SBIRT with Adolescent Patients

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OHSU FAMILY MEDICINE

SBIRT OREGON

Oregon Pediatric Society
A Chapter of the American Academy of Pediatrics
Website: sbirtoregon.org

- Demonstration videos
- Screening forms
- Billing code information
- Pocket cards and tools
- Training curriculum
- Role plays
SBIRT

Screening  Brief Intervention  Referral to Treatment

“A public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders.”

SAMHSA
1. Why SBIRT?
# SBIRT vs. business as usual

<table>
<thead>
<tr>
<th>SBIRT implemented</th>
<th>No SBIRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Routine and universal screening, regardless of medical complaint</td>
<td>• Inconsistent and selective screening</td>
</tr>
<tr>
<td>• Validated, standardized screening tools</td>
<td>• Non-systematized narrative questions</td>
</tr>
<tr>
<td>• Alcohol use seen as a continuum</td>
<td>• Alcohol use seen as dichotomous</td>
</tr>
<tr>
<td>• Evidence-based, patient-centered change talk</td>
<td>• Ineffective, directive style of communication</td>
</tr>
<tr>
<td>• Ongoing transition between primary care and treatment</td>
<td>• Discoordinate/unclear referrals and follow up</td>
</tr>
</tbody>
</table>
SBIRT metrics

- Oregon: Medicaid performance measure for primary care and ED settings
- Affordable Care Act: reimbursement for brief interventions
- Joint commission: Alcohol SBI plus drug treatment
- Trauma centers mandated for alcohol SBI
Some reasons teens use alcohol and drugs

- Desire for new experiences
- Attempt to deal with problems
- Perform better in school
- Peer pressure
- To feel good

NIDA, 2011
Risks of adolescent substance use

- Morbidity and mortality.
- Even first use can result in tragic consequences.
- Teenagers are particularly susceptible to health risk-taking behaviors and injuries related to substance use.
- Neurodevelopmental vulnerability
- Age at first use is inversely correlated with lifetime incidence of developing a substance use disorder.

AAP, 2011
Reasons to routinely screen for substance use with teen patients

- It’s common
- It’s risky to their health
- It often goes undetected
- Validated screening tools can identify risk

NIAAA, 2011
Adolescent substance use at a glance

Of high school seniors:

- Almost 70% have tried alcohol
- Half have taken an illegal drug
- More than 20% have used a prescription drug for a nonmedical purpose

Johnston et al, 2013
Alcohol use among adolescents

Johnston et al, 2013
Alcohol Use in the Past Month, ages 12-17, (2012-2013)
“During the past 30 days, on how many days did you have at least one drink of alcohol?” (Oregon, 2015)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>8th graders %</th>
<th>11th graders %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 or 2 days</td>
<td>7.7</td>
<td>16.8</td>
</tr>
<tr>
<td>3 to 5 days</td>
<td>1.9</td>
<td>6.6</td>
</tr>
<tr>
<td>6+ days</td>
<td>2.3</td>
<td>5.7</td>
</tr>
<tr>
<td>Total</td>
<td>11.9</td>
<td>29.1</td>
</tr>
</tbody>
</table>
Binge Alcohol Use in the Past Month, ages 12-17, (2012-2015)
“During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?” (Oregon, 2015)

<table>
<thead>
<tr>
<th></th>
<th>8th graders %</th>
<th>11th graders %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 days</td>
<td>2.5</td>
<td>7.0</td>
</tr>
<tr>
<td>2 days</td>
<td>1.2</td>
<td>4.2</td>
</tr>
<tr>
<td>3 to 5 days</td>
<td>0.9</td>
<td>3.4</td>
</tr>
<tr>
<td>6+ days</td>
<td>0.7</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5.3</strong></td>
<td><strong>16.5</strong></td>
</tr>
</tbody>
</table>

Oregon Healthy Teens Survey
Perceptions of Great Risk of Having Five or More Drinks Once or Twice a Week ages 12 to 17 (2012-2013)

[Map of the United States with color coding for percentages of persons]

Percentages of Persons
- 41.50 - 47.67
- 38.60 - 41.49
- 37.46 - 38.59
- 35.64 - 37.45
- 30.01 - 35.63

