Primary Care, Mental Health, and Substance Use Integration
A Webinar Series Sponsored by:

California Institute of Mental Health
Alcohol and Drug Policy Institute
Integrated Behavioral Health Project

Addressing Substance Use Issues in Primary Care:
SBIRT and Emerging Opportunities

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This free webinar series is supported through MHSA funding under contract with the CA State Department of Mental Health as well funding from the Alcohol and Drug Policy Institute. IBHP participation is supported by The California Endowment.
Integrating Substance Abuse Screening and Treatment into the Patient-Centered Medical Home

Eric Goplerud, Ph.D.
April 13, 2010
It’s important that SUD be addressed in PCMH

• Prevalence of SUD in Primary Care
• Unmet SUD Treatment Needs in Primary Care
• Cost of Unmet SUD
• Effective Screening & Treatment Models, but not Frequently Done
• Lower cost, Better Health when SUD Treated
• Patients and Providers like integrated care
Causes of Premature Mortality: Why People Die Early

Co-morbidity ought to be expected:
Washington State GA-U Project
(General Assistance Unemployable)

Co-occurring Diagnoses and the GA-U Population

- 52 percent had substance abuse or mental illness identified
- 31 percent had a chronic physical condition only

Chronic Physical Condition
- Chronic Physical Only 31%
- Chronic Physical + AOD 11%
- AOD Only 5%
- AOD + MI 3%
- MI Only 5%

Primary Conditions
- Chronic Physical 69%
- Mental Illness 36%
- Substance Abuse 32%

Additional Details:
- All three: 13%
- Physical + MI: 14%

Sources:
- MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003-04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper

DSHS | GA-U Clients: Challenges and Opportunities August 2006
What drugs? Past month use
(millions of persons age 12+, US)

- Marijuana: 14.8
- All other drugs: 9.6
- Psychotherapeutics: 7.0
- Pain relievers: 5.2
- Cocaine: 2.4
- Methamphetamine: 0.7
- Heroin: 0.3
- Oxycontin: 0.3

Alcohol: 140

Source: NSDUH
12-Month and Lifetime Prevalence Rates - US

- **Alcohol dependence**
  - 12 Mo: 4.3%
  - Lifetime: 12%
  - Annual mortality: 85,000

- **Other (non-nicotine) drug dependence**
  - 12 Mo: 0.6%
  - Lifetime: 2.7%
  - Annual mortality: 17,000

Hasin et al., 2007; Compton et al., 2007
The Substance Use Cost Calculator

- www.alcoholcostcalculator.org
- Computes the costs of untreated alcohol, drug and prescription opioid problems to companies, Medicaid and uninsured
- Identifies steps that employers and public sector can take
- No cost, anonymous
- Research-based, using 2005-2008 National Survey on Drug Use and Health epidemiology data with more than 210,000 respondents
- Endorsed and used by businesses, business groups and states
### The Substance Use Disorder Calculator

The Substance Use Disorder Calculator is an online tool that can help you estimate the prevalence of alcohol, illicit drug, and prescription pain medication abuse or dependence in your population.

Alcohol is by far the most widely used drug in the United States: over 8% of employed adult workers and almost 11% of adults with Medicaid or no health insurance either abuse or are dependant on alcohol. Approximately 15% of Americans 12 years or older have used illegal drugs in the past year and approximately 6 million have used prescription pain medications non-medically.

**By investing in substance use treatment, employers and payers can reduce their overall costs.** Substance use disorders cost the nation an estimated $276 billion a year, with a significant amount of this expense resulting from lost productivity and increased health care spending.

Use this calculator to learn about the effects and costs of substance use disorders in both the workplace and in uninsured populations.

[Learn about the Employed and Insured](www.alcoholcostcalculator.org)

[Learn about Medicaid and Uninsured](www.alcoholcostcalculator.org)
Could also do LA, SF, Riverside metro breakouts

Number could be county, sub-county
## Number of Individuals With a Problem

<table>
<thead>
<tr>
<th></th>
<th>Alcohol Abuse / Dependence</th>
<th>Illicit Drug Abuse / Dependence</th>
<th>Pain Medication Abuse / Dependence</th>
<th>Any Substance Abuse / Dependence Problem</th>
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<td>Number with Problem</td>
<td>1,502,289</td>
<td>722,941</td>
<td>153,139</td>
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## Total Health Care Costs

