Sentara® Health Plans

BEHAVIORAL HEALTH GUIDELINE

ADULT SCREENING AND BRIEF INTERVENTION FOR ALCOHOL USE

Guideline History

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Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use

A Step-by-Step Guide for Primary Care Practices

National Center on Birth Defects and Developmental Disabilities

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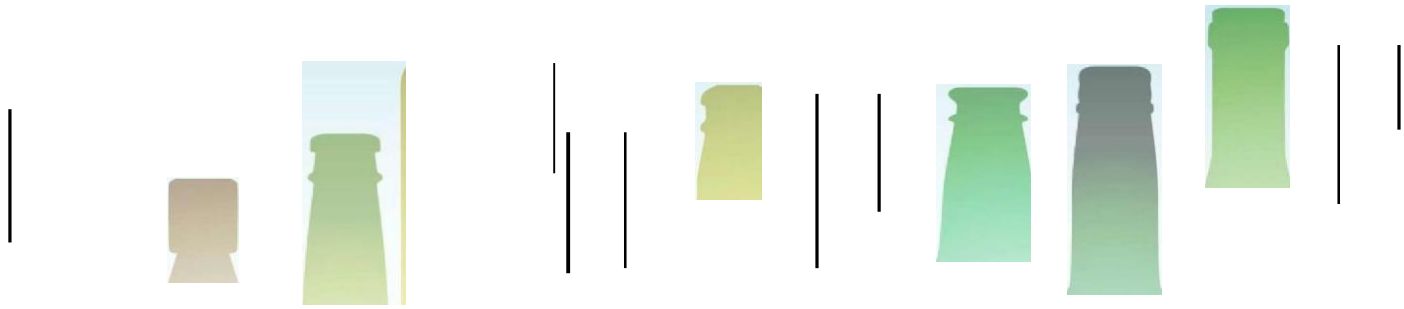
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Introduction

Alcohol Screening and Brief Intervention:A Critical Clinical Preventive Service

Like hypertension or tobacco screening, alcohol screening and brief intervention (alcohol SBI) is a clinical preventive service. It identifies and helps patients who may be drinking too much. It involves:

- A validated set of screening questions to identify patients' drinking patterns,
- A short conversation with patients who are drinking too much, and for patients with severe risk, a referral to specialized treatment as warranted.

The entire service takes only a few minutes, is inexpensive, and may be reimbursable. Thirty years of research has shown that alcohol SBI is effective at reducing the amount of alcohol consumed by those who are drinking too much. Based on this evidence,[1,2,1,4] the U.S. Preventive Services Task Force[5] and many other organizations• have recommended that alcohol SBI be implemented for all adults in primary health care settings.

Risky drinking affects your patients' health.[6]

Risky drinking can have many negative health effects including increasing the risk of hypertension, stroke, type 2 diabetes, cancers (breast, upper gastrointestinal tract, and colon), cirrhosis of the liver, injury, and violence. Risky drinking is also associated with increased bodyweight and can impair short- and long-term cognitive function. Binge drinking is associated with a wide range of other health and social problems, including sexually transmitted diseases, unintended pregnancy, and violent crime. See Appendix E, Negative Effects of Risky and Binge Drinking.

a Examples of select professional organizations:

American Academy of Family Physicians: The AAFP recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (2004)

American College of Obstetricians and Gynecologists: At-risk drinking and alcohol dependence: obstetric and gynecologic implications. Committee Opinion No. 496. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:383-8.

American Medical Association: American Medical Association. House of Delegates, Policy: H-30.942 Screening and Brief Interventions for Alcohol Problems.

American Academy of Pediatrics: Policy Statement: Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians Committee on Substance Abuse *Pediatrics* 2011; 128:5 el330~el340

Purpose of the Guide

This guide is designed to help an individual or small planning team adapt alcohol SBI to the unique operational realities of their primary care practice. It takes them through each of the steps required to plan, implement, and continually improve this preventive service as a routine element of standard practice. Rather than prescribing what the alcohol SBI services should look like, the Guide will help you and your colleagues create the best plan for your unique situation.

Implementing alcohol SBI in your practice should be a team effort.



The Process

The Guide consists of 10 steps arranged in four major sections. Although **the steps are presented sequentially, you may find that it makes sense to address some of them concurrently.**

As you consider the decisions you must make **to** design and implement your program, you can use Appendix A, Our Alcohol SBI Service, to record your decisions. This appendix can serve not only as a historical record of your decisions, but as **a** framework for making needed refinements over time as your practice gains experience and comfort with alcohol SBI.

I. Laying the Groundwork

1. Familiarize the planning team with alcohol SBI- why it is an important medical service and how it works
2. Ensure that practice leaders are committed to implementing alcohol SBI

II. Adapting Alcohol SBI to Your Practice

3. Plan screening procedures
4. Plan brief intervention procedures
5. Establish procedures to refer patients with severe problems

III.ImplementingAlcohol SBI in Your Practice

6. Train staff for their specific roles
7. Pilot test and refine your plan
8. Manage initial full implementation so it succeeds

IV. Refining and Promoting

9. Monitor and improve your alcohol SBI plan over time
10. Publicize your efforts so that others can learn from your experience



What is the difference between SBI and SBIRT?

The acronym SBI originated in the mid-1990s to refer to screening and brief intervention research. Most study protocols called for referral of dependent patients to specialty treatment services. In the fall of 2003 the Substance Abuse and Mental Health Services Administration (SAMHSA) initiated a grant program designed to encourage implementation of SBI. SAMHSA added "and referral to treatmentff to the program title, whichchanged the acronym to SBIRT to emphasize the role of treatment services agencies. When RT is added to the acronym and program title, some people may misinterpret this to mean that all patients who screen positive should be referred to treatment, which is not the case. Therefore, CDC has chosen to use the traditional acronym of SBI.

I. Laying the Groundwork

Implementing any new service in a primary care practice typically requires changes in routines and job duties. Those changes sometimes require tweaking of administrative procedures. Staff will want to know why things need to change. Sharing the rationale for this new intervention *before* you start to make specific changes in routine will help to foster institutional commitment for alcohol SBI and ensure that procedures are appropriately tailored for your practice.

Step 1: Understand the Need for Alcohol SBI

It's about much more than alcohol dependence.

When Americans discuss drinking too much, alcohol-related harm, or alcohol problems, they tend to think the conversation is about alcoholism, or in medical terms, about alcohol dependence. The screening instruments used in alcohol SBI will identify both patients who are dependent on alcohol and those who are drinking too much but not dependent. Brief interventions are designed to help both groups.

- The main target population for brief interventions is nondependent, risky drinkers, about 25% of the general population. The goal of the brief intervention is to motivate them to cut back or stop drinking.
- Patients who drink too much and are dependent also need help, but there are relatively few of them, fewer than 4% in the general population. For this group the goal is different. Although we would like them to decrease or stop drinking, the brief intervention, by itself, may not be sufficient. The brief intervention can also focus on motivating them to seek further help.

What is risky drinking? How much Is too much?

Here is a simple definition: Risky drinking is any level of alcohol consumption that increases the risk of harm to a person's health or well-being or that of others. However, this definition does not provide any quantitative guide. A more complete answer to the question *How much is too much?* has three elements. See Table 1 on the following page for the different elements of risky drinking.



Table 1: The Levels of Risky Drinking

A. Risky Drinking Levels For Healthy Adults

Any person drinking more than either the daily or weekly levels in the table below is drinking too much. If a person exceeds the weekly levels, a *long-term risk* for a wide range of chronic conditions can occur. If a person exceeds the single-day levels, he or she risks intoxication, which is associated with a variety of more *immediate risks*.[7]

Healthy men ages 21-65	No more than 4 drinksb on any single day (5 or more drinks consumed within 2 hours is bingec drinking) AND No more than 14 drinks a week
All healthy women ages 21 and older	No more than 3 drinks on any single day (4 or more drinks consumed within 2 hours is binge' drinking) AND No more than 7 drinks a week
Healthy men over age 65	

B. For some people, even less is risky. [7,8]

The levels provided above are just one consideration in defining risky drinking. A variety of health conditions and activities may warrant limiting drinking to even lower levels or not drinking at all. Here are some examples.

- Individuals taking prescription or over-the-counter medications that may interact with alcohol and cause harmful reactionsd
- Individuals suffering from medical conditions that may be worsened by alcohol, e.g., liver disease, hypertriglyceridemia, pancreatitis
- Individuals who are driving, planning to drive, or participating in other activities requiring skill, coordination, and alertness

C. For some people, any drinking at all Is risky.

Here are some examples.

- Individuals unable to control the amount they drink. This group includes people dependent on alcohol."
- Women who are pregnant or might become pregnant (see Women *Who Are Pregnant or Might Become Pregnant* on the next page for more information)
- Individuals younger than age 21

b In the United States, a standard drink is defined as approximately 0.6 ounces (14 gm) of alcohol, such as 12 oz. of most beer, 5 oz. of most table wine, or one shot (1.5 oz.) of 80 proof spirits. For greater detail, see Appendix C.

c Binge drinking is essentially drinking above the single day limit within a two-hour period. It is commonly used because drinking at this level typically brings the average adult's blood alcohol concentration (BAC) above 0.08 *gf*dL, the legal threshold for impaired driving.[9]

d For more information see the list of medicines and potential reactions in *NIAAA's* Harmful Interactions: Mixing Alcohol with Medicines, available **at** http://pubs.niaaanih.gov/publications/medicine/harmful_interactions.pdf and NIAAA's Alcohol Alert No. 27, Alcohol-Medication Interactions, available at http://pubs.niaaa.nih.gov/publications/aa27.htm

e Diagnostic procedures for alcohol use disorders (DSM IV,[10] DSM 5[11]) do not generally involve an attempt to quantify how much patients are drinking. Instead, they evaluate the extent to which patients have experienced acute and chronic health or social problems that can be attributed to their drinking. Nonetheless, patients with these diagnoses typically drink above the risky drinking guidelines. For example, epidemiologic research has shown that US adults who meet either the single day or weekly risky drinking levels described above are much more likely to have an alcohol use disorder than patients who do not.

Are staff knowledgeable about alcohol use?

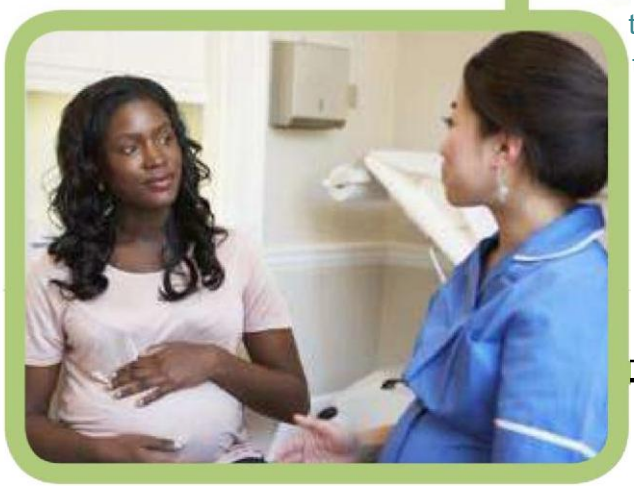
Mt;:mpers Qf }'.91JJ pl:inn.lng teilcm mc1y haye cl.iffei::t;nt levels of knowledge about alcohol issues, so doing some homework together can build a common understanding of alcohol SBI. This will help you adapt it to your practice more quickly.

- The Alcohol SBI Fact Sheet in Appendix B briefly describes target population, acute and chronic health outcomes associated with risky drinking, and cost of risky drinking. It also compares the ranking of alcohol SBI with other preventive services. It can be used to inform and engage others in the practice and be personalized for your needs.

Alcohol SBI is a medical issue.

Risky drinkingis.not just a "substance abuse" issue: it is a medical issue. It is a causal factor for some health conditions and exacerbates other health conditions.[14] {see Appendix B) The connection between risky drinking and adverse health outcomes starts long before individuals become alcoholic. It affects the health of many patients who never become alcoholic. This is why it is important for practitioners to know how much patients are drinking, and this is why risky drinking is a medical issue. Finally, this is why screening should focus on how much patients are drinking. If you just screen for alcoholism, you are intervening too late, when chances of success dwindle and cost of treatment soars.





