
Screening Brief Intervention and Referral to Treatment (SBIRT) Report to the State Council on Alcohol and Other Drug Abuse



May 2013

Wisconsin State Council on Alcohol and Other Drug Abuse
Planning and Funding Committee
SBIRT Ad-hoc Committee



State of Wisconsin
State Council on Alcohol and Other Drug Abuse

1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851



Table of Contents

Abstract.....	1
Charge to SBIRT Ad-hoc Committee.....	2
Committee Membership.....	3
Statement of Need.....	4
Barriers to SBIRT Implementation.....	6
SBIRT Implementation to Scale.....	7
Summary, Motions and Recommendations.....	12
References.....	14
Figure 1: SBIRT Flow of Services.....	17
Figure 2: Considering SBIRT to Scale.....	18
Appendix 1: Behavioral Screening and Intervention.....	19
Appendix 2: Projected First Year Savings for WI Company with 100 Employees.....	20



Abstract

Wisconsin continues to rank nationally among states for the highest rates of risky and problem drinking, alcohol use disorders, and related consequences. Approximately one million adults show signs of risky drinking (Linnan, Lecoanet, & Moberg, 2012) and an additional 384,000 meet clinical criteria for an alcohol use disorder (SAMHSA). Alcohol misuse and abuse is costing the state an estimated \$6.8 billion annually (Black & Paltzer, 2013). Existing prevention, intervention, and treatment services are inadequate to meet the immense need. However, the well-established and evidenced-based service, Screening, Brief Intervention, and Referral to Treatment (SBIRT), can greatly enhance the continuum of care. Delivery of SBIRT in "opportunistic" settings such as primary health care can reduce risky drinking by 20% and this magnitude of reduction on a population-level is associated with 33% less injuries, 20% less emergency visits, 37% less hospital admissions, 46% less arrests, and 50% less automobile crashes. Moreover, SBIRT cost-benefit analyses show that these reductions offer significant cost savings. If implemented fully to scale, it is estimated that SBIRT could save Wisconsin Medicaid \$170 million within the first year and, for businesses, \$895 per employee annually. Despite the benefits of SBIRT, few health care providers actually deliver the services and many barriers exist to its uptake and systematic delivery.

The SBIRT Ad-hoc Committee was created in 2012 to explore the continued implementation and financing of Wisconsin's nascent SBIRT program. Most of the Ad-hoc Committee's deliberations centered on the question: *"What would need to happen if SBIRT were to achieve large-scale implementation?"* This report summarizes the Ad-hoc Committee's findings in terms of systems and settings in which SBIRT could be delivered, provider implementation factors, behavioral targets of services, workforce training and development, financing, and drivers of demand. The picture that emerged is that health care is the system best suited for large scale implementation and SBIRT should address a broader range of risk behaviors and conditions beyond just alcohol and drug use, and these services should ideally be delivered by well-trained paraprofessionals hired for the sole purpose of delivering SBIRT. Recommendations by the SBIRT Ad-hoc Committee include:

- 1) increasing coordination of implementation activities,
- 2) creating incentives for providers to take up and deliver services,
- 3) encouraging purchasers to have SBIRT covered in health plans,
- 4) adjusting reimbursement policies to maximize effectiveness, and
- 5) disseminating the findings of this report to other State Councils.



Charge to SBIRT Ad-hoc Committee

Following the completion of a 5-year federal Screening, Brief Intervention, Referral to Treatment (SBIRT) grant, the State Council on Alcohol and Drug Abuse (SCAODA) in March 2012 passed a motion "that the Council affirm the value of the SBIRT project and agree to a closer examination of its implementation." Shortly thereafter, an Ad-hoc Committee was created through SCAODA's Planning and Funding Committee with the charge to "present recommendations regarding future funding for SBIRT and to present recommendations regarding additional implementation strategies." This SBIRT Ad-hoc Committee comprised a dozen members and met six times (July 27, August 20, October 15, September 17, November 19, 2012, and January 14, 2013) to gather expert testimony, to discuss published materials, and to formulate recommendations for the implementation and financing of SBIRT in Wisconsin. This report has four parts: 1) statement of need and how SBIRT can help; 2) identification of barriers to implementation; 3) consideration of SBIRT implemented to scale; and 4) recommendations.



SBIRT Ad-hoc Committee Membership

Duncan Shroul, M.S.

SBIRT Ad-hoc Committee Chair;
Vice Chair SCAODA

Pamela Bean, Ph.D.

Rogers Memorial Hospital

Steven Dakai, Ph.D.

Maehnowesekiyah Wellness Center

Michael Davis

CEO, IMPACT, Inc.

Nina Emerson, J.D.

University of Wisconsin-Madison
Law School

Jay Ford, Ph.D.

University of Wisconsin-Madison
Center for Health Enhancement
System Studies

Tom Fuchs, M.S.

LE Phillips Libertas

Shel Gross

Wisconsin Council on Mental Health

Carol Hanneman-Garuz, B.S.

Addiction Resource Council, Inc.

Claudia Roska, Ph.D.

Addiction Resource Council, Inc.

Larry Miller, Psy.D.

Rogers Partners in Behavioral Health

Kevin Moore,

Deputy Secretary, Wisconsin Department
of Health Services (DHS)

Guest presenter:

Richard Brown, M.D., M.P.H.

Director of the Wisconsin Initiative to
Promote Healthy Lifestyles

Committee Staff:

Scott Caldwell,

SBIRT Program Coordinator



Thank you to the SBIRT Ad-hoc Committee members for their time, contributions, and lively discussions. Thank you also to Joyce O'Donnell and the Planning and Funding Committee members for their support of this Ad-hoc Committee's work.



Statement of Need

I. Statement of Need and How SBIRT Can Help



Wisconsin continues to rank nationally among states for the highest rates of risky drinking, alcohol use disorders, and related consequences (SAMHSA). In a typical month, nearly 70% of adults report drinking alcohol (DHS, 2010a) and estimates of binge drinking range from 23% (DHS, 2010a) to 30% (SAMHSA). An estimated 22% of adults presenting to primary care, almost one million individuals, met criteria for risky drinking (Linnan, Lecoanet, & Moberg, 2012). An additional 9.1% of adults, or about 384,000 individuals, met the diagnostic criteria for an alcohol use disorder (SAMHSA). The consequences from risky and problem drinking are astounding. In Wisconsin during a recent year, alcohol was directly linked to 1,624

deaths, 51,119 hospitalizations, and 94,000 arrests, as well as 23% of sexual assaults, 30% of physical assaults, and 41% of motor vehicle crashes (DHS, 2010a). A recent study of the economic costs directly linked to excessive alcohol consumption in Wisconsin showed a staggering \$6.8 billion in annual costs (Black & Paltzer, 2013).

