SBIRT

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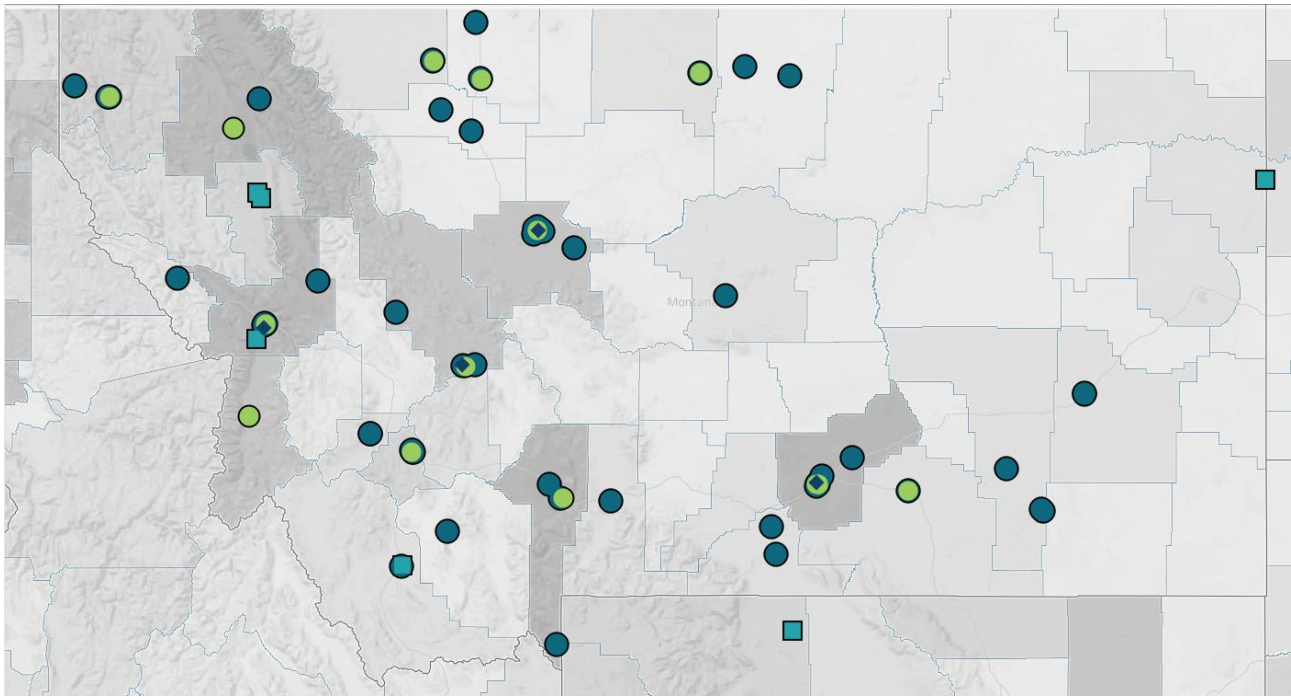
MPCA

The **Mission** of the Montana Primary Care Association is to promote integrated primary healthcare to achieve health and well-being for Montana's most vulnerable populations.

The **Vision** of MPCA is health equity for all Montanans.

MPCA values integrity, collaborations, and innovation.

The Montana Primary Care Association is the support organization for Montana's 14 Community Health Centers and 4 of our Urban Indian Centers. MPCA centers serve over 117,500 patients across Montana.



Agenda:

1. Barriers to Using SBIRT
2. The Data in Montana
3. Screening – What to use and how to ask.
4. Brief Interventions – Using Motivational Interviewing Skills
5. Referrals to Treatment – Both Internal and External
6. Wrap Up and Practice…

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Group Agreement

- 4-Hours is a LONG TIME
  - Please participate so I don't get bored
- If you can, please use your camera…
  - 4-hours is a long time to talk to myself
- Be open to new ideas.
- Be kind to each other and yourselves!

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Introductions

1. Name, Role, Where you Work
2. What do you hope to gain from this training?
3. What made you decide to register for this training?

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What the heck is SBIRT?

- Screening, Brief Intervention, Referral to Treatment (SBIRT)
- An evidence-based approach to identifying patients who use alcohol and other substances at risky levels with the goal of reducing and preventing related health consequences, disease, accidents and injuries.
- Risky substance use is a health issue and often goes undetected.

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Not Really…

- This sounds so simple.
- So what makes it so difficult?
- Any ideas?

SBIRT

Alcohol Screening, Brief Intervention, and Referral to Treatment

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What do you picture...

Case Example:

A 52-year-old patient who does not have housing. He has been in and out of jail and prison most of his life. He is complaining of pain in his stomach. He smells like alcohol and is carrying a small brown bag with him today as he tells you his symptoms and struggles. His eyes are blood shot, and he has visible tremors as you speaking to him. You go consult with the PCP.

What might you hear from the PCP?

What might your front desk staff say to the patient?

What might the people in the waiting room be thinking?

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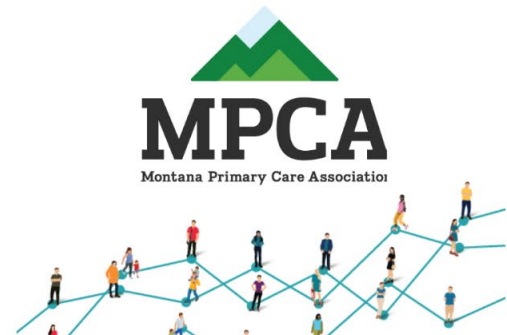
Accurate Empathy

How might this patient feel?

How difficult was it for them to walk into your clinic in the first place?

How can you improve the chances that they get what they need today and build a relationship with you or your providers?



What do you picture...

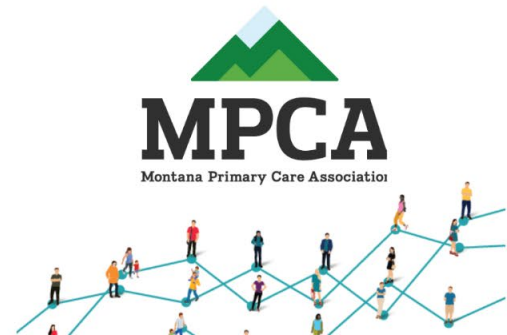
Case Example:

A 20-year-old college student who has come to see the PCP with a black eye and bruising after falling at a party. They were drinking and having fun.

How might this person be received by the PCP?

By the front desk?

Patients in the waiting room?



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One More…

Case Example:

A 48-year-old woman with a professional career. She has high blood pressure and difficulties managing her A1C.

How might this person be received by the PCP?

By the front desk?

Patients in the waiting room?

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Barrier: Bias

A human trait resulting from our brain's need to classify individuals into categories so that we can quickly process information and make sense of the world.

This largely happens below consciousness.

This "unconscious" classification of people occurs through schemas, or "mental maps," developed from life experiences to aid in "automatic processing."

Stereotypes…

These schemas become templates that we use to process new information…

We then respond according to how we have been trained to react to that category/template.

When these schemas are used to categorize people by age, gender, race, or other criteria, they are called **stereotypes.**

This isn't necessarily bad…it's how the brain sorts information so that it can process quickly.

Attitude

- The positive or negative feelings or thoughts towards a person or thing.
- Attitudes are shaped by personal experiences and cultural exposure that leave a recorded imprint on our memory.

Explicit Bias

- The traditional concept of bias.
- The individual is aware of their prejudices or attitudes toward certain groups.
- Ex) Overt racism and racist comments
  - Understanding Bias: A Resource Guide (justice.gov)

Implicit Bias

- Involves subconscious feelings, perceptions, attitudes, and stereotypes that have developed from prior influences and imprints.
- The automatic positive or negative preference for a group, based on one's subconscious thoughts.
- Can be just as problematic as explicit bias and may produce discriminatory behavior.
- Individual may be unaware that biases, not facts, are driving decision-making.
- Ex) Officers becoming suspicious of two young Hispanic males driving in a neighborhood where few Hispanics live.

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So, What Can We Do?

- Discuss biases and recognize them for what they are.
- Once recognized, they can be reduced or "managed," and individuals can control the likelihood that these biases will affect their behavior.
- Engage in positive contacts with members of that group of people.
- "Counter-stereotyping,"
  - Individuals are exposed to information that is the opposite of the stereotypes they believe.

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Barrier: Stigma Towards Self…

Patients who experience or expect stigma…

- Less likely to seek or access services
- Drop out of treatment early

Stigma is the primary persistent barrier to high quality integrated SUD services.

Patients often feel guilt and shame towards themselves for pain or disappointment they've caused others…

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Bias in Health Care:

- We may view patients with SUDs differently
  - We have lower expectations for their health outcomes
    - Perceived Control
    - Perceived Fault

THE PYGMALION EFFECT

management30.com

MANAGEMENT 3.0

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Barrier: We Don’t Ask!

- Believing that patients do not want us to ask
- Or that they will not tell us anyway
- Or us not wanting to know…
- Or believing that they aren’t using or drinking excessively
- Or worries that we have no options to help them anyway…

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How Do Patients React to Alcohol Screening?

The University of Connecticut School of Medicine's "*Cutting Back Study*"

Some medical personnel believe that when patients are asked about their drinking, many are uncomfortable and resistant. One reason personnel typically give for not asking about alcohol use is that "drinking behavior is private." This view is not, however, supported by research.

Screened primary care patients in five states for smoking, diet/exercise, and alcohol use.

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Patients were asked…

1. How comfortable do you feel answering these questions?
2. How important do you think it is that your health care provider knows about these health behaviors?

❖They were asked to express their views on a five-point scale from “very comfortable” and “very important” to “very uncomfortable” and “very unimportant”

❖***FEWER THAN 9% OF PATIENTS INDICATED ANY DISCOMFORT OR ANY THOUGHT THAT SUCH INFORMATION WAS UNIMPORTANT TO THEIR HEALTHCARE PROVIDERS.***

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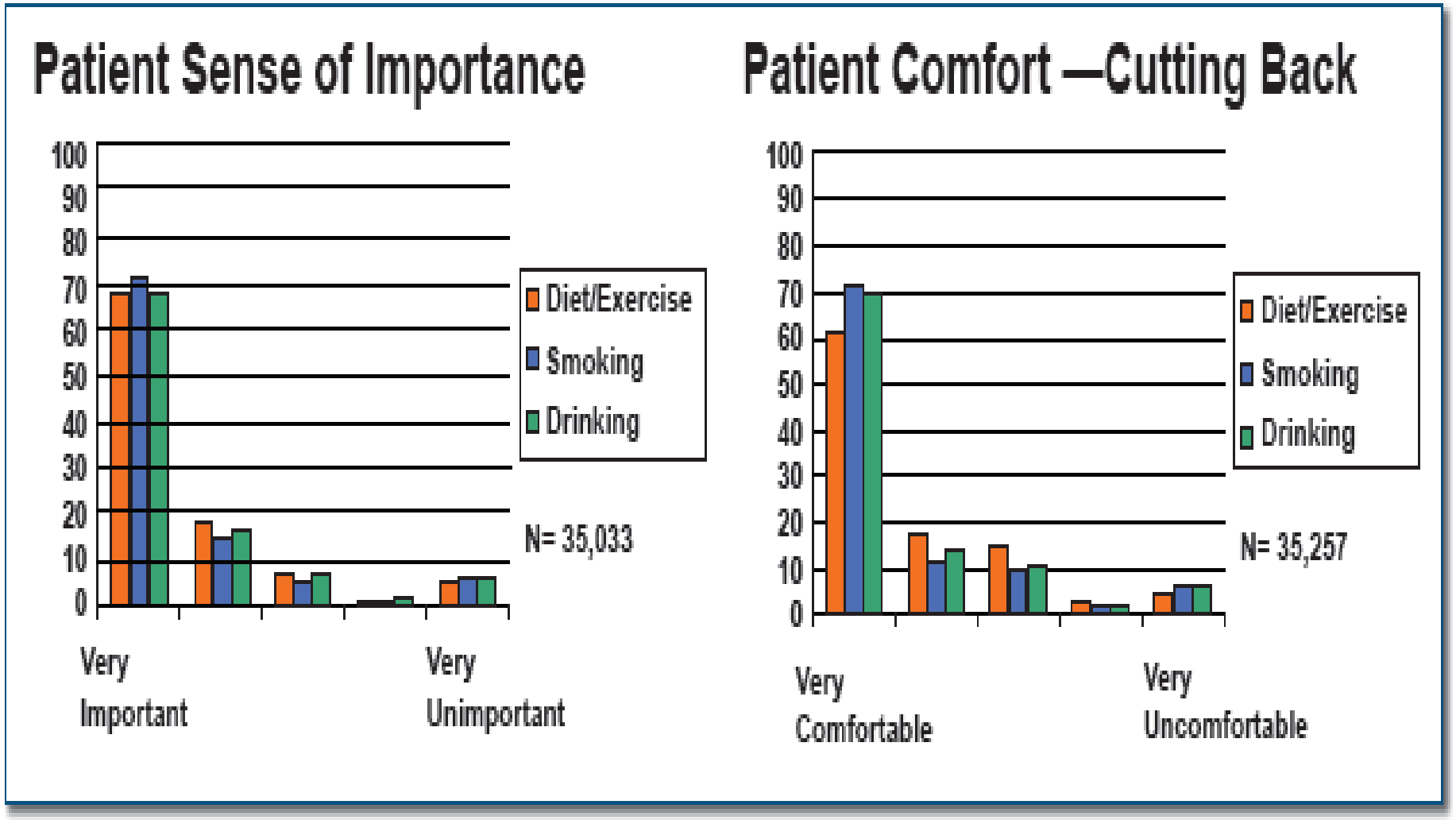
The University of Connecticut School of Medicine's *"Cutting Back Study"*



Reactions to One Another…

Language Study by Recovery Research Institute

- Dr. John Kelly, Harvard-MGH Recovery Research Institute published a 2010 study & 2015 editorial in American Journal of Medicine which showed an impact on clinical care

- Trained clinicians were given identical scenarios about someone with a substance use disorder and the only thing changed was in one scenario the person was called a 'substance abuser,' and in the other scenario, a 'person with a substance abuse disorder.' Dr. John Kelly found that when you called someone a substance abuser, it elicited, even from trained clinicians, a **much more punitive response**.

