

Hello. The time is now 12:30 PM Eastern. The official start time for today's broadcast. The topic today is Understanding and Applying the SBIRT model, and efficient approach for primary and integrated care. This is part one of a two-part series. Now without further ado, I'd like to turn things over to your host, Stacy Hull, behavioral health task lead for Alliant Quality. Stacy, the floor is yours.

Thank you. Good afternoon. I would like to thank you for participating in Alliant Quality's learning in action network today, and for your continued commitment to address the behavioral health needs of your patients. Before we get started, I'd like to share that in addition to the monthly Quickinars, Alliant is available to provide free personalized technical assistance to you and your staff. We can assist with trainings on the alcohol and depression screening codes, process flows to integrate the screens into your service model and the collaborative care model just to name a few. Please reach out to us. We welcome the opportunity to work with you.

I would like to turn your attention to the depression codes you see on the screen as well as the alcohol codes on the next slide. These are Medicare reimbursable codes. We encourage you to screen your patients annually utilizing these codes.

And now, it is with great pleasure that I introduce Doctor Tiffany Cooke. Dr. Cooke is a board-certified adult psychiatrist. She is currently in private practice at Innovations Behavioral Health LLC, where she provides both patient care and consultation services. She is also the psychiatrist for the DeKalb County Mental Health, Drug, and Veterans Treatment Courts. Her past work includes faculty appointments at Morehouse and Emory Schools of Medicine as an assistant professor of clinical psychiatry. She also worked with Grady and Tanner Health Systems at Georgia State University's counseling and testing center as well as numerous metro-Atlanta community mental health centers. She has also worked in the field of trauma in HIV and AIDS in Haiti. Dr. Cooke is a public speaker and a behavioral health advocate. Now I would like to turn things over to Dr. Cooke.

Thank you so much Stacy for that introduction. I am so excited to be with you to discuss SBIRT. In the interest of time, I'm just going to jump right in. So by the end of today's session, you will be able to name the three components of SBIRT, name four benefits of universal screening, name at least three behavioral health screening tools and the conditions they help identify and to name the four steps associated with brief intervention.

So what is SBIRT? It is an acronym that has been such a hot button topic and getting a lot of buzz in healthcare as of late. This model was actually incited by the Institute of medicine recommendation that called for community-based screening for health risk behaviors including substance use. So the first component, the S is an annual universal screening for unhealthy alcohol and illicit drug use. Based on the results of that screen a provider can identify what if any treatment is necessary for a patient and at what level. Next the BI or brief intervention. It increases the patient's awareness of his or her drug use and it is based on the principles of motivational interviewing. Then finally, there is the RT, referral to treatment. This is where patients with severe use are referred to specialty treatments. This SBIRT model is best used in patients that haven't already been diagnosed with a formal substance use disorder but it is better in those where you are trying to determine or figure out if there is an unhealthy use pattern.

So why even use SBIRT? One is because it is evidence-based. A second key factor is that data has shown that early identification and prevention for risky substance use will ultimately lead to a decrease level of

substance use. Another great perk about this model is that it can be used for any chronic condition, and it can be used in almost any healthcare setting. So in clinics, ER, trauma centers, inpatient.

Now referring back to those polling questions. What are the benefits of a universal screening? One reduces ER visits, two lower self-care costs, three early prevention, or four all of the above. And it looks like the majority of people chose all of the above. That is the correct answer.

So piggy-backing off that question, do we need universal substance use screening and the answer is a resounding yes. Risky substance use is a preventable cause of morbidity and mortality and a leading cause of disability. It can also exacerbate or even cause chronic conditions like diabetes or hypertension, cardiovascular disease, depression, anxiety, and many others. Risky substance use occurs frequently in primary care yet it is underdiagnosed. This is key because a lot of people will disclose their use but they are simply not asked about it. People are more likely to disclose their use to their primary care provider than to seek specialty care on their own or often times, people will seek treatment if the primary care suggests it, whereas on their own, they might not see their use as problematic. Universal screening also leads to less ER visits, less inpatient days, and lower healthcare costs. That in turn decreases that morbidity, mortality, and disability mentioned in that top bullet.