Existing alcohol prevention and treatment resources are inadequate to address the immense need. An analysis of the 2011 Substance Abuse Prevention Services Information System identified 267 various programs throughout Wisconsin. Only 42 of 72 Counties (58%) and 2 out of 11 Tribes (18%) have universal prevention strategies in place (DMHSAS, 2013a). Furthermore, only 6% of Wisconsin adults with an alcohol use disorder and 15% with a drug use disorder receive treatment (SAMHSA). In the context of this tremendous unmet need, it is particularly concerning that the number of available treatment programs are declining (McClellan, 2006; SAMHSA) and a professional workforce shortage is projected in the coming years (DMHSAS, 2013a).

The delivery of SBIRT in Wisconsin could provide much needed prevention, early intervention, and brief treatment resources. SBIRT offers an evidence-based, comprehensive, and cost-effective public health approach to address risky and problem drinking and other drug use (SAMHSA). A nascent SBIRT program in health care exists in Wisconsin (Brown, Moberg, & Linnan et al., in press). From 2006-2011, a federally-funded SBIRT grant called the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL; www.wiphil.com) delivered SBIRT to approximately 3% of the adult primary care population. Delivery followed a multiple step process (see Figure 1).

First, a screen was administered to most eligible patients. The screen consisted of 3-4 items to ascertain if the person was alcohol or other drug (AOD) involved; 113,642 patients received this screening. For the 33% of patients who showed "positive" results (i.e., recent AOD use was endorsed), a brief assessment was administered with the following results: 19% of patients showed no or low risk (e.g., drinking within normative guidelines), 67% showed risky or hazardous use (e.g., binge drinking), 6% showed problem use, and 8% showed likely dependent use (DMHSAS, 2012). For patients who showed no or low risk AOD involvement, affirmation was provided. For those with risky use, a protocol-guided Brief Intervention was initiated lasting about 15 minutes. Brief Intervention services respectfully guide the patient to examine their current AOD use and to consider motivations for change, such as reducing or temporarily ceasing use. For patients with problem use, up to 4-hours of Brief Treatment sessions were provided.



Statement of Need (continued)

Brief treatments for problem alcohol and drug use are well-established and can be highly effective (Bien et al., 1993; Miller, 2000; Miller & Wilbourne, 2002). For patients with likely dependent use, a Referral to Treatment was initiated.

A 6-month follow-up study was conducted with a large sample of WIPHL patients (N = 675) who received Brief Intervention services and the following outcomes were shown: 20% reduction of risky drinking; 18% reduction of marijuana use; and high levels of patient satisfaction (DMHSAS, 2012; Linnan, Lecoanet, & Moberg, 2012). A reduction of risky drinking by 20% on a population- level has been linked with 33% less injuries, 20% less emergency visits, 37% less hospital admissions, 46% less arrests, and 50% less automobile crashes (Naimi et al., 2006).

The effectiveness of SBIRT to reduce risky substance use and related behavior, and to increase population health is underscored by its cost effectiveness. Systematic delivery of SBIRT shows a 4-to-1 return on investment for alcohol Screening and Brief Intervention services within the first year (Fleming et al., 2000; Osilla et al., 2010). Guest presenter, Dr. Rich Brown, highlighted data which estimated savings of \$170 million to Wisconsin Medicaid within one year of fully implementing SBIRT in health care settings to address risky and problem patient alcohol use (see Appendix A).

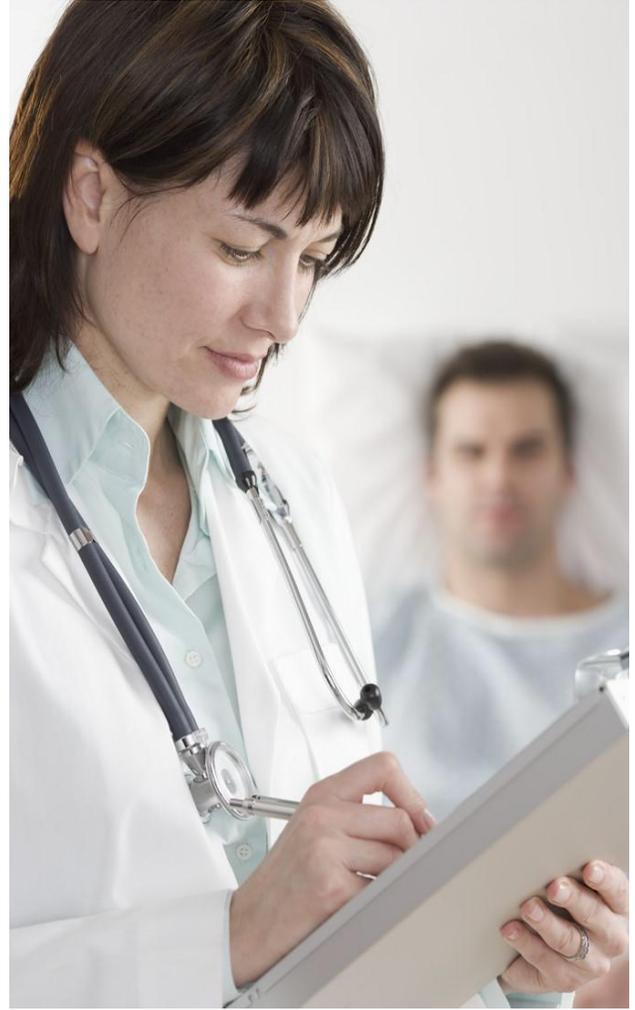


Barriers to SBIRT Implementation

II. Barriers to SBIRT Implementation

Despite the efficiency, efficacy, and cost-effectiveness of SBIRT, few providers actually deliver the services. There are several reasons for this: SBIRT is a low priority when competing with other initiatives; as a medical procedure SBIRT is not a big money-maker; many providers do not recognize the value in addressing patient AOD use. For provider organizations that do perceive benefits and that seek to integrate SBIRT into practice, multiple barriers exist to systematic implementation to fidelity standards. Systematic implementation means administering the screens to at least 80% of the eligible patient population, then at an equally high rate, providing brief assessments for positive screens and delivering intervention services, as indicated.