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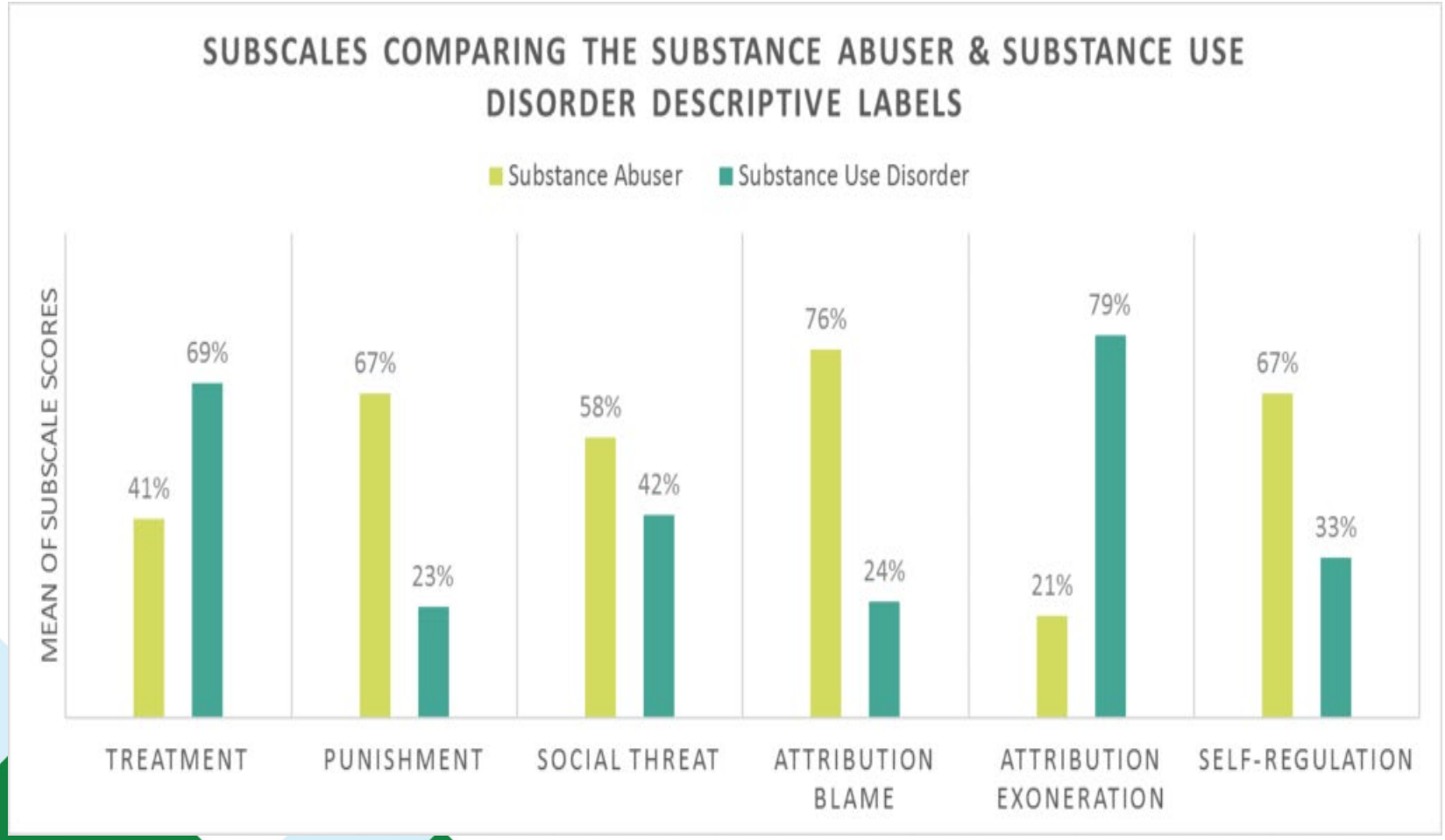
Study by Recovery Research Institute



- 50% or participants were in health care
- 20% students
- 29% outside healthcare
- 01% nothing listed
- Average age 31 (range 17-68
- 81% White
- 76% Female
- 50% Bachelors degree or higher

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Person-Centered Language

LANGUAGE MATTERS

When words are used inappropriately to describe individuals with a substance use disorder, it not only negatively impacts the cultural perception of their disease, but creates stigma that can stop people from seeking help. Language matters. Let's replace terms like "addict" and "junkie" with smarter language that aligns with the science.

Say This	Not That
Person with a substance use disorder	~~Drug addict~~
In recovery	~~Clean~~
Currently using substances	~~Dirty~~
Substance use	~~Substance abuse~~
Not engaging with treatment	~~"Bombed out"~~
Recurrence of symptoms, return to use	~~Relapsed~~
Positive drug screen	~~Dirty drug test~~
Medication assisted treatment (MAT)	~~Medication replacement, substitution therapy~~

ADDICTION POLICY FORUM

Sources:
JAMA: "Changing the Language of Addiction", Michael P. Botticelli, MEd
Howard K. Koh, MD, MPH
Language, Substance Use Disorders, and Policy: The need to Reach Consensus on an "Addiction-ary". John F. Kelly PhD, Richard Saitz MD & Sarah Wakeman MD

DON'T: use stigmatizing language that labels people.

"She's depressed."
"He's bipolar."
"She committee suicide."

DO: use people-first language that shows acceptance.

"She has depression."
"He has bipolar disorder."
"She died by suicide."

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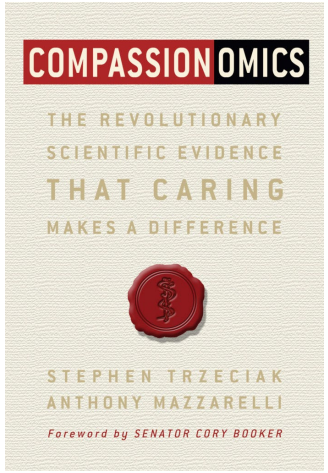
Compassion

- 80% higher odds of better blood sugar control in patients with diabetes
- Pt with a common cold had improved symptoms
- Pts more likely to take medications
- Lower Healthcare Costs



- 56% of physicians believe they do not have time for compassion
- 40 seconds of compassion makes a meaningful difference for patients
  - Powerful to the workers delivering compassion also
  - Triggers reward pathways in the brain

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We all have bias rooted in:

- *Our privilege*
- *Our worldview*
- *Our upbringing and socialization*

Break Out!!

Project Implicit Health – Redirect

- Questions for yourself…what patients do you least enjoy working with?
- Who do you struggle to relate to or empathize with?
- Is this something you have considered in the past? How do you work through it?
- Do you staff this with YOUR supervisor?
- 15 Minutes then we will be back.

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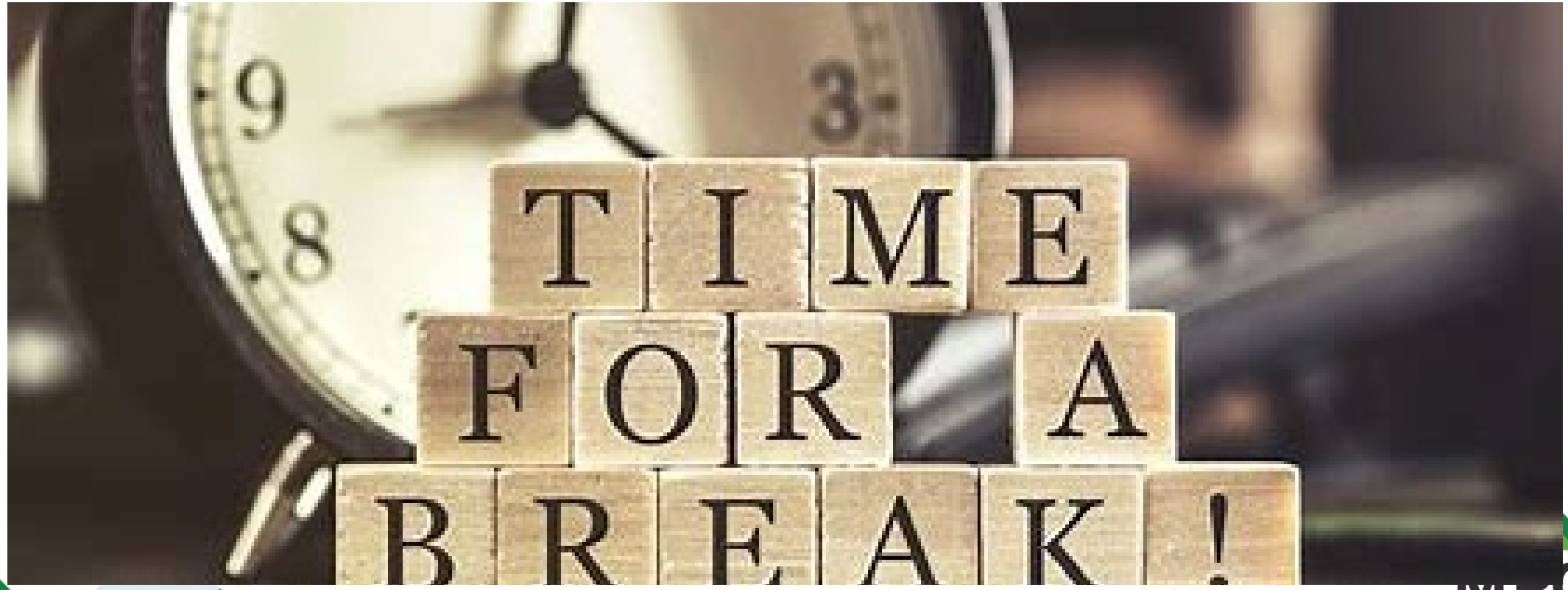
Other Barriers?

Take 10 Minutes – See You Soon!



