Statewide SBIRT Manual

Guidance for Providers

A Manual for Hawai'i for Screening, Brief Intervention, and Referral to Treatment

Statewide SBIRT Manual

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Prepared for the Med-QUEST Division of the Hawai'i Department of Human Services by Health Management Associates.

Authors

Elizabeth Wolff, MD, MPA

Shelly Virva, LCSW, FNAP

Scott Haga, MPAS, PA-C

Lindsey Kato, MPH

Cami McIntire, BS

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Introduction: The "Why" of This Statewide SBIRT Provider Manual

Hawai'i's Med-QUEST (MQD) primary care and emergency department (ED) providers address many patient issues daily. Patient use of tobacco, alcohol, and illicit drugs is just one among them. You know it is important, but you must diagnose and treat many other pressing clinical problems as well. Why has Med-QUEST created this Statewide Provider Manual on Screening, Brief Intervention, and Referral to Treatment (SBIRT) for you now?

Substance misuse is a perennial issue in Hawai'i—and is getting worse.

According to the National Survey on Drug Use and Health 2018–2019, 68 percent of people 12 and older in Hawai'i used tobacco, alcohol, or illicit drugs during the previous year, with 5 percent experiencing alcohol use disorder (AUD), and 2 percent experiencing illicit drug abuse or dependence in the last year. Of those with an alcohol or other SUD, 30 percent had Med-QUEST insurance.[1] Since the pandemic, the use of illicit substances, such as fentanyl and methamphetamines, has grown in Hawai'i and across the country.

SUD screening works and is a recognized best practice.

From asking about bike helmets to sexual activity, primary care, and ED providers screen patients for risky behaviors all the time. Why is screening for SUD so important? Because patients often don't reflect on or readily offer information about their use of substances until asked by an interested, nonjudgmental clinician. That is often the single most important motivator for patients to reduce or eliminate alcohol and drug use, mitigate risky behavior, or seek specialized care for severe SUD. That's why the US Preventative Services Task Force recommends universal screening for substance use for adults ages 18 and older, and the American Academy of Pediatrics recommends universal screening for all adolescents.[2,3]

But why should SUD screening be universal? Why not just screen some patients?

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[1] Kiyokawa, M., & Quattlebaum, T. H. N. (2022). Implications for a System of Care in Hawai'i: Primary Care Integration of Substance Use Disorder Treatment. Hawai'i journal of health & social welfare, 81(12 Suppl 3), 62–68.
[2] U.S. Preventive Services Task Force. Recommendation: Unhealthy Drug Use: Screening | United States Preventive Services Taskforce. Published 2020. Accessed January 2023. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening#fullrecommendationstart.
[3] Levy, S. J. L., & Williams, J. F. (2016). Substance Use Screening, Brief Intervention, and Referral to Treatment. PEDIATRICS, 138(1), e20161211–e20161211. doi:10.1542/peds.2016-1211

Deciding to screen some patients but not others may introduce the risk of racial, ethnic, socioeconomic, gender, age, and other biases that result in missed opportunities to identify a problem and intervene.

SBIRT is evidence-based universal screening and intervention that helps prevent more severe problems.

SBIRT is a flexible framework for universal SUD screening and intervention for which a solid evidence base has been developed over the past two decades. It provides a broad approach to addressing substance use, including early diagnosis and treatment, for patients who are developing a SUD or already have one. To encourage such early intervention and consequently lower patients' healthcare costs, MQD has set a goal that by 2028, 90 percent of MQD beneficiaries ages 12 and older who present for care in a primary care or ED setting are screened using SBIRT at least once a year.

Hasn't MQD tried to implement SBIRT before?

You probably have already heard of SBIRT and have perhaps used it with your patients. MQD and other Hawai'i state agencies have tried to make it a standard clinical practice for years.

In November 2016, MQD began its first SBIRT program, in collaboration with the Hawai'i Department of Health (DOH) and the Hawai'i Maternal and Infant Health Collaborative, in a project funded by Aloha United Way and Omidyar Ohana Fund and administered by Hilopa'a Family to Family, Inc. The project provided SBIRT training for inpatient and ambulatory maternity care providers who were unaffiliated with a federally qualified health center (FQHC). Providers were incentivized in a pay-for-performance program to embed screening into hospital workflows and screen at least 3 percent of their maternity patients.