So time. One of the biggest questions I get about is time. In a busy practice, it may seem really cumbersome to have another task but it only takes a few minutes to screen. The screening process can easily be incorporated into a triage while the patient is in the waiting room. It only takes a few minutes. For most patients, it will only need to be done annually. Remember, most patients are going to screen negative. That is for the majority. Screening will take about 2 to 5 minutes. Not all of this is physician time. About 20% of patients, it may take 15 minutes. Again, not all of that is physician time. All new patients should be screened and then follow-up patients should be screened at least annually. Once you get really familiar with doing SBIRT with repeated practice, that time tends to shorten.

So how does this model work? If you look over to the left, the first part again is screening. So if you screen a patient and the screen is negative, you want to reinforce their good behavior. You want to commend them for not having risky substance use. If you screen and the patient gets a positive screen, then you want to ask questions to kind of determine the level of use. Some screens just ask one question where as a simple yes will give you a positive screen. Have you used any illegal drugs in the past year? If the answer is yes, that is only one question and screen is positive. In that case, you want to do a little digging and kind of establish the severity level. Once you do that, if a person has high risk use, you go into your brief intervention. If they have a severe use, that is when you go into your referral to treatment.

So I want to talk about some of the screening tools that you can use. The first is the AUDIT. This is the screen for alcohol. It is a go-to for alcohol screening, really a gold standard. It is really an excellent tool for alcohol screening. The ASSIST and the NIDA Modified ASSIST are also tools that can be used. They screen for stimulants, sedatives, tobacco, and misuse of prescription opioids; and that's good because we sometimes tend to forget tobacco use. The DAST-10 is another screen. It is screened for drug use excluding alcohol and tobacco. And the CAGE-AID is a screen for alcohol and drugs.

Some models suggest performing a brief screen and then giving a full-screen only if that brief screen is positive. However, I find it more timely to just go ahead and give the full-screen. It doesn't have that many more questions than the brief screen. If you give someone a brief screen, you have to stop and score it. If it is positive, you have to go back and possibly give another screen and then rescore that versus just giving the entire screen which just takes a minute more and the staff only has to stop once. It is a little bit easier for the workflow.

In patients under 21, there are some specific screens that can be used, such as the CRAFFT. It screens for alcohol and drugs. The DAST-20 which is based on the DAST-10 and that is for adolescents. The Hooked on Nicotine Checklist, this can be used in teens and adults and the S2BI used in patients 12-17 for tobacco, alcohol, and drug use.

So some non-substance abuse screens that I really want to point your attention to our the PHQ-9 for depression and the GAD-7 for anxiety. Again, depression and anxiety like unhealthy substance use are leading causes of (inaudible) morbidity and mortality, and again, underdiagnosed. People often tend to want to receive treatment from their primary cares or when their primary care providers recommend it. It is a good idea to complete these screens initially and at least annually as well just like you would with your substance use screen.

This is so important because both depression and anxiety have a high comorbidity with unhealthy substance use. Of the two, I really really really emphasize the PHQ-9. Depression carries a little bit more stigma than anxiety. People are a little more likely to come in and disclose that they are feeling anxious. So you really want to make sure that you are screening for depression, both are good screens but if you have to choose between the two, make sure you are at least doing the PHQ-9. It is a very brief screen and will give you good feedback to discuss with your patient.

We have another polling question. The SBIRT model can only be administered by the physician in the examination room. Is that true or is that false? So that is false. Most of you answered 70% of you answered that correctly.

So let's talk about screening during a visit. The next webinar we are going to put the workflow for the whole SBIRT process together but for now, let's focus on the screening flow. These are listed in order from less to more time-consuming for the provider. So one screen in the lobby, you can use paper for this, a kiosk, a tablet. That tends to be really really effective as far as cutting down on staff time but it tends to be more ideal in an outpatient setting. Next you can do it during nurse triage and that can be done with paper or your electronic medical record. Or again during the actual provider visit. Paper and electronic medical record can be used. Your medical record may have built in screens but it is relatively easy to build them into some different platform if that is not already available.

So let's talk about brief intervention. This is used when a patient screen indicates moderate substance use. It is (inaudible) 15 to 20% of those people that you are going to screen. This is where you are going to educate the patient regarding moderate drinking limits and health risks if they are exceeded to encourage them to change their thinking and commit to a change and empower them to do so. This is where you problem solve. You want to build positive coping skills. This is not to be punitive or to scare patients. This is a supportive measure to educate them and move them in the direction of setting a tangible goal to really decrease their use.