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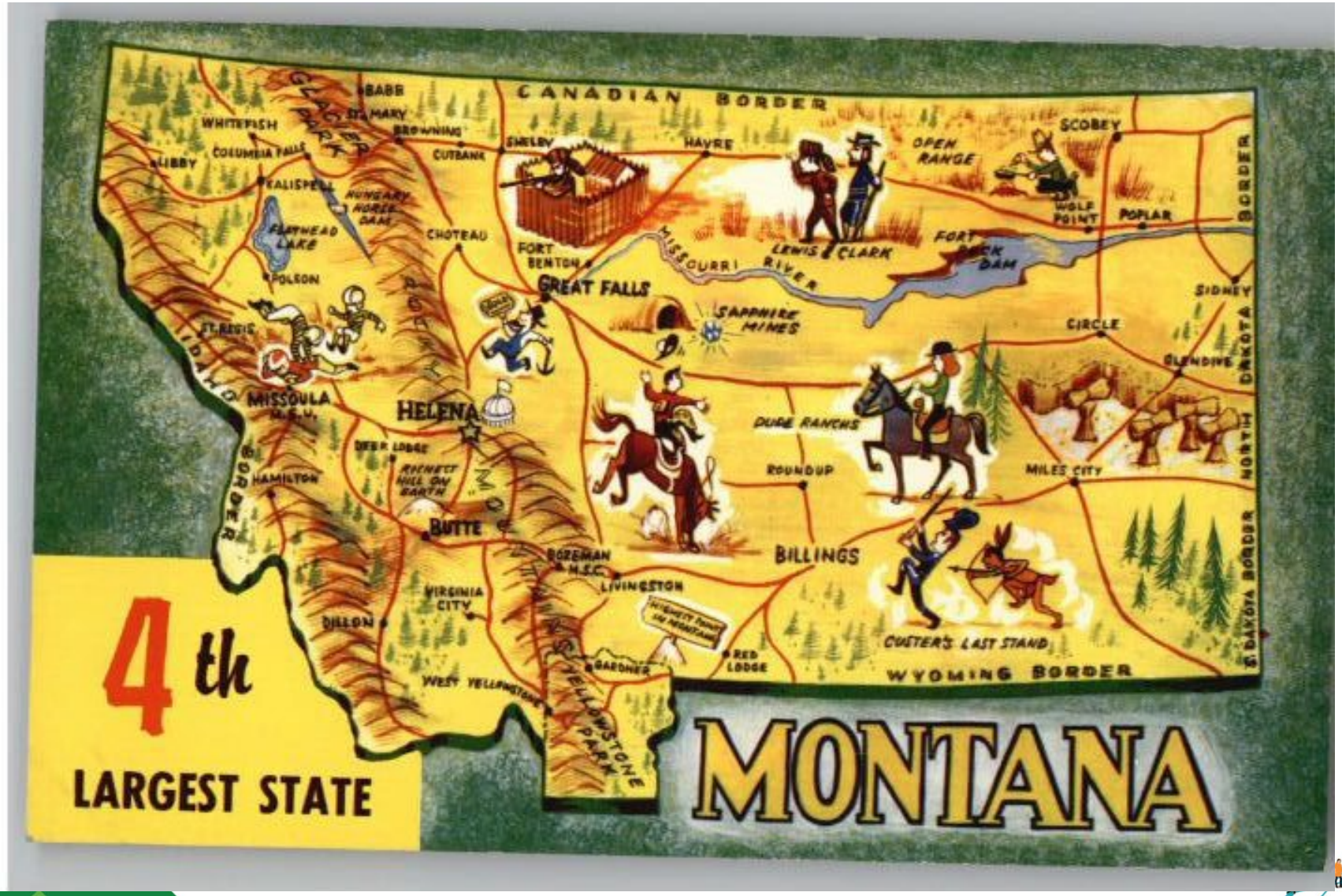
Use in Montana



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Alcohol Use in Montana

	United States	Montana
Percent of adults aged 18+ who report drinking alcohol in the past month[1]	**55%** 2019-2020	**63%** 2019-2020
Percent of fatal crashes that involve an alcohol-impaired driver (BAC 0.08+)[2]*	**29%** 2020	**46%** 2020

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Alcohol Use

- The number of Montanans dying from alcohol-related diseases and poisonings has increased over the past two decades. From 2000 to 2004, there were 488 alcohol-related deaths in Montana; from 2015-2019, there were 1,043 alcohol-related deaths.
- 31% of Montana high school students report having at least one drink of alcohol in the past month.
- Alcohol-related hospitalizations and emergency department visits have been on the rise over the past five years. In 2020 alone, over $200 million was charged by Montana hospitals for hospitalizations and emergency departments visits due to alcohol consumption.
- Among Montanans receiving treatment for substance use disorders in 2020- 6 2021, 56% reported alcohol as their primary substance of misuse.

Alcohol_1pager.pdf (mt.gov)

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Alcohol Use and Adolescents

49% of 12th graders in Montana used alcohol within the past month

(Montana Prevention Needs Assessment (2021)

Methamphetamine Use

	United States	Montana
Percent increase in deaths caused by methamphetamine from 2018 to 2020[1]	**81%** 2018-2020	**150%** 2018-2020
Percent of people aged 12+ who report using methamphetamine in the past year[2]	**0.9%** 2019-2020	**1.7%** 2019-2020

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Methamphetamine

- Methamphetamine and stimulant seizures by law enforcement increased by 385% in Montana between 2012 and 2021.
- In 2020, methamphetamine was found in 48% of drug overdose deaths.
- $48.5 million were charged by hospitals across the state to treat 4,804 patients for methamphetamine-related admissions and emergency department visits in 2020.
- Methamphetamine was the second most common drug (not including alcohol) found in impaired driver blood samples or postmortem blood samples after cannabis. Methamphetamine was found in 13% of driver blood samples.

Methamphetamine Use in Montana (mt.gov)

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Opioid Use in Montana

	United States	Montana
Percent of people aged 12+ who report misusing opioid pain relievers in the past year[1]	**3.4%** 2019-2020	**3.9%** 2019-2020
Number of opioid prescriptions per 100 people[2]	**43.3** 2020	**46.1** 2020

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Opioid Use

- Between 2019 and 2020, 287 Montanans died from a drug overdose. 145 of these drug overdose deaths (51%) were due to opioids.
- Nearly $5 million were charged by Montana hospitals for opioid-related hospitalizations and emergency department visits in 2021.
- 16% of fatal drug overdoses involved fentanyl in 2020, 30% of fatal drug overdoses involved fentanyl in 2021
- Dosage units of fentanyl seized by Rocky Mountain High Intensity Drug Trafficking Area officers has increased by 424% (75 to 393) from 2016 to 2020.

Opioid Use in Montana (mt.gov)

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Yes…that’s concerning…

But why do we need to talk about this in Primary Care?

Setting

Why treat Substance Use in Primary Care?

- Primary Care is often the first stop for people needing ANY type of care- including SUD.
- SUD is a chronic, reoccurring disease – In Primary Care, we are experts in managing chronic illness.
- PCBH Providers are *accessible* – And when a patient is motivated to change, we need to meet their need now, not place them on a wait list.
- We follow patients until symptoms improve (Episode of Care), then complete Reoccurrence Prevention Plans.
  - Patients are patients in primary care for their lifespan. There is no discharge.

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Chronic Disease

Addiction is a **chronic disease** like other **chronic diseases** such as type II diabetes, cancer, and cardiovascular **disease**. Human studies of **addictive** behaviors have clearly implicated both environmental and genetic influences, as well as interactions between the two.

Like other chronic diseases, the condition must be continually managed to reduce the risk of reoccurrence. Many affected individuals receive no intervention or detoxification without subsequent treatment. As with all chronic diseases, SUD has no cure and is characterized by reoccurrence requiring long term care. Medical and psychiatric co-morbidities are the rule rather than the exception.

All conditions require life-long management; interventions and monitoring don't stop after initial interventions or services.

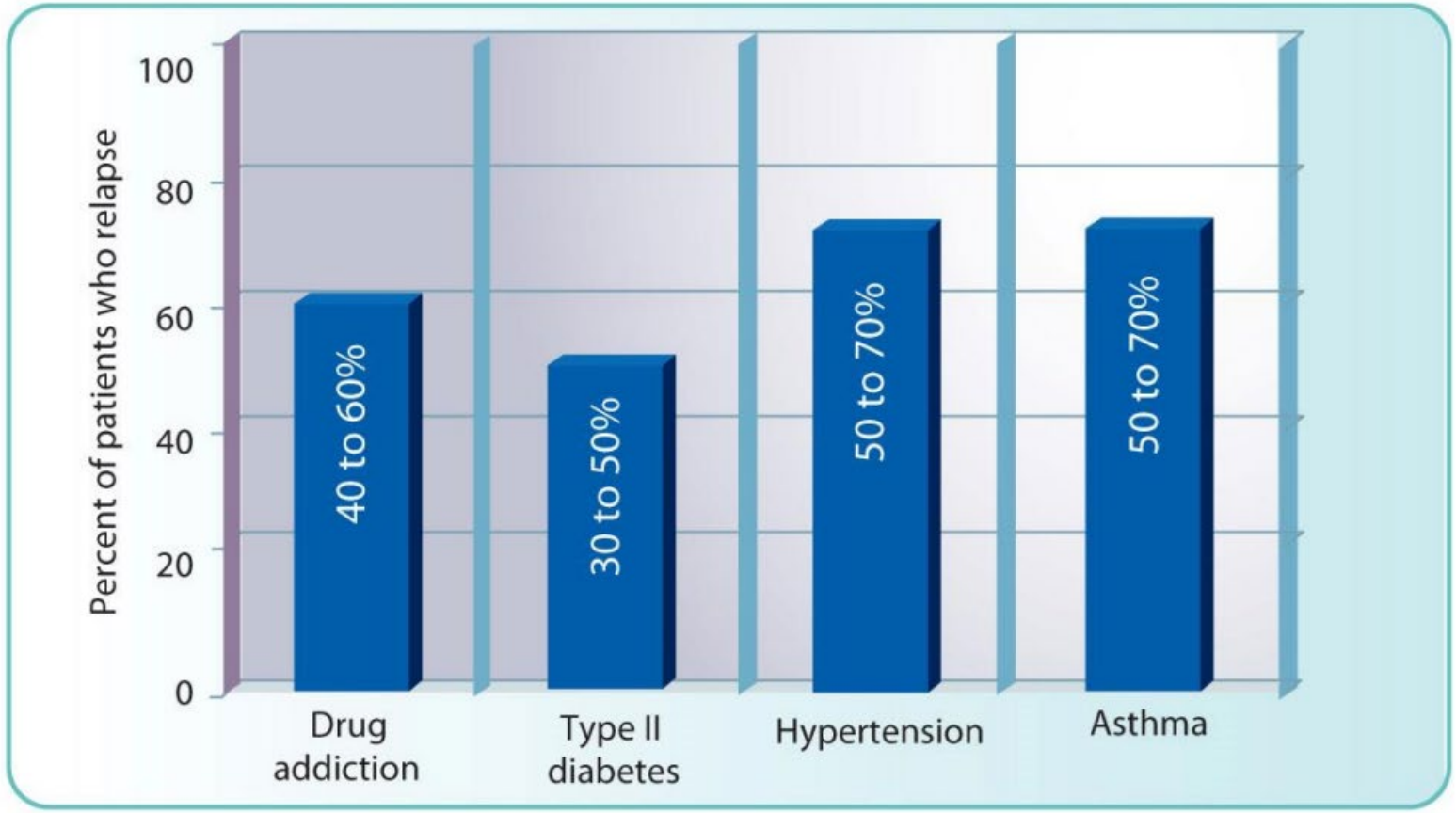
Substance Use Disorders (SUD) are Chronic Medical Conditions

"From a neurobiological perspective, drug addiction is a disease of the brain, and the associated abnormal behavior is the result of dysfunction of brain tissue."

~Christopher Cavacuiti – "*Principles of Addiction Medicine: The Essentials*"

Like any other chronic disease…

- Has genetic predisposition.
- Can be treated.
- Can have high morbidity and mortality if untreated.
- Can achieve remission!



McLellan, Lewis, O'Brien & Kleber (2000) JAMA, 284: 1689-1695.

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Chronic Disease Management

Screenings – Identifying risk factors through screening can help prevent disease and lessen the severity of illness through early detection.

Checkups – Monitoring and learning how to manage chronic disease

Coordinating Treatment – PCP's know their patients' history and coordinates care which avoids redundant medical tests and procedures, unnecessary ER visits, hospitalizations, and medication errors. Can also help manage medications.

Patient education – PC Teams help patients understand and work towards target numbers for heath measures such as blood pressure, cholesterol and weight, improving health outcomes.

These measures are not only management of chronic illnesses, but preventative measures.

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DISEASE	SPECIALIST	WHO CARES FOR THESE PATIENTS IN PRIMARY CARE?
Heart Disease	Cardiologist	PCP, Clinical Pharmacist, BH, Care Management
Cancer	Oncologist	PCP, Clinical Pharmacist, BH, Care Management
Diabetes	Dietician, Endocrinologist	PCP, Clinical Pharmacist, BH, Care Management
Alzheimer's Disease	Neuropsychologist, neurologist	PCP, Clinical Pharmacist, BH, Care Management
Substance Use Disorder	Licensed Addiction Counselor, Addiction Medicine Doctor	PCP, Clinical Pharmacist, BH, Care Management

Thoughts on the Treatment of Chronic Disease in Primary Care

- **Screenings**
- **Checkups**
- **Coordinating Treatment**
- **Patient education**

These measures are not only management of chronic illnesses, but preventative measures.

In traditional care of SUD, we do not offer treatment until patients are proven ill enough to meet criteria for treatment.

> *How is that different than treatment of other chronic illnesses?*
>
> *What other chronic diseases do you treat in your clinic? What interventions do you use?*

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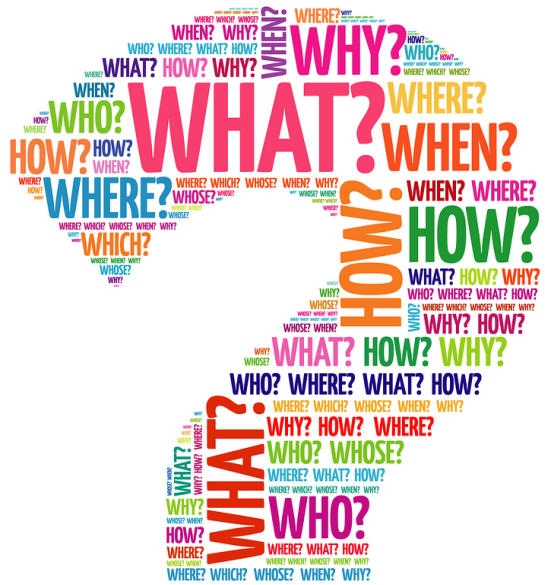
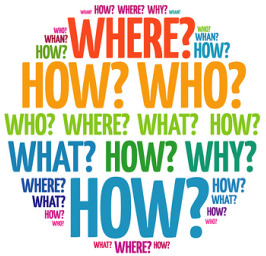
....But we have to start ASKING!