SAMHSA
“How much do you think people risk harming themselves (physically or in other ways) if they have five or more drinks of an alcoholic beverage once or twice a week? (Oregon, 2015)

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>8th graders %</th>
<th>11th graders %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No risk</td>
<td>7.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Slight risk</td>
<td>14.9</td>
<td>13.5</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>29.8</td>
<td>29.8</td>
</tr>
<tr>
<td>Great risk</td>
<td>47.4</td>
<td>51.8</td>
</tr>
</tbody>
</table>

Oregon Healthy Teens Survey
Marijuana Use in the Past Month, ages 12 to 17 (2012-2013)
“During the past 30 days, how many times did you use marijuana?” (Oregon, 2015)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>8th graders %</th>
<th>11th graders %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 or 2 times</td>
<td>3.6</td>
<td>6.4</td>
</tr>
<tr>
<td>3 to 5 times</td>
<td>1.6</td>
<td>3.5</td>
</tr>
<tr>
<td>6 to 9 times</td>
<td>1.0</td>
<td>1.8</td>
</tr>
<tr>
<td>10+ times</td>
<td>2.6</td>
<td>7.4</td>
</tr>
<tr>
<td>Total</td>
<td><strong>8.8</strong></td>
<td><strong>19.1</strong></td>
</tr>
</tbody>
</table>

Oregon Healthy Teens Survey
Illicit Drug Use Other Than Marijuana in the Past Month, ages 12-17 (2012-2013)

Percentages of Persons

- 3.87 - 5.40
- 3.46 - 3.86
- 3.01 - 3.45
- 2.74 - 3.00
- 2.39 - 2.73

SAMHSA
Drugs other than marijuana used at least once in the last 30 days (2013)

<table>
<thead>
<tr>
<th>Drug Description</th>
<th>8th graders %</th>
<th>11th graders %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs w/out Dr.'s orders</td>
<td>3.9</td>
<td>6.4</td>
</tr>
<tr>
<td>Sniff glue or inhale paint</td>
<td>2.7</td>
<td>1.4</td>
</tr>
<tr>
<td>LSD or other halluc.</td>
<td>1.2</td>
<td>1.9</td>
</tr>
<tr>
<td>Ecstasy/MDMA</td>
<td>1.3</td>
<td>1.8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Meth</td>
<td>1.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.8</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Oregon Healthy Teens Survey
Percent experiencing addiction in lifetime, based on age of first use, U.S.

Hingson et al 2006, SAMHSA 2010
Adolescence is a critical time for preventing addiction

% of treatment admissions of persons ages 18 - 30

<table>
<thead>
<tr>
<th>Age started using</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤11</td>
<td>10</td>
</tr>
<tr>
<td>12-14</td>
<td>30</td>
</tr>
<tr>
<td>15-17</td>
<td>50</td>
</tr>
<tr>
<td>18-24</td>
<td>20</td>
</tr>
<tr>
<td>25≥</td>
<td>5</td>
</tr>
</tbody>
</table>

SAMHSA 2011
Risks of adolescent alcohol and marijuana use

- Brain damage
- Injuries
- School Failure
- Violence
- Arrests, Incarceration
- Sexual assaults
- Pregnancy
- STDs
- Later addiction
- Stunted growth and fertility
- Suicide

NIDA, Office of the Surgeon General, NPR, CSAM, Hendershot et al, IBT GWU, 2007 - 2014
## Leading Causes of mortality, ages 10-24

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor vehicle crashes</td>
<td>30%</td>
</tr>
<tr>
<td>Other unintentional injuries</td>
<td>16%</td>
</tr>
<tr>
<td>Homicides</td>
<td>16%</td>
</tr>
<tr>
<td>Suicides</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>74%</strong></td>
</tr>
</tbody>
</table>

All are associated with alcohol and drug use

Eaton et al., 2010
Factors increasing problem use among adolescents

- Presence of mental health disorders:
  - Depression, anxiety, bipolar, schizophrenia
- Minority race and ethnicity
- Genetics
- Personality traits
- Influence of family and peers
Images of brain development

Blue represents maturing of brain areas.