Women Who Are Pregnant or Might Become Pregnant

Any alcohol consumption by a woman who is pregnant or may be pregnant puts her child at risk for fetal alcohol spectrum disorders (FASDs), which include physical, behavioral, and learning problems.[12] The average lifetime cost for a single person with fetal alcohol syndrome (FAS) alone (only one condition along the FASD continuum) is estimated at $2 million.[13] There is no known safe amount of alcohol a woman can consume while pregnant. Women who are trying to get pregnant should avoid alcohol since most women won't know they are pregnant for up to 4 to 6 weeks. Women who are not trying to get pregnant but are sexually active should talk with theirhealth care provider about using contraception (birth control) consistently. If a woman does not drink alcohol during pregnancy, FASDs are completely preventable.(See **Appendix D)**

Step 2: Get Organizational Commitment

Implementing an effective alcohol SBI plan requires:

- A firm commitment from the leaders of your practice.
- Communication of that commitment to all relevant staff.

Is there organizational commitment?

Determining whether your practice is committed and ready to implement alcohol SBI is perhaps the most pivotal step in planning this new service.

Share the Alcohol SBI Fact Sheet (Appendix B) with key managers in your practice and meet with them to answer their questions. Strive to reach a common understanding of:

- The need for alcohol SBI in your practice,
- What alcohol SBI is,
- Your goals, and
- How you will inform staff members of your decision to implement alcohol SBI.

Who should be informed?

Ensure that all relevant staff know about your alcohol SBI implementation. The announcement should include why alcohol SBI is being implemented, who will be responsible for planning it, and how others might help. Include the *Alcohol SBI Fact Sheet* so that everyone has a general overview of alcohol SBI and the health impacts associated with risky drinking.

Planning Team

If you have a larger practice, creating a planning team could be helpful. Consider those individuals whose day-to-day jobs will be most affected. Tuey may include:

- Individuals most likely to perform the alcohol screening (e.g., receptionists, medical assistants, nurses)
- Individuals most likely to deliver the brief interventions (e.g., physicians, physician assistants, nurse practitioners, nurses, health educators, or other allied health professionals)
- Staff who handle medical records and billing for the practice.

Implementing alcohol SBI requires planning and involving a range of stakeholders, including physicians, nurses, medical assistants, administrative staff, billing departments, and organizational leaders. An effective (and sustainable) service cannot be created without commitment from each of these groups.

A service planned by the people whose work is affected-rather than imposed by someone else-is far more likely to work well and to last. Greater involvement means fewer surprises.

II. Adapting Alcohol SBI to Your Practice

It is critical to plan fully all the elements of your alcohol SBI service before you start implementing or training staff to provide it.

Step 3: Plan for Screening

A complete alcohol SBI screening plan specifies:

- Which patients you will screen
- How often you will screen patients
- Which screening instrument you will use
- How and where you will screen
- How you will store and share screening results

Who will be screened?

Ideally, you should screen all of your patients with two possible exceptions:

- Children under 9 years of age, who are not likely to drink alcohol.f
- Patients who are too ill to answer screening questions at a particular visit.

Your final plan should carefully specify which patients will not be screened so that you can calculate the number *in* your target population. Later, that will allow you to calculate the percentage of the target population that, in practice, gets screened. (See Table 2: Implementation Measures.)

How often should patients be screened?

Because drinking patterns change over time, patients should be screened at least annually. If nearly all of your patients receive preventive-care physical examinations annually, the best time to provide alcohol SBI might be that visit. Alternatively, if many of your patients do not have annual physicals, you might want to screen every patient on the first visit of each year.

All screening systems require a method to identify which patients have received alcohol screening and which patients have not yet been screened that year. It may be easiest to adapt an existing reminder system you have implemented for other preventive services.

Screening for Youth

By age 15,more than 50% of teens have had at least one drink and by age 18 more than 70% have. Although they drink less often than adults do, when they do drink, they drink more. If you decide to screen youth, it is recommended that you read and follow either the **American Academy of Pediatrics** (AAP)g or **NIAAA**[1]guides designed specifically for this population.

f See the following reference to understand why screening should start at such a young age. National Institute on Alcohol Abuse and Alcoholism. *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide.* http://niaaa.nih.gov/youthguide

g Levy SJ, Kokotailo PK, Committee on Substance Abuse. Substance use screening, brief intervention, and referral to treatment for pediatricians. *Pediatrics.* 2011; 128:el330-40.

Which screening instrument will you use?

Screening instruments provide an objective means to determine whether patients' drinking creates a risk for themselves or others, i.e., which patients are drinking too much. There are many screening instruments readily available (Appendix I), but most do not focus directly on how much patients are drinking. For a very brief screening instrument, we recommend either of the following two instruments.

The **Single Question Alcohol Screen** has the advantage of being very short, quick to administer orally, easy to remember, and simple to score. A limitation, however, is that some patients who do not exceed the single day drinking limits do drink enough to exceed weekly drinking limits. For example, a woman who has 3 drinks every day does not exceed the NIAAA's single-day limit, but her 21 drinks per week is triple the NIAAA's recommended maximum weekly limit and exceeds the US Dietary Guidelines daily limits.

AUDIT-1-3 (US)his the first three questions of the AUDIT (see below). It identifies patients who consume more than the recommended limits both on one occasion (or day) and weekly. **It** can also be administered in about a minute, but is best administered on paper or computer. It can be used as part of a longer health questionnaire.

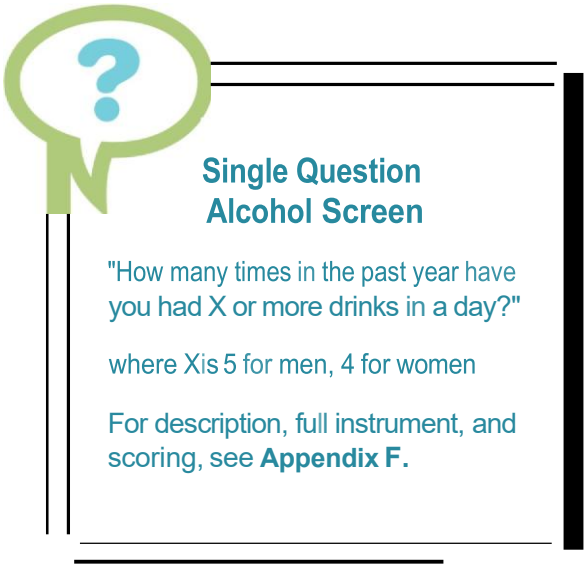
To provide an appropriate intervention, you need more information.

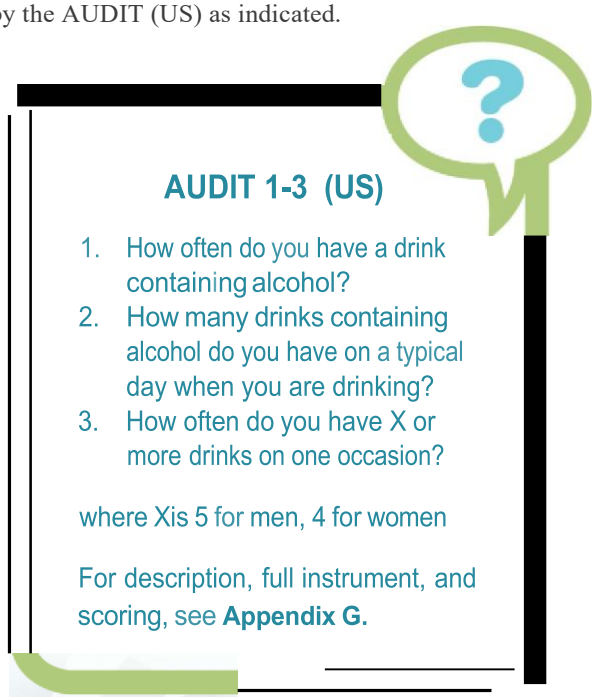
Once you know which patients are drinking too much, you need two more pieces ofinformation before you can provide them with appropriate help. The full AUDIT (US) will provide that information.

1. Which patients have already experienced problems from their drinking?
   When medical staff can connect patients' drinking to a medical concern or to something patients report as problematic in their lives, that connection may strengthen the effectiveness of the intervention.
2. Which patients are likely dependent on alcohol?
   Although the AUDIT (US) does not yield a formal diagnosis of alcohol dependence, high scores indicate a likelihood of dependence. For those patients who rely heavily on alcohol, the brief intervention may assist them in accepting more extensive help.

The full, IO-question **AUDIT (US)** (Appendix H) is the global "gold standard" of alcohol screening instruments. The first three questions measure alcohol consumption, and the next seven questions measure alcohol-related harm and symptoms of dependence. The full AUDIT can be answered in 2-3 minutes using paper or computer. Administration orally requires training and is likely to produce less accurate results, but is an option for patients with literacy or vision issues.

You can use either of the shorter instruments as your screener-the single question or the AUDIT 1-3 (US). To obtain the additional information you need to provide an appropriate intervention to patients with positive screening results, follow with the full AUDIT (US). See the following Figure 1 for an example flow chart for using the Single Question or AUDIT 1-3 (US) initally followed by the AUDIT (US) as indicated.

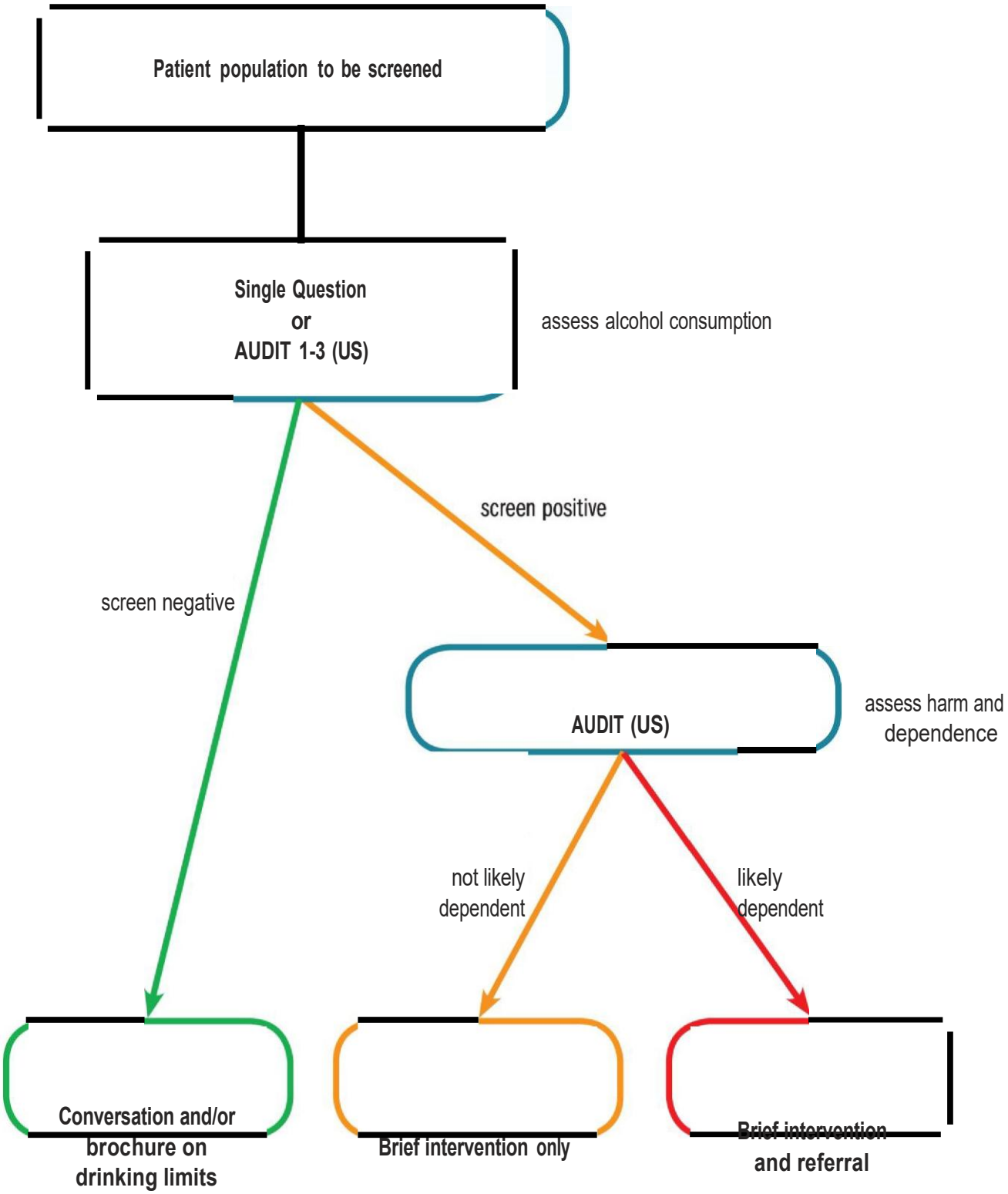




h The AUDIT 1-3 (US) screening instrument provided in this guide has been modified to provide greater precision in

measuring U.S. drink sizes.