So what are the four steps associated with it? The first thing you are going to do is raise the subject. Understand the patient's use and kind of built a rapport. So you ask permission to broach the subject on substance use. Ask the patient what they think the pros and cons of their use are. Next, you want to provide feedback. You want to make sure you are reviewing the health risks associated with use. Then you want to enhance the patient's motivation to change. So you use readiness and confidence skills for this. Those are those rulers you see that may have a scale from 1 to 10. On a scale from 1 to 10, how ready for change are you right now? On a scale of 1 to 10, how confident are you that you can change right now?

Finally, you want to provide advice, negotiate a goal and thank the patient for letting you discuss this with them. That is where you want to summarize everything that you have talked about. So in order for us to educate our patients regarding drinking limits, we need to know them. So in men ages 18 to 65, no more than four drinks per day and no more than 14 drinks per week. That is considered a low drinking limit. And women ages 18 to 65, no more than three drinks per day or seven drinks per week. And in men or women, 66 and older, no more than three drinks per day, seven drinks per week. One drink is considered a 12 ounce can of beer, a 5 ounce glass of wine, or a shot of hard liquor.

So now you know the four steps of the brief intervention but a common question is what exactly do I say? Just remember the corresponding. You want to ask open ended questions, give affirmations, reflect, and summarize. An example of an open ended question would be what are the good things about using alcohol? Tell me some of the drawbacks of your drinking? You mentioned you have some concerns about your substance use. Tell me what they are. What would you like to do about that. An affirmation would be something like I know it is difficult to discuss opiate use. Thank you for keeping on with this or I appreciate your openness about discussing your smoking. I can see you are very strong person. Reflective listening usually starts with statements where you say something like if I understand you correctly and then you go ahead and recap in your own words. Summarize is just a recap.

Other mnemonics to help you with what to say are FRAMES and FLO. As you do this frequently, this will become second nature. So FRAMES is the Feedback - you want to make sure you're giving the patient information about their substance use level based on the answers to their screen. Responsibility - you want to make sure that you empower the patient to have control over their behavior and consequences and let them know that the choice to change is theirs and that you are going to be there to support them no matter what they decide. A is for advise - you want to make sure you are giving them some education on the harm will effects of substance. M - menu of options - you want to give them some strategies to help them cut down. Not just leaving it as you need to cut down but how can they do that, like keep a diary of their use or identify high risk situations. Some alternate activities, give them some quitting guides. You can even invite them back to an appointment where you can further discuss. E - you want to enhance motivation. That is where you just really want to be empathetic; and S - self efficacy, you want to encourage their confidence to change. And even simpler mnemonic than this is a FLO. Feedback, listen, options. Again, this will become easier and a second nature as you do it fairly often.

So we have talked about screening. We have talked about brief intervention. Part two next month, we're going to talk about referral to treatment. Then we will put this all together and go over a sample workflow of how you can incorporate all this into your practice in a timely fashion. These are my references. And if you have questions, we are going to open it up but if you would like to contact me

further, here is my email address. Feel free to contact me with questions or further information. I am happy to do that.

Thank you, Dr. Cooke for a wonderful presentation. We do have an opportunity now for some questions. And Dr. Cooke, it looks like we have our first question: Should the brief interventions be spread out over multiple visits or can it be conducted in one?

Thank you for that question. It can be conducted in one but you can also spread it out in multiple visits. Again, in the interest of time and that the patient has a lot of questions, you can invite them to come back and discuss further. You may want to make a note in the plan part of the note that you are going to type, that you are going to come back and revisit with them and check their progress that they have made on their goal. Once you check the progress, if you need to go through those for brief intervention steps again, you can. If something happens where you don't get to finish, you can spread it out. If it can be done in one session, yes but it can also be done in multiple sessions as well.

Thank you.

You're welcome.

Let's see. We have time for more questions. It looks like we have got one minute. Can you provide an example of using the SBIRT model technique for other conditions?