Screening





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Screening:

Goal: Identify patients at-risk for developing substance use disorders.

- Early Identification of risky use and early intervention.
- Normalize discussing substance use as part of your healthcare – BECAUSE IT IS!

We are meeting people where they are with an appropriate intervention.

- Not trying to identify Substance Use Disorder.

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Primary Care Already Does This…

	• **Immunizations** – children • **Tobacco** use screening, preventative counseling – youth & adults
	• **Alcohol** screening & brief intervention – adults • **Aspirin** daily low dose – adults 50-59 at higher CVD risk • **Cervical cancer** screening – women 21-65 • **Colorectal cancer** screening – adults 50-75
	• **Chlamydia and gonorrhea** screening – sexually active women ≤24 and older women at increased risk for infection • **Cholesterol** screening - adults • **Hypertension** BP screening - adults

Maciosek, M. et al. Ann Fam Med 2017;15:14-22

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Preventative Services: Ranked

Rank	Service	CPB	CE	Total
1	Childhood immunizations	5	5	10
1	Tobacco use, brief prevention counseling, youth	5	5	10
1	**Tobacco use screening and brief counseling, adults**	**5**	**5**	10
2	**Alcohol screening & brief intervention, adults**	**3**	**5**	8
2	Aspirin chemoprevention for those at higher risk of CVD	3	5	8
2	Cervical cancer screening	4	4	8
2	Colorectal cancer screening	4	4	8
3	Hypertension screening	4	3	7

Higher score= Better

Maciosek MV et al. Annals of Family Medicine. 2017. PMID: 28376457

National Commission on Prevention Priorities

25 USPSTF-recommended services ranked 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?

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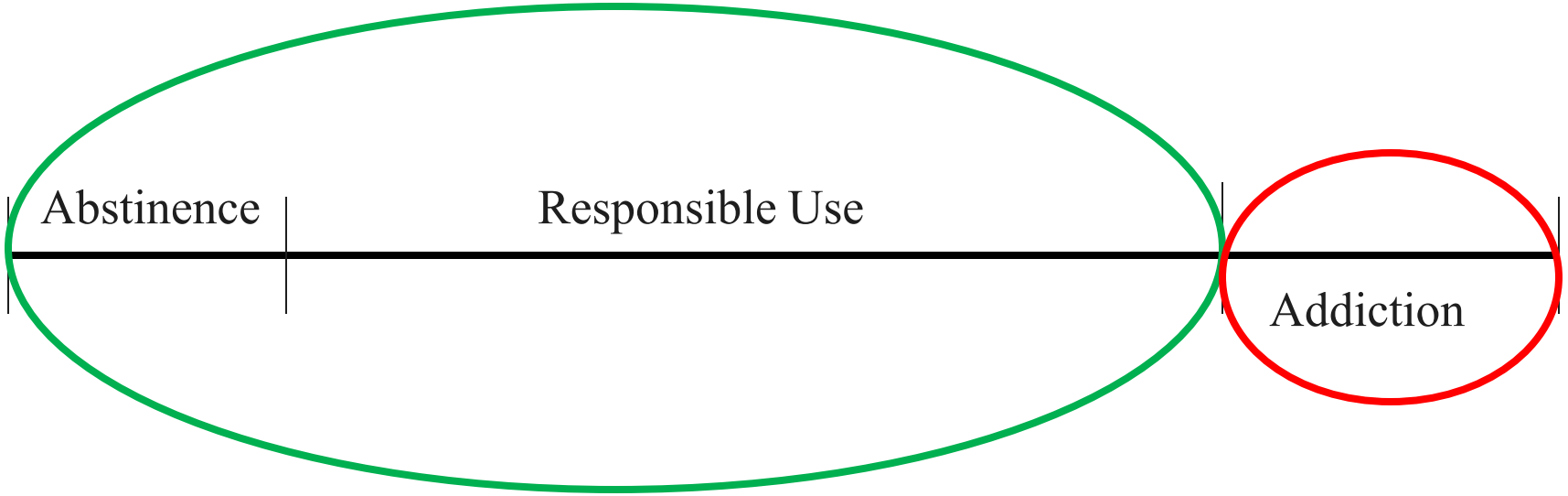
Continuum of Substance Use



National Addiction Technology Transfer Center (ATTC)

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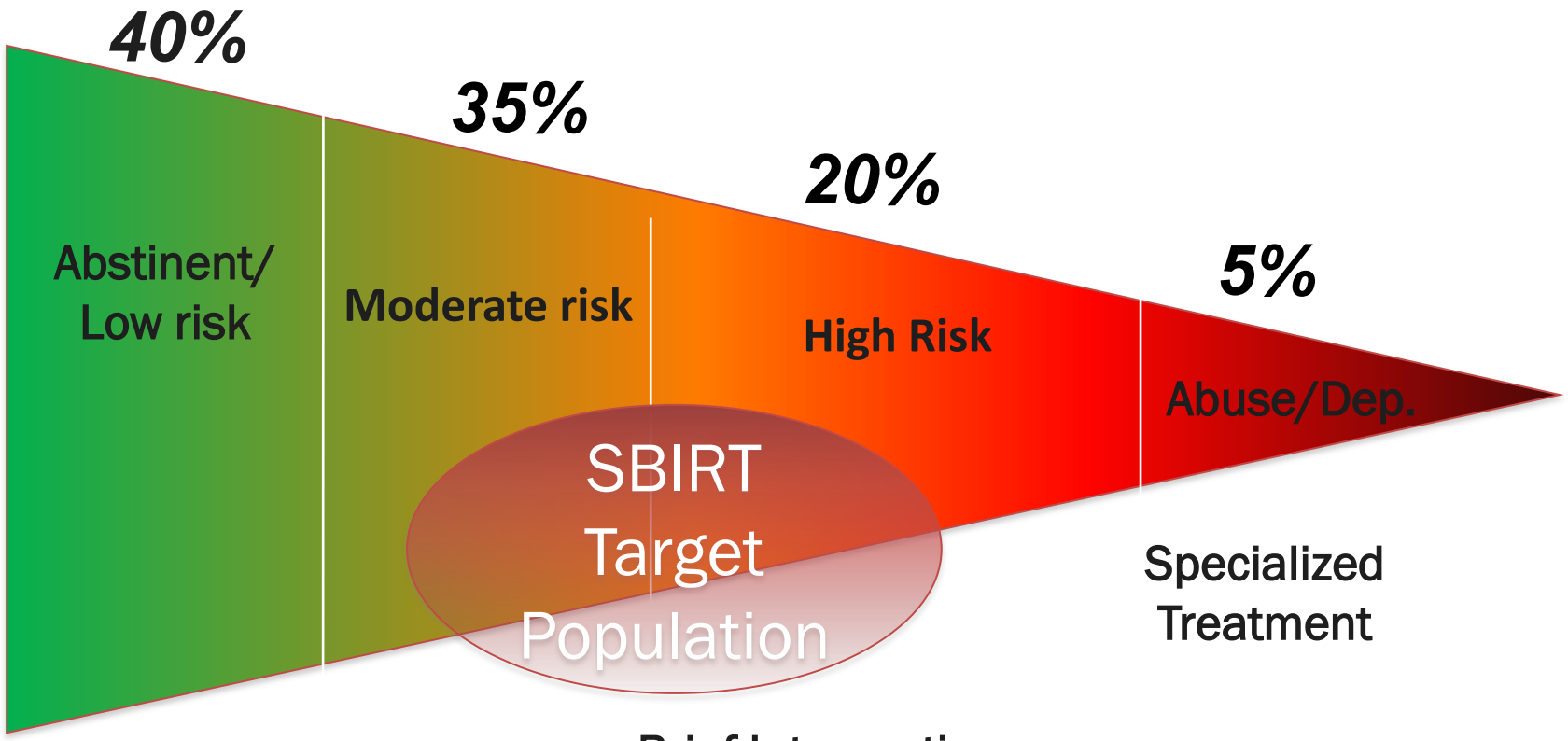
Continuum of Alcohol Use



Dawson, Alcohol Clin Exp Res 2004
Grant, Drug Alcohol Dep 2004

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At Risk Drinking

How Much is Too Much?

Males <65 yrs. old: more than 14 drinks per week or more than 4 drinks/day.

Females & males age 65 and older: more than 7 drinks per week or more than 3 drinks per day.

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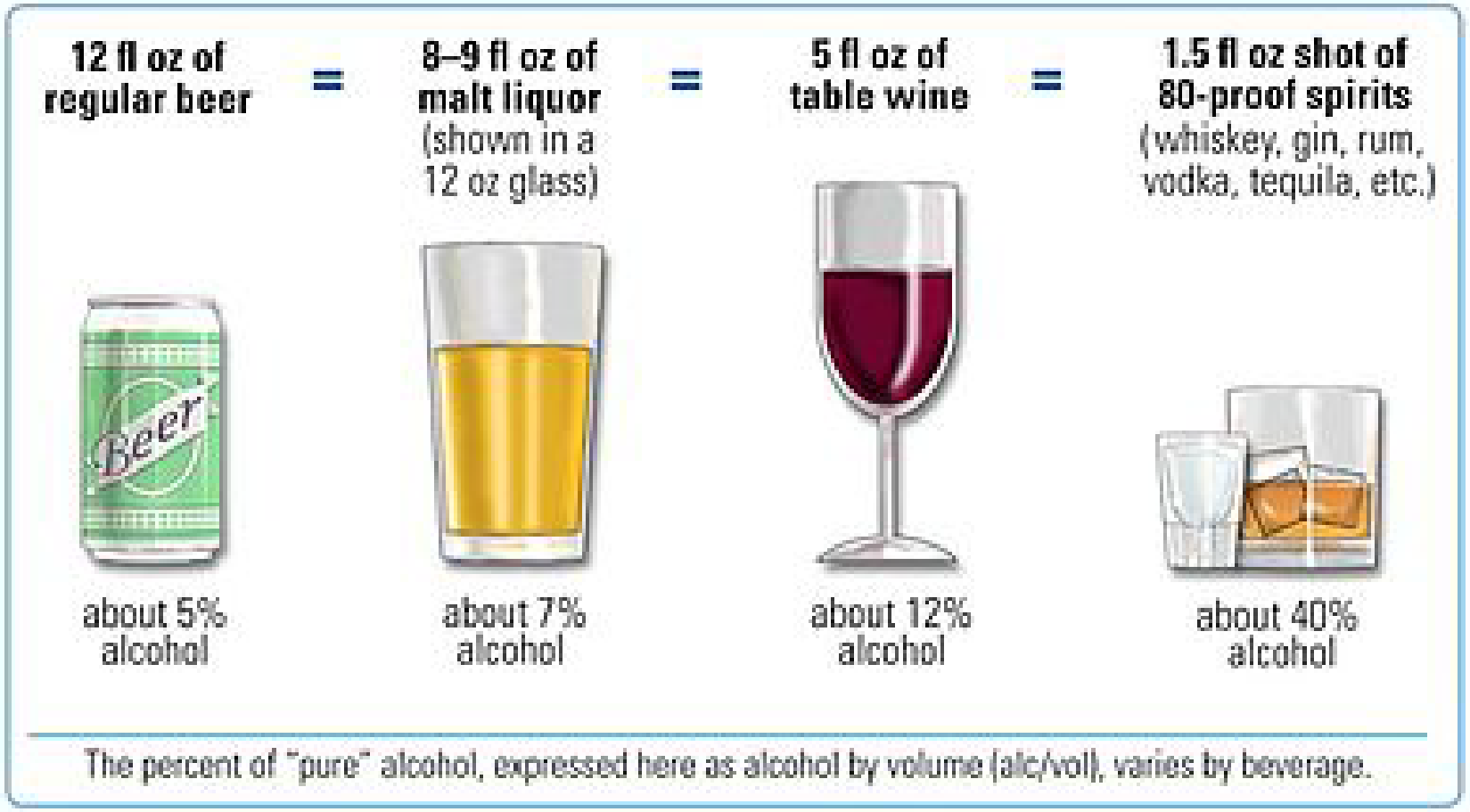

Important to Clarify

What is a standard drink?

Screening Strategy

Prescreen

Alcohol:

Do you sometimes drink beer, wine, or other alcoholic beverages?

NO

YES

NIAAA Single Screener: *How many times in the past year have you had five (men) or four (women or patients over age 65) drinks or more in one day?*

Positive score=one or more times→ ask quantity and frequency, do full AUDIT.

Drugs:

In the last 12 months, on how many days did you use pot, use another street drug, or use a prescription medication 'recreationally' (just for the feeling, or using more than prescribed)?

NONE

ANY

Positive score=one or more times→ ask quantity and frequency, do full DAST-10.

