Medicaid Innovation Accelerator Program (IAP)

IAP Learning Collaborative: Substance Use Disorders (SUD)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Primary Care Settings

Targeted Learning Opportunity #4

6/8/15
Logistics Placeholder
Facilitator

- Cathy Fullerton, MD, MPH
- Senior Research Leader, Truven Health Analytics
Speakers (1 of 4)

- Adam Brooks, PhD
- Senior Research Scientist, Treatment Research Institute
Speakers (2 of 4)

• Peggy Bonneau
• Director, Health Initiatives, New York State Office of Alcoholism & Substance Abuse Services
Speakers (3 of 4)

- Michael Oyster, LPC, CADC III
- SBIRT Specialist, Oregon Health Authority
Speakers (4 of 4)

- John Muench, MD, MPH
- Associate Professor; Director of Behavioral Medicine for the Department of Family Medicine, Oregon Health and Sciences University
- Director, SBIRT Oregon Primary Care Residency Initiative
Agenda

• What is SBIRT?
• Evidence for SBIRT
• Opportunities for increasing SBIRT uptake
• State experience: New York
• State experience: Oregon
Goals of Webinar

• Participants will better understand how SBIRT can benefit risky alcohol users
• Participants will grasp the evidence limits around SBIRT interventions
• Participants will be lead through a discussion of financial, workflow, and perception barriers of SBIRT
• Participants will examine a case study example of SBIRT implementation in Oregon
Section 1

Overview of SBIRT
Pyramid

- In Treatment ~ 2,300,000
- SUD ~ 25,000,000
- Diabetes ~ 24,000,000
- “Risky/Harmful Use” ~ 60,000,000
- Little or No Use
## U.S. Population Risk Prevalence

<table>
<thead>
<tr>
<th>Category</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Alcohol Use</td>
<td>42%</td>
</tr>
<tr>
<td>Low Risk Alcohol Use</td>
<td>39%</td>
</tr>
<tr>
<td>Risky Alcohol Use</td>
<td>14%</td>
</tr>
<tr>
<td>High Risk Alcohol Use</td>
<td>3%</td>
</tr>
<tr>
<td>Severe Risk Alcohol Use</td>
<td>2%</td>
</tr>
</tbody>
</table>
Screening: Who are We Looking for?

• Not just the “addict”– but the “at risk”, such as:
  – Young adults periodically binging
  – Individuals who are rarely intoxicated but do consume outside safe limits
  – Those whose drinking is slowly increasing
  – Individuals with health conditions who should slow down
  – Recreational illicit drug users

• Detecting severe users who NEED treatment
SUDs and Chronic Health Problems

- SUDs related to increased risk:
  - Hypertension, heart failure, etc.
  - Renal and GI (liver failure, cirrhosis, Hep B and C, kidney failure)
  - Neurological (stroke, ischemic events, TBI)
  - Pulmonary (pneumonia, edema, TB)
  - Perinatal, postnatal complications
  - Endocarditis
  - HIV transmission
  - Mental health problems (depression, bi-polar disorder)
What is SBIRT?

• **Screen** Everyone for Risk in Primary Care

• **Brief Intervention** (for those at Risk)
  – Give Feedback
  – Be Empathic
  – Give Advice / Offer a Menu of Change

• **Referral To Treatment** (for Severe Risk)
  – Brief Treatment
  – Specialty Care / Detox / Rehab
Real-time Screening and Intervention

• Broad to focused screening / assessment
  – Brief screener (AUDIT-C / DAST-1 / Single ?)
  – Full screener (AUDIT / DAST / ASSIST)

• Who does the screening? And how?
  – Pencil and paper?
  – Medical Assistant / Provider Interview?
  – Automated electronic input – linked to EHR?

• Timing of Screening
  – Annual visits, new patient visits
  – Every visit
Brief Intervention: FRAMES

- Feedback (normative perspective)
- Responsibility (patient’s choice)
- Advice (cut back or quit)
- Menu of Options (different quit strategies)
- Empathy (take patient perspective)
- Self-Efficacy (support patient ability)
Basic SBIRT Model

- Assess: 2-3 min
- Advise (Feedback): 1-2 min
- Agree (Responsibility, Empathy): 3-5 min
- Advise 2.0 (Advice, Menu of Options): 1-2 min
- Assist (Support Self-Efficacy): 2-3 min
- Arrange
- Total: 9-15 min

But – a busy provider can shorten it if equipped with good referrals and a practiced strategy!
Brief Intervention: Feedback

AUDIT Scores
- 20+: 5% - Probable Alcohol Dependence
- 8 - 19: 20% - High-Risk Drinkers
- 1 - 7: 35% - Low-Risk Drinkers
- 0: 40% - Abstainers

Types of Drinkers

Medicaid.gov
Keeping America Healthy
Brief Intervention: Education

• What is a Drink?