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<td>Per Capita Cost</td>
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<td>Total Cost</td>
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<td>Condition</td>
<td>Alcohol abuse/dependence Excess # w/social problem</td>
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<td>Serious psychological distress</td>
<td>431,124</td>
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<td>Major depressive episode (past year)</td>
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<td>Anxiety (past year)</td>
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<td>DUI alcohol or drugs (past year)</td>
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<td>Ever arrested and booked</td>
<td>850,735</td>
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Cost Benefit of Treatment

Numerous studies have examined the costs and benefits associated with substance abuse treatment in the public sector. In order to better understand the relative contribution of medical and non-medical savings associated with substance abuse treatment, we have identified several recent, well-designed studies that estimate costs and benefits for substance abuse treatment in various public sector populations.

**Medical Savings:** The state of Washington recently reported that individuals receiving Social Security Insurance benefits who received substance abuse treatment services had medical, mental and nursing home costs that were $6756 lower per year than individuals who did not receive substance abuse services. The average cost of the substance abuse services was $2660 per year. If you were able to achieve similar results in your population, here are the **yearly** costs and benefits that you could expect:

Change the percentage treated here to see how this affects the amount saved:

<table>
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<th>Percentage</th>
<th>10%</th>
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<td><strong>Submit</strong></td>
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<table>
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<th>Number of People Treated: 10% of People with a SA Problem:</th>
<th>193,350</th>
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<tr>
<td>Treatment Costs: ($2660 per person treated):</td>
<td>$514,311,407</td>
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<tr>
<td>Treatment Benefits (lowered medical, mental health and nursing home savings): ($6756 per person treated):</td>
<td>$1,306,273,635</td>
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<tr>
<td><strong>Total Estimated Savings:</strong></td>
<td>$791,962,227</td>
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**Additional Savings:** Studies completed in publicly funded substance abuse clinics in the state of Washington have also reported significant savings in employment and criminal justice costs associated with residential substance abuse treatment. A 2002 study of individuals receiving care at publicly funded substance abuse clinics found significant increases in income and reductions in legal costs following substance abuse treatment. Average six month savings associated with increases in employment and decreases in legal costs amounted to $26,144 and the average cost of treatment was $7319. If you were able to achieve similar results in your population, here are the six month costs and benefits you could expect:

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<tr>
<th>Number of People Treated: 10% of People with a SA Problem:</th>
<th>193,350</th>
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</thead>
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<tr>
<td>Treatment Costs: ($7319 per person treated):</td>
<td>$1,415,129,771</td>
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<tr>
<td>Treatment Benefits (Increased employment income and decreased crime related costs): ($26144 per person treated):</td>
<td>$5,054,946,404</td>
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<tr>
<td>Total Estimated Savings:</td>
<td>$3,639,816,633</td>
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For more information on the studies presented here, and other cost-benefit studies that focus on public sector populations, see our methodology paper, here.

* All costs and savings are expressed in September, 2009 dollars.

Learn about the health care and productivity costs of untreated substance use problems

Learn about the social costs of untreated substance use problems
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<th>Condition</th>
<th>Identification Rate</th>
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<td>Alcohol use disorders</td>
<td>7% to 18%</td>
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<tr>
<td>Depression</td>
<td>45%</td>
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<tr>
<td>Diabetes</td>
<td>65%</td>
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<tr>
<td>Hypertension</td>
<td>70%</td>
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Unmet BH Needs in Primary Care

• 67% with a behavioral health disorder do not get behavioral health treatment

• 30-50% of referrals from primary care to an outpatient behavioral health clinic don’t make first appt

• Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental health care access

What we don’t do that’s effective!
SBI, CBT, Medications

Miller & Hester, Mesa Grande, 2006

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<tr>
<th>Treatment modality</th>
<th>Rank order</th>
<th>CES</th>
<th>% +</th>
<th>Mean</th>
<th>% MQS ≥ 14</th>
<th>% Clinical</th>
<th>Rank order</th>
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<th>% +</th>
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What do we really do? What doesn't work! AA, Counseling, Educational Lectures

<table>
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<tr>
<th>Treatment modality</th>
<th>Rank order</th>
<th>CES</th>
<th>% +</th>
<th>N</th>
<th>Mean MQS</th>
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<td>Educational lectures, films, groups</td>
<td>46</td>
<td>-343</td>
<td>27</td>
<td>22</td>
<td>8.74</td>
<td>12</td>
<td>38</td>
<td>44</td>
<td>-161</td>
<td>0</td>
</tr>
</tbody>
</table>
Heterogeneity of Alcohol Use: Diagnosis