The number one barrier is that current health care providers simply do not have the time to deliver SBIRT (Yarnall et al., 2003). Moreover, figuring out how to integrate SBIRT into clinic work flow takes leadership and some provider time and attention. For the Referral to Treatment component of SBIRT, many system-level barriers exist for successfully referring likely AOD dependent patients to specialist treatment. In Wisconsin, about 5% of all referrals to public treatment programs come annually from health care settings (DMHSAS, 2013b) underscoring the disconnection and lack of coordination between the two systems (McLellan, 2006; TRI, 2010). As treatment system expert, Tom McLellan notes, "substance abuse treatment may be the only area of medical care where there is *specialty care* without corresponding *primary care* (McLellan, 2006, p. 286).





SBIRT Implementation to Scale

III. SBIRT Implementation to Scale

Given the clear benefits of SBIRT and the barriers to implementation, most of the Ad-hoc Committee's deliberations centered on the question, “*What would need to happen if SBIRT were to achieve large-scale implementation?*” As depicted in Figure 2, this question encompasses several areas, including the systems and settings in which SBIRT could be delivered, provider implementation factors, behavioral targets of services, workforce training and development, financing, and drivers of demand (SAMHSA, 2013). This section provides further elaboration of these areas and the related questions.

A. Systems and Settings

In what systems and settings could SBIRT be delivered?

Delivery of SBIRT in healthcare settings is the best location for large-scale implementation because it would reach most of the population and the system is resource-rich. SBIRT can be delivered in a variety of healthcare settings, including primary care, hospitals, nursing homes, and Medical Homes. In Wisconsin, the delivery of SBIRT is becoming integrated into Medical Homes. Delivery of SBIRT meets several quality measures of Accountable Care Organizations. Also, with healthcare reform, all U.S. Preventive Services Task Force recommended screening will be reimbursed with no patient co-pays. This includes tobacco services as a Grade A recommendation (USPSTF, 2009a) and alcohol and depression services as Grade B recommendations (USPSTF, 2004, 2009b). SBIRT could potentially be delivered in a variety of other "opportunistic" settings:

- Crisis Intervention and Pre-Natal Care Coordination services could screen all clients for AOD use and be ready to provide either Brief Intervention or Referral to Treatment services, as needed.
- Schools (i.e., middle and high schools; colleges) already address student AOD involvement. Research shows that SBIRT is a promising approach with adolescent and young adult populations (Mitchell et al., 2013) and that SBIRT could be readily integrated into student services and campus health centers (Winters et al., 2007).
- Criminal Justice and Corrections populations present with a high prevalence of AOD involvement and related problems compared to the general population. SBIRT could be delivered in jails, prisons, and detention centers.
- Employment Assistance Programs could deliver SBIRT, however, studies show general healthcare settings produce better results than employer-specific settings.

B. Provider Organizations

Although SBIRT is a recommended evidence-based practice in health care, few providers actually deliver the services. A necessary step in moving SBIRT to scale may be to create incentives for providers to deliver services. Developing a pay-for-performance program may be one approach. Once management decides to adopt SBIRT into practice, a complex implementation process ensues. Elements of successful SBIRT implementation processes and



SBIRT Implementation to Scale (continued)

factors were identified by Ad-hoc Committee members, Jay Ford and Pamela Bean, and by guest presenter, Rich Brown, and include the following:

- Leadership buy-in and support.
- Creation of an implementation team to guide strategic planning. Planning includes defining who is eligible to receive screening; determining timing of services; roles and responsibilities of staff; how to integrate the SBIRT point-person into the healthcare team.
- Provision of technical assistance to organizations following initial training.
- Rapid cycle testing (e.g., Plan-Do-Study-Act) to accelerate successful implementation.
- Set up billing sooner than later to obtain reimbursement and therefore help sustain services.
- Implementation of quality measures. Several SBIRT quality measures have been developed through the Joint Commission for use in hospitals. These measures help to ascertain the extent to which SBIRT is being delivered and include the following (see Figure 1):
 - percentage of those who receive screening of total eligible patients;
 - percentage of patients with positive screen results who receive brief assessment;
 - percentage of patients who show risky, problem, or likely dependence who receive the Brief Intervention or Brief Treatment services;
 - percentage of those likely dependent patients who receive a Referral to Treatment; and
 - percentage of patients referred who enter treatment.
- Implementation of outcome measures. *How do providers know if SBIRT services are showing the desired effects?* One way to measure outcome is to use the initial screening as "baseline" data, and subsequent screenings as "follow up" data. In this way, providers can ascertain practice-based evidence to determine if brief intervention services are promoting positive patient behavior changes.

Delivering SBIRT services in healthcare settings means that provider organizations must also be ready and able to refer those who are likely AOD dependent to specialist treatment. Because only 1 in 10 people who meet diagnostic criteria for a substance use disorder receive treatment (DMHSAS, 2013a), SBIRT can greatly help identify and get help for those in need. There are several ways primary care can develop and strengthen linkages to specialist treatment. Dr. Steve Dakai, Ad-hoc Committee member, described an example of how SBIRT seamlessly integrated primary and behavioral health care with these ingredients: commitment by medical and behavioral health staff to increase linkages; regular communication; cross- training of healthcare and treatment professionals; better coordination of services such as prioritizing admission of referrals from SBIRT and obtaining prior authorization to share relevant clinical information. Beyond strengthening linkages, there is great potential for primary care providers to deliver effective pharmacotherapy to patients in need, thus greatly expanding the capacity of health care to address unmet treatment need (CSAT, 2009).



SBIRT Implementation to Scale (continued)

What might be the targets of screening?

Typically, SBIRT only addresses peoples' AOD use, however, services can readily be expanded to include screening and intervention services for a range of risk behaviors and conditions. Called Behavioral Screening and Intervention (BSI), such services can address alcohol and illicit drug use, as well as tobacco use, depression, poor diet, obesity, and physical inactivity. There are several reasons why SBIRT should embrace the BSI approach. First, studies are emerging to show that addressing a range of risk behaviors and conditions within the SBIRT approach is feasible and effective. For example, patient tobacco quit rates can greatly increase from a screen only approach (3%) to including a robust brief intervention and referral approach (28%) (Fiore et al., 2008). Systematic delivery of depression screening and behavioral activation services in healthcare settings can also be effective (Cuijpers et al., 2007; Gil body et al., 2006). During the WIPHL grant, a small pilot study showed that integrating depression services into SBIRT and having well-trained paraprofessionals deliver services was not only feasible, but highly effective as patients showed a 55% reduction of depressive symptoms and reported high levels of satisfaction (Breidenbach et al., 2011).