• NIAAA Drinking Limits
  – Men – On average, no more than 2 drinks per day, no more than 14 per week, and no more than 4 on an occasion.
  – Women – On average, no more than 1 drink per day, no more than 7 per week, and no more than 3 on an occasion.
Treatment Referral

- Most difficult aspect of SBIRT intervention
- Providers unaware of solid treatment options
- Difficulty getting patients to follow-up
- Leaves the perception of failure with the most difficult patients
Evidence: SBIRT for Alcohol Use

• Three decades of research supporting the efficacy of brief intervention for alcohol
  – Strong evidence for BI in primary care and office based settings
  – Mixed / weak evidence for BI in hospitals and Eds
    • (i.e., earlier studies were strong but flawed)

• BI is effective for “at risk” and “risky” drinkers
  – Brief multiple contacts appear to exert the best effect (3-4)
  – Few drinks, drinking days, and safer drinkers
  – Fewer hospital days

• BI does not seem to be effective for “severe” drinkers
Evidence: SBIRT for Drug Use

• Weak evidence for 1-session BI for drug use
  – Controlled studies show limited efficacy:
    • Screen only vs. Screen + BI
    • Screen + printed info vs. Screen + BI
  – Most recent rigorous designs = no effect

• Some indication that participation in more intensive interventions (more than one consult) yields better results
What is SBIRT+?

• Increasing patient access to on-site change strategies
  – Patients may need a little more help executing change
  – Barriers to accessing referrals

• Features of SBIRT +
  – 2-6 on-site consults, based on patient need
  – Phase 1: Motivational Enhancement Therapy
  – Phase 2: Brief quit / reduction strategies
    • Cognitive Behavioral / Relapse Prevention
    • 12-Step Facilitation
    • Referral to Specialty Care for Sever Users with Case Management Follow-up
Ongoing Coaching / Support

Phase 1: MET- Explore and Resolve Ambivalence

Phase 2: MET- Negotiate Change Plan

CBT
- Functional analysis
- Scheduling
- Stimulus control
- Drug refusal
- Coping w/ cravings
- Managing feelings, stress, and sleeplessness
- Coping w/ withdrawal

12 Step Facilitation
Encouraging engagement with 12-Step Fellowships, and assisting with referrals and connection.

Referral to Treatment

Importance and Confidence Ruler

Redoing Motivation + Renewing Commitment
Questions and Discussion (1)
Section 2

Opportunities to Effectively Implement SBIRT
Why Limited Uptake of SBIRT?

• Past implementation efforts in the context of research and provider grants
  – Grant dries up, SBIRT dries up
  – Must generate revenue OR reduce, not add to, provider hassle

• Opportunities in multiple areas to improve uptake of SBIRT
  – Financial
  – Workflow
  – Perception
Financing Barriers

• Payers may or may not reimburse for SBIRT

• Clinicians may perceive that reimbursement rates for SBIRT are not worth the hassle

• Cost effectiveness of SBIRT is not felt at the primary care level
# SBIRT Codes & Fee Ranges

<table>
<thead>
<tr>
<th>Medicaid Code</th>
<th>Purpose</th>
<th>Fee Range (USD$)</th>
<th># States with Open Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services: 15-30 minutes</td>
<td>14.00-60.22</td>
<td>18</td>
</tr>
<tr>
<td>99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services: &gt;30 minutes</td>
<td>27.60-117.57</td>
<td>17</td>
</tr>
<tr>
<td>H0049</td>
<td>Alcohol and/or drug screening</td>
<td>14.35-35.35</td>
<td>11</td>
</tr>
<tr>
<td>H0050</td>
<td>Alcohol and/or drug service, brief intervention, per 15 minutes</td>
<td>16.15-65.55</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: Institute for Research, Education & Training in Addictions, [SBIRT Reimbursement](https://www.medicaid.gov)

[Medicaid.gov](https://www.medicaid.gov) - Keeping America Healthy
# Health and Behavior Assessment Codes & Fee Ranges