Prefrontal Cortex
23–43% of Peds and 14–27% of FPs routinely ask adolescent pts about alcohol use

Less often with younger pts 11-14 years old

Screening quality varies

Millstein and Marcell, 2003
Accuracy of clinical impressions of teen substance use

- 14-18 year old patients
- 109 medical providers
- Adolescent Diagnostic Interview used as gold standard

<table>
<thead>
<tr>
<th></th>
<th>Sensitivity (CI)</th>
<th>Specificity (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any use</td>
<td>.63 (.58-.69)</td>
<td>.81 (.76-.85)</td>
</tr>
<tr>
<td>Any problem</td>
<td>.14 (.10-.20)</td>
<td>1.0 (.99-1.0)</td>
</tr>
<tr>
<td>Any disorder</td>
<td>.10 (.04-.17)</td>
<td>1.0 (.99-1.0)</td>
</tr>
<tr>
<td>Dependence</td>
<td>0.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Wilson et al., 2004
Top 6 cited barriers to screening for adolescent substance use

- Not enough **TIME**
- No **TRAINING** (to deal with + screen)
- Need to **TRIAGE** competing priorities
- Perceived lack of **TREATMENT**
- **TENACIOUS** Parent (who won’t leave teen)
- Not familiar with screening **TOOLS**

Van Hook et al., 2007
## Remedies to barriers

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Remedy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>Screening can be completed prior to visit</td>
</tr>
<tr>
<td>Training</td>
<td>Short trainings can provide skills</td>
</tr>
<tr>
<td>Triage</td>
<td>Challenging but also consider what NOT to miss</td>
</tr>
<tr>
<td>Treatment</td>
<td>Local treatment options/resources</td>
</tr>
<tr>
<td>Tenacious parent</td>
<td>Screening can be done in private</td>
</tr>
<tr>
<td>Tools</td>
<td>Brief, valid, reliable, developmentally appropriate tools available</td>
</tr>
</tbody>
</table>
II. Screening
AAP recommendations for SBIRT

- Ensure appropriate confidentiality
- Screen with a validated tool at every visit
- All pts age 11 or older
- Respond with brief interventions and referrals when indicated

Bright Futures, AAP 2008
Pts ≥15 can consent to medical services. (ORS 109.640)

Oregon law does not give minors a “right” to confidentiality or parents a “right” to disclosure.

Providers are encouraged to use their best clinical judgment over whether to disclose (ORS 109.650)

Bright Futures, AAP 2008
Recommended confidentiality towards SBI

- Establish a confidentiality policy
- Establish a standard routine to screen universally
- Communicate to patient and parent that privacy is needed to complete the screen.
When parents ask to review their minor’s records

Things to consider:

- Review your confidentiality policy with parents.
- Discuss the benefits of maintaining confidentiality.
- Assure parents that their teen has been screened.

How does your clinic handle disclosure?
Adolescent full screen

Front

CRAFFT

PHQ-2

Back

PHQ-9 Modified for Teens

www.sbirtoregon.org
Common clinic workflow

Adolescent Full screen + Brief intervention and/or referral

When patient is roomed or during exam

In the exam room
Teens “very comfortable” with CRAFFT delivery method

<table>
<thead>
<tr>
<th></th>
<th>Paper</th>
<th>Computer</th>
<th>Doctor</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>75%</td>
<td>67%</td>
<td>59%</td>
<td>57%</td>
</tr>
<tr>
<td>Originally interview administered</td>
<td>76%</td>
<td>66%</td>
<td>62%</td>
<td>60%</td>
</tr>
<tr>
<td>Originally computer administered</td>
<td>65%</td>
<td>72%</td>
<td>39%</td>
<td>35%</td>
</tr>
<tr>
<td>Pts with CRAFFT score ≤ 1</td>
<td>76%</td>
<td>68%</td>
<td>61%</td>
<td>58%</td>
</tr>
<tr>
<td>Pts with CRAFFT score ≥ 2</td>
<td>68%</td>
<td>61%</td>
<td>51%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Knight et al 2007
Teen pts “very likely to be honest” on substance use screening form

