MGMA Health Care Consulting Group

SBIRT Assessment with Recommendations: Phases II & III

Presented to:

Peer Assistance Services

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SBIRT Assessment with Recommendations

PROJECT SCOPE

Phase I research assessment, key informant interviews, insurance company feedback, and input from Peer Assistance Services staff were utilized to form Phase II scope of work.

The phase II project scope was to conduct further research with consumer, employer, and payer to assess perspective on SBIRT diffusion of innovations, dissemination, and implementation models to further the utilization and outcomes of SBIRT. Assessment questions will test diffusion process through which an innovation (SBIRT) can be communicated through defined channels and diverse locations, over time, among the consumers, employers, and members of a social system (consumers, employers, and payers). The surveys will be qualitative and sample sizes small so further validation of concepts will need to be tested.

Phase III scope will summarize and analyze the discoveries from Phase II research; developing recommendations and interventions to address dissemination and implementation. The interventions will include in a webinar and in-person seminars to disseminate findings with clinicians.

With the increasing interest and activity to diffuse innovations into healthcare systems, the awareness and realization of what goes on in adopting organizations can make all the difference in the likelihood of observing positive and intended outcomes. ***In addition, the societal sector perspective*** has promise in dissemination science because of its basis in organizational social sector networks and subsequent efficiency in communicating interventions to sector members. Formative learning about social networks allows for sophisticated social influence strategies that have been shown to work in practice.

Increasing evidence in conjunction with long theorizing suggests that voluntary social change occurs as a result of the ***cumulative effects of multisource, co-occurring messages and interventions, including those that work at different levels of intervention.*** Timing is important in social change and can be strategically addressed through media monitoring and/or coordinated action by like-directed organizations. Dissemination science, especially when focused on practitioners as adopters, needs to focus on implementation as a process that is subject to a variety of organizational environment variables as well as social sector networks.

It is with this background that we look at the perspective of consumer, employer and payer:

1. Assess consumer thoughts and perspectives on clinical practice dissemination of SBIRT. The consumer thoughts will be gathered through focus groups or one- on-one interviews. Note: the consumer information will be a random sample and will not ask consumers about their direct experience of SBIRT or substance abuse. Rather, exploratory interviews on the inclusion of preventative health interventions in their general healthcare.
2. Test case development, utilizing two employers in Colorado, to examine thoughts and philosophies about insurance benefits for SBIRT. Theorizing about the diffusion of new ideas, beliefs, knowledge, practices, programs, and technologies surrounding benefits of SBIRT at the employer and payer level.
3. Test case with payer to look at value-based incentives for clinicians, such as streamlining and clarifying the requirements for SBIRT in the clinician practice.

Introduction

SBIRT Colorado is an initiative funded by the Substance Abuse and Mental Health Services Administration and administered through the Colorado Office of Behavioral Health. Peer Assistance Services Inc. manages SBIRT Colorado.

Peer Assistance Services approached the MGMA Health Care Consulting Group in May 2016 to conduct an assessment of practices and payer's consumers and employers to determine barriers to SBIRT, screening for potential alcohol abuse, providing brief intervention when screen is positive. In addition, the research looked at innovation, dissemination and implementation of SBIRT from multiple modality points of view. The assessment results and follow-up initiatives will serve to meet the goals of Peer Assistance five areas of growth:

- Establish substance use screening as a vital sign.
- Focus on effective screening and brief intervention for adolescents.
- Ensure SBIRT is included in healthcare delivery and payment reform initiatives.
- Promote inclusion of SBIRT in health professional education.
- Demonstrate effect of screening and brief intervention on health outcomes and healthcare costs.

Background

A recent report, 2016, by the Surgeon General, *Facing Addiction in America; The Surgeon General's Report on Alcohol, Drugs and Health* provides some insight to the importance of innovation, dissemination and implementation of SBIRT at the level of provider, employer, consumer and payer.

"The United States has a serious substance misuse problem. Substance misuse is the use of alcohol or drugs in a manner, situation, amount, or frequency that could cause harm to the user or to those around them. Alcohol and drug misuse and related substance use disorders affect millions of Americans and impose enormous costs on our society. In 2015, 66.7 million people in the United States reported binge drinking in the past month and 27.1 million people were current users of illicit drugs or misused prescription drugs. The accumulated costs to the individual, the family, and the community are staggering and arise as a consequence of many direct and indirect effects, including compromised physical and mental health, increased spread of infectious disease, loss of productivity, reduced quality of life, increased crime and violence, increased motor vehicle crashes, abuse and neglect of children, and health care costs.

The most devastating consequences are seen in the tens of thousands of lives that are lost each year as a result of substance misuse. Alcohol misuse contributes to 88,000 deaths in the United States each year; 1 in 10 deaths among working adults are due to alcohol misuse. In addition, in 2014 there were 47,055 drug overdose deaths including 28,647 people who died from a drug overdose involving some type of opioid, including prescription pain relievers and heroin—more than in any previous year on record" (U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016)

The report continues, even though the United States spends more than any other country on health care, it ranks 27th in life expectancy, which has plateaued or decreased for some segments of the population at a time when life expectancy continues to increase in other developed countries—and the difference is largely due to substance misuse and associated physical and mental health problems. For example, recent research has shown an unprecedented increase in mortality among middle-aged White Americans between 1999 and 2014 that was largely driven by alcohol and drug misuse and suicides, although this trend was not seen within other racial and ethnic populations such as Blacks and Hispanics. An analysis from the Centers for Disease Control and Prevention (CDC) demonstrated that alcohol and drug misuse accounted for a roughly 4-month decline in life expectancy among White Americans; no other cause of death had a larger negative impact in this population (2016).