<table>
<thead>
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<th>Purpose</th>
<th>Fee Range (USD$)</th>
<th># States with Open Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>96151</td>
<td>Health and behavior assessment/re-assessment</td>
<td>7.16-30.95</td>
<td>30</td>
</tr>
<tr>
<td>96152</td>
<td>Health and behavior intervention, individual, face-to-face, per 15 minutes</td>
<td>5.30-26.25</td>
<td>27</td>
</tr>
<tr>
<td>96153</td>
<td>Group intervention (≥ 2 patients present)</td>
<td>2.76-18.96</td>
<td>28</td>
</tr>
<tr>
<td>96154</td>
<td>Intervention with family and patient</td>
<td>10.90-28.83</td>
<td>27</td>
</tr>
<tr>
<td>96155</td>
<td>Intervention with family, patient not present</td>
<td>13.62-30.15</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: Institute for Research, Education & Training in Addictions, [SBIRT Reimbursement](https://medicaid.gov/medicaid-innovation-accelerator-program)
States that Reimburse SBIRT Codes

Source: Institute for Research, Education & Training in Addictions, [SBIRT Reimbursement](#)
Addressing Financial Barriers

• Turn on SBIRT codes
• Examining payment rates relative to other prevention efforts (e.g., tobacco use screen, depression screen)
• Evaluation of providers permitted to provide SBIRT
• Encourage uptake in settings such as FQHCs where increasing the opportunity for behavioral health interventions makes strong fiscal sense to provider
• Incentive payments
  – Recognize that SBIRT reimbursement may not entice
  – Tying incentives to “quality care” - such as universal screening
Workflow Barriers

• SBIRT implementation takes time
• PCP’s under mandate to screen for multiple conditions
• Limited referral options for BI (brief intervention) or RT (referral to treatment)
• Self-administered / self-scoring screening instruments are more attractive
Addressing Workflow Barriers

• Develop partnerships
  – Agency partnerships (SSAs, Academic)
    • See the Massachusetts ED SBIRT Initiative webpage -- Massachusetts’ Boston College Effort
  – Primary care referral pathways
    • See Colorado’s PC Referral Network

• Incorporate SBIRT screening, intervention pathways, and referral pathways into EHRs and population-based registries
  – Put the single question screeners right in the EHR
  – Attach educational PDFs to intervention tabs
Addressing Workflow Barriers, cont’d

• Encourage the use of paraprofessionals for SBIRT
  – Effects are stronger when nurses and behavioral health specialists provide BI (will spend more time, can follow-up)
  – Frees physician time
  – Requires initial training and ongoing support to build paraprofessional skills and integration of SBIRT into clinical flow

• Example – The Christiana “Concierge” Model
  – Embedded Peer Specialists in hospital and ED
  – Intervene with patients to encourage SUD treatment
  – Address other medical provider concerns
    • Reduction of “slip and fall” in ED
Perception Barriers

• Primary care clinicians are often unaware of SBIRT
• Clinicians do not believe their patient caseload has problems with substances
  – They “detect” only the highly problemed patients
• Clinicians are not confident regarding their ability to provide brief intervention (BI)
• Clinicians erroneously believe that SUD treatment doesn’t work
Addressing Perception Barriers

• Clinician and practice education
  – Sponsor training and dissemination of SBIRT
    • Link SUD to medical problems
    • Increase comfort with SBIRT
  – Encourage communication with main SUD providers and persons in recovery

• Perception Management – Colorado Example
  – Engaged numerous partners
    • Providers
    • The SSA, Office of the Governor, and Behavioral Health Associations
    • Peer Networks
    • Academic Institutions
Implementing SBIRT at the State-Level

Peggy Bonneau, Director, Health Initiatives, NYS Office of Alcoholism & Substance Abuse Services
Provider Types Who Are Eligible to Bill for SBIRT Services (1 of 4)

• Provider Type: Required OASAS Approved Training/Certification

• Physicians:
  – Services may be performed by another provider type while under the supervision of the physician
  – 4 hours
    • Unless certified by the American Society of Addiction Medicine, the American Board of Ambulatory Medicine, the American Academy of Addiction Psychiatry, or the American Academy Osteopathic Association
Provider Types Who Are Eligible to Bill for SBIRT Services (2 of 4)

- Nurse Practitioners:
  - 4 hours
    - Unless qualified as a Certified Addictions Registered Nurse (CARN)