Second, these risk behaviors and conditions drive a large proportion of preventable suffering, deaths, chronic diseases, and health care costs. Addressing these together in SBIRT can greatly contribute to population health while reducing costs. Third, provider organizations perceive greater value in delivering services that address a range of behaviors instead of a narrow focus on patient AOD involvement. Fourth, patient acceptability of SBIRT may be higher if AOD screening is embedded within a larger behavioral health screening protocol. In this way, AOD screening is framed as a health issue and potential stigma may be minimized. Finally, return on investment is better when SBIRT addresses a broader range of targets. Greater cost savings are captured when SBIRT addresses alcohol, drugs, tobacco, and depression, compared to the cost savings of only addressing AOD (see Appendix B).



C. Workforce Training and Development

Who will deliver services?

There are many variables to consider in this question: Should staff be professional (licensed) or paraprofessional (non-licensed)? Should delivery of services within an organization utilize current staff, or should a new position be created? Should SBIRT be delivered by a staff person in a position dedicated to delivering SBIRT, or should delivery be spread out among several staff? Experience suggests the following answers to these questions. First, current healthcare workers simply do not have the time to systematically deliver SBIRT (e.g., Yarnall et al., 2003). Current licensed health care workers should be practicing to the "top of the license" and SBIRT, as a relatively simple and straight-forward service, can readily be delivered by well-trained paraprofessionals. Second, research shows that with proper training, supervision, and support, paraprofessional "health educators" can deliver services that are comparable in outcome to services delivered by licensed professional staff (Brown et al., in press). Traits of successful health educators include being proactive, persistent, mission-driven, thick-skinned, flexible and adaptive to clinical workflow, a team player, self-sufficient and independent, and a good communicator (DMHSAS, 2012). Third, because SBIRT takes some time to deliver, creating a position dedicated to the sole purpose of delivering the necessary screens and brief interventions is probably the best way to maximize effectiveness. If SBIRT is to be systematically delivered, the health care team must be expanded to include the SBIRT health educator (Brown, 2011).



SBIRT Implementation to Scale (continued)

If SBIRT is to go to scale, a workforce will need to be trained. SBIRT training curricula should be integrated into academic programs within the University of Wisconsin System and technical colleges. To the Ad-hoc Committee's knowledge, SBIRT does not currently exist in alcohol and drug counselor training or educational curricula. In a pilot project, SBIRT was integrated into a health education curriculum. Through a Wisconsin Partnership Grant, the University of Wisconsin -La Crosse Health Education Program added a 1-year training track on SBIRT. The first cohort of 10 health education students were trained during fall 2011 and are now delivering SBIRT in preceptorship sites. Also, a four-hour internet based training is available to appropriate licensed professionals who seek to deliver SBIRT in healthcare, crisis intervention, and Pre-Natal Care Coordination settings; completion of this training is required by Medicaid for providers to obtain reimbursement. For appropriate non-licensed staff, a 60-hour training is required by Medicaid to obtain reimbursement. To date, several SBIRT trainings have been offered by WIPHL and DMHSAS which have produced non-licensed staff ready and able to deliver SBIRT: 62 health educators in healthcare; 19 crisis workers; 16 pre-natal care coordinators; and 12 HIV case managers. Commercial reimbursement rates for a paraprofessional delivering 14 billable services daily (i.e., screens and brief interventions totaling 5.0 hours) based on 240 workdays per year yields \$504 daily or \$120,984 annually (DMHSAS, 2012). With paraprofessional personnel costs estimated at \$60,000 annually, current reimbursement rates could readily sustain a position dedicated to the delivery of SBIRT.



D. Payers

How will SBIRT be financed?

In January 2010, Wisconsin Medicaid (MA) expanded SBIRT reimbursement under codes H0049 and H0050 to cover members age 12 or older (DHS, 2009). The MA reimbursement policy exemplifies "effective reimbursement" in that 1) reimbursement is under national billing codes, 2) there are no out-of-pocket payments required by patients, 3) reimbursement is allowed for paraprofessional-delivered services, and 4) reimbursement is allowed when paraprofessionals deliver SBIRT during the same visit that other providers also deliver services. To date 4,419 SBIRT claims have been submitted to Medicaid with \$140,197 reimbursed (DHCAA, 2013).

Most national commercial health insurance companies also reimburse for alcohol, drug, and tobacco services. Reimbursement codes exist for AOD screening (CPT 99408) and brief intervention (CPT 99409) as well as for tobacco screening and brief intervention (CPT 99406 and CPT 99407, respectively). However, commercial insurance reimbursement policies are largely unknown. Although to date in Wisconsin, 19 commercial insurance providers have each reimbursed at least one SBIRT claim, many claims have been denied. Starting January 1, 2014, all U.S. Preventative Services Task Force Grade A and B recommended services that are delivered must be reimbursed with no patient co-pay; these services include SBIRT for alcohol, drug, and tobacco use, as well as depression. Although the elimination of patient co-pay takes away a barrier, other barriers and glitches remain within both MA and commercial insurance systems. These will need to be addressed if provider organizations are to successfully sustain delivery of SBIRT.



SBIRT Implementation to Scale (continued)

E. Promoters of SBIRT

Who can drive the demand for SBIRT services?

The institutions and organizations that are most affected by the consequences and costs of unaddressed risky binge drinking, illicit drug use, tobacco, and depression stand to gain the most by the adoption and systematic delivery of SBIRT. The social and economic costs of risky drinking are staggering. A recent study estimated that the annual costs of excessive drinking in Wisconsin totals \$6.8 billion and about half of this figure is incurred by governments and businesses because of the costs related to health care expenditures, lowered worker productivity, and criminal justice and social services costs (Black & Paltzer, 2013). Because SBIRT promotes health and saves money, a diverse group of stakeholders in Wisconsin have come together to endorse SBIRT:

- Department of Health Services.
Delivery of screening and brief intervention services in primary care is one of ten pillar objectives in the state's strategic health plan, Healthiest Wisconsin 2020 (DHS, 2010b). The SBIRT Program Coordinator position was made permanent following completion of the WIPHL grant.
- Medical organizations.
The Wisconsin Medical Society and Wisconsin Primary Health Care Association endorse the delivery of SBIRT in all health care settings.
- Business groups.
SBIRT saves costs for businesses (Quanbeck et al., 2010). When screening and intervention services for alcohol, drugs, tobacco, and depression are provided annually to employees, businesses can save \$895 per employee (see Appendix B). These savings are captured through increased employee health and productivity and decreased health care costs. Wisconsin Manufacturing & Commerce, The Alliance, and Business Health Care Group of Southeastern Wisconsin (Wisconsin's largest employer healthcare purchasing cooperative) support SBIRT and would like to have SBIRT services included in all employee health plans. If the Wisconsin Employee Trust Fund (ETF) were to include SBIRT for alcohol, drugs, tobacco, and depression in employee health plans, it is estimated that \$52 million would be saved within the first year of implementation, plus an additional \$124 million over four years (see Appendix A).