So if you look at someone with diabetes type II, you might want to do -- your screen might be consisting of something you ask. How often do you monitor your A1C? How often do you do your (inaudible) how often are you complying with your diabetic diet? It can be one of those questions or several. If you see that they are on task with that, then -- we can go back to that slide with the model. Pull that backup. If you see that they are on task with that, then you would go ahead and reaffirm and congratulate them on that goal. If you see -- this is the slide. If you see that no, they are not monitoring their finger sticks periodically, no they are not following their diet, then you want to say, maybe you want them to do finger sticks before each meal and they do it once a day. So that may be high risk to you rather than severe use. You would do your brief intervention where you would go through those four steps. Ask open ended questions. You go through the (inaudible) model, you go through FRAMES and FLO. If you see they're not complying with any of the diabetic recommendations -- not getting their eye exam, not getting the podiatry exam, not monitoring A1C. They have been hospitalized for complications related to diabetes, then you are going to refer to specialty treatments. You may say now you need to go to this diabetes clinic or this diabetes education class. That would be an example of how to do it for another chronic condition.

Thank you. We have another question. Is there any other training opportunities for individuals that will be working with individuals in SBIRT?

Yes. If you go to the ATTC website or SAMHSA, there are a lot of courses. There is a lot of materials. Massachusetts has a great SBIRT site and also if you want to scroll back and look at some of those references and click on there, that may give you a guide. But ATTC and SAMHSA are great resources to get a little bit more information. Some of those offer continuing education credits as well for those.

Okay. It looks like we have another question. We still have some more time. Can you role-play doing SBIRT for geriatric patients who drink more than two glasses of wine per night for having a healthy heart?

Okay. Who wants to be the patient?

This is Stacy. I will be the patient.

Tiffany Cooke: Okay. Hello, Miss Hull. How are you today?

Stacy Hull: I am great. How are you?

TC: Good. Thank you so much for completing the screen while you were in the waiting room. I appreciate that. That is something we are doing every year just to make sure everybody is on track and it is a screen that we give to everybody. I looked at this screen and noticed that you are drinking about 3 to 4 drinks a night. Is that correct?

SH: Yes. Because I've seen that it is good for my heart.

TC: Okay. Is it okay if we discussed that a little bit further?

SH: Sure.

TC: I hear you saying that it is good for your heart. Are there any other reasons that you drink about 3 to 4 glasses?

SH: Not really but it also helps to relax me at times.

TC: Okay. It helps to relax you. I hear you saying you are interested in it for a healthy heart and helping relax. Do you think that there any drawbacks to the amount of alcohol that you use?

SH: I haven't seen any.

TC: Okay. Well you know you also have hypertension and I know you are interested in a healthy heart. But drinking at the level where you are is a little bit above moderate so it might actually be more harmful to you than helpful. Were you aware of that?

SH: I was not aware of that.

TC: Okay. Based on that, I think it might be a good idea for you to cut back just a little bit. Is that something that you would be interested in doing?

SH: I would. What you recommend?

TC: Okay. That is something I will work with you on. I would say gradually cut back this week maybe instead of three drinks, you have two and then the following week, you have one. Is that something you think would be helpful to you?

SH: I think I can do that.

TC: Okay. Was there anything else you think might work for you to kind of help you stay on track with that goal?

SH: No. I will just be mindful of and I will reduce it. I didn't know it was going to cause additional problems.

TC: Okay. I'm happy to hear that. Is it okay if I check back with you next session to see how you are doing on that when I see you at your next appointment?

SH: Yes. Please do.

TC: Okay. Just to summarize, it sounds like you right now are drinking maybe three glasses of wine a night for healthy heart and to help you relax. It sounds like you want to cut that back to about one drink and that next visit would be a good time to check back with you. In that next visit, we can also talk about helping you relax because you mentioned that as well as something you want to do. So some alternate ways to help you relax.

SH: That sounds good.

TC: Okay. Great. Thank you for letting me discuss that with you.

SH: Thank you.

TC: You're welcome.

That was a wonderful on-the-fly role-play. Thank you both Dr. Cooke and Stacy. We have approximately one minute left in our session. I'm going to turn it back over to Stacy to close us out.

Thank you. I would like to thank you all for joining us today. I hope you found the information shared to be of great value. Our next Quickinar will be held at 7 PM on August 24. Dr. Ciechanowski will present on integrating care for the whole person and be sure to mark your calendars for September 21st at 12:30. Dr. Cooke will present part two of utilizing and applying the SBIRT model. If we can be of assistance, please reach out, enjoy the rest of your day.