The program's next iteration occurred in 2019 in a partnership between MQD and DOH's Alcohol and Drug Abuse Division (ADAD). Managed care organizations (MCOs) completed a Train the Trainer (TtT) curriculum that included an online SBIRT course, a daylong Motivational Interview training, and in-person SBIRT training, totaling 16 hours of education. The MCOs then led in-person trainings for providers using this curriculum.

Most recently, the 2022 Substance Use State Plan from ADAD identified a specific SBIRT focus area to "integrate substance use disorder screening in primary care settings and develop referral and entry system into a continuum of care." [4]

[4] Hawaii State Department of Health. (2022, October). State plan on substance abuse – 2022 revision. State Plan on Substance Abuse – 2022 REVISION. Retrieved 2023, from https://health.hawaii.gov/substance-abuse/state-plan/

So why hasn't SBIRT become a standard clinical practice in Hawai'i?

We hear many reasons why most Primary care and ED providers still don't use SBIRT with every patient.

"It takes too much time."

Since the pandemic, you've probably been busier than ever. Screening for a SUD may feel impossible when there's so much else to address and then document. But other clinical staff can administer SBIRT, and it shouldn't take much of their time. For the 75 to 85 percent of patients who will have a negative prescreen, it takes 1 to 2 minutes to complete. For patients who initially screened positive, administering a full screen will take 3 to 5 minutes. For patients who could benefit from a brief intervention, it may require 5 to 15 minutes.

"Why screen if there are no local providers to refer patients with SUD?"

This can be a significant challenge on smaller islands and in primary care and ED practices where providers lack training in brief SUD interventions. However, SUD providers may be more accessible than in the past. More SUD treatment is being provided nowadays through telehealth. More mental health providers and agencies are willing to treat SUD in the context of mental disorders. Moreover, for many patients who screen positive, brief intervention provided onsite is sufficient.

"I don't have the time and resources to train my staff in SBIRT."

It's vital for clinical and non-clinical staff to gain competency in SBIRT to make it an integral part of a primary care or ED practice. Fortunately, more SBIRT training is available for free online and can be self-paced to complete at times of low office or ED volume. (Please see Training section below. This Statewide Provider Manual should also be of help.)

"SBIRT is not a standard component of my electronic health record (EHR)."

Documentation matters. If SBIRT isn't part of the EHR template and is, therefore, not prompted and more challenging to document, providers may be less inclined to use it. We anticipate that

SBIRT is of enough clinical value to justify an EHR optimization—especially if screening identifies growing problems early enough to prevent higher utilization and costs.

In summary, SBIRT is not complicated, but it does require some know-how. Most of all, though, it requires commitment. In the rest of this manual, we lay out the nuts and bolts of SBIRT, describe billing for it, and answer other important questions about its practice.

Clinical Director: Consider This First

Before your primary care or ED decides to commit the time and resources to implement SBIRT, every clinical director should first consider these essential questions:

- How will you communicate the implementation of this program across your organization?
- How will your approach be culturally responsive?
    - How will you identify the language and literacy level?
    - How will you build trust?
    - How will you ensure the services to which you are referring are culturally sensitive to patient needs?[5]
- To what degree do you need to address the stigma around SUD, and how will you build empathy?
- Regarding the workflow:
    - How often will you screen, and during what types of visits?
    - Who will perform the prescreen and screen?
    - How will EHR documentation occur?
    - How will you bill for SBIRT?
- Who in your organization should be trained on SBIRT, especially in brief interventions?
- What evidence-based practices (e.g., medications for addiction treatment) can you provide within your organization?
- To whom can you refer patients needing a higher level of SUD treatment?

[5] Satre, Derek & Manuel, Jennifer & Larios, Sandra & Steiger, Scott & Satterfield, Jason. (2015). Cultural Adaptation of Screening, Brief Intervention and Referral to Treatment Using Motivational Interviewing. Journal of Addiction Medicine. 9. 352-357. 10.1097/ADM.0000000000000149.