- **None** (70%)
  - Never exceeds daily limits
  - No distress or harm

- **Mild ("At-risk")** (~21%)
  - Exceeds daily limits
  - Harmful use

- **Moderate (Harmful use)** (~5%)
  - Exceeds daily limits
  - Harmful

- **Severe (Dependence)** (~3%)
  - Daily or near daily heavy drinking
  - Impaired control
  - 3-5 criteria

- **Chronic dependence** (~1%)
  - Daily or near daily heavy drinking
  - Chronic or relapsing
  - 6-7 criteria
  - Functional impairment

**DSM-IV Abuse/Dependence**
Many people with SUDs remit spontaneously

NESARC, 2003
Facilitated self change

Heavy drinking only

Increased quantity, frequency & consequences of alcohol use

Brief motivational counseling

Medical management + pharmacotherapy or CBI

Specialized remission-oriented treatment

Dependence

Disease Management

Extended Continuum

Willenbring, 2009
The extended continuum

Widespread availability
- Internet
- Toll-free telephones (QUIT lines)
- EAP & occupational health
- Schools & workplaces
- Primary care, hospital emergency departments
- Criminal justice system

Facilitated self change

Brief motivational counseling
The extended continuum

Facilitated self change

Moderate

Severe

Disease Management

Specialized remission-oriented treatment

Brief motivational counseling

Medical management + pharmacotherapy or CBI

Next step
- Primary care
- General MH care
- Bulk of people needing treatment are here
The extended continuum

SUD Specialty sector
- Fully integrated with medical and psychiatric care systems
- Able to manage severe co-morbidities
- Disease management for chronic or relapsing disorders
SBIRT Core Components

- Screen: Identification of behavioral problems (alcohol, drug, depression, tobacco, anxiety?)
- Brief Intervention: Raises awareness of risks and motivates client to change
- Brief Treatment: Cognitive behavioral, medications with clients who acknowledge risks and are seeking help
- Referral to TX: Referral of those with more serious or complicated mental or substance use conditions

Adapted from Tom Stegbauer, DHHS, 2008
Federal SBIRT Demonstration Program Accomplishments

<table>
<thead>
<tr>
<th>Area</th>
<th>As of 3/27/08</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received Screen</td>
<td>638,576</td>
<td>100.0</td>
</tr>
<tr>
<td>Screened Negative</td>
<td>491,598</td>
<td>77.0</td>
</tr>
<tr>
<td>Brief Intervention</td>
<td>104,026</td>
<td>16.3</td>
</tr>
<tr>
<td>Brief Treatment</td>
<td>19,707</td>
<td>3.1</td>
</tr>
<tr>
<td>Referral to Treatment</td>
<td>23,245</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Adapted from Tom Stegbauer, DHHS, 2008

N = 11 states
SBIRT Program Accomplishments

- Alcohol use to level of intoxication (5+ drinks) declined 38.4%
- Use of any illegal drugs decreased 49.6%
- Nearly 50% of those who received a brief intervention changed their patterns of misuse

Adapted from Tom Stegbauer, DHHS, 2008

N = 11 States
SBIRT Program Accomplishments

Adapted from Tom Stegbauer, DHHS, 2008

N = 11 States
Washington SBIRT Findings

• Reduction of $2.7 million per year assuming:
  - 22,000 patients per year in the same 9 hospitals
  - 1,200 Medicaid disabled clients who would receive at least a brief intervention

• Overall reduction in costs due to:
  - Fewer days of hospitalizations from ED admissions
  - Effects for injured patients (about -$500 PM/PM)
  - Effects for patients who get at least a BI but had no alcohol or drug treatment in past year
Brief interventions by health care professionals are effective

- Average reduction in drinking of 25% after one year
- Very brief (5”) intervention is effective in primary care settings
- Equally effective for men and women
- Use empathic, non-judgmental approach (e.g. FRAMES, 5A’s)
- USPFTF recommendation for adults

Ballosteros et al., ACER 28: 608-618, 2004
Ask

AUDIT-C: http://www.hepatitis.va.gov/vahep?page=prtop03-audit_c

Inform

Drinking guidelines: http://www.alcoholscreening.org/learnmore/consumption.asp

Motivate

Brief Negotiated Interview:
What's your pattern?

