what I’d do without our daily keggers.”
Or More Unexpected
Who Causes Alcohol Harm?

- Small group with Dependence experience & cause the most harm--individually
- But there are far more Hazardous and Harmful users
- So together Hazardous & Harmful drinkers cause at least half of alcohol/drug harm
- Two ways—high-level regular use and occasions of intoxication leading to work, health, social, legal problems
What we don’t see can hurt!
Brief Intervention/Referral

- 4%

Brief Intervention

25%

No Intervention

70%

Alcohol Dependent

Harmful and Hazardous

Low-risk and Abstaining

Drinkers

Interventions

~ 4%

~ 25%

~ 70%

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Summary of the Problem

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

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

• Rough estimates of excessive use by setting:
  ✓ Primary Care—10-25%
  ✓ Ob-Gyn—10-20%
  ✓ Emergency—20-40%
  ✓ Trauma—40-60%

• Research shows providers cannot identify hazardous & harmful drinkers without screening

• So everyone should be screened annually

• Drinking patterns change over time
Screening for Alcohol Use

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

N = 35,257

Diet/Exercise
Smoking
Drinking

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Patient Sense of Importance

- Diet/Exercise
- Smoking
- Drinking

N = 35,033
Goals of Screening

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

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

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

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

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

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

Healthy men up to age 65:
• No more than 4 drinks in a day AND
• No more than 14 drinks in a week

Healthy adult women and healthy men over age 65:
• No more than 3 drinks in a day AND
• No more than 7 drinks in a week

Lower limits or abstinence for patients:
• Taking medications that interact with alcohol
• With health condition exacerbated by alcohol
• No consumption if pregnant or trying to get pregnant

Source: National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism
Who can do BI?

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

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

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

http://www.prevent.org/content/view/43/71
## Rankings: Preventive Services

<table>
<thead>
<tr>
<th>#</th>
<th>Service</th>
<th>CPB</th>
<th>CE</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Aspirin: Men 40+, Women 50+</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Childhood immunizations</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Smoking cessation</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol screening &amp; intervention</td>
<td>4</td>
<td>5</td>
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<tr>
<td>5</td>
<td>Colorectal cancer screening</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Hypertension screening &amp; TX</td>
<td>5</td>
<td>3</td>
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</table>
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<th>CE</th>
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<tbody>
<tr>
<td>7</td>
<td>Influenza immunization</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Vision screening - 65+</td>
<td>3</td>
<td>5</td>
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<tr>
<td>9</td>
<td>Cervical cancer screening</td>
<td>4</td>
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<tr>
<td>10</td>
<td>Cholesterol - men 35+, women 45+</td>
<td>5</td>
<td>2</td>
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<td>11</td>
<td>Pneumococcal immunization</td>
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<td>4</td>
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<td>12</td>
<td>Breast cancer screening</td>
<td>4</td>
<td>2</td>
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<tr>
<td>13</td>
<td>Chlamydia screening - women &lt;25</td>
<td>2</td>
<td>4</td>
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Referral To Treatment

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

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

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

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<th>Payer</th>
<th>Code</th>
<th>Service</th>
<th>Fee</th>
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<tr>
<td>Commercial</td>
<td>CPT 99408</td>
<td>15-30 min.</td>
<td>$33.41</td>
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<td></td>
<td>CPT 99409</td>
<td>&gt;30 min.</td>
<td>$65.51</td>
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<tr>
<td>Medicare</td>
<td>G0396</td>
<td>15-30 min.</td>
<td>$29.42</td>
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<tr>
<td></td>
<td>G0397</td>
<td>&gt;30 min.</td>
<td>$57.69</td>
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<tr>
<td>Medicaid*</td>
<td>H0049</td>
<td>Screening</td>
<td>$24.00</td>
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<tr>
<td>*State plan approval required</td>
<td>H0050</td>
<td>BI per 15 min.</td>
<td>$48.00</td>
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SAMHSA SBIRT Initiative

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