<table>
<thead>
<tr>
<th>N=2133</th>
<th>Paper</th>
<th>Computer</th>
<th>Doctor who pt does know</th>
<th>Nurse who pt does know</th>
<th>Doctor who pt does not know</th>
<th>Nurse who pt does not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>All pts</td>
<td>95%</td>
<td>91%</td>
<td>90%</td>
<td>89%</td>
<td>84%</td>
<td>84%</td>
</tr>
<tr>
<td>Pts with problem use</td>
<td>96%</td>
<td>92%</td>
<td>91%</td>
<td>90%</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>Pts with SUD</td>
<td>91%</td>
<td>89%</td>
<td>83%</td>
<td>83%</td>
<td>80%</td>
<td>79%</td>
</tr>
</tbody>
</table>

Knight et al 2007
CRAFFT screening tool

- **Car Relax Alone Forget Friends Trouble**

- Validated for:
  - Adolescent patients, ages 12-17
  - Spanish-speaking and Native American teens

- Can be self-administered or clinician-administered

Mitchell et al, 2014; Harris et al, 2015; Cummins et al 2003; Gomez, 2011
Score: No risk

- “No” to three first questions and “No” to car question
- Even a few positive words can delay initiation.
- Summarize risks
- “If it ever changes, I hope that you trust me enough to tell me.”

Levy & Kokotailo, 2011
Score: Low risk

- “Yes” to one or more of opening questions, but CRAFFT score = 0
- Brief advice
- Provide relevant medical information
- Ask at next visit

Levy & Kokotailo, 2011
Brief advice examples

“Because I care about your health, I recommend that you don’t use drugs or alcohol at all, because . . .

- Marijuana directly affects your brain and your ability to think clearly.
- Teens make decisions when they are drinking or using drugs that they often regret.
- Teens who use are more likely to be victims of car accidents”
Score: Riding risk

- “Yes” to the CAR question
- Teens should not drive even after a single drink – often teens don’t notice the early effects of alcohol
- Discuss safer alternatives
- Ask teen to take home the “Contract For Life” to discuss with parent(s) or adult. Offer to facilitate conversation.

CONTRACT FOR LIFE
Between Teenagers and Parents

Teenager:
I will not drive if I have been drinking or using drugs. I agree to call you for advice and/or transportation at any hour from any place if I am ever faced with a situation where a driver has been drinking or using illegal drugs. I have discussed with you and fully understand your attitude towards any involvement with underage drinking or using illegal drugs.

Teenager’s signature Date

Parent or trusted adult:
I agree to come and get you at any hour, any place, no questions asked and no argument at that time, or I will pay for a taxi to bring you home safely. I expect we would discuss this at a later time.

I agree to seek safe, sober transportation home if I am ever in a situation where I have had too much to drink or a friend who is driving me has had too much to drink.

Parent or trusted adult’s signature Date

Levy & Kokotailo, 2011
Score: Moderate risk

- CRAFFT score = 1.
- Brief intervention recommended to enhance pt’s motivation to change behavior.
- Consider recommending a time limited trial of abstinence (3-month) and return visit to discuss.

Levy & Kokotailo, 2011
Brief interventions with adolescents

- Employ motivational interviewing (MI)
- Well suited for adolescents (desire for autonomy, resistance to authority)
- Evidence accumulating on the effectiveness

Score: High risk

- CRAFFT score ≥ 2.
- Indicates referral for further assessment and possible specialized treatment
- Deliver referral through brief intervention

Levy & Kokotailo, 2011
## Validity study of CRAFFT score ≥ 2

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sens</th>
<th>Spec</th>
<th>PPV</th>
<th>NPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any problem use or SUD</td>
<td>.79</td>
<td>.97</td>
<td>.84</td>
<td>.95</td>
</tr>
<tr>
<td>Mild SUD</td>
<td>.91</td>
<td>.93</td>
<td>.64</td>
<td>.99</td>
</tr>
<tr>
<td>Moderate – severe SUD</td>
<td>.88</td>
<td>.87</td>
<td>.32</td>
<td>.99</td>
</tr>
</tbody>
</table>

- **N=525, ages 12-17**
- 45% male, mostly African American
- Setting: CHC in Baltimore
- Used DSM-V definitions