Answer these questions, then select "Click for feedback" to find out how your drinking pattern compares to those of other U.S. adults.

1. On any day in the past year, have you ever had
   - For MEN: more than 4 "standard" drinks?
   - For WOMEN: more than 3 "standard" drinks?

2. Think about your typical week:
   - On average, how many days per week do you drink alcohol?
   - On a typical drinking day, how many drinks do you have?

Click for feedback >>

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Brief Intervention
In the “Real World” of Primary Care

REALSBIRT

David Pating, MD
Kaiser, San Francisco
Assistant Clinical Professor, UCSF
Welcome to California…
the Land of
Prevention and Opportunity.
Rationale for Primary Care Screening

20% of Primary Care Patients At-Risk for Alcohol Use Problems. 80% of At-Risk, Problem or Dependent Drinkers seen only by Primary Care.

Abstainer 35%
Low Risk Drinkers 45%
Alcohol Dependent 5%
Problem Drinkers 7%
At-Risk Drinkers 8%

(CSAT, TIP 24, 1997)
CASA 2000: Primary Care Alert

- Less than one-third of Primary Care Physicians (32.1 percent) carefully screen for substance abuse.

Center on Addiction and Substance Abuse (CASA) at Columbia University
N=648 physicians; 498 patients (CASA, 2000)
CASA 2000: Primary Care Alert

- Only 20% Primary Care Physicians feel “very prepared” to diagnose substance abuse.
What Patients Say

- “Doctor’s should ask about Substance Abuse…but Don’t!”
Tobacco Cessation

Success: 90% physicians ask about Smoking!

Why?

Q: Yes/No
Why Physicians don’t screen?

- Lack of adequate training in medical school.
- Skepticism about treatment effectiveness
- Patient resistance
- Discomfort discussing substance abuse
- Time Constraints
- Fear of Losing Patients
- Lack of Insurance Coverage
- Etc. (CASA, 2000)

“Too Busy”
“Don’t Know How”
Stigma!
Real World: Task

- Design a useful primary care intervention to:
  - Overcome Stigma?
  - Increase Knowledge?
  - Practical & expedient?
The evidence for addiction as a brain disease

PET scans conducted at NIDA’s Brain Imaging Center reveal selective activation of brain circuits during cocaine craving. Scans from volunteers who experienced a high level of cue-induced cocaine craving show activation of brain regions implicated in several forms of memory. The scans at right show activation of the dorsolateral prefrontal cortex (DL), which is important in short-term memory, and the amygdala (AM), which is implicated in emotional influences on memory. When these volunteers were exposed to neutral (non-drug-related) cues, this activation was not seen (scans at left).

NIAAA 2005
Screening Guidelines

Helping Patients Who Drink Too Much

A CLINICIAN’S GUIDE
2005 Edition
Screening and Intervention Protocol for At-Risk Substance Use

- **Ask:** Two Questions?
- **Assess:** Risk Level
  - *At Risk*
  - *Problem Use*
  - *Dependence*
- **Assist:** Brief Intervention
Ask: Two Risk Screening Questions

NIAAA Screening Questions

1. In the past year, have you had 5 (4) or more drinks at any one time?

2. On average, how many drinks do you drink in a week?
Safe Drinking Guidelines

Moderate Drinking is...

For Men: no more than 2 day, 14 week or 5 drink tolerance
For Women/Elderly: no more than 1 day, 7 week or 4 drink tolerance

(M) 2 - 14 - 5  (W) 1 - 7 - 4

(NIAAA, 2000)
Substance Dependence Disorder

- Tolerance & Withdrawal
  - Larger/longer amounts than intended.
  - Desire/attempts to Cut Down.
  - Increased Time to Obtain/Recover.
  - Important Activities Reduced.
- Loss of Control
- Persistent Use despite Negative Consequences

(DSM-IV, 1994)
Ask: Two Follow Up Questions

2 Item Conjoint Screener for Dependence

- In the past year, have you every drunk alcohol more than you meant to?
- In the past year, have you ever thought you should cut down on your alcohol use?

Sensitivity: ~70%, Specificity unknown
Two Better AUD Questions

2 Item Vinson Screener for Dependence

- In the past year, have you sometimes been under the influence of alcohol in situations where you could have caused an accident?

- Have there often been times when you had a lot more to drink than you intended to have?

Sensitivity: 72-96%, Specificity: 81-95%

(Vinson, Alcohol Clin Exp Res, V31, No8, 2007)
Dependence: Better Definition

Three C’s...