Many organizations that have adopted, implemented, and successfully sustained SBIRT are also promoters of SBIRT. There are countless stories from providers of how SBIRT positively impacted patient care and outcomes in ways that would not have been achieved otherwise. Additionally, organizational innovations such as Accountable Care Organizations and Medical Homes stand to benefit from systematic delivery of SBIRT.



Summary, Motions and Recommendations

IV. Summary, Motions, and Recommendations

With the emphasis on delivery of preventative services in healthcare reform, now is the time to consider large-scale SBIRT implementation in healthcare settings across Wisconsin. The SBIRT Ad-hoc Committee believes that SBIRT should address a broad range of risk behaviors and conditions (i.e., BSI for alcohol, illegal drugs, tobacco, and depression) rather than a narrow focus on AOD use. To maximize cost-effectiveness while promoting quality services, SBIRT should ideally be delivered by paraprofessionals within positions dedicated to the purpose of administering screens, conducting interventions, and making referrals to treatment.

On April 19, 2013 the SCAODA Planning and Funding Committee passed four motions: 1) SCAODA accept the SBIRT Ad-hoc Committee Report dated May 1, 2013; 2) SCAODA forward the accepted SBIRT Ad-hoc Committee Report to the Wisconsin Council on Mental Health and the Wisconsin Council on Public Health for their information and further action; 3) SCAODA forward the accepted SBIRT Ad-hoc Committee Report to the Majority and Minority Leadership of the Wisconsin Senate and Assembly for their information and further action; and 4) SCAODA forward the accepted SBIRT Ad-hoc Committee Report to Governor Scott Walker for his information and further action.

Furthermore, the SBIRT Ad-hoc Committee has five recommendations:

Recommendation #1 (Coordination)

It is recommended that the Governor's Office be part of a coordinated effort to bring together healthcare policymakers, purchasers, payers, and providers to advance the implementation of SBIRT in healthcare settings (e.g., primary care, emergency care, hospital inpatient care) so that SBIRT becomes a standard of care in health care in Wisconsin.

Recommendation #2 (Providers)

As a part of a coordinated effort, it is recommended that incentives be developed for provider organizations to deliver SBIRT. For example, a pay-for-performance program could be developed such that actual or anticipated reductions in health care costs resulting from SBIRT services are distributed back to providers to a degree that corresponds with performance on SBIRT quality measures.

Recommendation# 3 (Purchasers)

It is recommended that the Governor's Office harness the purchasing power of the Employee Trust Fund (ETF) to ensure that SBIRT is included in all employee health plans. With the ETF as a model, it is also recommended that the Governor's Office lead a coordinated effort to encourage other public purchasers as well as private-sector purchasers of health care to include SBIRT in health plans.



Summary, Motions and Recommendations (continued)

Recommendation# 4 (Payers)

It is recommended that the Governor's Office coordinate efforts among health care payers to reimburse on a fee-for-service basis SBIRT for alcohol, illegal drugs, tobacco, and depression by (a) promulgating Wisconsin Medicaid's current policy for reimbursing paraprofessional-administered alcohol and drug SBIRT services as a model reimbursement policy and extending that policy to reimbursement of tobacco and depression services, and by (b) instituting within Medicaid existing quality measures for SBIRT delivery to ensure effective services are being delivered. Additionally, it is recommended that the Wisconsin Legislature enact legislation requiring Wisconsin health care payers to describe their current policies on SBIRT reimbursement and that the Wisconsin Department of Health Services maintain a repository of such policy descriptions on a public website.

Recommendation# 5 (Dissemination)

The Ad-hoc Committee recommends the State Councils on Public Health and Mental Health endorse this report and add their support to the implementation of SBIRT.



References

- Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). *Brief interventions for alcohol problems: A review*. *Addiction*, 88, 315-35.
- Black, P., & Paltzer, J. (2013). *The burden of excessive alcohol use in Wisconsin*. Madison, WI: University of Wisconsin Population Health Institute.
- Breidenbach, K. B., Croyle, M.D., Saunders, L. A, Woods, T. E., & Brown, R. L. (2011). *Employing paraprofessionals to deliver depression screening services*. Unpublished manuscript, University of Wisconsin• Department of Family Medicine.
- Brown, R. L. (2011). *Configuring health care for systematic behavioral screening and intervention*. *Population Health Management*, 14(6), 299-305.
- Brown, R. L., Moberg, D.P., Linnan, S., et al. (in press). *A team approach to systematic behavioral screening and intervention*. *American Journal of Managed Care*.
- CSAT (Center for Substance Abuse Treatment). (2009). *Incorporating alcohol pharmacotherapies into medical practice*. DHHS Publication No. SMA 09-4380. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Cuijpers, P., van Straten, A, & Warmerdam, L. (2007). *Behavioral activation treatments of depression: A meta-analysis*. *Clinical Psychology Review*, 27, 318-326.
- DHS (Department of Health Services). (2009). *Forward Health Update: New substance abuse screening and intervention benefit covered by BadgerCare Plus and Medicaid* (DHS Publication No. 2009-96). Madison, WI: Department of Health Services.
- DHS (Department of Health Services). (2010a). *Wisconsin epidemiological profile on alcohol and other drug use* (DHS Publication No. P-45718-10). Madison, WI: Department of Health Services.
- DHS (Department of Health Services). (2010b). *Healthiest Wisconsin 2020: Everyone living better, longer: A state health plan to improve health across the life span, eliminate health disparities, and achieve health equity* (DHS Publication No. P-00187). Madison, WI: Division of Public Health, Office of Policy and Practice Alignment.
- DHCAA (Division of Health Care Access and Accountability). (2013). Staff analyst database query on SBIRT reimbursement claims and payment by Medicaid. Madison, WI: Department of Health Services.
- DMHSAS (Division of Mental Health and Substance Abuse Services). (2013a). *Wisconsin mental health and substance abuse needs assessment*. Madison, WI: Department of Health Services.
- DMHSAS (Division of Mental Health and Substance Abuse Services). (2013b). Staff analyst database query on source of referral Human Services Reporting System/Treatment Episode Data Set. Madison, WI: Department of Health Services.
- DMHSAS (Division of Mental Health and Substance Abuse Services). (2012). *Wisconsin Initiative to Promote Healthy Lifestyles: Final progress report to the Substance Abuse and Mental Health Services Administration* (SBIRT Grant TI-18309). Madison, WI: Department of Health Services. Retrieved from http://www.dhs.wisconsin.gov/subst Abuse/SBIRT/Wisconsin%20SBIRT_Final%20Progress%20Report.pdf
- Fiore, M., et al. (2008). *Treating tobacco use and dependence: 2008 update*. Bethesda, MD: Public Health Services.
- Flemming, M. F., Mundt, M. P., French, M. T. et al. (2000). *Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings*. *Medical Care*, 28, 7-18.
- Gil body, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A J. (2006). *Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes*. *Archives of Internal Medicine*, 166, 2314-2321.