Smith, P. C., Schmidt, S. M., Allensworth-Davies, D., & Saitz, R. (2009). Primary care validation of a single-question alcohol screening test. J Gen Intern Med 24(7), 783–788.

In the past 3 months...

1. How often did you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month		2-3 times a week	4+ times a week
	0	1	2		3	4
2. How many drinks containing alcohol did you have on a typical day when you were drinking?	Never	1 or 2 drinks	3 or 4 drinks	5 or 6 drinks	7, 8 or 9 drinks	10 or more drinks
	0	0	1	2	3	4
3. How often did you have **5 or more** drinks on one occasion?	Never	Less than monthly	Monthly		Weekly	Daily or almost daily
	0	1	2		3	4
4. How often have you used marijuana?	Never	Not monthly	Monthly		Weekly	Daily or almost
	0	1	2		3	4
5. How often have you used an illegal drug or a prescription medication for non-medical reasons*?	Never	Less than monthly	Monthly		Weekly	Daily or almost daily
	0	1	2		3	4

* if patient needs further explanation, "for example, for the feeling or experience it caused."

AUDIT-C Plus 2

Patients who screen positive with scores below 7 are appropriate for brief intervention

Patients with high-positive scores (7-10) should have symptoms of *alcohol* use disorders elicited. They are also appropriate for ongoing counseling in primary care

Possible Screeners:

- AUDIT-C +2
- AUDIT
- DAST
- S2BI
- CRAFFT
- Others you are using in your clinics?

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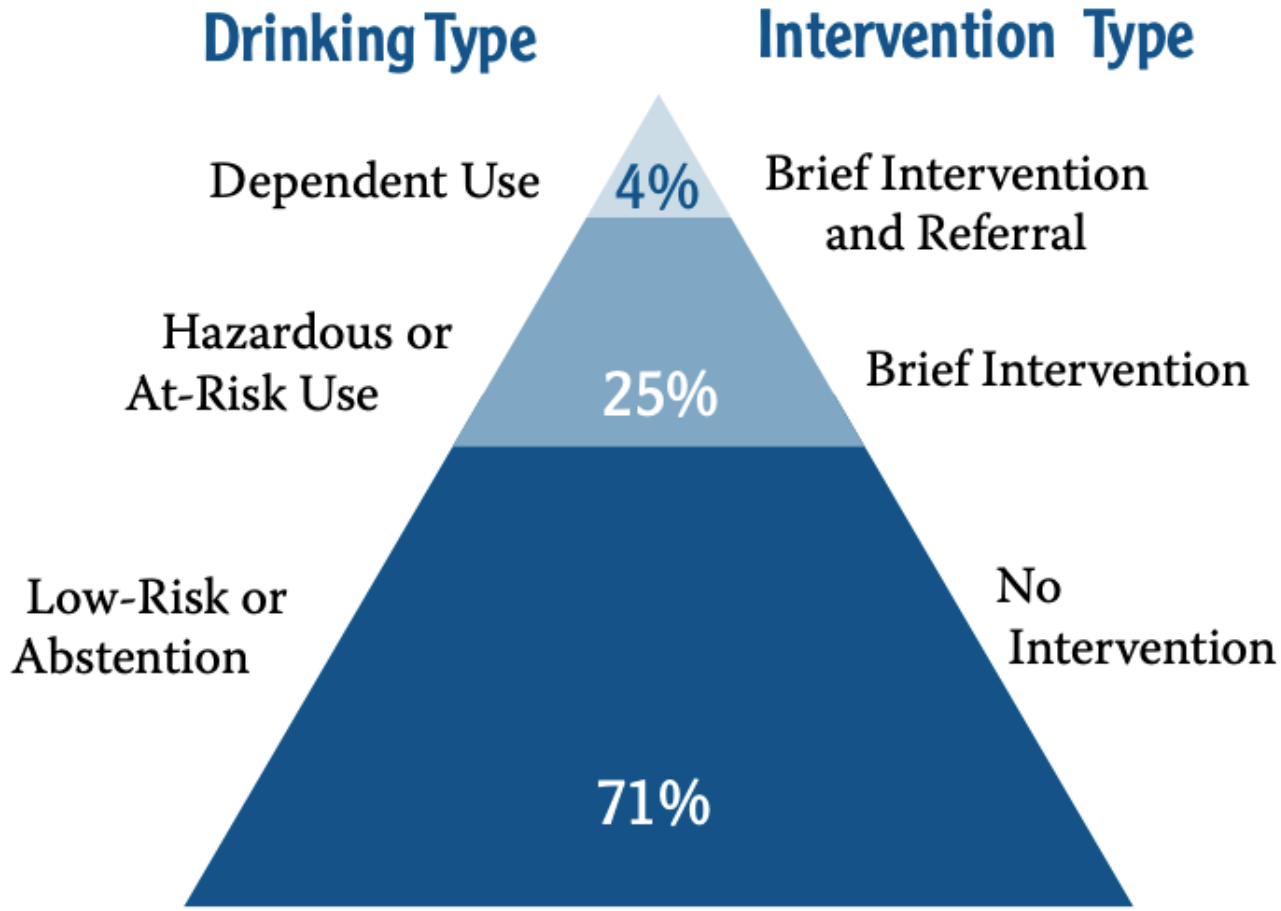

Note: The prevalence estimates in this figure are for non-institutionalized U.S. population, not trauma patients.

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AUDIT

Alcohol screening questionnaire

0 to 7 points: Low risk

8 to 15 points: Medium risk

16 to 19 points: High risk

20 to 40 points: Addiction likely

Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

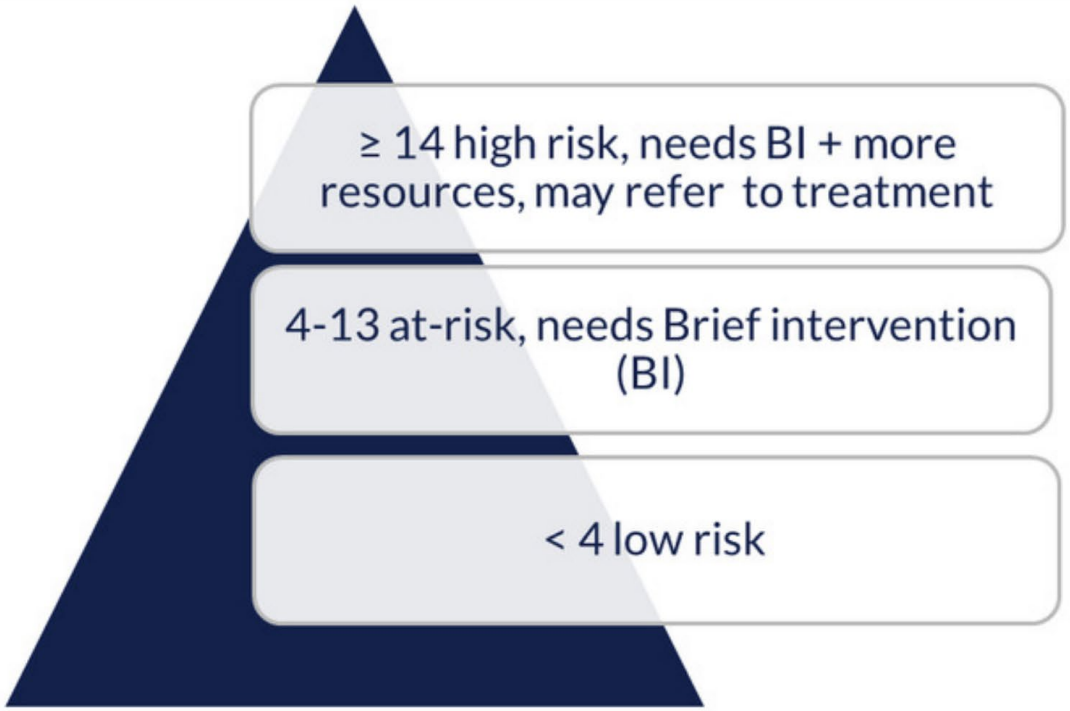
One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ○ Never ○ Currently ○ In the past

I	II	III	IV
0-3	4-9	10-13	14+

Scoring the AUDIT



Johnson, Lee, Vinson & Seale, 2013; McGinnis, Justice, Kraemer, Saitz, Bryant & Fiellin, 2013; Rubinsky, Kivlahan, Volk, Maynard, & Bradley, 2010.

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Single Question Screen

In the last twelve months, did you use pot (marijuana), use another street drug, or use a prescription medication 'recreationally' (just for the feeling, or using more than prescribed)?

- A response of > 1 is considered positive.
- 65% sensitive, 99% specific for detecting drug use
- Similar sensitivity and specificity to previous single drug screen (Smith et al), but clearly identifies marijuana use and avoids use of the word "illegal"

Seale JP et al, Drug Alc Dep, 193:104-109, 2018; Smith, PC, et.al., Arch Int Med, 170:1155-1160, 2010

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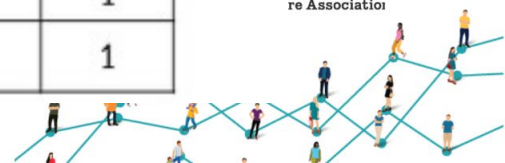
DAST-10

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed, hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions **do not include alcohol or tobacco**.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

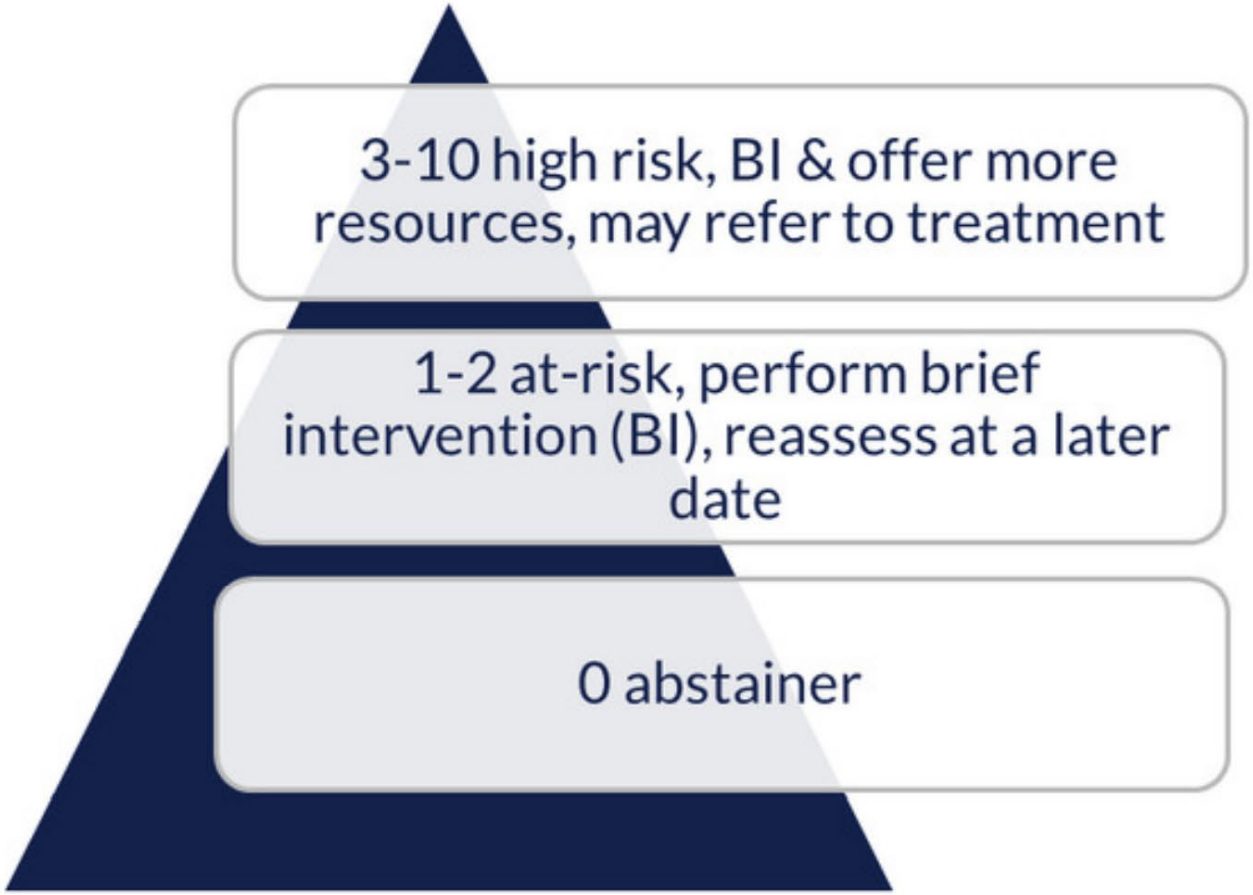
These questions refer to the past 12 months	No	Yes
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes")	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parent) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.?	0	1