Figure 1: Alcohol SBI Patient Flow - Single Question or AUDIT 1-3 (US)



For some patients, ANY alcohol use will be considered a positive screening result, regardless of the score on the screener:

- Women who are pregnant, trying to get pregnant, or at risk of becoming pregnant (See **Appendix D** for more information on FAS and FASDs)
- Anyone taking medications with harmful interactions with alcohol
- Patients with other health conditions for which drinking alcohol is contraindicated.

How will the screening be performed and where?

If you typically screen for other conditions via computer before the patient arrives, you can include either the AUDIT 1-3 (US) or Single Question instrument in your plan with an automatic scoring system that leads patients who screen positive to the AUDIT (US). If you normally obtain such information via a questionnaire completed by patients in the reception room, you can amend that questionnaire to include the single question or the AUDIT 1-3 (US) questions.

How will screening fonns be scored and the results be shared and stored?

Having a system in place is essential to doing the job efficiently and accurately day in and day out. The following questions will help you and your team to focus on important system issues.

1. Who will score the screening instruments?
2. How will screening results be shared with staff who will provide brief interventions?
3. How will screening results be recorded *in* the patient's chart?
4. Where will screening forms (if used) be stored and managed?
5. How will patients who screen positive be followed during future visits? If a patient screens positive, you will need to follow up appropriately as you would with any other risk factor.

Screening for Drug Misuse

Although less research has been done on SBI for illicit and prescription drug misuse than for alcohol, drug use is common and poses significant health risks. If your practice decides to implement SBI for both alcohol and drugs, several screening options are presented in Screening for Drug Misuse **(Appendix J).**

Providers in your practice can use the alcohol consumption information from the screening results when they are prescribing any medication that has possible interactions with alcohol.

4 Plan for Brief Intervention

Patients who screen positive for risky drinking need a brief intervention. The goal is to help them decide to lower their risk for alcohol-related problems. Tailoring the plan for alcohol brief interventions to your practice requires decisions about two main issues:

- Who will deliver the interventions?
- What basic elements will you use in your brief interventions?

Who will deliver interventions?

Factors to consider:

1. **Time availability.**
   - The same person who delivers interventions may not have to be involved in the screening.
   - Interventions can be delivered in the course of providing other services.
2. **Knowledge and experience.** Research suggests that most medical staff can perform the necessary functions if they have some training. Background in alcohol treatment is not required.
3. **Interpersonal skills.** This is **a** key factor. Alcohol SBI requires relating to patients about drinking behavior and alcohol-related health consequences. A non-judgmental, open, confident demeanor sets patients at ease and makes them comfortable talking about their lives. More important than content expertise, the abilities to listen well and get people talking are perhaps the most important skills contributing to alcohol SBI success.
4. **Willingness.** Important factors in choosing the right person are their interest in implementing a new service to discuss alcohol use and a willingness to adjust to competing time requirements from their other responsibilities.



What will the basic elements of your intervention system be?

1. **When will interventions be delivered?** It is best to deliver the brief intervention during the same visit as the screening; the patient is available and the screening questions are fresh in her or his mind. It also saves the trouble and expense of another visit. However, if this is not possible, it is better to schedule a follow-up visit as soon as possible rather than to ignore the patient's risk by not delivering an intervention.
2. How will **you introduce the intervention for patients who screen positive?** Patients tend to be more comfortable and honest if you first introduce yourself and your goal. Draft a short statement of just a few sentences for this purpose. For example, you might say, "To provide the best quality health care, our practice discusses with all our patients various issues that may affect their health, like smoking, exercise, diet, and alcohol use. Is it all right if we take just a few minutes for that now?"
3. **What elements will you include in the intervention?** Because brief intervention protocols from clinical trials vary, it remains unclear which *active ingredient* in the brief intervention helps people decide to change their drinking. Evidence does suggest that enhancing patients' motivation to change may be central to success.[15] It would be helpful to include the following elements in your brief intervention:
   - **Provide feedback about screening results.** To ensure that patients understand why you are initiating this conversation, compare their drinking to risky drinking levels as defined in Table 1. Your plan may also call for collecting further information at this point, e.g., evaluating drug or tobacco use, or reviewing the patient's medical condition for subsequent reminders that alcohol use may affect existing conditions.

Step A□k patients what they like and what they don't **like about their drinking** (in that order). **Listen carefully** so you can mirror back to them what they don't like and, perhaps, probe for more information about that. This step allows them **to** identify problems with their drinking. This does not set you up to argue with them but to explore their own thinking and experience.

- Ask if **they would like your medical advice.** If they do, provide them with your reasons that their drinking may be harming their health, valued relationships, or their work. Follow the method suggested under "If You Give Advice" in AppendixN.
- **Listen for change talk.** Summarize what the patient says and reflect back to them. Ask if they are interested in change. Continue with reflection and summary of their own words.
- **Provide options the patient can choose from.** If the patient is interested in making a change (e.g., reducing amounts, reducing the number of drinking days, stopping for a time or permanently), help establish a goal and develop an action plan.
- **Seek agreement for a follow-up visit** within four to six weeks to reassess, as appropriate.
- **Thank all patients** for being willing to discuss their drinking, even if they are not willing to make changes.

4. **How long will interventions typically take?** As little as five to fifteen minutes of simple advice from a health care professional has been shown to help many patients reduce their drinking.[4]

5. **How will you intervene with patients who are likely to be dependent on alcohol?** Although some patients who are dependent on alcohol may respond favorably to a brief intervention and decide to stop drinking for a time or permanently, most require more assistance than a typical brief intervention. If your screening process indicates the likelihood of dependence, there are two options. One is to offer the patient a referral to further treatment. (See step 5.) A second option is for a qualified clinician in your practice to manage dependent patients. Offering medications for alcohol dependence gives primary care practitioners a valuable opportunity to care for their patients, particularly if they refuse to go to traditional alcohol treatment. For guidance on how to prescribe medications for alcohol dependence, seep. 13-22 ofNIAAA's *Helping Patients Who Drink Too Much: A Clinician's Guide* (http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf).

6. **How will you follow patients who receive an intervention?** Some patients who receive a brief intervention will reduce their drinking to moderate levels; others may not. Research suggests that many patients-particularly young patients and patients with more severe use patterns-benefit from a follow-up visit.[2] To provide the best care, therefore, establish a follow-up system to monitor patients' drinking, provide encouragement and support, and, if necessary, refer them to more specialized help.

7. **How will the intervention be documented?** Written or electronic documentation will assure that relevant staff can determine whether a brief intervention was provided and, if appropriate, support the intervention as part of their treatment regimen. Consistent and uniform documentation will also allow you to 1) calculate the proportion of patients who screen positive and receive an intervention, 2) measure the number of interventions conducted, and 3) ultimately facilitate reimbursement for *this* service.

Documentation of the intervention .n the patient record is essential. Subsequent visits require follow up and reinforcement of the message.

The message to all women who are pregnant, trying to get pregnant, or at risk of becoming pregnant should be: abstain from drinking alcohol.

5 Establish Referral Procedures

Although screeaing does not yield a diagnosis of alcohol dependence, the screening results and information collected during the brief intervention will indicate that a small percentage of patients are likely to be dependent. (See Appendix H.) These patients are less likely to change their drinking patterns in response to a single brief intervention than those who are not dependent. Patients who are likely to be dependent on alcohol should be referred for further assessment and possible specialty treatment.

Remember that many patients with dependence and some without it will refuse help, at least for now, but success in motivating a patient to accept additional help now or later is an accomplishment worth celebrating.

If a patient is open to additional services, three resources are available:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) supports alcohol treatment services. Its website is designed to help you or your patient find a service that might help. The service is available at: http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx
- Your practice should also establish contacts with local psychologists, counselors, and hospitals that provide services that would benefit your patients who need additional help.
- Alcoholics Anonymous (AA) is listed in nearly all local telephone directories in the country. AN.s website also provides a way to find local meetings: http://www.aa.org/pages/en_US/find-aa-resources



III. Implementing Alcohol SBI in Your Practice

Now that you have tailored alcohol SBI to your practice setting, you are ready to implement it. Careful implementation is as important as devising the plan. The steps in *this* section increase your odds of success by 1) orienting and training all staff, 2) planning and evaluating a pilot test, and 3) managing startup of full implementation.

Step 6: Orientation and Training

Determine who needs training

Since every primary care practice is different and the alcohol SBI system you have designed is unique, only you can determine who will need orientation or training and how best to provide it.

Orient All Staff about Risky Alcohol Use and Alcohol 581.

Ideally, everyone working in your primary care practice needs to understand what alcohol SBI is, why it is necessary, how it will be implemented in your practice, and the benefits to your practice and patients. Appendix K contains suggestions that you or another member of your practice can adapt for your own orientation.

In medical practice, training by itself seldom produces change! Training may be the culmination of planning, but for most trainees, it is only the first step of implementation. Gaining experience by doing the work creates the biggest change.

Help staff become comfortable discussing alcohol use.

Some staff will not be comfortable with their own alcohol use and consequently may conclude that patients will be equally uncomfortable talking about theirs. To address this, you might consider sharing findings from the *Cutting Back Study* (Appendix L), which shows that patients are comfortable answering questions about tobacco, alcohol, exercise, and diet. The study also found that patients believe this information is important to their health care providers.

Training for Alcohol 581 Specialized Functions.

The next level of skills training is more complicated. Each staff person must have instruction and practice in the specific functions he or she will perform.

Specialized training is required for staff who will 1) conduct the screening, 2) provide brief interventions and referrals, and 3) manage medical records or billing. Appendices M, 0, and Q will help you develop those training sessions. Adapt these training materials to meet the needs of your program.

7 Plan a Pilot Test

Evaluate the feasibility and acceptability of the alcohol SBI plan you have prepared by pilot testing **it** under "real world" conditions to monitor, measure, and evaluate each element. A pilot time period also allows you to address procedural issues when implementing alcohol SBI, such as evaluating the ease with which the practice is able to utilize their medical records or electronic health record (EHR) to include alcohol SBI.

What will you measure?

The primary purpose of the pilot is to determine which aspects of your plan for alcohol SBI implementation work well and which need improving. To gather data, you might consider:

- Asking staff to time themselves to see how long each function takes.
- Using a simple questionnaire to gather staff feedback on their experience and satisfaction (including medical records and billing).

During the pilot phase you should measure the following five SBI elements to ensure a good start-up and continued high quality performance.

Pilot testing has multiple advantages

- Makes clear that you expect glitches to occur and be corrected.
- Announces that staff should suggest improvements.
- Identifies precisely what works and what doesn't.
- Suggests fixes to problems and general improvements.
- Garners attention of all staff to the issue and the new alcohol SBI intervention.

Table 2:ImplementationMeasures

S81Element	Description
1. Number of patients in target population	This is the number of people who, according to your plan, should have been screened.
2. Percentage screened	The number of patients who are actually screened divided by the number in the *target population* is the percentage of patients screened. This is a good measure of the effectiveness (coverage) of your screening system. Set a realistic goal to start, perhaps 80%, and work toward it.
3. Number and percentage who screen positive	The percentage of screened patients deemed positive (i.e., the number positive divided by the number screened) is important in communicating to staff and administrators about the size of the problem and the number of patients needing help.
4. Percentage of positives receiving an Intervention	The number of patients who received interventions divided by the number who screen positive will measure your effectiveness in actually getting help to those who need it. Again, set a performance goal to start, see how you do, and later raise it as high as is realistically achievable.
5. Percentage referred to treatment	The number referred divided by the number who should have been referred (those screened using AUDIT (US) as likely to have alcohol dependence) will provide another measure of effectiveness.

Why should you measure?