References (continued)

- Lecoanet, R. M., Linnan, S. M., & Moberg, D. P. (2012). *Final program evaluation of the implementation and operation of WIPHL in Wisconsin clinical settings*. Unpublished report, University of Wisconsin - Population Health Institute.
- Mclellan, A. T. (2006). *What we need is a system: Creating a responsive and effective substance abuse treatment system*. In W. R. Miller, & K. M. Carroll (Eds.), *Rethinking substance abuse: What the science shows, and what we should do about it* (pp. 275-292). New York: Guilford Press.
- Miller, W. R. (2000). *Rediscovering fire: Small interventions, large effects*. *Psychology of Addictive Behaviors*, 14, 6-18.
- Miller, W. R., & Wilbourne, P. L. (2002). *Mesa Grande: A methodological analysis of clinical trials of treatments for alcohol use disorders*. *Addiction*, 97(3), 265-277.
- Mitchell, S. G., Gryczynski, J., O'Grady, K. E., & Schwartz, R. P. (2013). *SBIRT for adolescent drug and alcohol use: Current status and future directions*. *Journal of Substance Abuse Treatment*, 44, 463-472.
- Naimi, T., Brewer, R. D., Campbell, K. P., & Chattopadhyay, S. (2006). *Alcohol misuse evidence-statement: Screening and counseling*. In *An Employer's Guide to Clinical Preventive Services: Moving Science into Coverage*. Retrieved from: http://www.businessgrouphealth.org/preventive/topics/alcohol_misuse.cfm
- Osilla, K. C., Del a Cruz, E., Miles, J. N. V. et al. (2010). *Exploring productivity outcomes from a brief intervention for at-risk drinking in an employee assistance program*. *Addictive Behaviors*, 35, 194-200.
- Quanbeck, A., Lang, K., Enami, K., & Brown, R. L. (2010). *A cost-benefit analysis of Wisconsin's Screening, Brief Intervention, and Referral to Treatment: Adding the employer perspective*. *Wisconsin Medical Journal*, 109(1), 9-14.
- SAMHSA (Substance Abuse and Mental Health Services Administration). *States in Brief Substance Abuse and Mental Health Issues At-A-Glance*. Retrieved from: http://www.samhsa.gov/stateinbrief/2009/WISCONSIN_508.pdf
- SAMHSA (Substance Abuse and Mental Health Services Administration). *National Survey on Drug Use and Health, 2007-2008. Tables of Model-Based Estimates (50 States and the District of Columbia)*. Office of Applied Studies. Retrieved from: <https://oas.samhsa.gov/2K8State/AppB.htm>
- SAMHSA (Substance Abuse and Mental Health Services Administration). *National Survey on Drug Use and Health, 2007-2008. State Tables*. Office of Applied Studies. Retrieved from <http://oas.samhsa.gov/2k8state/stateTabs.htm>
- SAMHSA (Substance Abuse and Mental Health Services Administration). (2011). *Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Behavioral Healthcare*. Retrieved from: <https://www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf>
- SAMHSA (Substance Abuse and Mental Health Services Administration). (2013). *Systems-level implementation of Screening, Brief Intervention, and Referral to Treatment*. Technical Assistance Publication, Series 33. DHHS Publication No. SMA 13-4741. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- TRI (Treatment Research Institute). (2010). *Integrating appropriate services for substance use conditions in health care settings: An issue brief on lessons learned and challenges ahead [Forum on Integration]*. Philadelphia: Treatment Research Institute.
- USPSTF (U.S. Preventive Services Task Force). (2004). *Screening and behavioral counseling interventions in primary care to reduce alcohol misuse*. Retrieved from: <http://www.uspreventiveservicestaskforce.org/uspstf/uspdsdrin.htm>



References (continued)

- USPSTF (U.S. Preventive Services Task Force). (2009a). *Counseling and interventions to prevent tobacco use and tobacco-caused disease in adults and pregnant women*. Agency for Healthcare Research and Quality. Retrieved from <http://uspreventiveservicestaskforce.org/uspstf/uspstbac2.htm>
- USPSTF (U.S. Preventive Services Task Force). (2009b). *Screening for depression in adults, 2009*. Retrieved from <http://www.uspreventiveservicestaskforce.org/uspstf/uspaddepre.htm>
- Winters, K. C., Leitten, W., Wagner, E., & O-Leary Tevyaw, T. (2007). *Use of brief interventions for drug abusing teenagers within a middle and high school setting*. *Journal of School Health*, 77(4), 196-206.
- Yarnall, K. S. H., Pollak, K. I., Ostbye, T., Krause, K. M., & Michener, J. L. (2003). *Primary care: Is there enough time for prevention?* *American Journal of Public Health*, 93, 635-641.