Key Talking Points

Let's say you are at a clinical team meeting, and there's a heated debate about whether implementing SBIRT is a good idea. What will you say to support it and win the argument? The talking points below are recommended for reassuring clinical and non-clinical staff who may be hesitant to screen for various reasons. They include points related to the number of specialized SUD treatment centers available for referral and why it's crucial to understand SUD in your patient population:

Most individuals screened for SUD do not need referral to a SUD treatment center.

Screening in and of itself is impactful as it requires a patient to reflect on their use of substances and how it affects their life.

Substance misuse and SUD are essential for clinicians to be aware of since they impact a patient's other behavioral and physical health conditions.

Brief Interventions (BI) are effective, evidence-based strategies for reducing substance use and can be provided in multiple care settings, including primary care.

BI can be useful for patients awaiting admission to SUD treatment centers.

"Treatment" isn't confined to the formal SUD treatment system. It can occur in primary care, ED, and more general behavioral health settings in the form of medication-assisted treatment (MAT) and brief treatment.

Access to SUD treatment in primary care can be expanded by integrating behavioral health into primary care using an evidence-based model such as collaborative care.[6]

[6] Collaborative care. Collaborative Care | University of Washington AIMS Center. (2023). Retrieved 2023, from https://aims.uw.edu/collaborative-care

Training

Although MQD is *not* mandating training for reimbursement, training is highly recommended as it helps to support model fidelity. MQD recommends that both clinical and non-clinical staff take advantage of virtual training, which has become more available since COVID-19.

Two SBIRT trainings that are recommended include:

- With a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), the University of Missouri Kansas City SBIRT created free training for medical and behavioral health clinicians that includes 3.5 hours of continuing medical, nursing, and social work education credits. It can be accessed at https://sbirt.care/training.aspx.
- Pacific Southwest Addiction Technology Transfer Center Network, also funded by SAMHSA, has a four-hour, self-paced online course that can be accessed at https://psattcelearn.org/courses/4hr_sbirt/. It provides 4.0 hours of continuing education credits for behavioral health clinicians, including psychologists.

In addition to these recommended SBIRT trainings, other training resources on addiction and early-life trauma are listed in Table 1. These training programs inform a sensitive approach to patients, as we know most patients with SUD have experienced early-life trauma. Increased knowledge of both will help staff better understand the value of SBIRT.

Table 1. Suggested Training

Title	Description	Link
Health Knowledge – Substance Use Disorder Basics	Courses cover introductory topics in the substance use disorder field	https://healtheknowledge.org/course/index.php?categoryid=53
The Science of Addiction – Addiction Neuroscience 101	An overview of the neurobiology of addiction.	https://www.youtube.com/watch?v=bwZcPwlRRcc&t=6s
TED MED – How childhood trauma affects health across a lifetime by Nadine Burke Harris	Explains how the repeated stress of abuse, neglect, and parents struggling with mental health or substance abuse issues has tangible effects on the development of the brain and greatly increases their risk of chronic disease.	https://www.youtube.com/watch?v=95ovIJ3dsNk&t=6s

High-Level Workflows

In planning for SBIRT implementation, workflow development is a key step for any healthcare facility, whether a primary care office or ED. Each facility has its own resources and operations, so workflows should be customized to be facility specific. The following two pages include recommended workflows for primary care, which could be generalized to other ambulatory practices, and the ED, which can be adapted for other hospital departments.