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk</th>
<th>Recommended action</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No” to 3 opening questions</td>
<td>Low risk</td>
<td>Positive reinforcement</td>
</tr>
<tr>
<td>“Yes” to car question</td>
<td>Driving/Riding risk</td>
<td>Discuss plan to avoid driving after alcohol or drug use or riding with a driver who has been using alcohol or drugs (Consider offering Contract for Life)</td>
</tr>
<tr>
<td>CRAFFT score = 0</td>
<td>Moderate risk</td>
<td>Brief advice</td>
</tr>
<tr>
<td>CRAFFT score = 1</td>
<td></td>
<td>Brief intervention</td>
</tr>
<tr>
<td>CRAFFT score ≥ 2</td>
<td>High risk</td>
<td>Consider referral for further assessment</td>
</tr>
</tbody>
</table>

Levy & Kokotailo, 2011
## CRAFFT scores across sites

<table>
<thead>
<tr>
<th>CRAFFT score/Specific question</th>
<th>All (n=2133)</th>
<th>Peds clinic (n=747)</th>
<th>HMO (n=483)</th>
<th>Adoles. Clinic (n=499)</th>
<th>Rural Fam Prc (n=282)</th>
<th>School clinic (n=122)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>65%</td>
<td>78%</td>
<td>69%</td>
<td>58%</td>
<td>52%</td>
<td>42%</td>
</tr>
<tr>
<td>1</td>
<td>20%</td>
<td>15%</td>
<td>17%</td>
<td>26%</td>
<td>24%</td>
<td>28%</td>
</tr>
<tr>
<td>≥ 2</td>
<td>15%</td>
<td>7%</td>
<td>14%</td>
<td>16%</td>
<td>24%</td>
<td>30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific question</th>
<th>12-18 year old pts presenting over 2½ years in New England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Car</td>
<td>24%</td>
</tr>
<tr>
<td>Relax</td>
<td>10%</td>
</tr>
<tr>
<td>Alone</td>
<td>8%</td>
</tr>
<tr>
<td>Forget</td>
<td>10%</td>
</tr>
<tr>
<td>Friends/Family</td>
<td>7%</td>
</tr>
<tr>
<td>Trouble</td>
<td>7%</td>
</tr>
</tbody>
</table>

Knight et al 2007
### Same study: visits and pt status

<table>
<thead>
<tr>
<th>Reason for visit/status</th>
<th>All (n=2133)</th>
<th>Peds clinic (n=747)</th>
<th>HMO (n=483)</th>
<th>Adoles. Clinic (n=499)</th>
<th>Rural Fam Prtc (n=282)</th>
<th>School clinic (n=122)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well child or routine</td>
<td>68%</td>
<td>93%</td>
<td>67%</td>
<td>55%</td>
<td>44%</td>
<td>16%</td>
</tr>
<tr>
<td>Follow up</td>
<td>16%</td>
<td>3%</td>
<td>13%</td>
<td>32%</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>Sick or urgent care</td>
<td>12%</td>
<td>4%</td>
<td>17%</td>
<td>12%</td>
<td>24%</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
<td>0%</td>
<td>3%</td>
<td>1%</td>
<td>11%</td>
<td>44%</td>
</tr>
</tbody>
</table>

| Established                     | 92%          | 98%                 | 94%         | 84%                    | 90%                   | 80%                   |
| New                             | 8%           | 2%                  | 6%          | 16%                    | 10%                   | 20%                   |

Knight et al 2007
Additional reasons to consider a referral

- Patient ≤14 years old
- Daily or near daily use of any substance
- Alcohol-related "blackout" or substance use-related hospital visit
- Alcohol use with another sedative drug
### Screening codes in Oregon

<table>
<thead>
<tr>
<th>Service</th>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full screen (CRAFFT)</td>
<td>Medicaid &amp; Commercial</td>
<td>CPT 99420 plus Z13.89 (alcohol) or Z13.9 (unspecified)</td>
<td>• Administration and interpretation of a full screen.</td>
</tr>
</tbody>
</table>

- Screening results must be discussed with the adolescent and education or brief intervention be facilitated” for the CCO measure.
- Z13.89 may be used as a standalone code

OHA, 2015
In discussing this issue, I educated the patient about risks associated with adolescent substance use and abstain from using alcohol or drugs or ride in a car with an impaired driver.