SBIRT is an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of individuals with more severe substance use or those who meet the criteria for diagnosis of a substance use disorder.

SBIRT consists of three major components:

1. **Structured Assessment:** Assessing a patient for risky substance use behaviors using standardized assessment tools; **or** Screening a patient for risky substance use behaviors using standardized assessment or screening tools
2. **Brief Intervention:** Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice
3. **Referral to Treatment:** Providing a referral to brief therapy or additional treatment to patients whose assessment or screening shows a need for additional services

The shift to value-based models of payment from fee-for-service positions SBIRT, along with other substance use interventions, with a positive format for inclusion in preventive care services among all healthcare providers.

Phase II Survey Results

Employer assessment results (See Appendix B for interview questions)

In-person and phone interviews were conducted with two employers, one sized 1-500 employees, the other sized 500-1000 employees, to determine opinions on the practice of screening and brief intervention for alcohol use for employees visiting provider office, urgent care and emergency room.

The employer benefit administrators (2 from each company) responded to my questions and engaged in conversation. The benefit employees that responded had long histories working in benefit planning for their current company and other companies as well.

Current evidence for adding benefits to health plans was important for both companies. They both depended upon their insurance brokers, and to a lesser degree the insurance plan itself, to keep them current with regulations and new or different benefit options. Neither company had ever heard of SBIRT, had no idea it was an essential benefit under the ACA, and could not tell me if it was a benefit paid by their company plan.

When questioned about the benefit to their employees, if SBIRT was offered to employees at the office urgent care or ED, only one had an issue with it being offered in any location. They thought it was a very "personal" issue and if the employee didn't bring it up it should not be asked. The other company was uncertain about the motive for asking it at urgent care or ED if the visit was unrelated, why ask it. Upon completing the survey discussion, I did offer evidence for the use of SBIRT, at which time the opposing individual was willing to consider it an appropriate action at all three levels of care. The other employer was willing to consider urgent and ED appropriate if evidence was there to support asking.

As far as billing the plan for SBIRT services, neither company had a problem as long as it was identified as a benefit in the plan. The larger company believed if it was an ACA essential benefit, nothing should ever be charged to the employee. The other company had no problem billing the employee as long as they knew it was a benefit and knew what their responsibility was if the benefit was used in the course of a visit. Both benefit departments brought up their employee assistance plans, and we discussed why SBIRT was preventive and should happen long before an employee assistance plan is needed.

Payer assessment:

A look at incentives for clinicians to provide SBIRT; positioning SBIRT in a value-based model of care.

Phone conversations, for one hour or more, were conducted with three health plans in Colorado: With the exception of Kaiser the other two health plan conversations were with Medical Directors responsible for primary care services. For Kaiser, the Senior Manager of Regional Integrated Behavioral Health Quality & Chemical Dependency Treatment Services responded to my questions.

The three plans were:

- Kaiser Permanente
- Rocky Mountain Health Plan
- United Health Plan

The questions we discussed covered the following areas: (see Appendix C for survey questions)

- Knowledge of SBIRT
- Importance of SBIRT as preventive health measure

- Who should administer screening and provide intervention if indicated?
- Payment for SBIRT
- Incentives for providers to use SBIRT in practices urgent care and ED
- Barriers to use of SBIRT
- Pros and cons of incentives to use SBIRT
- SBIRT and other preventive services place in value-based models of care

Kaiser Health Plan Interview Summary

Interview with Dylan Ross, Senior Manager of Regional Integrated Behavioral Health Quality & Chemical Dependency Treatment Services. Evidence set the stage for implementing SBIRT within Kaiser Health Plan based on research done in Northern California by four women in the Kaiser research division, in 2008-2009. In addition, following the research grant from NIH gave Kaiser the opportunity to test implementation options at practice locations. In California today over 85% of Kaiser sites and practices have an implementation strategy to screen for alcohol, provide intervention and referral for treatment if required. In Colorado over 30 practices have received face-to-face training and receive analytical reporting on screening efforts.

Their research supported the need for behavioral health resources and evidence supports being proactive in screening for alcohol use to reduce burden of disease in hypertension and diabetes, for example. Over long term reduced disease burden translates into financial savings. In addition, initial incentive for Kaiser Health Plan was to score high on Insurance plan ratings and Medicare 5-star rating system. Kaiser has also worked, in their research division, with Dr. Judith Hibbard, author of the Patient Activation Measure® (PAM®) looking at patient activation levels for sustained self-management outcomes. The success to SBIRT for Kaiser practices exists in the technology and workflow they have developed. The workflow is “hard wired” for efficiency and consistency across the practices. There is not financial benefit to providers within Kaiser to utilize alcohol screening and brief intervention. The success in implementation of SBIRT has more to do with a commitment to the evidence, expectation and ease of workflow.

Future preventive population health screenings will include executive dashboards that show SBIRT as one of the quality measures as a piece of the composite quality score.