Figure 1: SBIRT Flow of Services

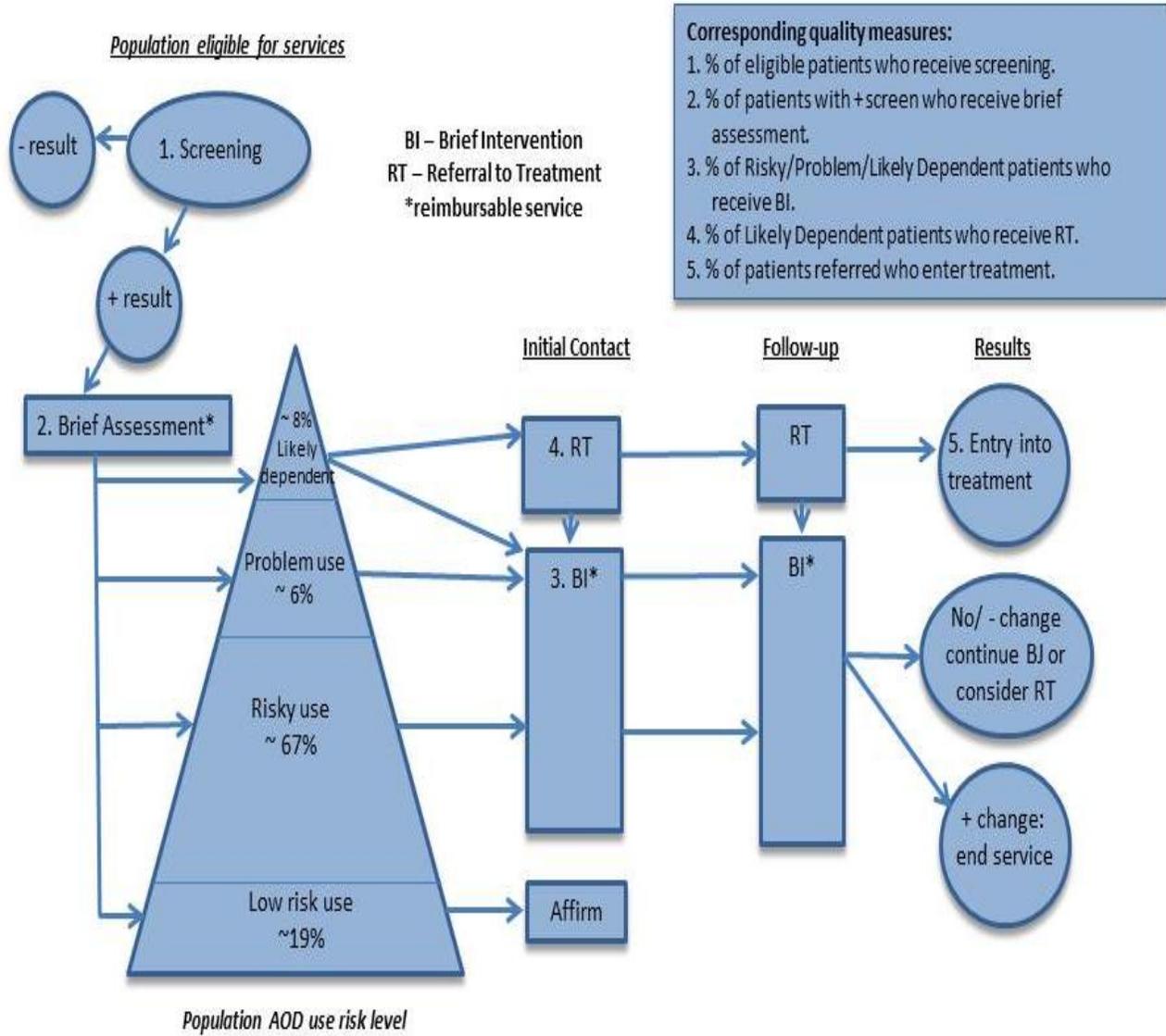
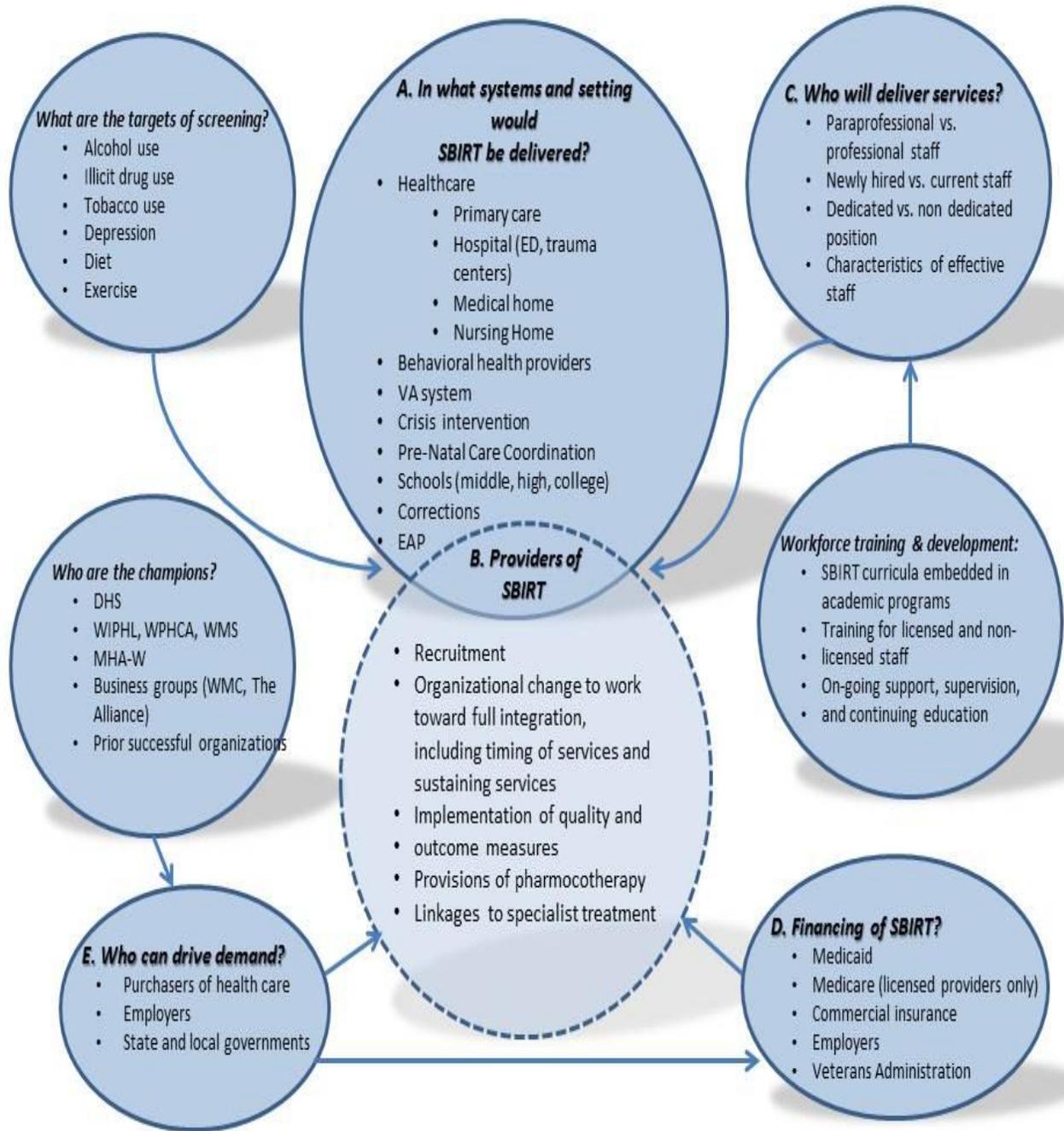




Figure 2: Considering SBIRT to Scale





Appendix A

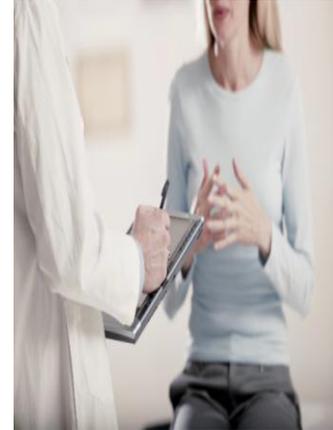
BEHAVIORAL SCREENING and INTERVENTION (BSI)

What is BSI?