- Psychologists:
  - 4 hours
Provider Types Who Are Eligible to Bill for SBIRT Services (3 of 4)

- Provider types requiring 4 hours:
  - Physician Assistants
  - Registered Nurses (unless CARN qualified)
  - Licensed Practical Nurses
  - Licensed Master Social Worker/Licensed Clinical Social Worker
  - Licensed Mental Health Counselors
  - Licensed Marriage and Family Therapist
  - Certified School Counselor
  - OASAS-credited professionals including Credentialed Alcoholism and Substance Abuse Counselors (CASACs), Credentialed Prevention Professionals (CPPs), Credentialed Problem Gambling Counselors
Provider Types Who Are Eligible to Bill for SBIRT Services (4 of 4)

• Provider types requiring 12 hours:
  – Health Educators
  – Unlicensed individuals

• These individuals may only provide SBIRT services under the supervision of a licensed health care professional, following consistent protocols
Number of SBIRT Screenings and Brief Interventions Per Calendar Year

Source: Salient Interactive Data Miner - June 01, 2015
Promoting SBIRT in New York

- Raising awareness with managed care organizations
- Integration
- Raising awareness
- Working with Performing Provider Systems (PPS) and Delivery System Reform Incentive Payment (DSRIP) program
- Training
Questions and Discussion (2)
Part 1. Implementing SBIRT at the State-Level

Michael Oyster, LPC, CADC III, SBIRT Specialist, Oregon Health Authority
Overview

- How SBIRT fits into the CCO structure
- The ramp up of SBIRT
- Where are we now
- What it will take to fully implement SBIRT
SBIRT in the CCO Structure

• SBIRT is 1 of 17 measures that CCOs are accountable to the Oregon Health Authority

• If the 3 percentage point improvement target toward the benchmark is met for SBIRT, then the CCO can receive an incentive payment for that measurement year

• Benchmarks
  – 2013-2014: 13%
  – 2015: 12%
Where Does the Incentive Payment go?

• Some CCOs pass this incentive straight through to participating clinics

• Other CCOs hold a percentage for infrastructure development
  – EHR forms for SBIRT
  – Motivational Interviewing training
  – Referral system coordination
Where We Started

Percentage of adult patients who had appropriate screening and intervention for alcohol or substance abuse (SBIRT) in 2011 & 2013.

B Bolded names met benchmark or improvement target.

- Willamette Valley Community Health: 8.7%
- Umpqua Health Alliance: 3.0%
- PacificSource: 3.0%
- Columbia Pacific: 2.8%
- Western Oregon Advanced Health: 2.3%
- FamilyCare: 2.0%
- Yamhill CCO: 1.7%
- Cascade Health Alliance: 1.6%
- PrimaryHealth of Josephine County: 1.3%
- Health Share: 1.0%
- All Care Health Plan: 0.7%
- Eastern Oregon: 0.8%
- Trillium: 0.1%
- Jackson Care Connect: 0.1%
- Intercommunity Health Network: 0.0%

Benchmark: 13.0%
Where We Are Going

SCREENING FOR ALCOHOL OR OTHER SUBSTANCE MISUSE (SBIRT)

CCOs continued to improve SBIRT between 2013 & June 2014.

Benchmark 13.0%
The Number of Services

After a gradual increase between 2011 and 2013, the number of Screenings, Brief Interventions, and Referrals to Treatment (SBIRTs) more than tripled between 2013 and mid-2014.
Where We Are Now – SBIRT Claims

Number of SBIRT Claims per Month over the Last Rolling Year (raw data)

Estimated total of SBIRT Claims:
33,462 (31,056 people)
Strategies for Implementation
Example Guidance Forms: Qualifications for Providers

Licensed Providers

- Physicians
- Physician Assistants
- Nurse Practitioners
- Licensed Psychologists
- Licensed Clinical Social Workers

Under general supervision, auxiliary providers (incident-to)

- **Students:** Medical, physician assistant, nursing; addictions, counseling, social work, psychology
- **Medical Assistants:** MAs
- **Nurses**
- **Registered Nurses**
- **Health Educators**
- **Wellness Coaches**
- **Certified Alcohol & Drug Counselors**
- **CADCs**
- **Qualified Mental Health Professionals & Assistants**
- **QMHPs**
- **QMHA**

Source: SBIRT Guidance Document
General Workflow of SBIRT in Primary Care

1. **Start**
   - Patient attends appointment
   - Patient completed a brief annual screen within last 12 months?