Rocky Mountain Health Plan Interview Summary

The questions we discussed covered the following areas: (see Appendix C for survey questions)

- Knowledge of SBIRT and importance to beneficiaries administered at the practice level?
- Is there a particular staff person that should approach a patient with questions about alcohol use other than the provider/doctor?
- What are current incentives, sticks or carrots, the plan is administering, if any, for use of SBIRT? Monetary and non-monetary options.
- Who decides what benefits are part of a health plan?
- Are preventive services, such as SBIRT, a key strategy for the health plan moving forward with value-based payments? If so, how do you plan to encourage providers and facilities to use preventive screens such as SBIRT?
- If they are not a key strategy for the health plan moving forward with value-based payments, can you explain why not?

The conversation with Rocky Mountain Health Plan took place with Medical Director Dr. Kevin Fitzgerald. He thanked me for the opportunity to discuss SBIRT with him and admitted he had to do some research prior to our call. The conversation, in my opinion, was based more on his awareness of SBIRT from a literature point of view rather than personal experience.

He believed that screening and brief intervention at all levels, practice urgent care and emergency department, is beneficial if, and he stressed this point, it is administered correctly by trained personnel. He believes the personnel in a clinical setting to initiate the screening, a quick screen, can be anyone including the patient. However, the screening beyond that needs to be a trained person with intervention conducted by clinician or trained staff nurse, social worker, a licensed person. Dr. Fitzgerald's main concern is SBIRT is not the *only screening* that needs to be done; SBIRT can't be singled out. Preventive screening needs to rolled up as part of the visit. Who is to say that SBIRT is more important than colorectal screening? Why just emphasize alcohol screening? Why bill just for that? Dr. Fitzgerald believes preventive care should be engrained as part of our healthcare system today. As to the incentives that can be offered to encourage SBIRT, he believes again it should be "part of a visit" but if we are looking at ways to encourage screening and brief intervention, then placing it as a HEDIS measure required by health plans is one option. However, he stressed they already have around 90 of

them to comply with. He is not in favor of a single measure but rather a rolled-up measure for preventive care that includes smoking, drug use (marijuana), alcohol, and Opioid use. He indicated there is confusion about the "in-depth" part of SBIRT and he questions patient's truthfulness when asked the question. He suggested maybe an online questionnaire, as he thought people are more honest when doing it online.

United Health Care Interview Summary

The questions we discussed covered the following areas: (see Appendix C for survey questions)

- Knowledge of SBIRT and importance to beneficiaries administered at the practice level?
- Is there a particular staff person that should approach a patient with questions about alcohol use other than the provider/doctor?
- What are current incentives, sticks or carrots, the plan is administering, if any, for use of SBIRT? Monetary and non-monetary options.
- Who decides what benefits are part of a health plan?
- Are preventive services, such as SBIRT, a key strategy for the health plan moving forward with value-based payments? If so, how do you plan to encourage providers and facilities to use preventive screens such as SBIRT?
- If they are not a key strategy for the health plan moving forward with value-based payments, can you explain why not?

The conversation with United Health Plan took place with Colorado Medical Director Dr. Cara Beatty. The questions presented to her were the same as Rocky Mountain Health Plan. Dr. Beatty was aware of SBIRT and her knowledge of the importance and impact of SBIRT began with the research from Kaiser. Dr. Beatty stated "I didn't believe screening and brief intervention could work until I read the research from Kaiser." She went on to say she had thought it was a "waste of time" but the evidence has shown her otherwise. Her idea of SBIRT is also coupled with screening for smoking and drug use, both prescription and recreational. The screening and intervention should be practice-specific in that it can be accomplished by individuals best suited for the task and may vary in each practice. Preventive screening and interventions in every practice needs to be defined as part of the care team. The idea of focusing on one element of health or healthcare is too overwhelming to a practice. The best practice is that SBIRT is tied into overall basic care programs, a group of metrics and then support and pay providers for the group metric. Dr. Beatty does not believe sticks accomplish

any compliance and she believes that non-monetary incentives such as assistance with workflow to incorporate such measures within the EHR and practice itself are the best incentives. She is not opposed to clinicians billing for preventive services, with SBIRT as part of an overall incentive, but feels we need to be careful how billing is perceived by the patient, and the message it sends to them.

Benefits added to the "health plan" are dictated by the perceived or known impact on cost of care and impact to members such as improved outcomes. It is important from United's perspective that the impact can be measured.

United Health Plan is committed to an overall strategy of population health, value-based models of care and contracting. Dr. Beatty does not believe value-based care will "go way."

Consumer Assessment Results:

Awareness and acceptance of screening and brief intervention SBIRT at all service levels of care.

The 29 consumer surveys were by far the most informative. The break down by gender, age and location is as follows. (The survey questions are located in Appendix A)

Female = 14

Male = 14

Age 20-30 = 6

- 30-40 = 3
- 40-50 = 5
- 50-60 = 9
- 60 plus = 5

Denver-metro = 22

Colorado Springs = 1

Rural = 5

Rural

Peyton, CO

Elizabeth, CO

Kiowa, CO

Franktown, CO

Note: 24 participants were paid a $20 gift card. Two (husband, wife) were paid $15 each, and three wanted no pay.