- Compulsion to Use
- Loss of Control
- Neg. Consequences

“CAN YOU STOP!?!”
The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

<table>
<thead>
<tr>
<th>Questions</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
<td>7 to 9</td>
</tr>
<tr>
<td>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>3. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>4. How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>5. How often during the last year have you failed to do what was normally expected of you because of drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>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?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>8. How often during the last year have you been unable to remember what happened the night before because of your drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>9. Have you or someone else been injured because of your drinking?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total

AUDIT Screen (WHO)

Positive Screen

>8 for Men
>4 for Women

Different Systems = Different Tools
Step 3: Brief Intervention Targeting Substance Use

At Risk \(\rightarrow\) “Cut Back”

Problem Use \(\rightarrow\) Brief Intervention Motivational Enhc

Sub. Dependence \(\rightarrow\) Formal CD Tx
“Cut Back”/Moderation

“I advise you to Cut Back your (alcohol/drug) consumption”

- Recommend drinking or using at “moderate levels” which are safe.
- Not a request to Abstain/STOP.
- Alcohol: (m) 2-14 -5, (w) 1-7-4

(NIAAA, 10th Report to Congress 2000)
Brief Intervention

“Based on my assessment, you are at-risk for future health problems... I advise you to “cut back”/quit.”

- Non-Judgemental feedback or appraisal of risks by Primary Care Providers.
- 10-30% patients will significantly reduce (alcohol/tobacco/diabetic) risky behavior

(WHO, 1996; CSAT TIP 24, 1997)
Guidelines for Screening & Advising Patients for At-Risk Alcohol & Drug Use

New Intake → Annual Physical → At-Risk Situ. Or Suspicion → Employee

Initial PCP (MD/NP) Screen
“Do you Drink or Use Drugs?... Ever?”

DRUGS (stimulants, opiates) In the last 30 days

ALCOHOL Review At-Risk Questions

No → STOP
MJ → STOP/(BMS)

Advise Risk/Benefits of Current Use
“...Based on your answer, you are at risk for alcohol (drugs) related problems. I suggest you cut back (quit).”

BMS

BHE

FILM

KAISER PERMANENTE
A Physicians Advice to “Cut Back”/Quit will significantly impact 20% of patients who are at-risk for alcohol/tobacco/diabetes related problems.

(Fleming, 1999; WHO, 1996)
Brief Intervention: 15 min (x2) Effective

N=17000 patients, 17 clinics in Wisconsin Research Network

Fig. 1. Seven-day drinking comparison, treatment versus control. **48-month treatment effect, p = 0.0018 (repeated measures analysis of variance).

Fig. 2. Thirty-day binge drinking comparison, treatment versus control. **48-month treatment effect, p = 0.0002 (repeated measures analysis of variance).

(Project TrEAT: 17 HMO PC Clinics; N= 382 control, 392 interv; Fleming, Alc Clin Exp Res 2002)
Table 5. Change in Prevalence and Odds Ratio of Excessive Weekly Drinking and Binge Drinking by Treatment Condition

<table>
<thead>
<tr>
<th></th>
<th>Usual Care</th>
<th>Special Intervention</th>
<th>Odds Ratio</th>
<th>P</th>
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</thead>
<tbody>
<tr>
<td>Excessive weekly drinking</td>
<td>107 (100%)</td>
<td>190 (100%)</td>
<td>1.83</td>
<td>0.1</td>
</tr>
<tr>
<td>Safe weekly drinking</td>
<td>66 (39)</td>
<td>102 (54)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at 6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binge Drinking @ baseline</td>
<td>174 (100)</td>
<td>192 (100)</td>
<td>1.24</td>
<td>.32</td>
</tr>
<tr>
<td>Non Binge drinking @ 6 mo.</td>
<td>61 (35)</td>
<td>77 (40)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive weekly or Binge</td>
<td>233 (100)</td>
<td>248 (100)</td>
<td>1.60</td>
<td>.02</td>
</tr>
<tr>
<td>Safe weekly or Non Binge</td>
<td>66 (28)</td>
<td>96 (39)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(N=530 @ 4 Academic PC sites; Ockene Arch Int Med 1999)
1997-2007 WHO ASSIST Effectiveness

Total Illicit Substance Involvement

ASKING QUESTION = IMPACT

2 minutes?