BSI screens patients annually for behavioral risks, including tobacco, alcohol, drugs, depression and obesity. Top healthcare and business authorities recommend BSI, and most health plans reimburse for some BSI services.

Here’s how it works:

- 1 All patients complete a brief annual lifestyle questionnaire on tobacco, alcohol, drugs, depression, diet and exercise.
- 2 Those with positive screens meet with an on-site health educator who conducts an additional assessment.
- 3 For most patients, the health educator delivers an on-site intervention and continues to support behavior change.
- 4 Some patients are referred for additional needed services.



Why does Wisconsin need BSI?

»BSI WOULD BENEFIT BUSINESSES.

BSI improves employee health and benefits employers, because it is proven to...

- » Improve workplace productivity, decrease employee absences and prevent workplace injuries.
- » Increase smoking quit rates from 3% to 28% while decreasing emergency department visits and hospitalizations.
- » BSI reduces healthcare costs - saving \$895 per employee screened in just the first year!

»BSI WOULD REDUCE COSTS FOR MEDICAID & ETF.

In the United States, these behavioral issues are responsible for 40% of deaths, most chronic illnesses, most disability and nearly \$900 billion in costs annually. If Wisconsin bears 2% of the costs, that’s nearly \$18 billion.

- » Likely healthcare cost savings for Medicaid:
 - » Alcohol BSI = **\$170 million in the first year**
 - » Depression BSI = **\$126 million over 4 years**
- » Likely healthcare cost savings for ETF.
 - » Alcohol BSI = **\$52 million in the first year**
 - » Depression BSI = **\$124 million over 4 years**

»BSI WOULD ADDRESS IMPORTANT MENTAL HEALTH ISSUES.

- » Typically, 30% to 50% of depression goes undiagnosed.
- » BSI helps treat depression by annual screening, frequent contacts with patients, interventions to maximize patient engagement in and promotion of behaviors that lift depression symptoms.
- » BSI would **uncover almost all cases of depression, double response to depression treatment and increase complete remission by 77%.**

“Wisconsin’s state government and private sector cannot afford to forgo the well-documented positive health outcomes and cost savings of behavioral screening and intervention. It’s time for a coordinated effort by Medicaid and ETF to increase incentives for the state’s healthcare providers to deliver BSI.”



Appendix B

Projected First-Year Savings for a Wisconsin Company with 100 Employees

	Alcohol	Depression	Tobacco
Per...	Risky drinker	Depressed employee	Employee who quits smoking
Healthcare	\$523 ^a	\$841 ^d	\$192 ^f
Productivity	\$1,200 ^b	\$991 ^e	\$1,897 ^f
Absenteeism	?	\$310 ^e	\$479 ^f
Injury	?	?	\$2,013 ^f
Savings per employee	\$1,723	\$2,142	\$4,581
Number of Employees	30 ^c	7 ^c	5 ^g
Savings for 100 Employees	\$51,690	\$14,994	\$22,905
Total Savings for 100 Employees			\$89,589
Total Savings per Employee			\$895

Likely Sources of Additional Savings:

- Reductions in alcohol use beyond Year 1 and associated changes in healthcare costs, productivity, absenteeism, injury, and turnover
- Continued improvements in depression, associated changes in healthcare costs (total decrease of \$2,522 in Years 2 to 4d), productivity, absenteeism and injury
- Reductions in tobacco use in Years 2 to 10 and escalating healthcare savings as risks increasingly decline for cardiovascular disease, lung disease, and cancer
- Reductions in drug use in Year 1 and beyond, and associated changes in healthcare costs, productivity, absenteeism, injury, and turnover
- Changes in diet, exercise, and weight
- Changes in family members' stresses and illness – e.g., fewer respiratory illnesses from second-hand smoke, fewer stress-related illnesses in family members of individuals who decrease their drinking or drug use, fewer risky behaviors in teens and young adults whose parents model low-risk behaviors

Data Sources & Notes

- Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. *Medical Care* 2000; 38:7-18.
- Osilla KC, dela Cruz E, Miles JNV, et al. Exploring productivity outcomes from a brief intervention for at-risk drinking in an employee assistance program. *Addictive Behaviors* 2010; 35:194-200.
- SAMHSA. National Survey on Drug Use and Health, 2008.
- Unutzer J, Schoenbaum M, Harbin H. Collaborative care for primary/co-morbid mental disorders; brief for CMS meeting (updated August 4, 2011). Unpublished manuscript.
- Rost K, Smith JL, Dickinson M. The effect of improving primary care depression management on employee absenteeism and productivity; arandomized trial. *Medical Care* 2004; 42:1202-1210.
- National Business Group on Health. Moving Science into Coverage: An Employer's Guide to Preventive Services. Tobacco Use Treatment, updated 9/23/11. Accessed at http://www.businessgrouphealth.org/preventive/topics/tobacco_treatment.cfm on June 18, 2012.
- According to the CDC's 2010 Behavioral Risk Factor Surveillance System, 19.1% of Wisconsin adults use tobacco. According to the US Agency for Healthcare Research and Quality's 2008 update of Treating Tobacco Use and Dependence, optimal screening and intervention would increase one-year quit rates from 3% to 28%. Thus, of 100 employees, 19 would smoke, and 5 would quit with optimal intervention.
- Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcoholism: Clinical and Experimental Research* 2002; 26:36-43.

Please visit us and show your support at www.wiphl.org/employers.

WIPHL (pronounced WIFF-el), the Wisconsin Initiative to Promote Healthy Lifestyles, is a program of the University of Wisconsin School of Medicine and Public Health. WIPHL is funded by a grant from the US Agency for Healthcare Research & Quality.





State of Wisconsin
State Council on Alcohol and Other Drug Abuse
1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851