High-Risk Substance Use

- Always ask validated screening questions as written.
- Demonstrate a respectful, nonjudgmental attitude.
- Because the screening question does not specify the drug(s) use, the provider must ask which drugs are used.
- Ask quantity and frequency of use.
- What other drugs, if any?
- Any IV drug use? Have you ever had a drug overdose?
- Administer DAST-10 (Drug Abuse Screening Test).
- (https://www.drugabuse.gov/sites/default/files/files/DAST-10.pdf)

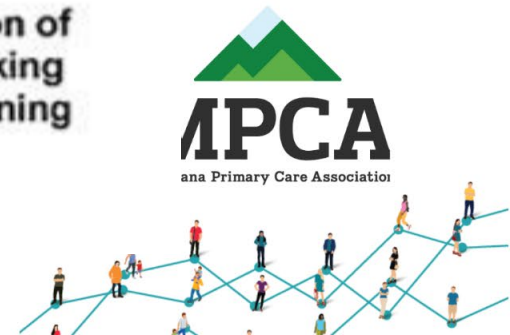
Scoring the DAST-10



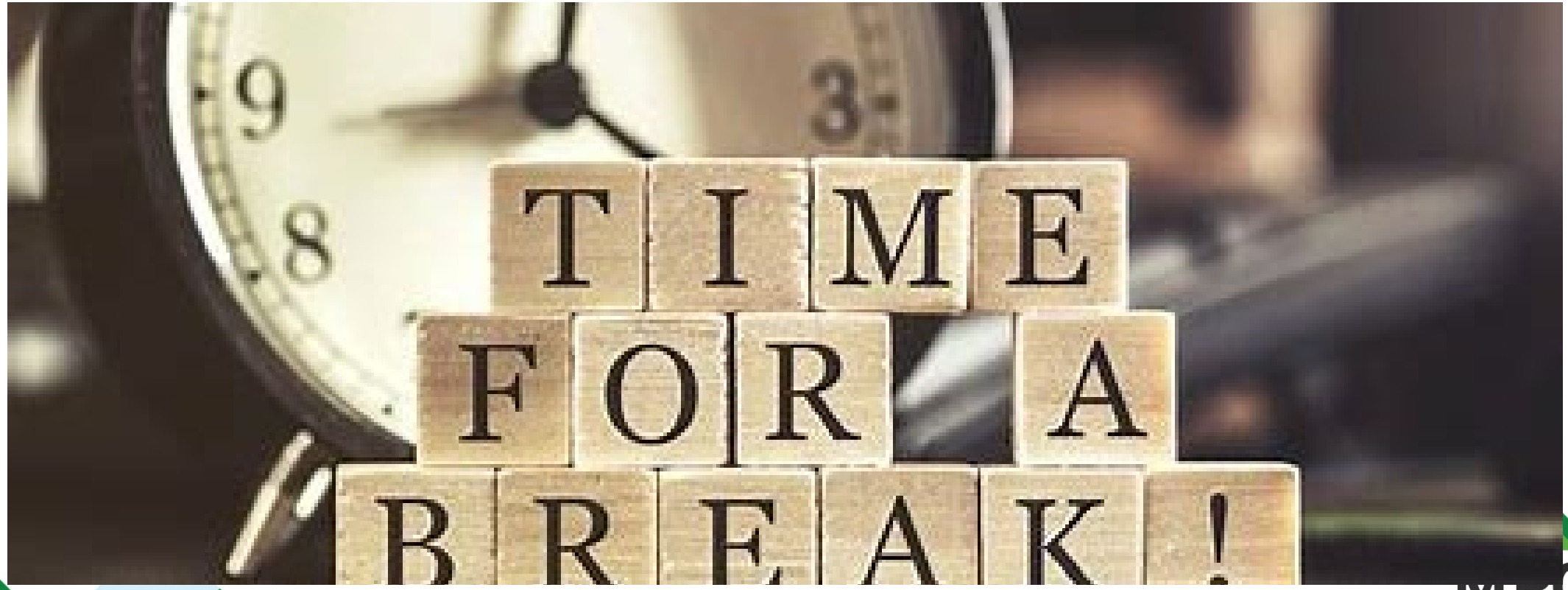
Tips for Screening:

1. Check your bias
2. Listen without judgement
3. Ask permission
4. Match their sophistication of speech while remaining professional – Be relatable!
5. Smile and Make Eye Contac

"Of course I'm listening to your expression of spiritual suffering. Don't you see me making eye contact, striking an open posture, leaning towards you and nodding empathetically?"



Take 10 Minutes – See You Soon!



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Brief Intervention:

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Brief Interventions:

- Engaging a patient that has risky substance use behaviors in a short conversation, providing feedback, motivation, and advice.
- Could be a conversation that happens only once.
- Could be a conversation that happens annually at their Wellness Visit.
- The conversation is guided by the patient's answers to the validated screener using Motivational Interviewing.

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What is MI?

- A particular way of talking with people about *change and growth* to strengthen their own motivation and commitment.
- MI flows like a normal conversation – It's not something being done **to** a patient.
- Directional and Purposeful
- Compassionate attention to the person while watching/listening for change and growth

- MI is a way of doing what you already do.
- It is person-centered.
- It is **not** primarily seeing deficits, diagnoses or problems to be solved.
- It sees a person with strengths, hopes, and relationships who wants to be heard, valued, and viewed as competent.

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Our Role:

- We are not responsible for the individual's decision to change or not.
- We are like a tour guide…
  - Listen well to where they want to go
  - Don't just follow them around.
  - Don't push them where you want them
  - Share your knowledge.
  - Combine your expertise with what they care about and want.

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Spirit of Motivational Interviewing

- Partnership
  - People are experts on themselves, and if they are the ones wanting to change, you need THEIR expertise!
- Acceptance
  - Belief that people have inherent worth and do not need to earn or prove that they deserve respect.
- Compassion
  - A commitment to support positive growth that is in the best interest of your patient.
- Empowerment
  - Helping people realize and use their own strengths and abilities.
  - *Adjusted in the 4th Edition to emphasize the importance of people's own strengths, motivations, resourcefulness, and autonomy.*

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Brief Intervention

Can take as little as 5 minutes, or as long as 30 minutes is to educate individuals and increase their motivation.

Using Motivational Interviewing techniques, individuals are provided information specific to their use.

Brief intervention consists of:

- The clinician will have a brief motivational conversation with a patient to guide the person through the standard drink sizes and Safer Drinking Guidelines.
- The clinician gauges the patient's readiness to change and motivation for change or offers a warm hand off to a behavioral health consultant.

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Brief Intervention

- For patients with **at-risk** use but no alcohol or substance use disorder: conduct a brief intervention, provide follow-up and ongoing care.
- For patients with **high-risk use and possible alcohol or substance use disorder:** conduct brief intervention, offer menu of additional support options, & negotiate a plan that may include referral.

Brief Intervention

Raise the subject

Provide feedback

Enhance motivation

Negotiate plan

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Raise the Subject

1. Ask Permission
2. “Thank you for completing the screener.”
3. “Can I share some information about the screener you took today?”
4. “Is it okay if I share what I know about the results of the alcohol screen you did today?”
5. “Is it alright with you if I tell you what I am concerned about?”
6. If they say, “Yes” then continue.
7. If they say, “No” then be respectful.

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PROVIDE FEEDBACK

Set the stage, Discuss the Screening Results

Range – "Scores on the AUDIT range from 0-40. Most people who are social drinkers score less than 8." (Or whatever screener you used)

Results – "Your score was 18."

Interpretation of results – "That is the moderate to high use range. At this level, your use is putting you at risk for a variety of health issues (physical, mental) now or sometime in the future."

Norms - "A score of 18 means that your drinking is higher than 75 percent of the adult population."

Patient Reaction – "What are your thoughts?"

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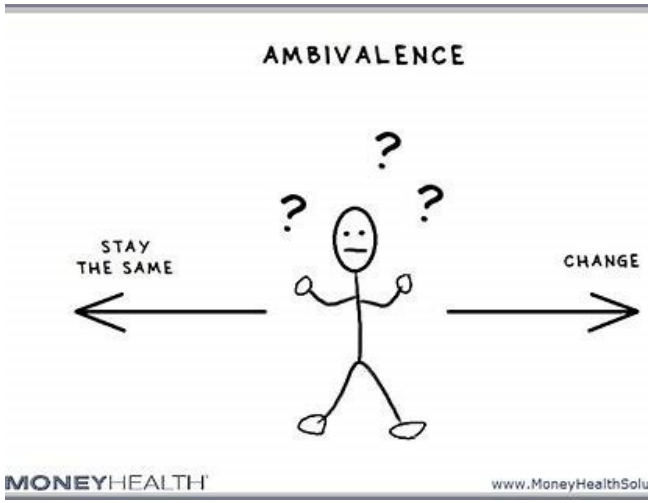
Side Note: Ambivalence

- No one is unmotivated.
- We are not **creating** motivation but **evoking** it.



- Ambivalence – simultaneously wanting and not wanting something
  - This is a normal part of the change process.
  - Not resistance
  - Not pathology

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Enhance Motivation

- Listen to understand – Not to respond.
- They will give us our road map.
- If you find the thing THEY want to do, you have had a successful intervention.

Preparatory Change Talk:

- Desire – "I want…"
  - Want, wish, like, and love
- Ability – How confident they are that they could make the change
  - Can, could, able, and possible
- Reasons – "if, then…" Advantages and disadvantages
  - Changing my diet would help me manage my diabetes.
- Need – Emphasizes urgency to change; it is important, but doesn't specify *why* it is
  - "Have to, need to, must, etc."

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Mobilizing Change Talk:

- Commitment Language
  - Assurance it will happen
  - "I will." "I promise." "I guarantee."
- Activation Language
  - Leaning towards action but haven't quite decided
  - "I'm willing to." "I'm considering it." "I'll think about it."
- Taking Steps Language
  - The person indicates they're already taking steps.
  - "I filled my prescription." "I called 3 places about possible jobs today." etc. "I bought a ring."

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Ambivalence

CHANGE TALK

1. I want to quit smoking.
2. I think it's possible for me to quit.
3. My kids are begging me to quit.
4. I have to quit smoking.
5. I'm willing to try to quit smoking.
6. I'm going to quit.
7. I bought nicotine gum today.

SUSTAIN TALK

1. I enjoy smoking.
2. I don't think I can stand the withdrawal.
3. Smoking is how I relax.
4. I need to smoke.
5. I plan to continue smoking.
6. I've decided to keep smoking.
7. I bought cigarettes today.

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We opened the can of worms...

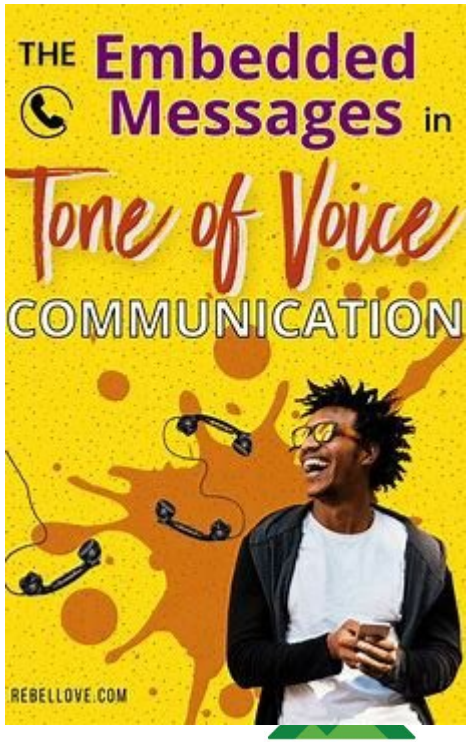
NOW WHAT DO I DO!?

Evoking Skills:

- What makes you want to do this?
- How much does it matter to you?
- What reasons are there for you to do this?
- How important is this?
- ***The change must be important, and they must have confidence.***

Directional Questions

- ✓ Elicit Change Talk
  - ✓ **How would you like things to be different…(Desire)**
  - ✓ **How might you…(Ability)**
  - ✓ **What are your reasons…(Reason)**
  - ✓ **How important is it… (Need)**
- ✓ Reflect what you've heard them state
- ✓ "You would like to cut back on your alcohol use for your kids. It's impacting your relationships."



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Importance and Confidence

- "How important is it for you right now to cut back on your alcohol use?"
- Why a 4 and not a 1?
  - Notice you get change talk
- Why a 4 and not a 7?
  - Notice you get sustain talk.
- On the confidence scale, we want the patient to rate themselves 7 or higher.

Importance & Confidence Ruler

IMPORTANCE SCALE:

How important is it for you right now to...? On a scale from 0- 10... what number would you give yourself?

0_____10

CONFIDENCE SCALE:

If you did decide to change, how confident are you that you would succeed? On a scale from 0 -10... what number would you give yourself?