These measures will allow you to keep staff and supervisors informed of how well they are doing. You may want to measure other aspects of your program as well; costs, billing, and revenue are important to any medical program.

How will you respond to results of your pilot test?

Consider how you will review the results of pilot testing and act on them. If everything operates smoothly or with only minor, easily correctible problems, a meeting or memo to all staff might be a great way to kick off regular program operations. If, however, your pilot reveals serious issues with your program design or staff performance, meetings with staff can solicit solutions, improvements, mutual encouragement, and enhanced morale. It is far better to do a second round of pilot testing than to launch a program that may contain serious flaws. Be prepared to continue in "pilot test" mode until you are comfortable with the program design and staff performance.

Step 8: Support a Strong Start-Up

When the pilot testing has demonstrated that all the elements and staff performance are functioning to the desired level, it is time to launch the new program as an official and permanent part of the practice's standard services. A few considerations may help your official start-up.

- **Communicate.** After the pilot, provide results of what worked and what changes were made to improve operations.
- **Provide hands-on help.** In the first week of implementation, you and your team should be available to observe and assist staff whose jobs have changed.
- **Address unforeseen issues quickly.** Even the best plans may not work in real time. Call on your team to help staff assess problems and work together to create alternative procedures.
- **Offer feedback, encouragement, and thanks.** Primary care staff is generally well aware of the impact their jobs can have on their patients' lives. Sharing feedback as quickly as possible about how the patients benefit will give staff an incentive to make the new program work.



IV. Refining and Promoting

Even after you have planned and implemented alcohol SBI, a few concerns may remain. The following steps suggest ways for you to monitor quality improvement within your own practice, to stay current with developments in other alcohol SBI programs, and to publicize your achievements.

Step 9: Monitor and Update Your Plan

The most effective leaders in medicine continually seek ways to improve their practices. As with all medical services, ideas for improving alcohol SBI come both from research and practical experience.

Four approaches to consider are:

- **Seek front-line** feedback-listen to your staff.
- **Set specific time intervals to evaluate your program.** Eventually alcohol SBI should become part of your practice's overall system so **it** needs its own quality improvement goals. As **it** becomes a permanent part of your practice, consider asking supervisors to make appropriate administrative changes, e.g., job descriptions, qualifications, and training.
- **Keep up on research.** Many journals publish alcohol and other SBI research. One way to keep current is to subscribe to a free service that reviews this literature. Boston University provides one such service (http://www.bu.edu/aodhealth/index.html).
- **Learn from others.** Although no two primary care practices are the same, finding out what works well in other practices can help you improve your program.

Step 10: Share Your Success

As you plan, develop, and refine your alcohol SBI service, you may want to let others know about the new service you are implementing, how you have integrated it into your everyday routine, and how it is accepted by your staff and patients. (See Appendix R for further communications tips.) Consider addressing these audiences:

- Your organization's leaders should know of your work and the opportunity alcohol SBI presents to improve patient health. They may want to notify the board of directors, payers, and customers of this new service. This is particularly important if you are part of a large healthcare system. Colleagues and other staff within your organization should know what is happening. Remind them why their support is important. This will facilitate and enhance continued communications about alcohol SBI in the future.
- Local community leaders, organizations, and citizens want to hear about state-of-the-art, evidence-based innovations in healthcare that benefit the community. This may be especially true of risky drinking, which carries so many consequences for traffic accidents, crime, and family and social problems.
- Members of regional and national organizations committed to quality medical services and advancing alcohol SBI (including CDC) will benefit from lessons you've learned, how well your service **is being implemented, and successes and challenges you have experienced.**

V. Appendices

Appendix A: Our Alcohol SBI Service

I. The Planning Team (Step 2)

Who is on the Planning Team?

Name	Position

How will the planning team work together?

How and why was the planning process established?	
Who does each team member represent and how will their input and feedback be elicited?	
What specific tasks should the planning process accomplish?	
What is the timeline?	
What are each person's responsibilities?	
How will decisions be made?	

The Screening Plan (Step 3)

Who will be screened?	
When will screening take place?	
How often will screening occur?	
Who will perform the screening and where?	
What screening instruments will we use?	

Where will screening forms be stored and who will manage them?	
How will screening results be recorded in the patient's chart?	
How will screening results be shared with staff who provide brief interventions?	

II. Brief Intervention Plan (Step 4)

Who will deliver the interventions?
When will interventions be delivered?
How will we introduce the intervention for patients who screen positive?
What elements will we include?
How will intervention personnel obtain necessary information that a patient needs an intervention, and the materials for conducting and documenting the intervention?
How will we intervene with patients who are likely to have alcohol dependence?
How will we follow patients who receive an intervention?
How will the intervention be documented?

III. Referral Plan (Step 5)

O	We have in-house social workers who handle referrals.
0	We have a readily available list of local alcohol treatment service providers, including local hospitals.
O	We have a contact at the state agency responsible for alcohol treatment services.
O	We have a list of local psychiatrists, psychologists, and counselors who work with patients who have alcohol dependence.
0	We have the phone numbers of local AA meetings.

IV. Implementation Plan (Steps 6, 7 and 8)

What training will be provided?		
Training	**Who**	**When/Where**
General orientation to alcohol S81		
How to conduct screening in our program		
How to conduct brief interventions		
Specialized training: For supervisors For quality improvement For billing Other		

How will we pilot test our program?	
When will the pilot test begin?	
Where will the pilot test be implemented? Which clinic? System wide?	
How will the pilot test be announced?	
What reminders and aids will be used to support staff?	
What data will be collected, how, and by whom?	
How and by whom will collected data be analyzed, summarized, and shared with staff?	
When will the planning team meet to review results and revise program plans?	
When will results of the pilot test be shared with key staff?	

What additional steps will we take to ensure a strong start-up?

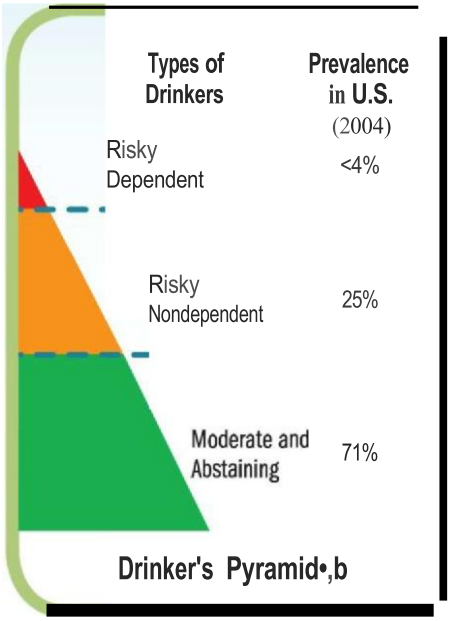
V. Plan for Refining and Promoting (Steps 9 and 10)

How will we evaluate our program?	
What quality improvement measures will we track?	
How will we share our successes?	

Appendix B: Alcohol SBI Fact Sheet
Screening and Brief Intervention (SBI) for Risky Alcohol Use

Risky Drinking: A Significant Public Health Problem

- Almost four percent of adults are alcohol dependent (alcoholic). **Another 25% are not dependent but drink in ways that put themselves and others at risk of harm.**[a,b]
- Everyone who engages in risky drinking is drinking too much, even if they have not yet begun to experience harm. For some people, any drinking at all is risky.[1]
- One common type of risky drinking is binge drinking-when women consume 4 or more drinks or men consume 5 or more drinks on a single occasion. More than **38 million** American adults binge drink an average of 4 times a month. Moreover, on average they drink 8 drinks per occasion.[d]
- Risky drinking causes more than 80,000 deaths each year.[c]



What are the health and social effects of risky drinking?

Drinking too much on a single occasion can result in intoxication and the *immediate risks* listed below. Drinking too much over a longer period of time injures cells in tissues throughout the body and can result in the *long-term risks* listed below. Further, risky drinking affects more than the drinker; it is associated with intimate partner violence, child abuse, crime, and is the largest single cause of lost productivity in the workplace.





a Grant BF, et al. The 12-month prevalence and trends in *DSM-N* alcohol abuse and dependence: United States, 1991-1992 and 2001-2002. *Drug Alcohol Depend.* 2004 Jun 10;74:223-234.

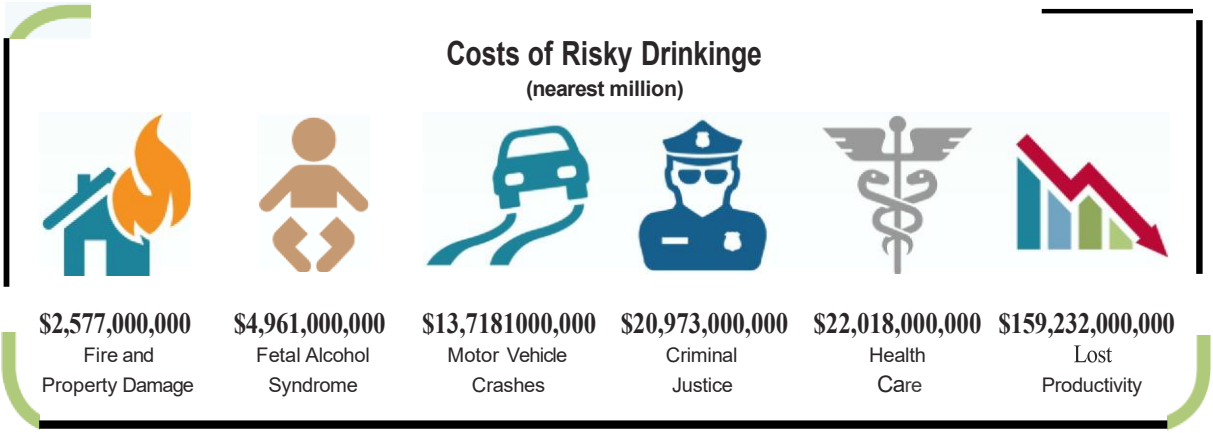
b Dawson DA, et al. Toward the attainment oflow-risk drinking goals: a 10-year progress report. *Alcohol Clin Exp Res* 2004 Sep;28:1371-1378.

c National Institutes of Health. National Institute on Alcohol Abuse and Alcoholism. Rethinking drinking: Alcohol and your health, 2010. http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf

d *Morbidity and Mortality Weekly Reports.* Vital signs: Binge drinking prevalence, frequency, and intensity among adults-United States, 2010. 2012;61:14-19.

What is the cost of risky drinking?

Each year, risky drinking in the U.S. *costs* $223.5 billion. That's more than smoking ($193 billion) or physical inactivity ($150 billion). The costs of risky drinking cut across many aspects of the U.S. economy.



Rankings of Preventive Services for the U.S. Population'

Rank	Clinical Preventive Services	CPB	CE	Total Score
1	Discuss daily aspirin use-men 40+, women 50+	5	5	
2	Childhood immunizations	5	5	10
3	Smoking cessation advice and help to quit-adults	5	5	
4	**Alcohol screening and brief counseling-adults**	**4**	**5**	**9**
5	Colorectal cancer screening-adults 50+	4	4	
6	Hypertension screening and treatment-adults 18+	5	3	8
7	Influenza immunization-adults 50+	4	4	
8	Vision screening-adults 65+	3	5	
9	Cervical cancer screening-women	4	3	
10	Cholesterol screening and treatment-men 35+, women 45+	5	2	7
11	Pneumococcal immunizations-adults 65+	3	4	
12	Breast cancer screening-women 40+	4	2	6

CPB (clinically preventable burden): disease, injury and premature death prevented if delivered to fu11 target population

CE (cost effectiveness): a standard measure for comparing services· return on investment

Services with the same total score tied in tile rankings:

10 - highest impact, most cost effective among these evidence-based preventive services

2 □ lowest impact, least cost effective among these evidence-based preventive services

Alcohol SBI: A Critical Clinical Preventive Service

Although many primary care practices ask patients something about alcohol use, alcohol SBI begins with a **validated** set of screening questions to identify patients' drinking patterns. The brief intervention is a short conversation with patients who are drinking too much. This approach takes little time and may be reimbursable.