Baseline     Follow-Up

ASSIST, 3 mo follow up (N=628)
Readiness for Change

Precontemplation (40%)

Relapse

Contemplation (40%)

Preparation

Maintenance

Action (20%)

Patient Readiness, Not Intervention Effect

SBIRT member utilization patterns:

- BH inpatient days decreased 63%
- Medical inpatient days decreased 51%
- ER visits decreased 20%
- Partial Hospital and IOP visits increased 81%
- Psychiatrist visits increased 31%
- Therapist visits decreased 22%
- Net total medical cost savings 15%

(N = 247 12 month continuous enrollment prior and post suboxone)
Specialty treatment for complex or severe SUD

- Social and Behavioral Treatment
  - Brief motivational counseling
  - Cognitive-Behavioral
  - 12-Step (MN Model)
  - Motivational Interviewing
  - Contingency management
  - Behavioral marital therapy
  - CRAFT approach for families
Alcohol Disease Management Results

- Rehabilitation facilities days decreased 67%
- BH inpatient days decreased 68%
- Medical inpatient days decreased 4%
- ER visits decreased 24%
- Partial Hospital and IOP visits decreased 69%
- Psychiatrist visits increased 44%
- Therapist visits increased 35%
- AUDIT score decrease 80%
- **Net total medical cost savings (ROI 2:1)** 34%

*know®*  
(N = 358, 12 month continuous enrollment prior and post enrollment)
The Patient-Centered Medical Home: Principles of PCPCC

- Personal Physician
- Whole person orientation
- Coordinated and integrated care
- Safe and high-quality care (e.g., evidenced-based medicine, appropriate use of HIT, continuous QI)
- Enhanced access to care
- Payment that recognizes the added value provided to patients who have a patient-centered medical home

*** A Systems Approach: Access, Quality and Efficiency

But –if Patient Centered Medical Home is so good, why is integrated SBIRT so rare?

• The advice from Deep Throat to Woodward and Bernstein:
  “Follow the Money”
• Silos
• Training
• Attitudes
• Time
• Privacy regulations, HIT
The Quality of Health Care in US

<table>
<thead>
<tr>
<th>Mode</th>
<th>No. of Indicators</th>
<th>No. of Participants Eligible</th>
<th>Total No. of Times Indicator Eligibility Was Met</th>
<th>Percentage of Recommended Care Received (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter or other intervention</td>
<td>30</td>
<td>2843</td>
<td>4,329</td>
<td>73.4 (71.5–75.3)</td>
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<tr>
<td>Medication</td>
<td>95</td>
<td>2964</td>
<td>8,389</td>
<td>68.6 (67.0–70.3)</td>
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<tr>
<td>Immunization</td>
<td>8</td>
<td>6700</td>
<td>9,748</td>
<td>65.7 (64.3–67.0)</td>
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<tr>
<td>Physical examination</td>
<td>67</td>
<td>6217</td>
<td>19,428</td>
<td>62.9 (61.8–64.0)</td>
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<td>Laboratory testing or radiography</td>
<td>131</td>
<td>5352</td>
<td>18,605</td>
<td>61.7 (60.4–63.0)</td>
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<tr>
<td>Surgery</td>
<td>21</td>
<td>244</td>
<td>312</td>
<td>56.9 (51.3–62.5)</td>
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<tr>
<td>History</td>
<td>64</td>
<td>6711</td>
<td>36,032</td>
<td>43.4 (42.4–44.3)</td>
</tr>
<tr>
<td>Counseling or education</td>
<td>23</td>
<td>2838</td>
<td>3,806</td>
<td>18.3 (16.7–20.0)</td>
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</table>