The consumer participants were very engaged in the qualitative survey questions and all had stories to tell me about doctor's office, urgent care or ER experiences when it came to the question about billing insurance for screening and brief intervention. For the most part all of the participants answered the question from their point of view, as if they were the patient.

Question One: Appropriateness of asking about alcohol use at doctor's office, urgent care and emergency room

The first question dealt with appropriateness of the healthcare provider asking the patient about their alcohol use. The same question was presented for urgent care and emergency room. Only one person decided it was not appropriate. However, when I provided him with some facts, as listed on the survey question, he decided it was ok to ask the patient in all situations. The provider office responses were far more affirmative and certain as to the value and appropriateness of asking about alcohol use.
The hesitation came when I asked about urgent care visit and ER. Thirteen participants paused and said yes *if* it pertains to, or the doctor believes it pertains to, the reason for the visit. One individual decided it was important because the doctor would need to know before they prescribed medication. When I asked about patients that may only, always, use urgent care or emergency room in lieu of regular doctor visits and this may be the only opportunity to discuss drinking. The majority response from the thirteen was "yes" but this doctor may never see the patient again, no relationship, no trust, not what I am there for, not interested in preventive services when I am sick or injured. Sixteen of the consumers surveyed had no problem with providers asking about alcohol consumption at urgent care or the emergency room.

Question Two: Who should ask a patient about alcohol consumption?

When I asked the participants to tell me who in the doctor's office should ask the questions about alcohol use, the first response in all cases was the doctor, nurse practitioner or physician assistant. However, when I went on to ask about other staff in the office, urgent care or emergency room, the responses ranged from "maybe" to "yes, the MA or nurse could ask the questions since they ask other questions." When I asked about a behavioral health worker or social worker, there was opposition. I am not familiar with those kind of people in a doctor's office; I would think I am "bad"; I don't trust social workers; they have hidden agendas. Seven people preferred doctor over other staff even after offering other staff and discussing why other staff might be more appropriate, such as time and already asking other questions. The

reasons given for the doctor to ask about alcohol use and responses to the question in general are:

- "I don't want everyone in the office to know my business"
- "Who are they to ask such a question?" (referring to nurse or MA)
- "I have a relationship with the doctor not with other staff"
- "Doesn't matter who asks as long as they have a relationship with the patient. You cannot get an honest answer if you don't have a relationship"
- "MA doesn't know anything; I would be afraid they would put their feelings into the answer"
- "Social worker or behavioral health worker asking would be weird"
- "Patient should just write it down themselves, how much they drink, no one needs to ask me"
- "If I have to, then MA or nurse ok"
- "Never MA, they only take vitals"
- "Nurse, yes that would be ok; they talk about other things"
- "BH or social worker ok if they are on site"
- "I don't want three people to ask me the same question, so they need to decide who"
- "I would be offended if social worker or behavioral health asked"
- "I would feel threatened with social worker or behavior health asking"
- Three people had no preference for either provider, MA, nurse social worker BH all were OK to ask the question about alcohol use.

Question Three: Who should provide brief advice/intervention?

When the question was asked as to who should provide the brief advice or intervention if levels of drinking met criteria for risky, without hesitation twenty-four responded with the Doctor, but NP or PA were ok as well. Three people responded that whoever is the best trained should provide the advice or intervention. If there is really a problem, then the social worker or behavioral health is ok. Three consumers responded to the need for staff to have sensitivity training before they asked such questions. The provider, most often named as the doctor, (but NP or PA was ok) being preferred for the following reasons given by the participants.

- Doctor has more authority

- I trust the doctor
- The doctor has a relationship with the patient
- Doctor has the knowledge
- If the doctor gives advice it is more serious
- Doctors don't know a D… thing but doctor should be the one to advise
- Receive it better if information comes from the doctor
- Doctor has more training to know why drinking is a problem
- Expect advice from doctor not others in the office
- Doctor's "duty" is to educate
- Doctor has the most knowledge

Question Four: What could healthcare professionals do or say to make a person more comfortable about discussing alcohol as part of their care?

Most of the participants interviewed included this as part of their response to "who should advise a patient if risky drinking is apparent." They included such things as:

- Be up front with patients; tell them why you are asking and advising
- Educate them to the harm alcohol can have on their health
- Don't just run down a "list" as if it was a duty and then expect people to be open about your advice
- Be objective
- Don't judge people or make jokes about drinking
- Don't give patient a guilt trip
- Don't beat around the bush; tell it like it is, but don't be rude or flippant
- Tell patient the pros and cons; give some context to what advice you give
- Don't fire questions at the patient, tell me why
- Staff need sensitivity training if they are going to ask or advise on the subject of alcohol
- Show compassion
- Give patient reason for asking and advising be sure to include it as part of broad healthcare, not singled out
- Be sensitive

- The connection is important; need to have a relationship to discuss this topic

Training of staff, trust and sensitivity by staff came out many times during the conversations with consumers. They strongly believed that if a patient is to listen and even be honest about their drinking, there must be a trusting, sensitive relationship. This was often the reason cited for *not believing* the urgent care or emergency room was a good place for SBIRT as the trusting relationship did not exist.