Thirty years of research has shown that alcohol SBI is effective at reducing risky drinking. Based on this evidence, in 2004 and 2013 the U.S. Preventive Services Task Force recommended that alcohol SBI be implemented for all adults in primary care settings.g

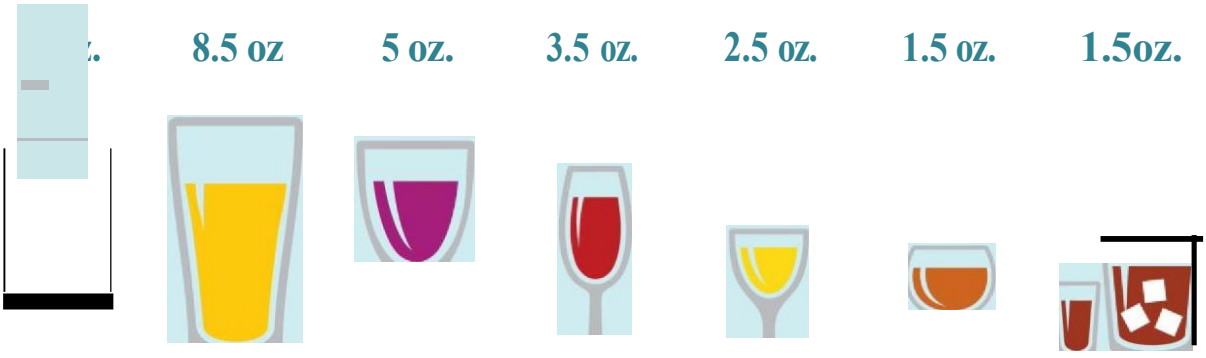
e Bouchery EE, et al. Economic costs of excessive alcohol consumption in the U.S., 2006. *Am J Prev Med* 2011 Nov;41(5):516-24.

f Rankings for all 25 available at http://www.prevent.org/National-Commission-on-Prevention-Priorities/Rankings-of-Preventive-Services-for-the-US-Population.aspx

g Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse, topic Page. U.S. Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsdrin.htm

Appendix C: What's a Standard Drink?a

A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents. These are approximate, since different brands and types of beverages vary in their actual alcohol content.



12 oz.	8.5 oz	5 oz.	3.5 oz.	2.5 oz.	1.5 oz.	1.5oz.
12 oz. of beer or cooler	**8-9 oz. of malt liquor** 8.5 oz. shown in a 12-oz. glass that, if full, would hold about 1.5 standard drinks of malt liquor	**5 oz. of table wine**	**3-4 oz. of fortified wine** such as sherry or port 3.5 oz. shown	**2-3 oz. of cordlal, liqueur, or aperitif** 2.5 oz. shown	**1.5 oz. of brandy** a single jigger	**1.5 oz. of spirits** a single jigger of BO-proof gin, vodka, whiskey, etc. Shown straight and in a highball glass with ice to show level before adding mixer*

Many people don't know what counts as a standard drink and so they don't realize how many standard drinks are in the containers in which these drinks are often sold. Some examples:



For beer the approximate number of standard drinks in

12 oz.= 1
16 oz.= 1.3
22 oz.= 2
40 oz.= 3.3

For malt liquor the approximate number of standard drinks in

12 oz.= 1.5
16 oz.= 2
22 oz.= 2.5
40 oz.= 4.5

For table wine the approximate number of standard drinks in

a standard 750 ml (25 oz.) bottle= 5

For 80-proof spirits or "hard liquor" the approximate number of standard drinks in

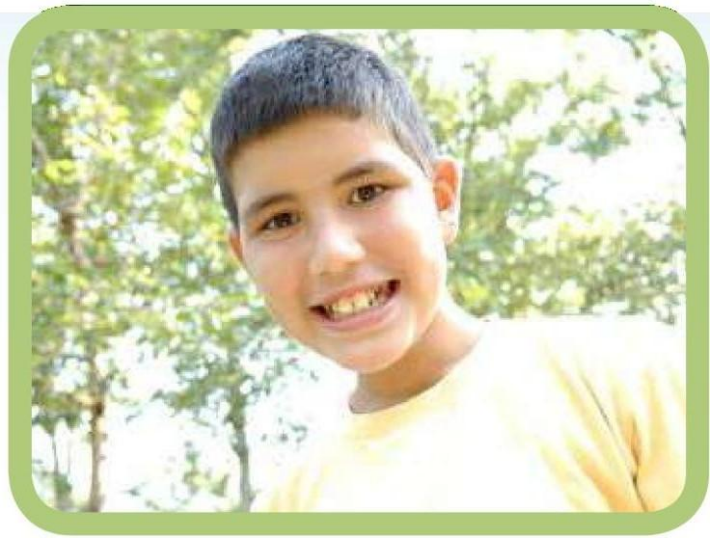
a mixed drink = 1 or more*
a pint (16 oz.) = 11
a fifth (25 oz.) = 17
1.75 L (59 oz.)= 39

'"Note: It can be difficult to estimate the number of standard drinks in a single mixed drink made with hard liquor. Depending on factors such as the type of spirits and the recipe, a mixed drink can contain from one to three or more standard drinks.

a National Institute on Alcohol Abuse and Alcoholism. Helping Patients Who Drink Too Much: A Clinician's Guide, 2007.

http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide13_p_mats.htm

D: FetalAlcohol Spectrum Disorders



Fetal alcohol spectrum disorders **(FASDs) can cause serious disabilities that last a lifetime. They can affect how a person looks, grows, learns, and acts. But, FASDs are completely preventable –if a woman does not drink alcohol while she is pregnant.•**

- Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother drank alcohol while pregnant. These effects can include physical and intellectual disabilities, as well as problems with behavior and learning. Often, a person has a mix of these problems.
- People with FASDs often have problems with learning, memory, attention span, problem solving, speech, and hearing. They are at very high risk for trouble in school, trouble with the law, alcohol and drug abuse, and mental health disorders.
- FASDs include fetal alcohol syndrome (FAS), which causes growth problems, abnormal facial features, and central nervous system problems. Children who do not have all of the symptoms of FAS can have another condition along the FASD continuum. These children can have problems that are just as severe as those of children with FAS.
- The exact number of children living with fetal alcohol spectrum disorders (FASDs) is difficult to determine. The rate of fetal alcohol syndrome (FAS) alone in the United States is estimated to be as high as 2 per 1,000 live births or 8,000 cases per year. The prevalence ofFASDs in the United States is estimated to be as high as 10 per 1,000 births. This means approximately 40,000 babies may be born with FASDs in the United States each year.b

There is no known safe level of alcohol use during pregnancy. There is no time during pregnancy when it is safe to drinkc.

- All drinks with alcohol can hurt a developing baby. A 12-ounce can of beer has as much alcohol as a 5-ounce glass of wine or a 1.5-ounce shot of liquor. Some drinks, like malt beverages, wine coolers, and mixed drinks, have more alcohol than a 12-ounce can of beer.
- A woman should not drink any alcohol if she is pregnant or trying to get pregnant. Drinking alcohol during pregnancy can cause miscarriage, stillbirth, and FASDs.
- It is not safe to drink at any time during pregnancy. This includes the earliest stage of pregnancy before a woman may know that she is pregnant. Without meaning to expose the developing baby to alcohol, a woman's drinking can cause damage during the first few weeks of pregnancy (weeks 3 to 8) when many body parts and organs are forming.

a Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Fetal Alcohol Spectrum Disorders, Alcohol Use in Pregnancy. http://www.cdc.gov/ncbddd/fasd/alcohol-use.htrnl

b American Academy of Pediatrics, Fetal Alcohol Spectrum Disorders Toolkit, Frequently Asked Questions. http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/fetal-alcohol-spectrurn-disorders-toolkit/Pages/Frequently-Asked-Questions.aspx

c Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, CDC Feature: **Akohol andPregnancy: WhyTake the Risler http:iiwww.cdc.govifeatureslalcoholpregnuic:yi**

- Negative effects can also occur if a woman drinks later in her pregnancy. The baby's brain is developing throughout pregnancy and can be damaged at any time.
- If a woman drinks alcohol and does not use contraception (birth control) when she has sex, she might become pregnant and expose her baby to alcohol before knowing she is pregnant.
- Nearly half of all pregnancies in the United States are unplanned. And many women do not know they are pregnant right away. So, if a woman is not trying to get pregnant, but is still having sex, her provider should talk to her about using contraception consistently.
- FASDs last a lifetime-there is no cure. However, identifying children with these conditions as early as possible can help them to reach their full potential.



FASDs are completely preventable- if a woman does not drink alcohol while she is pregnant.

Appemlix E: Negative Effects of Risky and Binge Drinkinga



Depression
Anxiety
.Aggressive behavior
Alco ol dependence
n omnia

Me ry loss

Stroke
Hypertension

Heart failure
Premature aging

Frequent colds
Reduced resistance to infection
Increased risk

of pneumonia

Anemia

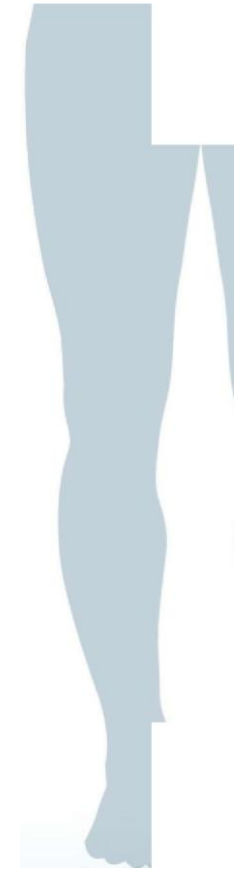
Blood clotting
Vitamin deficiency
Bleedlng

Cancer of the

throat and mouth
Breast cancer
Inflammation of the pancreas

Stomach

inflammation
Diarrhea
Malnutrition



Risk of fetal alcohol spectrum disorders, which include physical, behavioral and

learning disabilities

Painful nerves
Numb, tingling toes
Impaired sensation

leading to falls

'fype 2 Diabetes
Liver damage

Motor vehicle crashes
Failure to fulfill obligations

at work, school, or home

Men: Erectile dysfunction
Women: Unintended pregnancy

Sexually Transmitted Diseases

Injury
Violence
Violent crime
Legal problems

a Adapted from WHO AUDIT Manual. http://whqlibdoc.who.int/hq/2001/who_msd_msb_Ol.6a.pdf and SBIRT Oregon

Reference Sheet. http://www.sbirtoregon.org/resources/SBIRT-reference-sheet.pdf

Appemlix F: Single Question Alcohol Screen

A ingle screening question about whether a patient has recently consumed more than 5 drinks in one day (more than 4 drinks for females) has been found to be effective in identifying at-risk drinking among primary care patients.

Use

The question can be included on an intake questionnaire or asked orally while collecting vital signs. If it is asked in the context of collecting other patient information, efforts should be made to assure it *is* asked of all patients. Patients who score positive should then receive the full AUDIT (US) to determine their level of risk and any signs of dependence.

Cutoff Scores

Patients who report having exceeded the defined number of drinks 1 or more times within the past year are considered positive.

Advantages

This is a simple, quick, and easy method of screening to identify most (but not all) of those likely to benefit from brief alcohol counseling.

Instrument

"How many times in the past year have you had X or more drinks in a day?" where Xis 5 for men and 4 for women.

Source

Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. Primary care validation of a single-question alcohol screening test. *J Gen Intern Med.* 2009 Jul; 24(7):783-8.

The Single Question Alcohol Screen can be used for clinical purposes without permission or cost.



Appendix G: AUDIT 1-3 (US)

Description

A hort, easy-to-administer screening process using the first three questions of the AUDIT modified for the US standard drink (14 grams, rather than the 10 grams standard used in the international version of the AUDIT). It was developed for and used in the *Cutting Back Study* to measure patients' weekly consumption and occasions of excessive drinking.

Use

Can be included in an intake or health behavior questionnaire to provide a quick screen to identify excessive drinking. Best administered on paper or electronically, where the patient must choose one of the response alternatives. Patients who score positive should then receive the full AUDIT (US) to determine their level of risk and any signs of dependence.

How to Score

Each response is scored using the numbers at the top of each response column. Write the appropriate number associated with each answer in the column at the right. Then add all numbers in that column to obtain the total score.

Cutoff Scores

A total of 7 or more for women and men over age 65, and 8 or more for younger males is positive.

Advantages

Identifies both excessive regular drinking and excessive occasional drinking in only three questions.