Figure 1. Suggested Workflow for Hospitals

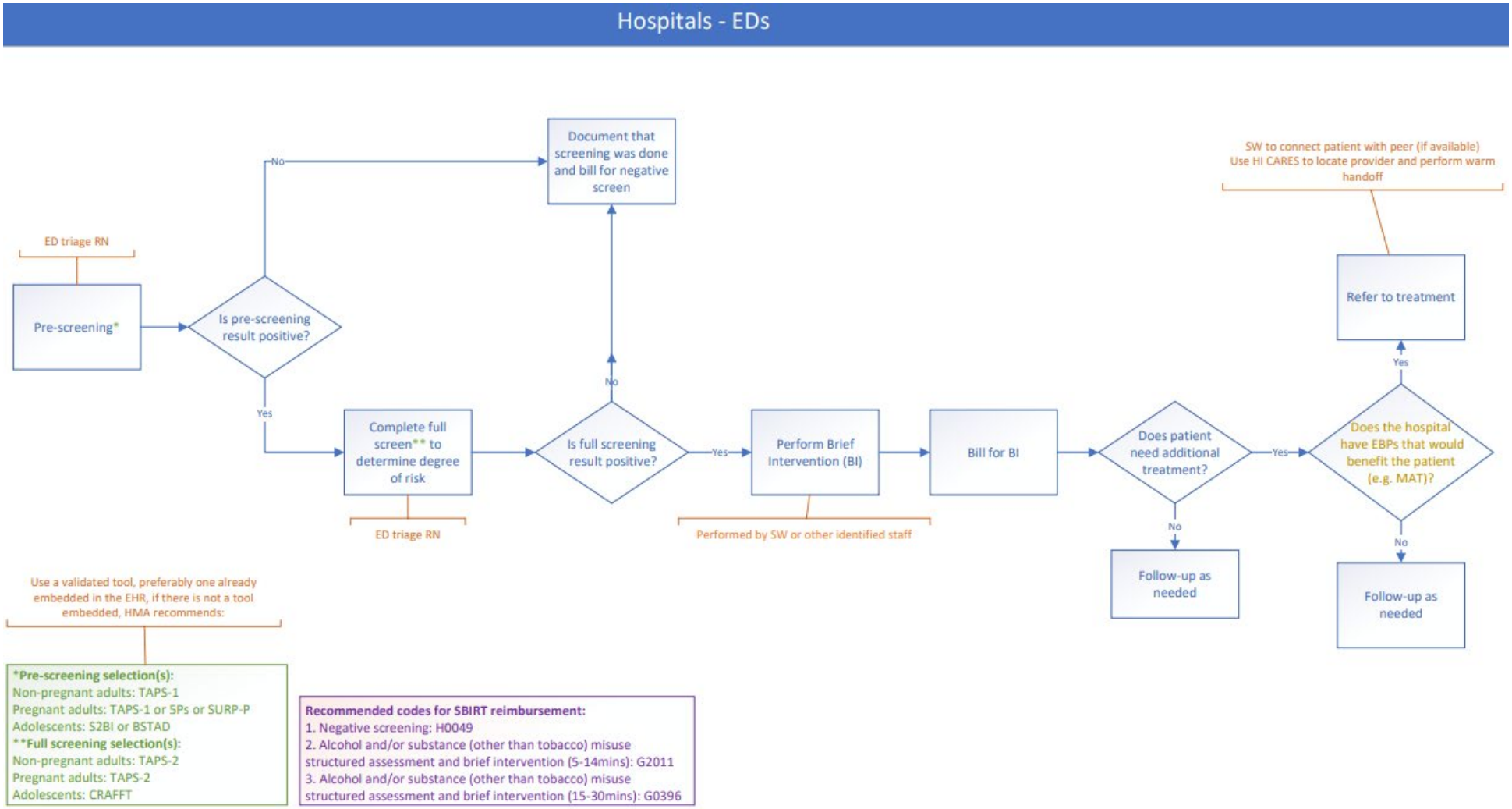
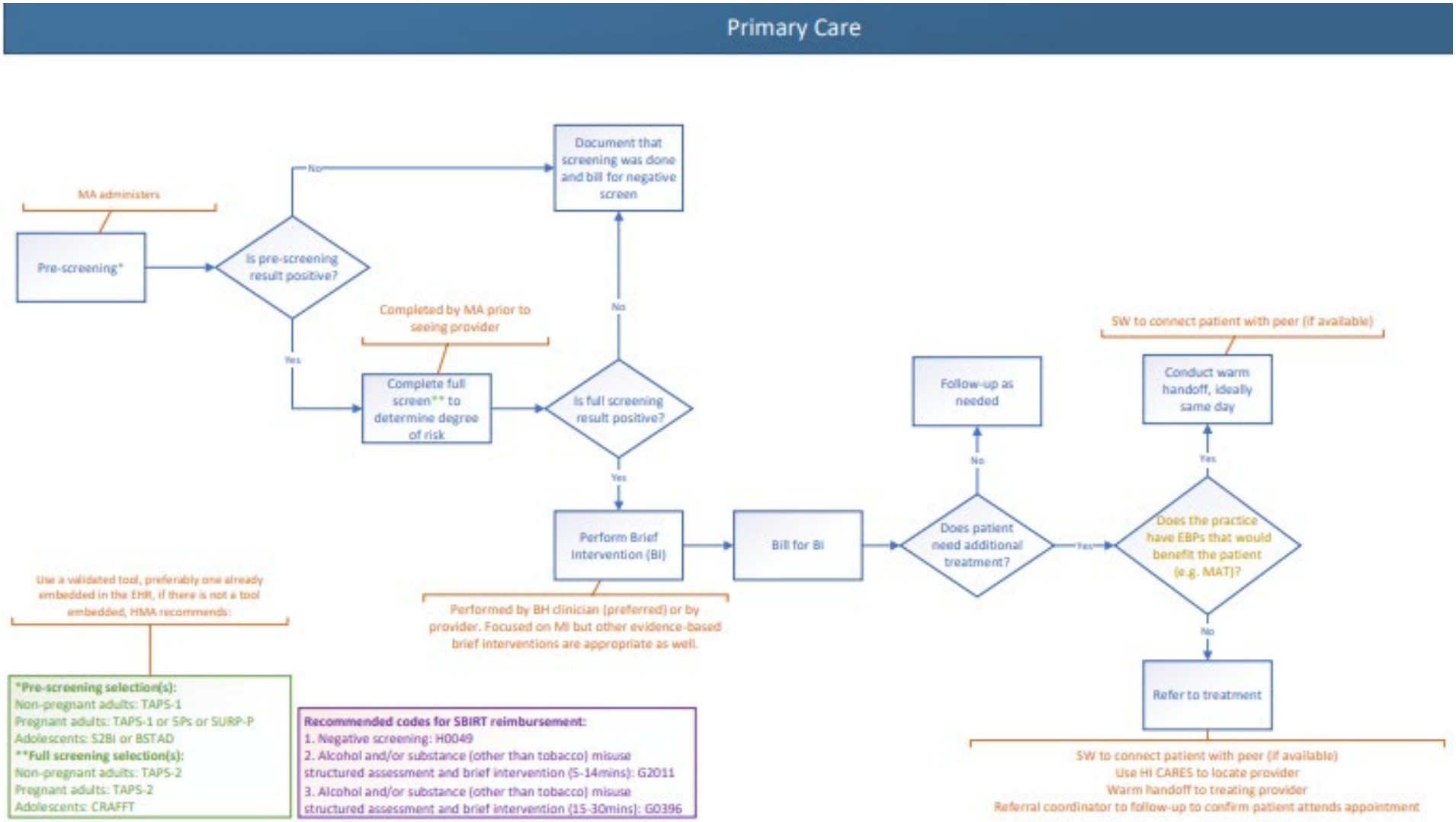