0_____10

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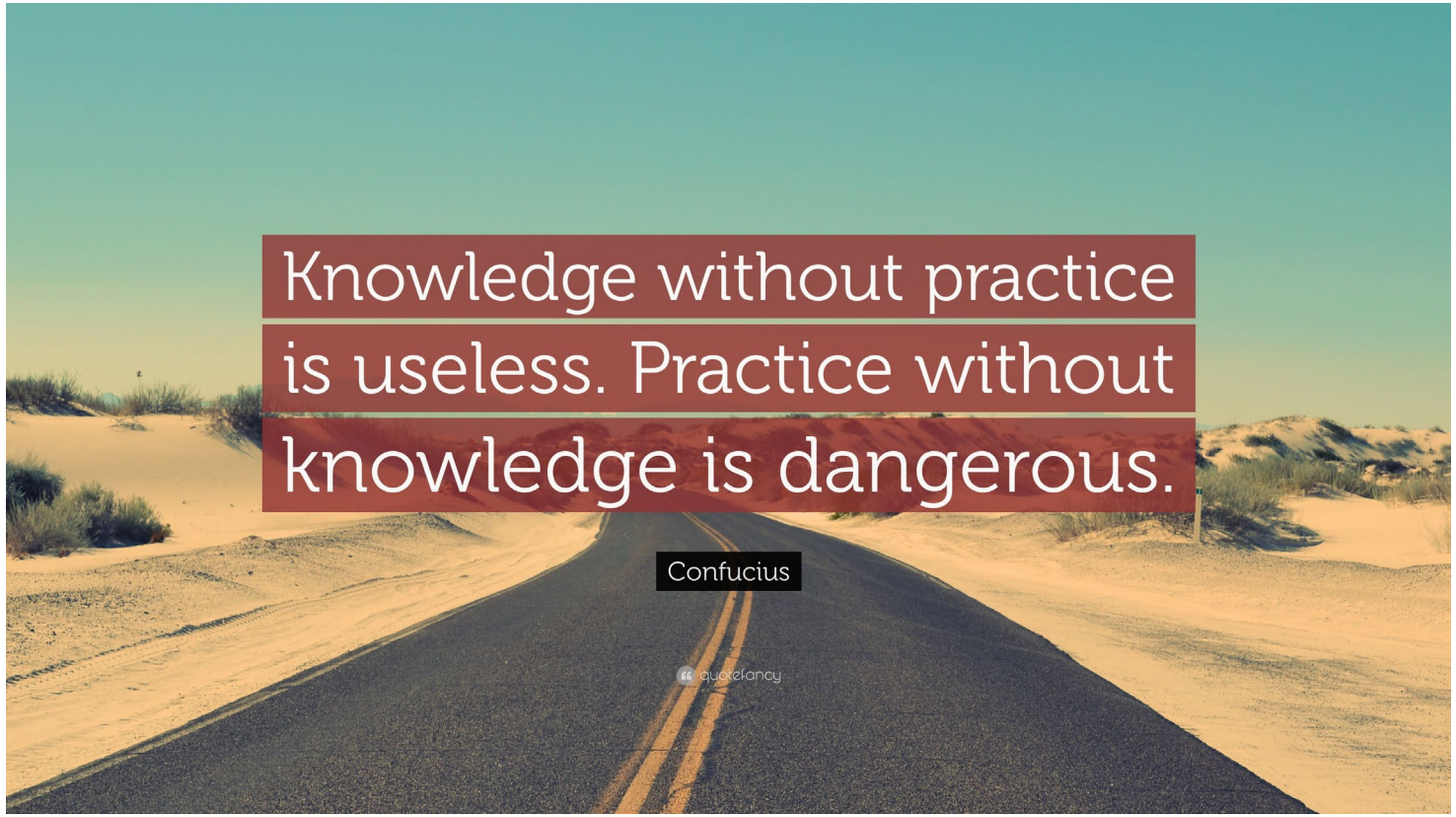
Real Play

Break Out Groups:

Choose something trivial that you feel "ambivalence" towards. Select an interviewer and person willing to explore their "ambivalence." Keep it simple. Use the Scaling Questions for Importance and Confidence.

Reflect on how this felt.



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Sustain Talk

“Smoking is how I relax.”

Ask - elicit what they already know. what concerns do you have about smoking?

Offer - ask permission - then share advice or feedback - get consent then offer

Ask - what do you think? what would you want to do with that? etc

“Smoking has become a coping skill.” (Reflection) Explore what is helpful about smoking. Use reflections.

LISTEN

“What is not so helpful about smoking?”

LISTEN

“Can I tell you what I know?”

ASK

“What do you think?”

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What if they say….

I DON'T KNOW…

Ask Permission

- " I have some ideas about things that have worked for other people and I'd like to share those with you to see if it generates any ideas for you. Would that be OK?"

I DON'T WANT TO DO ANYTHING…

Reflect – "You aren't ready to do anything right now."

Ask Permission – "Could I run an idea by you?"

"How about you do nothing and observe. Just notice what you use, maybe how much or when you tend to drink. Notice and make a note and then let's talk about it the next time we see each other."

It is a win/win

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Encourage Autonomy

- **<u>Even when you have permission…</u>**
- "It's up to you what you decide…"
- "You probably already know this…"
- "I wonder what you would think of…"
- "I can tell you what has worked for others, but at the end of the day, it's up to you. Would you like to hear some ideas you could consider?"
    - Then give multiple options to consider and ask an open-ended question.

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Choices:

- People are more likely to follow through on action they've chosen themselves.
- Suggesting one thing at a time will often lead to sustain talk…
- "Some people have had success using medications for SUD, attending group or IOP. Some people prefer 30 days of inpatient to get their feet under them, and some people continue seeing me for a while to see how things go. What do you think you would like to try?"

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Example…

Pt: What do you think I should do?

BH: We could look at medications that could help you to stop drinking.

Pt: I don't believe in meds. They are a crutch.

BH: There are some support groups in town.

Pt: I've been to support groups. It is just a way to meet people to go use with.

BH: There are in-patient options we could refer you to.

Pt: I would have to miss too much work. I'd lose my job and home.

BH: We could look at IOP. They have group in the evening.

Pt: Group is triggering for me. I get too anxious around people.

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Moving from Why to How…

- Summarize – Bouquet of Change Talk
- And ask…"What next?"
  - What are you considering?
  - What might you try?
  - How do you want to move forward?
- "You know yourself best, how do you think you could move forward?"
- "How **important** is this to you? How **confident** are you?"
  - Not "are you ready?"

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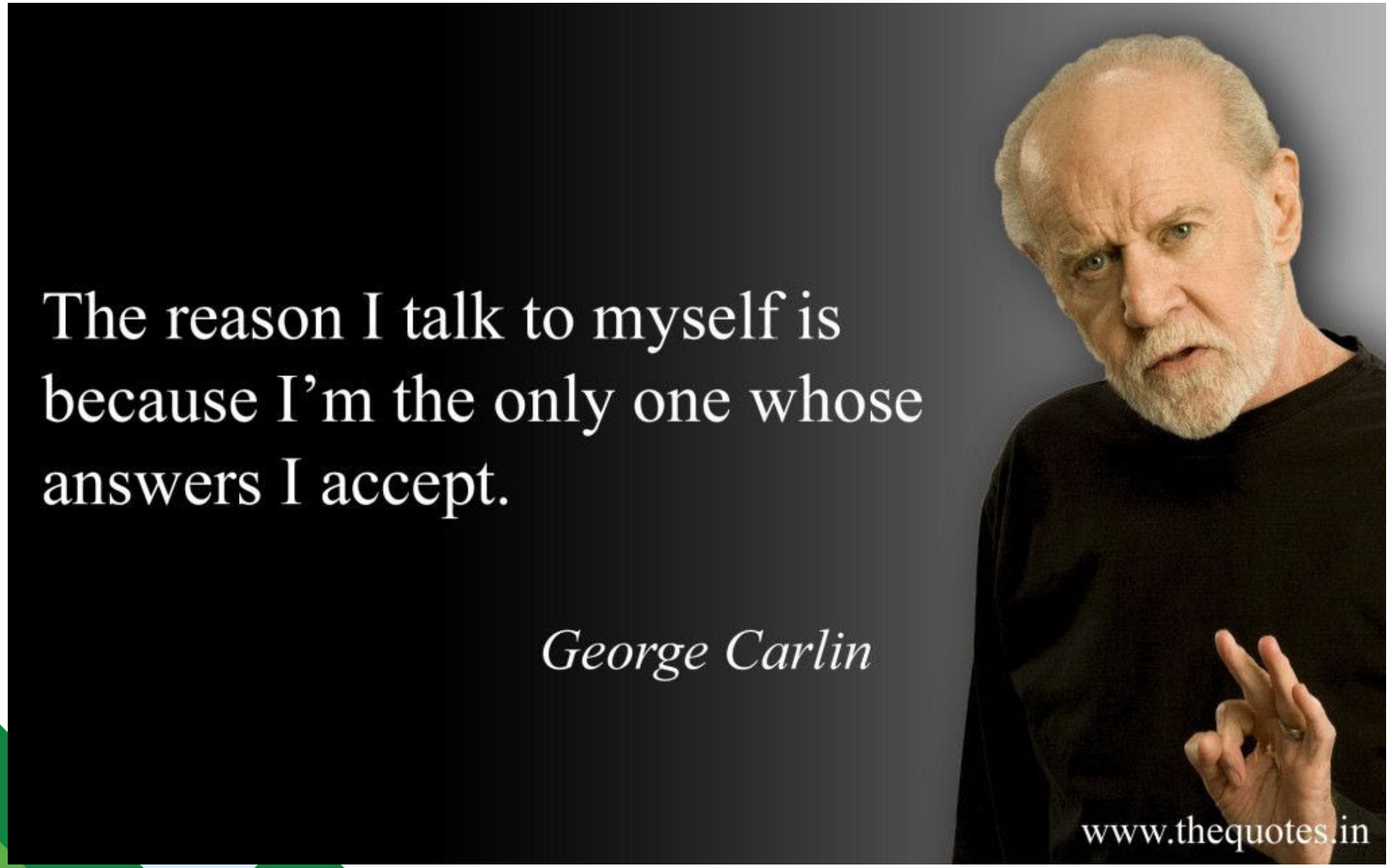

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Planning

How will you get there?

- Evoking the "how" of their change
  - What will you do…(Commitment)
  - What are you considering…(Activation)
  - What have you already done…(Taking Steps)
- Focusing on the specifics of the plan
- Must fit into the person's lifestyle – their daily patterns and routines
  - Where, when, and how etc.
- Only the individual knows what will work for them
- What are they ready, willing, and able to do?

Evoke Hope and Confidence

The change plan is an **experiment** – "Let's try and see how this goes..."

If this doesn't work, we will try something different next time.

Their belief that this is possible is a predictor of change happening.

Affirm strengths to boost confidence!

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8 Clinical Skills

Even when therapists follow a structured treatment manual, research shows that some therapists are just more effective than others regardless of years' experience...

1. Accurate Empathy
2. Hope
3. Positive Regard
4. Acceptance
5. Shared Goals
6. Evocation
7. Offering Information and Advice
8. **Genuineness**

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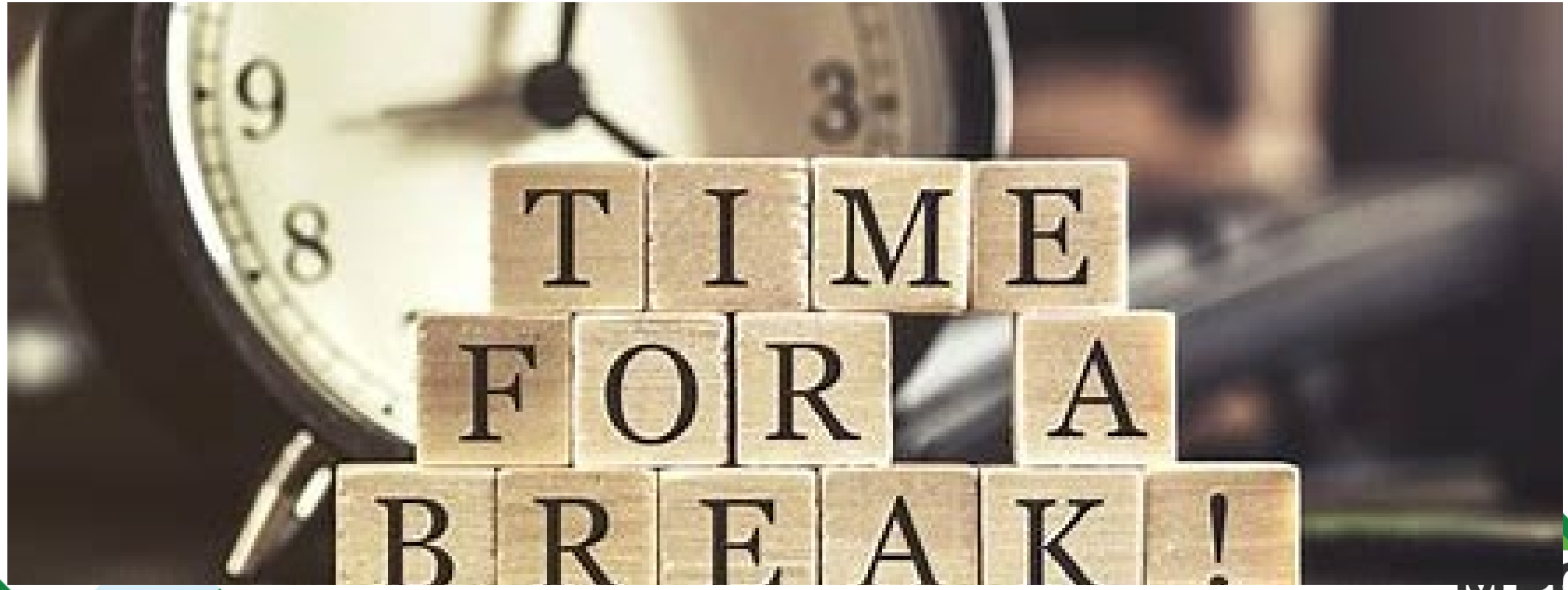
Take 10 Minutes – See You Soon!