Instrument

Instructions: Alcohol can affect your health, medications, and treatments, so we ask patients the following questions. Your answers will remain confidential. Place an x in one box to answer. Think about your drinking in the past year. A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

QUESTIONS	0	1	2	3	4	5	6	Score
1. How often do you have a drink containing alcohol?	Never	Less than Monthly	Monthly	Weekly	2-3 times a week	4-6times a week	Daily	
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-9 drinks	10 or more drinks	
3. How often do you have X (5 for men; 4 for women & men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily	
							Total	

The AUDIT 1-3 (US) can be used for clinical purposes without permission or cost.

Source

Baber TF, Higgins-Biddle J, Dauser D, Burleson JA, Zarkin GA, Bray J. Brieflnterventions for at-risk drinking: patient outcomes and cost-effectiveness in managed care organizations. *Alcohol Alcohol* 2006 Nov-Dec; 41(6): 624-31.

H: AUDIT (US)-Alcohol Use Disorders IdentificationTest

Thi 10-item screening instrument was developed through international testing by the World Health Organization. The AUDIT asks questions about alcohol consumption during the past year, symptoms of alcohol dependence, and alcohol-related problems or harm. It identifies 4 different groups of people-those unlikely to be at risk, those at risk because they drink excessively, those who have already experienced problems related to their drinking, and those who are likely to have alcohol dependence.

Use

The AUDIT (US) questions can be answered in 2-3 minutes by patients using paper or a computer. Administration by an oral interview requires training and is likely to produce less accurate results.

How to Score

Each response is scored using the numbers at the top of each response column. Write the appropriate number associated with each answer in the column at the right. Then add all numbers in that column to obtain the total score.

Cutoff Scores

We recommend that the AUDIT (US) not be used as an initial screening instrument, but be used with all patients who have already screened positive on either the Single Question Alcohol Screen or the AUDIT 1-3 (US). In this case the AUDIT (US) provides guidance for the intervention. The higher the score, the more severe the patient's drinking-related risk is likely to be.

At the time of the AUDIT manual publication (2001) research led the WHO authors to suggest the following services for patients with different ranges of scores. Clinical judgment may be used in deviating from these guidelines.

- A Score of 0- 7 suggests abstinence or drinking below low-risk guidelines. These patients should receive information that defines risky drinking levels and when any alcohol consumption is unhealthy.
- A Score of 8-15 suggests drinking in excess of screening guidelines, which merits a brief intervention.
- A score of 16-19 suggests not only drinking above guidelines but also the experience of alcohol-related harm, which merits a brief intervention and follow up.
- A score of 20 or more suggests but does not diagnose alcohol dependence syndrome, which may require a referral to specialized treatment.

Advantages

AUDIT (US) is sensitive to a broad spectrum of drinking problems, from early excessive use to severe dependence. It has been extensively validated and performs well with a wide variety of ethnic and cultural groups. It is available in Spanish and many other languages. It provides information about the three major domains used in screening for alcohol problems-alcohol consumption, alcohol-related harm, and dependence symptoms, all of which are valuable in conducting an intervention.

Instrument is available for clinical use without permission or cost.

Instrument AUDIT (US)

Instructions: Alcohol can affect your health, medications, and treatments, so we ask patients the following questions. Your answers will remain confidential. Place an X in one box to answer. Think about your drinking in **the past year.** A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing o& shot (1.5 oz.) of spirits.

QUESTIONS	0	1	2	3	4	5	6	Score
1. How often do you have a drinkcontainingalcohol?	Never	Less than Monthly	Monthly	Weekly	2-3 times a **week**	4-6 times a **week**	Daily	
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-9 drinks	10 or more drinks	
3. How often do you have X (5 for men; 4 for women & men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a **week**	4-6 times a **week**	Daily	
4. How often duringthe last year have you found that you were not able to stop drinkingonce you had started?	Never	Less than monthly	Monthly	Weekly	Dailyor almost daily			
5. How often during the past year have you failedto do Yitiat was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
6. How often duringthe past year have you needed a drinkfirst thing inthe morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Dailyor almost daily			
7. How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Dailyor almost daily			
8. How often duringthe past yearhave you been unable to remember Yitiat happened the night beforebecause you had been drinking??	Never	Less than monthly	Monthly	Weekly	Dailyor almost daily			
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the past year		Yes,during the past **year**			
10. Has a relative,friend, doctor,or other healthcare worker beenconcerned about your drinking and suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year			

Total

UI

Appendix I: Other Screening Instruments

This list of instruments is provided because they are well-known and validated, but typically for use in screening for alcohol use disorders, that is, the diagnoses of alcohol abuse and dependence. They do not directly measure alcohol consumption, and therefore do not provide-by themselves-a full picture of patients' alcohol use, one of the main goals of screening and brief intervention. If providers choose to use one of these instruments, it should be paired with another instrument that measures alcohol consumption. However, this is likely to be less reliable than the system recommended here and will make scoring more cumbersome.

Name	# questions	Validated setting	Validated Populations	am ms er score
CAGE"	4	Primary care	Adults, adolescents (over 16 yrs.)	1 min
RAPS4b	4	ED	Adults	1 min
T-ACEC	4	Ob/Gyn settings, primary care	Adults, pregnant women	1 min
IWEAKd	5	Ob/Gyn settings, primary care, ED	Adults- assessing risk during pregnancy	<2 min/1min

a Ewing JA. Detecting alcoholism: The CAGE questionnaire. *JAMA:* 1984 Oct 12;252(14):1905-7.

b Cherpitel CJ. A brief screening instrument for problem drinking in the emergency room: the RAPS4. Rapid Alcohol Problems Screen. *J Stud Alcohol.* 2000 May;61(3):447-9.

c Sokol R, et.al. The T-ACE questions: practical prenatal detection of risk drinking. *Am J Obstet Gynecol* 1989:150:868-70.

d Chang G, Wilkins-Haug L, Berman S, Goetz MA. The TWEAK: application in a prenatal setting. *J Stud Alcohol.* 1999;60:306-309.

J Screening for Drug Misuse

Single-Question Drug Screen

Description

Like the single alcohol screening question, this instrument allows easy screening for illicit drugs and the misuse of prescription medications.

Use

The single question can be added to the initial alcohol screen {either the single-question screen or the AUDIT 1-3 (US)) or it can be added to the AUDIT (US) or asked during interventions with patients who screen positive **for** alcohol.

Cutoff Scores

A response of one or more use is positive.

Advantages

This is a simple, quick, and easy method of screening to identify those likely to benefit from brief counseling for drug misuse.

Instrument

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

Source

Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. A single-question screening test for drug use in primary care. *Arch Intern Med.* 2010 Jul 12; 170 (13) 1155-60.

ASSIST

Description

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for the World Health Organization (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings.

Use

Although too long for an initial screening instrument, ASSIST is useful in providing a full picture of a patient's full substance use-alcohol, tobacco, illicit and prescription drugs. ASSIST can be used in place of the AUDIT (US) as a full screen or just for patients who respond positively to the single question drug screen.

Cutoff Scores

Varies by substance; see instrument and manual.

Advantages

Like the AUDIT (US), which deals only with alcohol, ASSIST offers not only a measure of whether the patient's use presents risk, but also provides a measure of severity.

Instrument

ASSIST (various languages) and supporting materials can be obtained from the WHO website: http://www.who.int/substance_abuse/activities/assist/en/index.html

Source

WHO ASSIST Working Group. The Alcohol, Smoking and Substance Involvement Screening Test {ASSIST): development, reliability and feasibility. *Addiction.* 2002 Sep; 97 (9): 1183-94.

□ix:

Description

The Drug Abuse Screening Test (DAST)-10 was designed to provide a brief instrument for clinical screening and treatment evaluation of drug use.

Use

This 10 question instrument has been condensed from the 28-question DAST and can be used for adults and older youth to determine extent of drug use.

Cutoff Scores

Anything greater than O is deemed risky and requires some type of intervention.

Advantages

Short, self-administered, yes/no screening instrument. It provides a quantitative index to the extent of problems related to drug abuse, allowing you to obtain a reliable estimate of the degree of problem severity.

Instrument

http://www.buppractice.com/node/ 1521

Source

Skinner, HA. The drug abuse screening test. *Addict Behav.1982;* 7(4): 363-71.



CRAFn

Description

The tool recommended by both the American Academy of Pediatrics and the National Institute on Alcohol Abuse and Alcoholism for screening adolescents for risky substance use (both alcohol and drugs) *is* the CRAFFT instrument.

Use

This tool asks about problem behaviors related to the use of alcohol and other drugs in adolescents. It can easily be administered orally during the course of an exam or be self-administered.

Cutoff Scores

"Yes" to two of the questions signals a problem needing further evaluation and a score of 4 or more should raise a suspicion of substance dependence.

Advantages

Quick and easy to administer, identifies problems that can be discussed during motivational interviewing. Allows for screening both alcohol and drug use at the same time.

Instrument

The CRAFFT (various languages) can be obtained from the following website: http://www.ceasar-boston.org/CRAFFT/screenCRAFFT.php

CRAFFT is a mnemonic acronym of first letters of key words in the six screening questions. The questions should be asked exactly as written.

C Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

R Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

A Do you ever use alcohol/drugs while you are by yourself, ALONE?

F Do you ever FORGET things you did while using alcohol or drugs?

F Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?

T Have you gotten into TROUBLE while you were using alcohol or drugs?

Source

Knight JR, Sherritt L, Shrier LA, Harris S, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med.* 2002 Jun;l56(6):607-14.

Appemlix K: Orienting Staff to Alcohol SBI

Orientation will help staff understand why this new service is being implemented in your practice, how it will help patients, and what different staff members will do to make it work. Providing this orientation has been shown[16] to change not only staff knowledge but also their actions and support.

The following annotated outline provides a picture of how you can develop your own orientation program.

Title and Introduction

A good place to begin is your practice's decision to authorize and plan the alcohol SBI program, with the names and titles of all those involved. This is also an opportunity to recognize and thank those who worked hard to design the program and who are leading its implementation.

An introduction to talking about alcohol issues

Many people find it awkward or uncomfortable to talk about their own drinking or that of others. Some think of drinking as a private matter, and not something medical practice should deal with. Others have had painful experiences with a loved one with severe drinking problems. They may mistakenly leap to the conclusion that alcohol SBI is intended to "cure alcoholism" and will dismiss it outright or argue that if it will not help alcoholics it is not worth doing.

Although your orientation will address all of these issues, at the outset it is best to acknowledge the difficulties many Americans have in discussing alcohol. Allow everyone to share experiences, and ask for suspension of judgment about the new program until the end of the training, after dissemination of all the material. Promise to come back to the issue at the end of the orientation and be sure to do so.

Refer to studies (e.g. the *Cutting Back Study)* that show patients are comfortable talking about alcohol with their healthcare providers and that they think it is important that their providers know this information.

Discussion of the full spectrum of unhealthy alcohol use

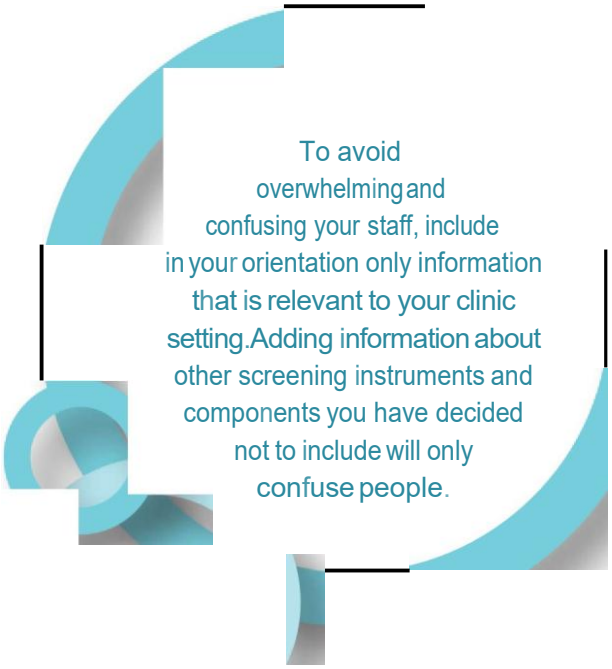
It is important to begin the training with facts about the consequences of excessive alcohol use in our society. When the subject of alcohol is raised, most Americans think first about alcoholism, that is, alcohol dependence. Unless the orientation makes it clear that this program is designed to identify and help people across a broad spectrum of unhealthy alcohol use-from hazardous use to dependence-many will not understand. You can copy the *Drinker's Pyramid* (Appendix B) here for use in this discussion. Grasping this new perspective should be among the first orientation topics. One aspect of describing this new perspective should be the recognition that this new program will not "cure alcoholics" in just a few minutes! Because most people will know someone who occasionally drinks too much, but who does not have alcohol dependence, learning the concept of nondependent, risky drinking should not be difficult.