The last consumer opinion question focused on payment. **Do you believe the provider, health delivery system, should bill a person's insurance for screening and brief advice if advice is warranted?**

With the exception of three people, who said "that is a tough one, let me think about that" the majority, twenty-six consumers, had strong immediate opinions as to why screening and advice should ***not*** be billed. The negative response to billing was without respect to the patient being charged or only the insurance company charged. The three who had to think about it decided if a problem was discovered and more was needed, then yes, you can bill; but just to ask questions and give advice, the answer was billing is not appropriate. This question generated the most conversation and storytelling by the consumers. Over half had stories to tell me about over-billing by the doctor. Urgent care or emergency room experiences were a target for strong feelings about what was billed and how much. Most patients were startled by the question; such things as "I can't believe you are asking me that question" and "you are not serious are you?" Nonverbal communication was strong on this question. People pulled away, eyes widened or leaned forward to say "say that again." One person even swore at the question and one person said "are doctors going to be like lawyers now-charge for every word?" The opposition fell into two categories; some participants included both as reasons they are opposed to billing:

The screening question and brief advice should be part of "what the doctor" does. They ask about diet, exercise, and my wellbeing and that is part of the office visit; why should drinking be any different?

- It looks like they are just trying to find ways to make more money
- You mean because I answered questions now I will be billed more?
- This is part of overall health; they should not bill
- I can't see how they can bill or expect to be paid for answering questions

- I won't talk to them anymore or answers questions anymore (this came up in half of the consumer conversations on this topic; people will not talk at all if they think they will be billed for asking questions)
- How can they charge me for a form I fill out?
- Conversation should be part of the discovery process a doctor has with his/her patient; that is why I pay for a visit, not for the questions I am asked

Consumers believed that if this is being billed, the provider, urgent care or emergency room should be transparent and even give the patient the choice. When I asked if they were given a choice if they would participate in the questioning, the answer was "100% no I would not answer the question if I knew I was going to be charged especially if I had to pay something for it." If the patient was billed and expected to pay a copay or deductible portion, the participants said they would be "mad" or "get right on the phone," to protest the charge for all the reasons listed above.

The second category for opposition was around patient privacy, the fear of what employer or insurance company (or any other insurance such as life or disability) would think or do if a code was on the claim that indicated alcohol use. This opposition came up less often, only five participants brought it up as their first reason, along with the first opposition stated above.

All the participants did believe that if the risky drinking was such that someone needed to see another doctor or extensive time was taken to address the alcohol abuse or other staff were brought in to set up appointments etc., then yes you could bill for that service.

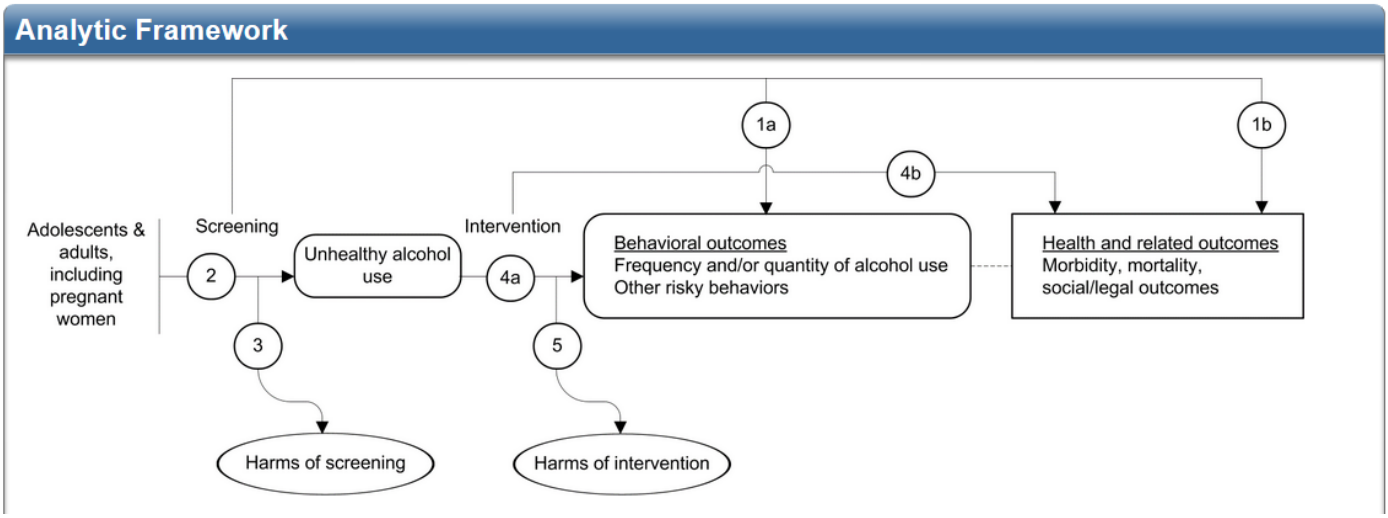
Conclusion

The move to value-based models and reimbursement must include preventive screenings such as SBIRT. Screening for alcohol use is part of the discussion on diet, exercise and smoking, and other behavioral health issues. Clinicians and staff need to be well-trained and understand their role in preventive health. The voice of the consumer needs to be heard. The power of the member stories conveys the evidence to screening. The concept of social determinants impacting health, and the need for integrated health systems that include public health and community resources, are slowly evolving. Duke University has developed core competencies for training physicians that include preventive care, social determinants of health and community resources as part of primary care training.