(CPT 99420 applicable)
### SBI billing codes in Oregon

<table>
<thead>
<tr>
<th>Service</th>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full screen plus brief intervention</td>
<td>Med &amp; Com.</td>
<td>CPT 99408</td>
<td>• 15-30 minutes spent administrating and interpreting a full screen, plus performing a brief intervention.</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
<td>G0396</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Med &amp; Com.</td>
<td>CPT 99409</td>
<td>• Same as above, only ≥ 30 minutes.</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
<td>G0397</td>
<td></td>
</tr>
</tbody>
</table>

- No diagnosis codes necessary
- Time requirements results in rare use of these codes
The patient completed a CRAFFT alcohol and drug screening tool today and the results indicate the patient has used alcohol or drugs with experiencing at least one related problem in the last 12 months. In discussing this issue, I educated the patient about risks associated with adolescent substance use and recommended the patient abstain from using alcohol or drugs or ride in a car with ban impaired driver.

The pt’s readiness to change was 3 on a scale of 0 - 10. We explored why it was not a lower number and discussed the patient’s own motivation for change.

The patient agreed to discuss substance use with a trusted adult. Total clinic time administering and interpreting the screening form, plus performing a face-to-face brief intervention with the pt was <15 minutes.

<15 minutes = CPT 99420
>15 minutes = CPT 99408
>30 minutes = CPT 99409
Who can independently bill for SBI

**Oregon Medicaid:**
- Physicians
- Physician Assistants
- Nurse Practitioners
- Licensed Clinical Psychologists
- Licensed Clinical Social Workers

**Medicare:**
- Physicians (MD, DO only)
- Physician Assistants
- Nurse Practitioners
- Licensed Clinical Psychologists
- Licensed Clinical Social Workers
- Clinical Nurse Specialists
- Certified Nurse Midwives

OHA, 2014
Incident-to billing

- Any clinic employee under supervision can bill for SBI

- Examples:
  - CADCs, Health Educators, Registered Nurses, Clinical Nurse Specialist, Students or Graduates entering medical profession, Community Health Workers

- Some limitations apply
SBIRT CCO measure

Numerator: SBIRT billing codes

Denominator: Medicaid visits of patients age 12 and older

“Perfect” implementation: ~22% (based on prevalence stats.)

OHA benchmark: 12%

OHA Improvement target: Reduction in the gap between previous year’s performance and benchmark by at least 3 percentage points.

www.sbirtoregon.org
SBIRT ED measure

Brief or Full screening rate:

\[
\text{Brief or Full screening rate} = \frac{\# \text{ patients screened}}{\# \text{ visits age 12+}}
\]

Brief intervention rate:

\[
\text{Brief intervention rate} = \frac{\# \text{ patients receiving brief intervention}}{\# \text{ patients who screen positive}}
\]

Hospitals must report both rates, and achieve either a benchmark or improvement target on the screening rate.

**Benchmarks:** Brief screen: 67.8% Full screen: 12%

**Improvement target:** Reduction in the gap between previous year’s performance and benchmark by at least 3 percentage points.

www.sbirtoregon.org
III. Brief intervention
Communication styles during the patient visit

- Directive
- Following
- Guiding
How do you approach conversations about behavior change with your adolescent patients?
Video demonstration:
Directive style of communication towards behavior change
Directive communication towards behavior change

- Explaining why the pt should change
- Telling how to change
- Emphasizing importance of changing
- Persuading

Rollnick, et al., 2008
Common patient reactions to the Directive style

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry</td>
<td>Afraid</td>
</tr>
<tr>
<td>Agitated</td>
<td>Helpless, overwhelmed</td>
</tr>
<tr>
<td>Oppositional</td>
<td>Ashamed</td>
</tr>
<tr>
<td>Discounting</td>
<td>Trapped</td>
</tr>
<tr>
<td>Defensive</td>
<td>Disengaged</td>
</tr>
<tr>
<td>Justifying</td>
<td>Not come back – avoid</td>
</tr>
<tr>
<td>Not understood</td>
<td>Uncomfortable</td>
</tr>
<tr>
<td>Procrastinate</td>
<td>Not heard</td>
</tr>
</tbody>
</table>

Rollnick, et al., 2008
Characteristics of guiding communication

- Respect for autonomy, goals, values
- Readiness to change
- Ambivalence
- Patient is the expert
- Empathy, non-judgment, respect
Brief interventions