McGlynn et al, NEJM, 2003
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVUs</th>
</tr>
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<tbody>
<tr>
<td>99203</td>
<td>Office/outpatient visit, new, 30 minutes</td>
<td>2.54</td>
</tr>
<tr>
<td>99283</td>
<td>Emergency dept visit, moderate complexity</td>
<td>1.68</td>
</tr>
<tr>
<td>99443</td>
<td>Physician or healthcare prof. follow-up phone call 21-30 min (Not Medicare reimb.)</td>
<td>0.98</td>
</tr>
<tr>
<td>98968</td>
<td>Administration, interpretation of health risk assessment instrument (not Medicare reimb.)</td>
<td>0.23</td>
</tr>
<tr>
<td>99402</td>
<td>Preventive medicine, individual, 30 min (not Medicare reimb.)</td>
<td>1.48</td>
</tr>
<tr>
<td>38100</td>
<td>Removal of spleen, total</td>
<td>28.23</td>
</tr>
<tr>
<td>61514</td>
<td>Removal of brain abscess</td>
<td>48.04</td>
</tr>
<tr>
<td>99409</td>
<td>SBI 30 minutes or more</td>
<td>1.67</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>RVUs</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>90804</td>
<td>Psychotherapy, office, 20-30 min</td>
<td>1.80</td>
</tr>
<tr>
<td>90816</td>
<td>Psychotherapy, hospital, 20-30 min</td>
<td>1.60</td>
</tr>
<tr>
<td>99202</td>
<td>Office/outpatient visit, new 20 min</td>
<td>1.77</td>
</tr>
<tr>
<td><strong>99408</strong></td>
<td><strong>SBI 15 to 30 min</strong></td>
<td>0.85</td>
</tr>
<tr>
<td>99203</td>
<td>Office/outpatient visit, new 30 min</td>
<td>2.54</td>
</tr>
<tr>
<td>99385</td>
<td>Prevention visit, new, age 18-39</td>
<td>2.66</td>
</tr>
<tr>
<td><strong>99409</strong></td>
<td><strong>SBI  over 30 min</strong></td>
<td>1.67</td>
</tr>
<tr>
<td>Payer</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Commercial Insurance and Medicaid</td>
<td>CPT 99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
</tr>
<tr>
<td></td>
<td>CPT 99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
</tr>
<tr>
<td></td>
<td>G0397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
</tr>
</tbody>
</table>
Reimburses, or will reimburse on SBI Codes 99408/99409

Aetna California PPO
Anthem California National PPO
BC of California HMO
BC of California PPO
CIGNA California PPO
Health Net of California HMO
Kaiser Northern California HMO
Kaiser Southern California HMO
PacifiCare of California, Inc. HMO
UnitedHealthcare of California PPO
Payment Reform Needed

Current System: Structured Around Reimbursement
- Behavioral health, medications, general medical in separate payment silos
- Disincentivizes collaboration, communication and coordination among clinicians
- Payment is requires diagnosis and procedures
- Ignores behavioral needs of medical patients
- Ignores medical needs of behavioral health patients
- Focuses on individual siloed care delivery not on collaborative treatment
- No relationship to performance

Proposed System: Patient Centered
- Carve in to medical expense target (defragment payment system; blended payment systems)
- Payment related to collaborative medical psychological efforts
- Financing for broad spectrum of medical need for behavioral intervention including psychological treatments of medical problems
- Financing related to performance and quality

Kessler & Miller, 2009
Barriers to Adoption of PCMH with SBIRT

• **Clinical information sharing:**
  – Registries
  – Modify 42 CFR Part 2 and State Mental Health and Substance Use Records Privacy Laws
  – Shared information systems with patients – Personal health records, e-mail, tele-health, tele-counseling, telephone SBI, Skype life coaching, internet support groups

• **Physical facilities:**
  – Teams work best in close physical proximity
  – Some practices more amenable to integration -- FQHCs

• **Research and evaluation:**
  – Comparative effectiveness trials to determine the necessary components of PCMH, alternative configurations, supports

• **Performance measurement, accountability**

Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home, National Council for Community Behavioral Healthcare. 2009.
Challenge unique to SUD:
The intersection of health care quality and patient safety with protection of sensitive SUD diagnosis and treatment information

- HIPAA, 42 CFR Part 2

- Risks of potential misuse, and inappropriate disclosure
  - Job loss,
  - Criminal prosecution,
  - Health and life insurance coverage barriers
Mental and substance-use problems are pervasive, often unrecognized, and if not resolved, ultimately make themselves known – if not initially as mental or substance use problems, then as general health conditions. (IOM, 2005)
### Primary Care, Mental Health, and Substance Use Integration
#### Upcoming Webinars

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressing Mental Health Issues in Primary Care: IMPACT Model</td>
<td>June 3, 2010</td>
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<td>Bridging Differences in the “Cultures” of PC/MH/SU</td>
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<td>Paying for Integrated Services: FQHC, Medi-Cal and Other Funding Strategies</td>
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This free webinar series is supported through MHSA funding under contract with the CA State Department of Mental Health as well funding from the Alcohol and Drug Policy Institute. IBHP participation is supported by The California Endowment.