Employers need to be aware of preventive service benefits to include them as key components to their health plan. Employers can provide the same awareness and support for decreasing alcohol use as they have with smoking, diet and exercise.

The US Preventive Services Task Force completed public comment in September 2016, on a new study to Research Unhealthy Alcohol Use in Adolescents and Adults, Including Pregnant Women: Screening and Behavioral Counseling Interventions. From this research, the resulting evidence will form the basis of the USPSTF Recommendation Statement on this topic of screening and brief intervention for alcohol use moving forward. This will be critical research to support even further the efficacy of SBIRT.

The analytic framework for the research will look like this:



Key Questions to Be Systematically Reviewed

1. a. Does primary care screening for unhealthy alcohol use in adolescents and adults, including pregnant women, reduce alcohol use or improve other risky behaviors?
   b. Does primary care screening for unhealthy alcohol use in adolescents and adults, including pregnant women, reduce morbidity or mortality or improve other health, social, or legal outcomes?
2. What is the accuracy of commonly used instruments to screen for unhealthy alcohol use?
3. What are the harms of screening for unhealthy alcohol use in adolescents and adults, including pregnant women?
4. a. Do counseling interventions to reduce unhealthy alcohol use, with or without referral, reduce alcohol use or improve other risky behaviors in screen-detected persons?
   b. Do counseling interventions to reduce unhealthy alcohol use, with or without referral, reduce morbidity or mortality or improve other health, social, or legal outcomes in screen-detected persons?
5. What are the harms of interventions to reduce unhealthy alcohol use in screen-detected persons?

Contextual Questions

Contextual questions will not be systematically reviewed and are not shown in the Analytic Framework.

1. What is the association between reduced alcohol use and health outcomes?
2. What is the evidence to support current recommendations for alcohol use?

See link for further details:

https://www.uspreventiveservicestaskforce.org/Page/Document/final-research-plan/unhealthy-alcohol-use-in-adolescents-and-adults-including-pregnant-women-screening-and-behavioral-counseling-interventions

Recommendation Summary

Summary of Recommendations and Evidence

Population	Recommendation	Grade (What's This?)
Adults aged 18 and older	The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse	B
Adolescents (under 18 years of age)	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.	I

Recommendations

This Surgeon General's Report, as referenced earlier, was created because of the important health and social problems associated with alcohol and drug misuse in America. As described in the recent Report, "a comprehensive approach is needed to address substance use problems in the United States."

Taking the research that has been conducted for Peer Assistance Services, along with the Surgeon General's report, several key recommendations include:

- Enhanced consumer public education to improve awareness about substance misuse vs dependency use problems and more effective policies and practices to address them.
- Widespread implementation of evidence-based prevention policies and programs to prevent substance misuse and related harms; at the employer, health plan and medical practice level.
- Improved access to evidence-based treatment services, integrated with mainstream healthcare.
- Research-informed public policies and financing strategies to ensure that substance misuse and use disorder services are accessible, compassionate, efficient, and sustainable. The health plans, employers and the consumers emphasized the importance of training, sensitivity and confidentiality in screening and giving advice on alcohol use.
- Serious consideration needs to be given to the billing configurations' policies and practices. The consumer voice needs to be heard. Billing becomes a barrier especially if the consumer is expected to contribute to the cost. All preventive services should be part of an overall reimbursement practice that does not signal a charge for asking questions. Assisting practices in workflow improvement is a powerful incentive to motivate them to include SBIRT.

Strategies Focused around these areas are supported by the recent research with consumers, employers, healthcare providers and health plans. A comprehensive approach has the potential to substantially reduce substance misuse and related problems; promote early intervention for substance misuse and substance use disorders; and improve the availability of high-quality treatment for persons headed toward substance use disorders.

Educational Dissemination and Tools

Evidence-based verified tools for screening recommended by the US Preventive Services Task Force include:

ASSIST - Brief interview about alcohol, tobacco products and other drugs

AUDIT - Alcohol Use Disorders Identification Test for Adolescents

CAGE - Alcohol Screening Instrument

T-ACE - 4-item Alcohol Screener for Pregnant Women This link goes offsite. Click to read the external link disclaimer)

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse - Clinical Summary of USPSTF Recommendation, 2013

Training material for practices include:

- Helping Patients Who Drink Too Much: A Clinician's Guide https://www.niaaa.nih.gov/guide
- Video Helping Patients Who Drink Too Much https://pubs.niaaa.nih.gov/publications/clinicianGuide/guide/intro/index.htm

Webinar link to The Impact of Alcohol on Patient Health: Protocols for Screening Intervention

Can be found at:

http://players.brightcove.net/1729207264001/default_default/index.html?videoId=5303027319001

Presented on January 25, 2017, by:

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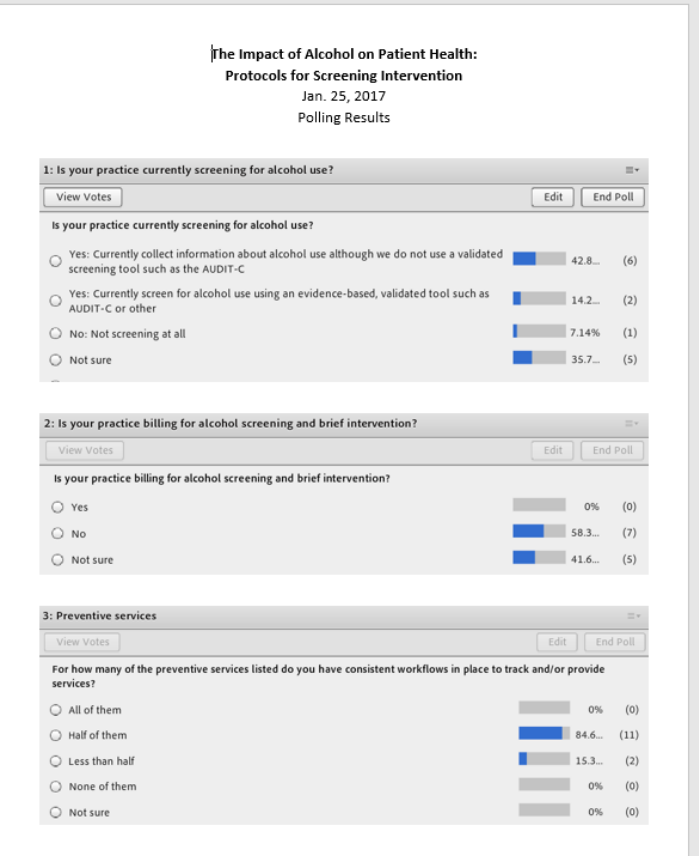
Results from Webinar

Webinar, "The Impact of Alcohol on Patient Health: Screening Intervention (SBIRT)." The attendance numbers were good with 35 live log-ins from across the country and 77 registered participants. There are currently 26 people registered for the on-demand version.

Polling question results



The Impact of Alcohol on Patient Health:
Protocols for Screening Intervention
Jan. 25, 2017
Polling Results

1: Is your practice currently screening for alcohol use?

View Votes | Edit | End Poll

Is your practice currently screening for alcohol use?

Yes: Currently collect information about alcohol use although we do not use a validated screening tool such as the AUDIT-C	42.8...	(6)
Yes: Currently screen for alcohol use using an evidence-based, validated tool such as AUDIT-C or other	14.2...	(2)
No: Not screening at all	7.14%	(1)
Not sure	35.7...	(5)

2: Is your practice billing for alcohol screening and brief intervention?

View Votes | Edit | End Poll

Is your practice billing for alcohol screening and brief intervention?

Yes	0%	(0)
No	58.3...	(7)
Not sure	41.6...	(5)

3: Preventive services

View Votes | Edit | End Poll

For how many of the preventive services listed do you have consistent workflows in place to track and/or provide services?

All of them	0%	(0)
Half of them	84.6...	(11)
Less than half	15.3...	(2)
None of them	0%	(0)
Not sure	0%	(0)

Appendix A

Consumer survey

Consumer questions:

Date _____Time: _____Location

Initials _____

I would like to offer you a $20 gift certificate to gain your perspective on 5 questions related to consumer health, prevention, and behaviors. Gain Perspective on health behaviors.

Statement:

1. Many different things can impact or change a person's chance for developing health problems or make current health problems worse. Some are things a person can change as part of a healthy lifestyle. How appropriate do you feel it is for a person's healthcare provider (doctor's office) to ask questions about alcohol use as part of the healthcare services they provide to all patients?

   Yes, appropriate _____

   I will ask about each entity How about if a person went to an urgent care, walk in clinic? _____

   How about the emergency room? _____

   a. **If Yes** _____

2. Who should ask these questions:

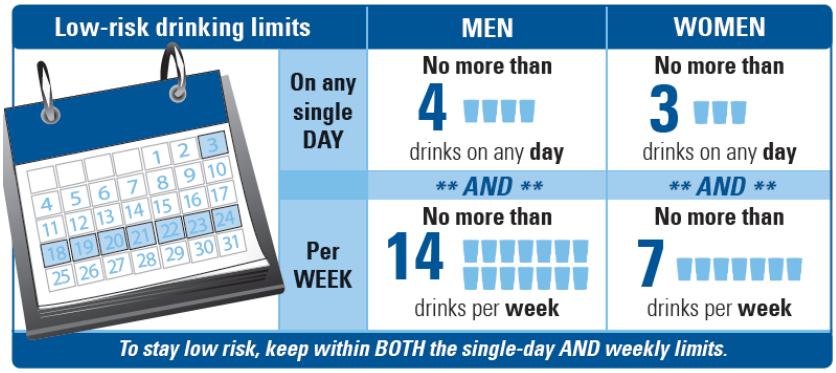
   doctor, nurse, medical assistant, social worker _____

   All of the above_____

   Other if person volunteers _____

3. If unhealthy behaviors, such as alcohol overuse, (defined below if needed) is discovered do you believe the healthcare provider, or staff, has a responsibility to offer brief education and a conversation about the health risks to alcohol overuse?

4. Accept brief education and conversation from social worker, nurse, medical assistant or be referred to a specialist on the subject of alcohol use? (I will Circle response)
5. None of the above or other explain_____
6. Some health behavior topics such as alcohol use are very sensitive, what are some ways or things a healthcare provider or staff could do to make a person feel more comfortable about discussing alcohol use as part of the care they provide?
7. ***If question is needed*** based on response where do you find helpful information about your health? _____



8. Do you believe a medical provider should or could bill a person's insurance for alcohol screening and a brief intervention as we discussed? Yes_____ How much?