2. **Receptionist**
   - Brief (annual) Screening
   - Receptionist gives brief screen and scores; positive?

3. **Patient attends apt**
   - Patient completed a brief annual screen within last 12 months?
     - Yes
     - No

4. **Receptionist**
   - Brief (annual) Screening
   - Reviews medical issues that could identify unhealthy substance use patterns, in case of false negative score
   - Gives Full Screening (AUDIT and/or DAST; positive?)

5. **Nurse / Assistant**
   - Full Screening
   - Previously positive Full Screen (AUDIT and/or DAST)?
     - Yes
     - No

6. **Provider**
   - Brief Intervention / Plan
   - Follows-up with patient about previous plan
   - Assesses any medical issue that may indicate possible unhealthy substance use patterns
   - Reviews score of full Screen with patient, begins the brief intervention & continuing plan

7. **Behavioral Health Specialist**
   - Brief Treatment / Referral
   - Coordination of Tx Team
SBIRT Encounters in Medical Settings

Medical
Physician, Nurse Practitioner, Physician Assistant

- Evaluation & Management (E&M)
  - Codes for medical appointment

- Warm Handoff to Behavioral
  - If warm handoff to behavioral health
  - then use E&M codes, document SBIRT work
  - and save CPT codes for behavioral health

- No Warm Handoff, use E&M and CPT codes
  - Alcohol Screen Diagnosis + CPT Code
    - V79.1 with 99420
      - Alcohol Screening (e.g. AUDIT)
  - Substance Screen Diagnosis + CPT Code
    - V82.9 with 99420
      - Substance Abuse Screening
        - (e.g. AUDIT and/or DAST)

Behavioral
Independently Licensed: Psychologist, Social Worker

  - Codes for behavioral health services

- Warm Handoff from Medical
  - Alcohol Screen Diagnosis + CPT Code
    - V79.1 with 99420, 99408 or 99409
      - Alcohol Screening (e.g. AUDIT)
  - Substance Screen Diagnosis + CPT Code
    - V82.9 with 99420, 99408 or 99409
      - Substance Abuse Screening
        - (e.g. AUDIT and/or DAST)

Sources: SBIRT Guidance Document and Addictions and Mental Health Services - SBIRT
What will it take for full implementation?

- Within the Clinic
- Community-Substance Use & Mental Health
- Telehealth-Services & Warm Hand-Off

- Clinic
- Health System
- CCO

- Forms
- Cues/Dropdowns
- Quality Improvement-Dashboards & SBIRT Elements

- Training
- Facilitator
- Licensing Boards

Integration
Multi-level
EHR
Standards
Part 2. SBIRT from the Trenches: A Primary Care Perspective

John Muench, MD, MPH,
Oregon Health & Science University
The Problem

- Unhealthy use of alcohol and drugs is a major factor preventing achievement of the triple aim in the United States

<table>
<thead>
<tr>
<th>Care</th>
<th>Health</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the experience of care</td>
<td>Improving the health of populations</td>
<td>Reducing per capita costs of health care</td>
</tr>
</tbody>
</table>
## Missed Opportunities / Possible Solutions

<table>
<thead>
<tr>
<th>Business As Usual</th>
<th>SBIRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconsistent and selective assessment</td>
<td>Routine and universal screening</td>
</tr>
<tr>
<td>Non-systematized, narrative questions</td>
<td>Validated screening tools</td>
</tr>
<tr>
<td>Usually seen as dichotomous</td>
<td>Substance use seen as a continuum</td>
</tr>
<tr>
<td>Directive style of communication</td>
<td>Patient-centered change talk</td>
</tr>
<tr>
<td>Discoordinate/unclear referrals and follow up</td>
<td>Transition between primary care and AOD treatment</td>
</tr>
</tbody>
</table>
Implementation Science – CFIR Elements

• 5 Domains
  – Intervention Characteristics
  – Outer Setting
  – Inner Setting
  – Characteristics of Individuals
  – Process of Implementation