- Fit under guiding style
- 3-5 minutes typical in medical settings
- Helps patients further resolve ambivalence
- Single session can have effect
Steps of the brief intervention

- Raise the subject
- Provide feedback
- Enhance motivation
- Negotiate plan
Video demonstration: Brief intervention: “Jacob”

https://www.youtube.com/watch?v=GvaOXREccHI
Steps of the brief intervention

- Screening forms act as conversation starters
- Ask permission
- "Tell me about your substance alcohol/drug use"

Raise the subject
Steps of the brief intervention

- Note CRAFFT score
- Summarize risks of use
- Note connection between use and health issue if applicable
- Give recommendation to abstain

Provide feedback

D`Onofrio, et al., 2005
“We both know that only you can decide whether or not to drink, but as your physician I recommend not to use at all. Teens often do risky things when they drink. If you are not going to quit, cutting down would be a good idea.”

Or:

“From a health perspective, I recommend to all my adolescent patients not to use alcohol or drugs. What you do is up to you.”
Steps of the brief intervention

- Ask and reflect back perceived pros and cons of use
- Use the 0 – 10 scale
- “Why not a lower number?”

D’Onofrio, et al., 2005
“You like to drink alcohol when you go to parties because you like the feeling of being ‘buzzed’. At the same time, alcohol has also gotten you into trouble a couple of times.

“You really enjoy smoking marijuana with your friends. On the other hand, you were suspended from the basketball team after the coach caught you with marijuana, and your parents wouldn’t let you drive the car if they found out.”
Steps of the brief intervention

- If pt is ready: “How do you plan to avoid drinking and drug use?”
- Re-state recommendation
- Schedule follow-up (be creative if necessary)

Negotiate plan

D`Onofrio, et al., 2005
Examples of planning

- Pt considers cutting down to 1 drink when out with friends.
- Pt will not get in a car with any driver who is intoxicated.
- Pt agrees not to have sex when he/she is intoxicated.
- Pt agrees to return for follow-up.
When all else fails the message should be:

- I care about you.
- I am concerned about you.
- I will be here for you.
Some risks of adolescent alcohol and marijuana use:

- 22% of teenage drivers in fatal car crashes were drinking. Car crashes are the leading cause of teen deaths.
- Marijuana affects a number of skills needed for safe driving, like reacting to sounds and signals on the road.
- Teens who use marijuana tend to get lower grades and are more likely to drop out of high school.
- High school students who use alcohol are five times more likely to drop out.
- Marijuana's effects on attention and memory make it difficult to learn something new or do complex tasks.
- Heavy use of marijuana as a teenager can lower IQ later in life as an adult.
- Teens who binge drink every month damage their brains in a way that makes it harder to pay attention and understand new information.
- Alcohol poisoning and suicide are major causes of alcohol-related teen deaths.
- Teen drinking and marijuana use raise the risk of unprotected sex, sexual assault, STDs, and unplanned pregnancy.
- Drinking increases the risk of death among teens.

A standard drink of alcohol equals:

- Beer 12 oz.
- Wine 5 oz.
- Malt liquor 8 oz.
- Liquor 1.5 oz.

One party cup 16 oz.

Readiness ruler:
Steps of the brief intervention

**Raise the subject**
- “Thank you for answering these questions - is it ok if we review this form together?”
- If yes: “Can you tell me in your own words about your drinking or drug use? How often, how much, etc.?”

**Provide feedback**
- “I recommend all my teen patients not use at all. Substance use can harm the brain of teenagers, as well as increase the risk of the things on the front of this page.”
- “Many teens who are dealing with these kind of problems may not be able to stop using on their own, even if they wanted to. I recommend these patients get help to stop.”

**Enhance motivation**
- “What do you like about your drinking/drug use? What do you not like, or are concerned about when it comes to your use?”
- “On a scale of 0-10, how ready are you to stop using/receive specialized treatment? Why do you think you picked that number rather than a ____ (lower number)?”

**Negotiate plan**
- Summarize conversation. If patient is ready to change: “What steps do you think you can take to reach your goal of cutting back/stop using/seeking specialized treatment?”
- “Can we schedule an appointment to check in and see how your plan is going?”