   NO _____
9. If subject to copay and deductible do you think the consumer should pay what insurance does not pay?

Comments:

1. Many different things can impact or change a person's chance for developing health problems or make current health problems worse. Some are things a person can change as part of a healthy lifestyle. How helpful or appropriate do you feel it is for a person's healthcare provider (doctor's office) to ask questions about alcohol use as part of the healthcare services they provide to all patients?
   a. **If No is the answer _____**

At this point depending on the No response and confirming the no response I could add the education section saying: Chronic diseases and conditions—such as heart disease, stroke,

cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems.

Health risk behaviors are unhealthy behaviors you can change. Four of these health risk behaviors—lack of exercise or physical activity, poor nutrition, tobacco use, and drinking too much alcohol—cause much of the illness, suffering, and early death related to chronic diseases and conditions.

In the United States, chronic diseases, conditions, and the health risk behaviors that cause them account for most health care costs.

Do you have some thoughts as to who or where is the right place to provide education and a conversation about the health risks to alcohol overuse?

a. Such as mental health worker
b. Social worker
c. Substance abuse
d. Such as employer _____
e. Health insurance company_____
f. Family
g. Other

2. Explain why the healthcare provider/practice or other entity if they said no to ED or urgent care is not the appropriate place/person?

_____-

Comments:

Appendix B

Employer survey

Use information below only if a no response to #1

The average healthcare cost for a healthy employee was roughly $3,000, and roughly $10,000 for an employee with at least one medical condition, ***the study found. Modifiable behaviors and conditions accounted for about $750 for healthy employees, and about $2,600 for those with pre-existing health problems.***

In addition to increased medical expenses, employees with unhealthy habits and behaviors can add to employer costs in terms of missed work time due to medical issues and lost productivity caused by spending work time worrying about personal issues.

Overeating, alcohol consumption, tobacco use and other "unhealthy behaviors" cost companies an average of $670 per employee in extra healthcare costs, according to a new calculation by an Ann Arbor-based division of information services giant ***Thomson Reuters****.*

This analysis shows that employers striving to reduce healthcare costs would be wise to address the behavioral risk prevalence of their workforce," (USE if needed post a no)

1. Do you support providers, staff such as MA, nurse, in physician practices screening consumers for alcohol use/abuse and offering education, brief intervention or referral?
2. Do you support providers, in Urgent care?
3. Do you support providers in ED department?
    a. Yes_____
    b. No_____
4. Do you know if your insurance plan has a provision to cover the cost for a provider, MA, RN, BH worker to screen and give a brief intervention to consumers when they visit their physician office/primary care doctor?
    a. Yes_____

   b. No_____

   c. Don't know _____

5. Urgent care?

   a. Yes

   b No

   b. Don't know

6. ED department?

   a. Yes_____

   b. No_____

   c. Don't know _____

7. If yes, ask them to describe the covered benefit to me.
8. Are you opposed to providers billing the health plan for the screening, brief education and discussion about alcohol misuse?
9. Do you believe your employees should pay a copay or deductible for the screening and intervention, education and discussion?
10. How do you decide what benefits ae covered?
11. If no, it is not a covered benefit or they don't know: ask, "Would you be willing to discuss this option with your insurance plan and make it an option so employees can be covered for such services?"
12. How can we assist you in this discussion with your health plan?

Comments: If needed, describe and briefly discuss the SBIRT as essential benefits per ACA

Appendix C

Payer survey

Kaiser Permanente

1. How did Kaiser decide to implement SBIRT in CO or elsewhere in the country?
    a. What drove that decision?
2. How does Kaiser measure the impact of SBIRT?
    a. Health outcomes
    b. ROI
3. What are current incentives, sticks or carrots, you are administering within Kaiser for use of SBIRT?
    a. Monetary
    b. Non-monetary
    c. For contract Kaiser clinicians is it the same?
4. What would/could be future carrots for preventive healthcare screenings such as SBIRT?
5. What impact have you seen on the use of incentives and implementation of SBIRT?
    a. Are there any risks to incentive payments?
    b. How do you choose the specific metrics measured for an incentive payment?
    c. Do you evaluate your incentives?
    d. How does SBIRT fit into value-based payment models?

Rocky Mountain Health Plan and United Health Plan

1. What is your understanding of SBIRT coverage as an essential benefit?
2. Do you believe SBIRT is important to beneficiaries and could/would have impact administered at the practice level? If so, how is it beneficial and why?
    a. At the urgent care _____
    b. At the ED _____

3. Is there a particular staff person that should approach a patient with questions about alcohol use other than the provider/doctor?
4. Could the MA or RN or BH worker in the office provide the screening?
5. Could these same people provide education and brief discussion about alcohol habits?
6. What are current incentives, sticks or carrots, the plan is administering, if any, for use of SBIRT?
    a. Monetary
    b. Non-monetary
7. Who decides what benefits are part of a health plan
    a. The health plan
    b. The employer
    c. Both
8. Are preventive services, such as SBIRT, a key strategy for the health plan moving forward with value-based payments.? If so, how do you plan to encourage providers and facilities to use preventive screens such as SBIRT?
9. If they are not a key strategy for the health plan moving forward with value-based payments, can you explain why not?

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