Review of screening instruments and scoring

Staff should know that the instruments your planning team has selected have been validated by research. These instruments are used widely in medical settings and do a credible job of identifying patients who drink to excess. You might distribute the instruments and also ask one of the people who will be conducting the screening process to demonstrate exactly how it will work. (See instructions for designing training for screeners in Appendix M.)

Describe and demonstrate a brief intervention

Many medical staff may find brief interventions a novel concept, even though they are now widely used in primary care counseling for hypertension, diabetes, obesity, and tobacco use. It may be useful to refer to the



Jtpp!tffliJti□ Services Task Fvet recommendation[17] and evidence.[18] Describe the empathic style of conversation with the patient and the specific steps included in a standard intervention. Finally, your follow-up procedures will assure doubters that you are not under the illusion that every intervention will succeed in just a few minutes.

An explanation of brief interventions is incomplete without a simple demonstration. Whether you use a video drawn from another training program or a live demonstration by your intervention team, seeing and hearing what is involved will help those new to this approach understand and appreciate your service. Videos from SBIRT Residency programs in Oregon and North Carolina provide an overview of screening and brief intervention in five minutes or less. You can access these videos in Appendix 0.

Orientation to when and how operations will begin

Review the results of your pilot and then set a specific time to begin the new intervention-ideally within a few days of the orientation. Your pilot phase should include a description of the review process you will use to identify anything that is not working well and how you intend to make adjustments.

Processes to follow if there are questions or problems

During the initial period of any new medical routine, you can expect problems to surface. If you have a mechanism to correct these problems quickly, the corrections can actually strengthen the plan. The orientation should encourage staff to identify and report anything that is not working as planned. Expecting, seeking, and addressing such issues should be part of the implementation process and communicated in the orientation.

What to expect in the way of goals and feedback

Most people will want to learn whether these new functions are actually having the desired effects. The end of the orientation is the ideal time to tell everyone how you will measure this work and how the results will be reported back to them. These reports should begin as quickly as possible-within the first week of operations if possible-so that staff learn quickly how well they are doing.

Thanks to everyone involved

Finally, thanking everyone who has initiated and participated in the planning of your alcohol SBI service is a fitting way to end your orientation.

L How Do Pati n s React to Alcohol Screening? The 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.

The University of Connecticut School of Medicine's *Cutting Back Study* screened primary care patients in five states for smoking, diet/exercise, and alcohol use using a questionnaire. Patients **were** also asked two questions about their attitudes toward the screening:

1. How comfortable do you feel answering these questions? (Figure 2)
2. How important do you think it is that your health care provider knows about these health behaviors? (Figure 3)

Patients were asked to express their views on a five-point scale from "very comfortable" to "very uncomfortable" and "very important" to "very unimportant:'

Fewer than 9 percent of patients indicated any discomfort or thought that such information was unimportant to their healthcare givers.

Not surprisingly, a high proportion of those who reacted negatively to screening were those who smoked, were overweight, or drank too much. The responses of people whose behavior creates health problems might sometimes be difficult to manage. But no one would refuse to screen for hypertension or diabetes out of fear that such screening might upset a patient.

In case someone in your facility raises this issue, you might want to print and share these *Cutting Back Study* findings.

Figure 2: Patients' Comfort with Questions

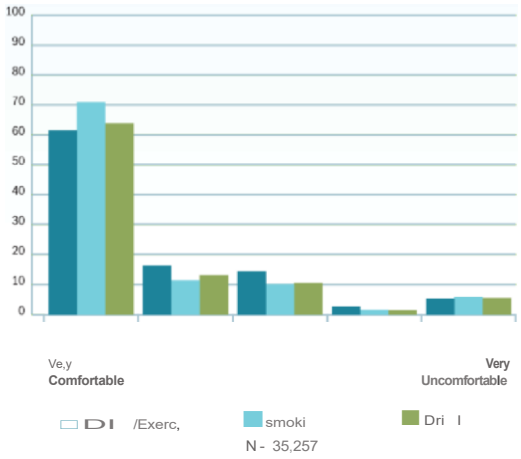
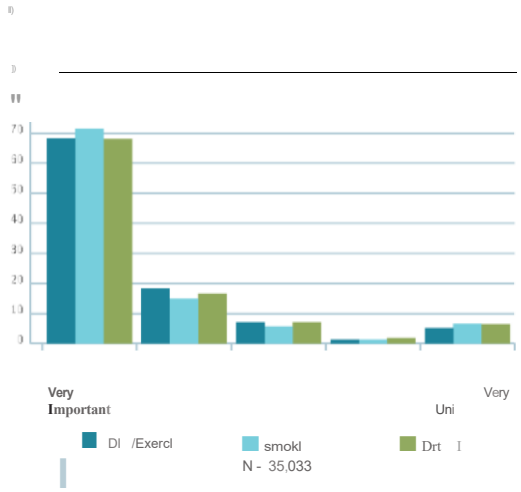


Figure 3: Importance that Provider Should Know about Behaviors



a These data on patient attitudes have not been previously published. For further information of the *Cutting Back Study,* see

"Cutting Back: Managed Care Screening and BriefIntervention for Risking Drinking" **at** http://www.rwjf.org/en/research-publications/find-rwjf-research/2007/04/cutting-back.html

Appendix M: TrainingfonSdreening Staff

It is probably best to create your own training for staff who will be screening patients. This avoids any confusion from videos and materials from other programs that use instruments and procedures different from those you have chosen.

Consider the following learning objectives and training elements as you create training for your screening staff.

Leaming Objectives

1. Understand the nature and scope of alcohol-related risks.
2. Understand the purpose of screening for alcohol use, rather than solely for alcohol problems and dependence.
3. Understand the screening instruments and be able to follow screening procedures.
4. Understand how screening fits within the overall alcohol SBI plan.

Training Elements for Screening Staff

- Describe the purpose of your screening plan so that screeners will understand how their work fits into the overall alcohol SBI plan.
- Explain why routine use of validated screening instruments produces better results than subjective judgments of staff.
- Describe the specific steps in your screening procedures. Name the instrument or instruments to be used, and describe how they help identify patients at risk.
- Review each instrument, its function within your overall system, the questions involved, how to introduce it to patients, how to score it, and how to report that score to all who need to know.
- Confirm that screeners understand what each score means and what will happen to patients with each score.
- Brainstorm what questions patients might ask with trainees, and help them develop appropriate responses.
- Discuss the limits of the screener's role and who will be performing the other alcohol SBI functions.
- Ask trainees for their questions about screening and the alcohol SBI plan in general, and discuss answers to those questions so they are both informed and comfortably supportive of their roles.
- Have all screening staff practice the functions they will be required to perform.

Appemlix N: Brief Intervention Guidance

The Brief Intervention Training Notes on the next page is a reference sheet developed from ten, day-long training sessions on alcohol SBI supported by three federal agencies and presented for staff from emergency departments and trauma centers around the United States. Although designed for acute-care clinical settings, it is also applicable in primary care settings.

Feedback on Screening Results

The FLO (Feedback, Listen, Options) mnemonic was developed to encompass the three major elements of a brief motivational intervention. Tue feedback element is more important than it might seem at first. Although you may choose not to use the RANGE mnemonic as presented (under the 'Feedback' section), each of those five elements is important in helping patients understand their screening results. Moreover, the fifth element, *'Elicit patient's reaction'* is particularly important because it turns responsibility for the discussion over to the patient.

Listen for Change Talk

The Listen step is the heart of the brief intervention. It may be the most difficult for many in the medical professions because they are trained to dispense expert advice, not to listen, so their first question might be, "Listen for what?" First, listen to how patients feel about getting a screening result that means they are drinking too much. Then summarize those feelings. The goal is to help patients think about the pros and cons of their current drinking pattern. By asking for both, you are not setting up an argument you will lose, that is, an argument where you are on the side of drinking less or stopping, and the patient is on the side of continuing the current behavior. That's an argument the patient has already practiced.

Instead, you set up a balanced approach by setting the patient up to argue with him or herself, both pro and con. Then, you are in a position to listen for "change talk;' the patient's own words that support change. The important thing is to listen for patients' specific language, so that you can repeat it back. By using their words, you make it clear that you are not arguing, but are just neutrally pointing out that they have thoughts and feelings on both sides of the issue.

Options

In the Options step, you start to conclude the interaction. If the patient is ready **to** do that, all you have to ask is "Where does this leave you?" They will take it from there. With other patients, you can just present the five choices provided by the MENUS mnemonic.

As a healthcare expert you may be pulled to provide advice. If you do that, make sure to use the Ask-Advise-Ask method outlined in the Options section in the Training Notes that follow this section. It not only reduces resistance but also indicates respect, strengthens rapport, and lets you know whether the patient actually heard your advice.

Sometimes, people wonder why *'Continue Usual drinking pattern'* is included as an option. No matter what you might believe, the power to decide, in reality, belongs to the patient. In acknowledging that reality, you communicate to them clearly that the responsibility for changing behavior is theirs. No matter which option they choose, you understand the difficulty of their situation and respect their right to control their own lives. That will help end the interaction on good terms.

Brief Intervention Training Notes

Orient the Patient

Identify yourself and explain your role on the trauma team.
Get permission, explicit or implicit, from the patient to talk together for a few minutes.
Explain the purpose of this discussion is to
1} give them information about health risks that may be related to their drinking,
2) get their opinions about their drinking, and
3} discuss what, if anything, they want to change about their drinking.

feedback [Using Binge Question)

Range: The number of drinks people have on a single occasion varies a great deal, from nothing to more than 10 drinks.
And we know that having too many drinks at one time can alter judgment and reaction times.
Normal: Most drinkers in the United States have fewer than 2 (□) or 3 (o') drinks on a single occasion.
Give Binge Questions results. "You drank more than **that**_ times last month, increasing your risk for health problems."
Elicit the patient's reaction. "What do you make of that?"

Using AUDIT

Range: AUDIT scores can range from 0 (non-drinkers) to 40 (probably physically dependent on alcohol).
AUDIT has been given to thousands of patients in medical settings, so you can compare your score with theirs.
Normal AUDIT scores are 0-7, which represent low-risk drinking. About half of the U.S. population doesn't drink.
Give patients their AUDIT score. "Your score of_ means you are (at risk or high riskl, putting you in danger of health problems."
Elicit the patient's reaction. "What do you make of that?"

Listen for Change Talk

Goals a) Listen for pro-change talk-the patient's concerns, problem recognition, and downsides of drinking.

b) Summarize the patient's feelings both for and against current drinking behavior.
"On the one hand. . . On the other hand ..."

Methods
"What role do you think alcohol played in your injury?"

Explore **pros and cons** of drinking. "What do you like about drinking? What do you like less about drinking?"

Is this patient interested in change?

"On a scale of Oto 10 (with 0 indicating not important, not confident or not ready], rate... "

"... how **important** it is for you to change your drinking behavior?"
"… your level of **readiness** to change your drinking behavior?"
"Why did you choose_ [the# stated] and not a lower number?"

If the patient is interested in changing, use these questions.

"What would it take to raise that number?"
"How **confident** are you that you can change your drinking behavior?"

Reflect and summarize throughout.

Options

"Where does this leave you? Do you want to quit, cut down, or make no change?"

You could:

Manage your drinking,
Eliminate drinking from your life,
Never drink and drive,
Continue Usual drinking pattern, or
Seek help.

If appropriate, ask about **a plan.** "How will you do that? Who will help you? What might get in the way?"

If You Give Advice

When you have significant concerns or important information to impart, use this approach. It reduces the possibility of patient resistance.

Ask:	Ask permission to discuss your concerns.
Advise:	If permission is granted, give information or share your concerns.
Ask:	Ask for the patient's reaction to your comments.

Close on Good Terms

Summarize the patient's statements in favor of change.
Emphasize the patient's strengths.
What agreement was reached?