• 39 Constructs

# SBIRT Clinic Workflow

<table>
<thead>
<tr>
<th>SBIRT Innovation</th>
<th>Clinic Workflow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine and universal screening</td>
<td>Annual tickler for all patients who come for care, leading to:</td>
</tr>
<tr>
<td>Validated screening tools</td>
<td>Collection of patient screening data leading to:</td>
</tr>
<tr>
<td>Substance use seen as a continuum</td>
<td>A risk stratification process that will automatically lead to:</td>
</tr>
<tr>
<td>Patient-centered change talk</td>
<td>An effective brief intervention that combines risk level with patient readiness to change that might lead to:</td>
</tr>
<tr>
<td>Transition between primary care and AOD treatment</td>
<td>A more intensive intervention from clinic behavioral health personnel OR referral into AOD treatment system.</td>
</tr>
</tbody>
</table>
Primary Care Prevention: USPSTF on Alcohol SBI

- For both alcohol screening and brief intervention for all adults
- Insufficient evidence for adolescents
- Insufficient evidence for drugs
- Insufficient evidence for “RT” (no clear effectiveness for higher severity EtOH problems)
The Oregon Experience

• SAMHSA Curriculum Project 2008-2013
  – 400 primary care residents (and their faculty) trained
  – 40,000 patients screened and tracked using EHR systems

• 2013: New Oregon ACO incentive metrics based on CPT/ICD9 codes

Billing Codes to Track Incentive Metrics

• Provision of AUDIT or DAST = 99420
  – Must be associated with V78.1 (EtOH) or V82.9 (drugs), as well as text that results have been given to patient

• OR: Provision of Brief Intervention = 99408 (15-30 minutes) or 99409 (>30 minutes) along with V78.1 or V82.9

• As laid out in the 24 page Oregon Health Plan SBIRT Guidance Document
When Figuring Out the Billing Takes Longer Than the Clinical Intervention...
# How to Maintain Fidelity to the Original Innovation?

<table>
<thead>
<tr>
<th>SBIRT Innovation</th>
<th>Clinic Workflow</th>
<th>EMR Overlay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine and universal screening</td>
<td>Annual tickler for all patients who come for care, leading to:</td>
<td>Clear, automatic tickler in health maintenance module</td>
</tr>
<tr>
<td>Validated screening tools</td>
<td>Collection of patient screening data leading to:</td>
<td>Patient screening data input optimally directly (tablet, kiosk, or portal)</td>
</tr>
<tr>
<td>Substance use seen as a continuum</td>
<td>A risk stratification process that will automatically lead to:</td>
<td>Automatic summation of risk level communicated to clinician</td>
</tr>
</tbody>
</table>
## How to Maintain Fidelity to the Original Innovation? (continued)

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<tr>
<th>SBIRT Innovation</th>
<th>Clinic Workflow</th>
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</thead>
<tbody>
<tr>
<td>Patient-centered change talk</td>
<td>An effective brief intervention that combines risk level with patient readiness to change that might lead to:</td>
<td>Required action (hard stop?) driven by Smart Text decision support reminding clinician of appropriate change talk for patient at given risk level</td>
</tr>
<tr>
<td>Transition between primary care and AOD treatment</td>
<td>A more intensive intervention from clinic behavioral health personnel OR referral into AOD treatment system.</td>
<td>Immediate availability of accurate info about referral resources. Automated reminders for follow-up phone call to patient</td>
</tr>
</tbody>
</table>

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Results After the First Year

• The North Star goal
  – Less heavy use of EtOH and drugs
  – Less morbidity/mortality
  – Less cost

• Currently
  – Increased provision of validated alcohol and drug screenings statewide
  – Unclear fidelity to brief intervention model
    • Much time being spent determining how to meet incentive measure criteria
  – From a clinical perspective, there has been some shift in culture
    • Addressing unhealthy alcohol and drug use in medical clinics is becoming normalized (anecdotal)
Questions and Discussion (3)
Resources (1 of 3)

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services, Centers for Medicare & Medicaid Services, Department of Health and Human Services Fact Sheet

- SBIRT: Screening, Brief Intervention, and Referral to Treatment, SAMHSA-HRSA Center for Integrated Health Solutions
Resources (2 of 3)

- SBIRT Colorado
- Massachusetts ED SBIRT Initiative
- SBIRT Oregon, Oregon Health & Sciences University
Resources (3 of 3)

• Screening, Brief Intervention and Referral to Treatment (SBIRT), Addictions and Mental Health Services, Oregon Health Authority

• Technical Specification and Guidance Documents for CCO Incentive Measures, Office of Health Analytics, Oregon Health Authority
Contact Information

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- Peggy Bonneau, NYS Office of Alcoholism & Substance Abuse Services
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• John Muench, MD, MPH, Oregon Health and Science University
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