Oregon hotline that quickly identifies treatment resources for patients experiencing a substance use disorder: **1-800-923-4357**

**Interpreting the CRAFFT screening tool**

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk</th>
<th>Recommended action</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No” to 3 opening questions</td>
<td>Low risk</td>
<td>Positive reinforcement</td>
</tr>
<tr>
<td>“Yes” to car question</td>
<td>Driving or Riding risk</td>
<td>Discuss plan to avoid driving after alcohol or drug use or riding with a driver who has been using alcohol or drugs (Consider using Contract for Life)</td>
</tr>
<tr>
<td>CRAFFT score = 0</td>
<td>Moderate risk</td>
<td>Brief advice</td>
</tr>
<tr>
<td>CRAFFT score = 1</td>
<td></td>
<td>Brief intervention</td>
</tr>
<tr>
<td>CRAFFT score ≥ 2</td>
<td>High risk</td>
<td>Consider referral for further assessment</td>
</tr>
</tbody>
</table>

**Billing codes**

### CRAFFT only
- Medicaid and Commercial:
  - CPT 99420
  - Recommended diagnosis code to meet CCO incentive measure in Oregon: Z13.9

### CRAFFT plus brief intervention
- Medicaid and Commercial:
  - ≥ 15 min: CPT 99408
  - ≥ 30 min: CPT 99409
Role play practice:
Erin

Groups of three:
- Clinician
- Patient
- Observer
Role play practice: Diego

Groups of three:

- Clinician
- Patient
- Observer
Stages of change

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse
Stages of teen substance use

- Abstinence
- Experimentation
- Non-Problem Use
- Problem use
- Dependence
- Abuse
IV. Referral to treatment
Most U.S. youths who need substance abuse treatment do not receive it.

- **Adolescents ages 12-17 in 2009**: 7%
- **1.8 million**: 8%

Needed treatment: 150,000

Percent of Substance Abuse Treatment Admissions by Drug, Ages 15-19, U.S.

- Marijuana: 56%
- Alcohol: 24%
- Heroin/Opiates: 6%
- Cocaine: 4%
- Meth/ Stimulants: 5%
- Other: 5%

SAMHSA, 2007
Types of adolescent treatment

Outpatient:
- Group
- Family
- Intensive outpatient
- Partial hospital program

Inpatient/residential:
- Detoxification
- Acute residential treatment
- Residential treatment
- Therapeutic boarding school

AAP, 2011
Treatment shown to be better than no treatment

In the year after treatment, patients report:

- Decreased heavy drinking, marijuana and other illicit drug use
- Decreased criminal involvement
- Improved psychological adjustment and school performance

AACAP, 2005
Oregon laws towards minor consent and treatment

- Youth 14 years or older may initiate treatment without parental consent (ORS 109.6750)

- Providers are to involve the parents before end of treatment unless parents refuse or there are indications not to involve parents (ORS 109.6750)

- Providers may advise the parent /guardian of diagnosis or treatment of chemical dependency or mental disorder when clinically appropriate and if condition has deteriorated (ORS 109.680)
Keys to the referral

- Deliver the referral as part of the brief intervention
- Become familiar with local options
- Ask permission to share info with parent
  - Best chance for good outcome from treatment
Confidentiality and the referral

Consider:

- May be difficult for teen to manage treatment requirements without parent knowledge.

- Teens respond better to treatment when parents are involved.

- Insurance carrier may notify parent if insurance is under their name.

Williams RJ, et al. 2000
An adolescent who discloses heavy drug use may be looking for help.

Ask patient if parents are aware of drug use. If so, inviting parents into conversation may be easy.

Special considerations when parents themselves use substances
Side with the teen when presenting information:

“Terra has been very honest with me and told me that he uses marijuana. She has agreed to see a specialist to talk about this further. I will give you the referral information so that you can help coordinate”.

Involving parents in a referral
Role play practice: Andrew

Groups of three:
- Clinician
- Patient
- Observer
Keys to implementing a sustainable SBIRT workflow

- Secure buy-in from leadership
- Identify workflow
- Train all staff involved
- Identify champions
- Optimize EMR
- Employ tools
Questions?

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