✓ **Always thank the patient for speaking with you.**

April 2009: C Dunn, C Field, D Hungerford, S Shellenberger, J Macleod

0:TnInIng to D Ilver Brief Intenentlans

In **general, brief intervention training consists of four broad areas: 1) Confidence or Self-Efficacy, 2) Style, 3) Content,** and 4) Practice.

1. Confidence or SeH-Efficacy

People are more likely to become good at any job if they not only know that the job can be done, but also that they can do it. The first step in brief intervention training is to review the rationale that has led you to establish your alcohol SBI service.

- The main target population for brief interventions is nondependent, risky drinkers. These drinkers are not addicted, so the goal of the intervention is to motivate them to cut back or stop drinking.
- Patients who have alcohol dependence are also risky drinkers, but there will be far fewer of them. For them the goal is different. Not only do we want to motivate them to change their drinking patterns, but we also want to motivate them to seek further help. We know the brief intervention, by itself, is unlikely to be sufficient help.
- Research on brief interventions for risky drinking has been widely successful in primary care settings. Many studies were implemented by regular primary care staff who received training similar to what you will provide to your staff.
- Staff should understand that not all patients will reduce their drinking with only one intervention. However, studies show that reductions in drinking by those patients who do respond make the overall service highly beneficial and cost-effective.
- Staff should also understand that such interventions are effective even though they are quite simple to provide, take only a few minutes, and are regularly done by their peers.

2. Style

You have selected certain members of your staff to perform brief interventions in large part because of the sort of people they are-friendly, interested in patients, good listeners, and empathetic. Those are also the primary skills that seem to make brief interventions successful.

- Staff should understand that the main job of a brief intervention is to motivate patients to be aware of alcohol consumption patterns, understand the associated risks, and make their own decisions. This slide presentation on "How to Increase Motivation"[19] by a physician who is one of America's leading SBI scholars provides useful information and tips on how best to motivate patients.
- An advanced degree or certification is NOT required to deliver an effective brief intervention. However, staff can enhance their skills by using tools taught by various programs of motivational interviewing. Some of those items are available at: http://motivationalinterview.org/clinicians/Side_bar/skills_maintenence.htrnl.
- Although the following videos demonstrate brief interventions conducted in an emergency department, they will help trainees recognize the features of a "good" brief intervention by dramatically comparing them with "bad" interventions. (See 1) Anti-SBIRT (Doctor A) and 2) using SHIRT Effectively (Doctor B) at http://www.bu.edu/bniart/shirt-in-health-care/sbirt-educational-materials/shirt-videos/)

3. Content

Staff need training in all the particulars of what they should do to deliver a brief intervention. It is important that they understand these matters *before* they watch videos and consult other training materials *so* that they will know how your plan differs from what they may encounter elsewhere. Only you can provide a full list of that content, based upon your planning. Address the following issues during your training:

- When and where brief interventions will be delivered, and what happens if they cannot be done on the same day as screening.
- How the subject will be introduced to patients.
- What elements are to be included in the intervention.
- What materials, if any, staff will use as reminders or share with patients as well as where those materials will be and who is responsible for producing and distributing them.
- How long (and how short) interventions should be.
- How staff will know which patients should receive interventions.
- What special elements are to be used with screened patients identified as likely to have alcohol dependence.
- What referral procedures have been established and how they are to be used.
- How follow-up should be scheduled and conducted with patients.
- How to document each intervention with respect to patient records, other clinicians, billing, etc.
- What data on interventions will be collected and analyzed for quality improvement.
- How to report issues relating to alcohol interventions that others should know about.

4. Practice

Understanding alcohol brief interventions is one thing; doing them is another. The best training *about* this subject is no substitute for actually *doing* it. So every training of staff who will perform brief interventions should include opportunities for practice, with feedback on performance.

Seeing others conduct interventions is one way for people to learn - as long as those demonstrations come close to being what your planning team has decided upon for your practice. The following websites provide video demonstrations that might prove useful.

1. NIAAA provides 10-minute videos of four cases of how practitioners can conduct alcohol SBI for at-risk drinkers but also manage severe cases, including addiction, if they choose.
2. View a 4:36-minute intervention with a male who is drinking at hazardous levels. You can play or download the example "Brief Intervention: Steve" at http://www.sbirtoregon.org/movies.php. To compare the same script with different actors, view the video labeled "Michael" at http://www.sbirtnc.org/video-demonstrations/.
3. View a 5:15-minute intervention with a woman who has hypertension and is drinking at harmful levels. You can play or download the example "Brief Intervention: Jill" at http://www.sbirtoregon.org/movies.php. To compare the same script with different actors, view the video labeled "Marie" at http://www.sbirtnc.org/video-demonstrations/.

After you view video demonstrations, you can easily create a fictional patient whose role can be played by you or another staff member. After practice, the person playing the patient can provide feedback on what seemed good and what could be improved. More practice, and practice with different "patients;' will build both skills and confidence. Practice will also help you and your trainees become comfortable delivering brief interventions. In time, delivering an alcohol intervention will be no more difficult than taking blood pressure.

Appemlix P: Follow-Up System

Developing a follow-up system is likely to involve two areas of planning and action:

1. Adapt reminder systems you currently use:

a. To set a follow-up appointment for risky drinking,

b. To inform patients that they should return for a follow-up visit within a reasonable period, perhaps 1-3 months, and

c. To include a reminder call to the patient just before that appointment date.

2. Create a plan for follow-up appointments that includes:

a. Determining the patients' current drinking levels and patterns-this could involve re-administering the screening instrument or equivalent questioning,

b. Reviewing goals patients set during the initial intervention, e.g., cutting back or quitting,

c. Reinforcing patients' motivational level and tips for reducing to or maintaining sensible limits, and

d. Establishing another follow-up visit if necessary or referral to specialized help if needed and desired.

Appemlix Q: Billing

The following information may help your practice get reimbursed for alcohol SBI services.

- Screening, Brief Intervention and Referral to Treatment-Coding, Billing and Reimbursement Manual. This manual was developed specifically for the Wisconsin SBIRT program "... to provide Wisconsin clinic and administrative staff with guidance on obtaining Medicare, Medicaid and commercial insurance payment for SBIRT services:' Although it was developed specifically for the state of Wisconsin, the background information describing the various codes and reimbursement processes may be useful.
- The following resources provide further information on coding and billing.
    - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Reduce-Alcohol-Misuse-ICN907798.pdf
    - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf
    - http://www.ems.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM779l. pdf
    - An article on Medicaid reimbursement for SBI has some helpful background information and a list of states with open or listed codes as ofJuly 2010. It can be accessed at http://ps.psychiatryonline.org/data/Journals/PSS/3936/pss6203_0306.pdf
    - A digital tool designed to help you determine whether billing codes are listed on a state's fee schedule, and, if listed, whether or not they are open for reimbursement (i.e., a billing amount has been assigned to the codes). Click on the state to see the information. http://ireta.org/sbirt-reimbursement-map

Can I get reimbursed for alcohol screening and intervention from insurance?

Some health plans will now pay for alcohol and substance use screening and brief intervention. These patient encounters must include both screening with a validated instrument, such as the AUDIT or any instruments mentioned in this guide, and counseling by a physician or other qualified health care professional of at least 15 minutes.

CPT codes are as follows:

- Screening and brief intervention 15 to 30 minutes duration-99408
- Screening and brief intervention over 30 minutes-99409

Medicare G codes:

- Screening and brief intervention 15 to 30 minutes duration-G0396
- Screening and brief intervention over 30 minutes-G0397

Medicaid H codes:

- Screening and brief intervention 15 to 30 minutes duration-H0049
- Screening and brief intervention over 30 minutes-H0050

Appemlix R:Tipsfor Communicatingabout Your Alcohol SBI Services

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- Publish articles in internal newsletters and patient publications produced by your organization.
- Provide news of this healthcare innovation to local newspapers, radio, and television. These media often look for healthcare news that benefits patients and the community.
- Develop pages on your organization's website to communicate with employees, patients, and interested citizens.
- Present papers at meetings oflocal, regional, and national professional organizations. Well-written, thoroughly researched papers serve to educate and engage professionals from other institutions who might also implement alcohol SBI.
- Publish academic papers that advance the knowledge base of alcohol SBI.

Key Considerations for Communications

Whenever you communicate to audiences that do not already know about alcohol SBI, share the lessons you had to learn early-things that may seem obvious now.

- **Explain and clarify.** It is always critical to explain that the overall goal of screening in alcohol SBI is to identify risky drinking. It does not just identify people who have alcohol abuse or dependence. If this point is not made emphatically and frequently, many in your audience are likely to think that you are seeking to identify only "alcoholics?'
- **Emphasize the health benefits of alcohol SBI.** Because alcohol SBI encourages patients to *stop* drinking or decrease the amount and frequency of drinking, calling attention to the health benefits of alcohol SBI and reduction of risky drinking is appropriate. For medical audiences, feature the reduction of cardiovascular, gastrointestinal, and mental health problems. For community audiences, highlight decreases in accidents, injuries, and social problems.
- **Be positive and realistic.** Emphasize that alcohol SBI is a public health approach that provides a low-intensity, low-cost clinical preventive service to identify and intervene with people who drink too much. Be sure to note that many people-but not all-who receive alcohol SBI will respond positively, and over time will reduce their use to safer drinking levels and thereby reduce related risks to themselves and others.
- **Provide drinking levels.** Mention the risky drinking levels. You may be the first person in your community ever to inform people about recommended drinking limits. Explain the difference between those who drink at risky levels (25% of general population) and those who are dependent on alcohol (about 4% of population). With all the publicity surrounding the health benefits of wine and alcohol, it should be noted that when the recommended thresholds for consumption are exceeded, any benefits from alcohol can turn to detriments.
- **Keep it simple.** Don't try to pack too much information into one story. A series of stories (if you can get them) may be much more effective than one long, complicated narrative.
- **Make it easy to understand.** If your audience includes non-medical people, remember to use easily understood, non-technical language.
- **Protect confidentiality.** Always protect patient confidentiality! Remember that the media will want stories of real people who have been helped, so they will often ask for personal identifiers. Follow established procedures and in large organizations engage your public relations/communications staff to be certain confidentiality is preserved.

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ADULT SBIRT- Screening, Brief Intervention, and Referral to Treatment -September 2025 Update:

There have been several updates to the SBIRT model. While the foundational three-step clinical structure remains unchanged, federal agencies have updated their frameworks to emphasize prevention, new funding cycles, and targeted digital adaptations.

1. Shift to "SBIRT/P" (Incorporating Prevention)
   The National Institutes of Health (NIH) explicitly integrated a prevention mandate into the clinical framework, introducing the acronym SBIRT/P.
   The Goal: Clinicians are directed to use the model not just for identifying active misuse, but to deliver targeted preventive interventions to adults who are deemed "at risk" before any diagnostic threshold for Substance Use Disorder (SUD) is met.
   Research Focus: Funding calls emphasize clinical trials testing SBIRT/P workflows explicitly tailored for adult populations experiencing health disparities.

2. New Federal Funding Frameworks (SAMHSA TI-26-005)
   The Substance Abuse and Mental Health Services Administration (SAMHSA) issued a revised Notice of Funding Opportunity (NOFO TI-26-005) for SBIRT.
   Target Areas: The framework heavily prioritizes deploying SBIRT in primary care, community health centers, and schools. Substance Mandates
   : Grantees must explicitly align their screening workflows
   toward catching underage drinking, opioid use, and other highly potent synthetic substances.

3. Emerging Focus on "Family-Based" SBIRT
   Recent pediatric and adolescent primary care data highlighted that traditional, solo adolescent screening frequently falls short during the "Referral to Treatment" phase. In response, newer clinical protocol rollouts (such as SBIRT-A and SBIRT-Family) systematically involve caregivers:
   Caregivers are screened alongside the adolescent to report co-occurring mental health observations.
   Brief interventions include mandatory, structured clinician-guided communication exercises between the youth and the caregiver

4. Overdose and Suicide Prevention Integration
   There is an increasing trend toward pairing SBIRT with specific overdose crisis toolkits rather than viewing it as a standalone substance screening. Programs are actively combining traditional workflows with " Zero Overdose" models. Under

these guidelines, a positive screening immediately pivots the brief intervention into the creation of a formal Overdose Safety Plan right in the clinical setting

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