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An Example...

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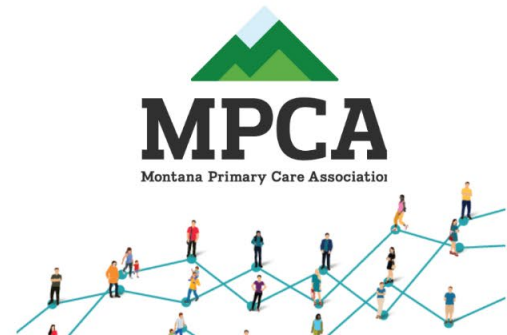
Discuss:

Did the interviewer hit all the steps:

- Raise the Subject
- Provide Feedback
- Enhance Motivation
- Negotiate a Plan

How do you think she did? How did the patient respond?

What would you do differently?



Paradigm Shift

Acute Care Model:

- Enter treatment.
- Complete assessment.
- Receive treatment.
- Discharge.

Goal of Treatment

- Help patients **stop all substance use.**

Chronic Care Model:

- Prevention
- Early Identification
- Referral to Treatment
- Recovery Supports

Goal of Treatment

- **Reduce** morbidity and mortality.
- **Maximize** function.
- **Improve** wellness.

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Plan with Harm Reduction Principles

Harm Reduction Principles

- Design and promote public health interventions that minimize the harmful effects of drug use.
- Drug use is a reality. Abstinence-only will not work for everyone.
- Accessible + Low Threshold Services for people who use drugs. Abstinence is NOT a requirement for services.
- Understand that drug use is complex and can include a range of behaviors from habitual, chaotic drug use to abstinence.
- Meets people where they are in their use and in their lives.

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Negotiate a Plan – Harm Reduction

Track what you drink. Become aware of how much, how often, where and with whom you drink

Buy less so you use less. Buying large amounts of a drug may be cheaper, but you could end up using more than you want to simply because it's there.

Set a time limit before you start. If you choose, say, to stop drinking at 10:00 p.m., watch the time, remind yourself of your time plan, and stick to it. Have some juice ready.

Eat a meal before you start, and avoid snacking on salty foods, especially if you're drinking. You may drink more out of thirst.

Lower your dosage and frequency. In other words, drink, smoke or inject in smaller amounts—and less often—than you do now. When it comes to alcohol, this could mean choosing light beer or other low-alcohol drinks, or alternating drinks with water or pop.

Choose the least harmful method of use. Injecting a drug carries more risk than smoking, snorting or swallowing it. (If you do inject drugs, avoid the neck area.) When it comes to cannabis, using a vaporizer or smoking a joint (with a rolled-up cardboard filter) is safer than using a bong and some pipes.

Plan out some drug-free days. The fewer days in a row you use a drug, the better. If you use the drug every day, try cutting back your use to every other day, and try not using it at all for two to three days. (Make sure you have in mind other ways to spend your time and energy, so y you don't end up sitting around and thinking about how you miss getting "buzzed".

Use at your own speed and don't feel pressured from others to pick up the pace.

Find someone caring and understanding to talk to when you're struggling to stick to your reduced use plan.

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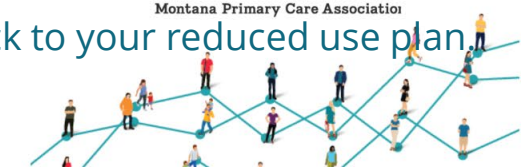


Another Example:

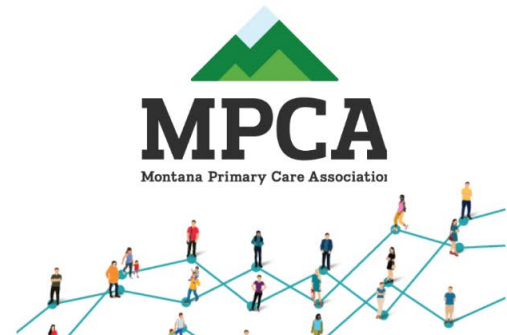
Discuss:

Did the interviewer hit all the steps:

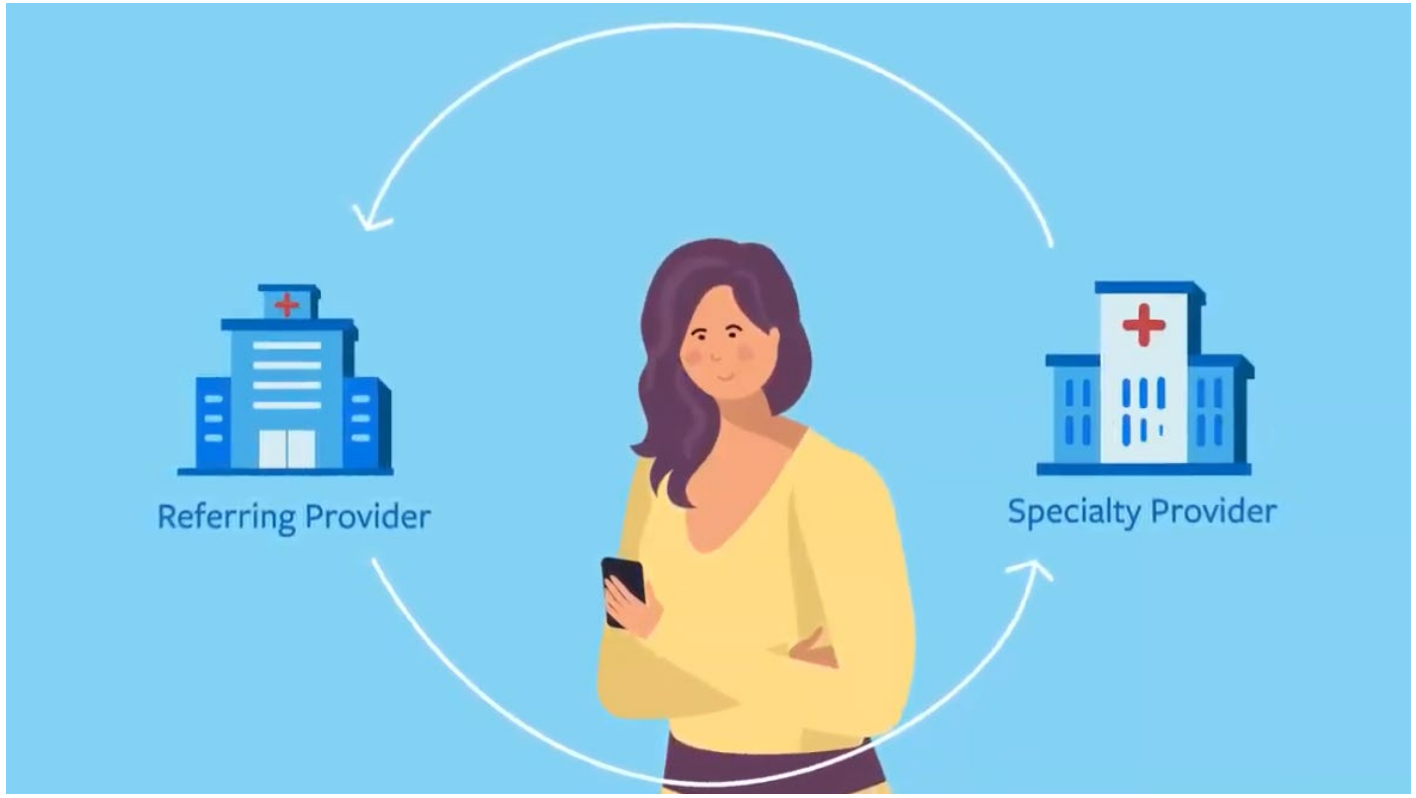
- Raise the Subject
- Provide Feedback
- Enhance Motivation
- Negotiate a Plan

What strategies did you hear the interviewer use? How did the patient respond?

What would you do differently?



Referral to Treatment:



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Referral to Treatment

- About 5% of patients screened could be referred to SUD evaluation and treatment.
- An appropriate referral is when the patient's responses to the screening reveals serious medical, social, legal, interpersonal consequences associated with their substance use
- Know local and state resources.
  - Have a well-developed workflow that is easily accessible to your patient!
  - Use the entire team
- Develop relationship with professionals and the patient.

Warm Hand Off

- "I have a co-worker, Jamie, who is great at helping people plan for how they want to make lifestyle changes and cut back on alcohol use. I'm going to have her visit with you for just a few minutes. Then I'll be back to finish up our appointment."
- "You have a lot on your plate right now, and it seems like using is your only option. My coworker, Camille, is an expert at helping people manage their stress and improve their health. She is going to visit with you for a minute, then I'll be back."

Primary Care Behavioral Health

- Ideally, your PCBH Team will engage the patient.
- Aim for at least 3 touches with the patient in the 1st week.
  - Use the entire team.
  - Care Management, PCP, Nurse, MA, Pharmacy, and BH
- The BHC will deliver their “Elevator Speech” and Intervention
- And schedule follow up as needed

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Follow up

Negotiating a time frame for follow-up with the patient may enhance the likelihood that the patient returns.

Studies indicate that just one additional visit can significantly improve the effectiveness of your intervention (Rubak et al., 2005).

Monitoring

Whether or not patients treated with medications or counseling in primary care are benefiting and if not, does their treatment need to be changed or augmented?

Monitoring

- At a minimum, monitor the frequency of use with AUDIT-C +2 every three months.
- Repeated visits should include repeated brief intervention with MI, tracking symptoms, and patients' self assessment.
- Plant a seed and show you accept the person as they are!

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Follow Up Example:

Referral to Higher Level of Care

- Could be Treatment Center
  - In-Patient, Outpatient, Intensive Outpatient
- May require a Substance Use Assessment (ASAM)
  - Create a workflow
  - When the patient is ready, this should be an easy to engage workflow that meets the patient's needs where they are.

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Putting it Together

SBIRT

Alcohol Screening, Brief Intervention, and Referral to Treatment

1. Use a validated Screener
   - Provided at check in by the front desk
   - Completed in Waiting Room
2. Brief Intervention
   - Raise the Subject
   - Provide Feedback
   - Enhance Motivation
   - Negotiate a Plan
3. Referral to Treatment
   - A Warm Hand Off

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Getting Started…

1. Identify a champion
2. Choose screening tool
3. Develop Reasonable Workflow
4. Train Staff
5. Practice
6. Normalize!
7. PDSA
   - Plan, Do, Study Act

Requirements for SBIRT – Policy 514

Definition Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based intervention to identify those members at risk for psychosocial or health care problems related to their substance use. Screening is intended to identify unhealthy substance use. Brief intervention provides feedback about unhealthy substance use and focuses on education, increasing member insight and awareness about the risks related to unhealthy substance use and enhances motivation toward healthy behavioral change.

Referral to treatment helps facilitate access to addiction assessment and treatment.

Medical Necessity Criteria (1) The member must present with patterns of substance use that puts their health at risk.

Provider Requirements (1) SBIRT may be provided by a licensed behavioral health professional, a physician, a midlevel, or a supervised unlicensed staff. (2) Appropriate staff providing this service must have a minimum of four hours training approved by the department related to SBIRT services that is documented in the staff's personnel file.

Billing SBIRT

- Many providers use standard billing guidelines and bill for SBIRT services based on time or complexity (clinical decision making) similar to billing for other services
- Special primary care billing codes allow providers to bill additional amounts, in addition to standard Evaluation & Management (E&M) codes, if screening and brief intervention takes at least 15 minutes
- Additional reimbursement using this approach is modest and requires careful documentation
- Detailed CMS billing guidelines available:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf

Billing Codes

Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes	$48.00

Coding for Screening and Brief Intervention Reimbursement | SAMHSA

Reflection Exercise

Share your reactions to SBIRT. Use the following questions to guide your discussion.

1. What are your “take-home lessons” for screening and brief interventions?
2. How might SBIRT work best for you?
3. What would make it more effective in your practice?
4. What questions or suggestions do you have regarding brief interventions for patients with possible alcohol or substance use disorder?

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