Figure 2. Suggested Workflow for Primary Care



Screening

Universal screening is a holistic approach to prevention and treatment that can reinforce safe use or abstinence, prevent negative consequences such as driving under the influence or other health problems, and support interventions before hazardous use leads to dependence. Screening for all substances that affect health will help with patient understanding and facilitate staff adoption of the screening process. As such, we have found that asking about tobacco use, which patients typically expect to be screened for, along with alcohol and illicit and prescription drug misuse is an effective approach.

Patients screened as having no or low risk may benefit from reinforcement of their behavior and primary prevention. Individuals at moderate risk should be referred for brief intervention, and those at high risk would benefit from brief treatment, MAT, or referral to a more appropriate level of care.

Introduction to Screening

How the screening is introduced and discussed is critical for ensuring patients are comfortable with answering questions honestly and openly so the provider can determine the severity of risky behavior. As such, a preamble to introduce the screening, along with using appropriate tone and open body language, is important. We recommend an introduction such as the one below, which can be customized to the setting and circumstances.

Hi, I'm _____. Nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.[7] *Everything we talk about is confidential.*

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[7] National Institute on Drug Abuse, (March 2012). Screening for Drug Use in General Medical Settings Resource Guide. Retrieved from: https://nida.nih.gov/sites/default/files/resource_guide.pdf

Approach and Validated Tools

Once introduced, **prescreening** can be performed. Prescreening is a brief screen with 2 to 4 questions to identify individuals who may be engaging in risky substance use. Validated prescreening tools have a high sensitivity, so risky behavior can be ruled out for those who screen negative. However, the tools have lower specificity, so individuals who screen positive will need a longer **full screen** to determine where they are on the spectrum of use—from risky behavior to severe use or dependence.

Using **validated tools** for both the **prescreen** and the **full screen** is important because these instruments have been well-researched and accurately capture an individual's risk. Organizations should determine which validated screening tools are already embedded in their EHR to facilitate SBIRT implementation and data tracking. If the EHR does not have SUD screening tools already embedded, we recommend those listed in Table 2, as they are concise and screen for alcohol, illicit and prescription drugs, and in some cases, tobacco.

Several validated prescreens and full screens exist for adults, pregnant people, and adolescents. The National Institute on Drug Abuse (NIDA)[8] provides a thorough list of validated screening tools for adults and adolescents, and the Indiana Perinatal Quality Improvement Collaborative[9] lists validated tools for pregnant people. Below are the ones that MQD recommends.

Table 2. MQD recommended Prescreen Tools for SUD

Name	Population	Description	Link
TAPS-1 (Tobacco, Alcohol, Prescription medication, and other Substance use)	Adults, including pregnant people	Four-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs that is adapted from the NIDA quick screen. If the prescreen is positive, the online version flows directly to the full-screen TAPS-2.	Online version: https://nida.nih.gov/taps2/ PDF: https://cde.nida.nih.gov/sites/nida_cde/files/TAPS%20Tool%20Parts%20I%20and%20II%20V2.pdf

[8] U.S. Department of Health and Human Services. (2023, January 6). Screening and assessment tools chart. National Institutes of Health. Retrieved March 2023, from https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

[9] Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Pregnant and Postpartum Women, October 2020 Issue Brief, Association of Maternal and Child Health Programs /National Association of State Alcohol and Drug Abuse Directors. Retrieved March 2023, from https://www.in.gov/health/ipqic/files/Validated-Screening-Tools-Final.pdf

5Ps (Parents, Peers, Partner, Pregnancy, and Past)	Pregnant people	Five-item screen for alcohol and drug use. An integrated version also screens for tobacco use, depression, and violence.	PDF: https://ilpqc.org/wp-content/docs/toolkits/MNO-OB/5Ps-Screening-Tool-and-Follow-Up-Questions.pdf Integrated version (PDF): https://ilpqc.org/ILPQC%202020%2B/MNO-OB/5ps-institute-for-health-and-recovery-integrated-screening-tool.pdf
S2BI (Screening to Brief Intervention)	Adolescents 12-17	Three-item screen that asks about the frequency of use in the last year of substances most commonly used by adolescents: tobacco, alcohol, and marijuana. Patients who admit to using any of these substances will be asked about other substances (prescription drugs, illegal drugs, inhalants, herbs, or synthetic drugs) The online version calculates risk. Anything other than "no risk" should receive a full screen.	Online version: https://nida.nih.gov/s2bi/

The TAPS-1 asks about the number of drinks but does not specify the volume of alcohol considered to be one drink. Figure 1 defines a standard drink.[10]

[10] D'Onofrio, G., et, al. (2008). (tech.). Screening, Brief Intervention & Referral to Treatment (SBIRT) Training Manual For Alcohol and Other Drug Problems (pp. 1–66). New Haven, CT: Yale University.

Figure 3. Definition of Standard Drink

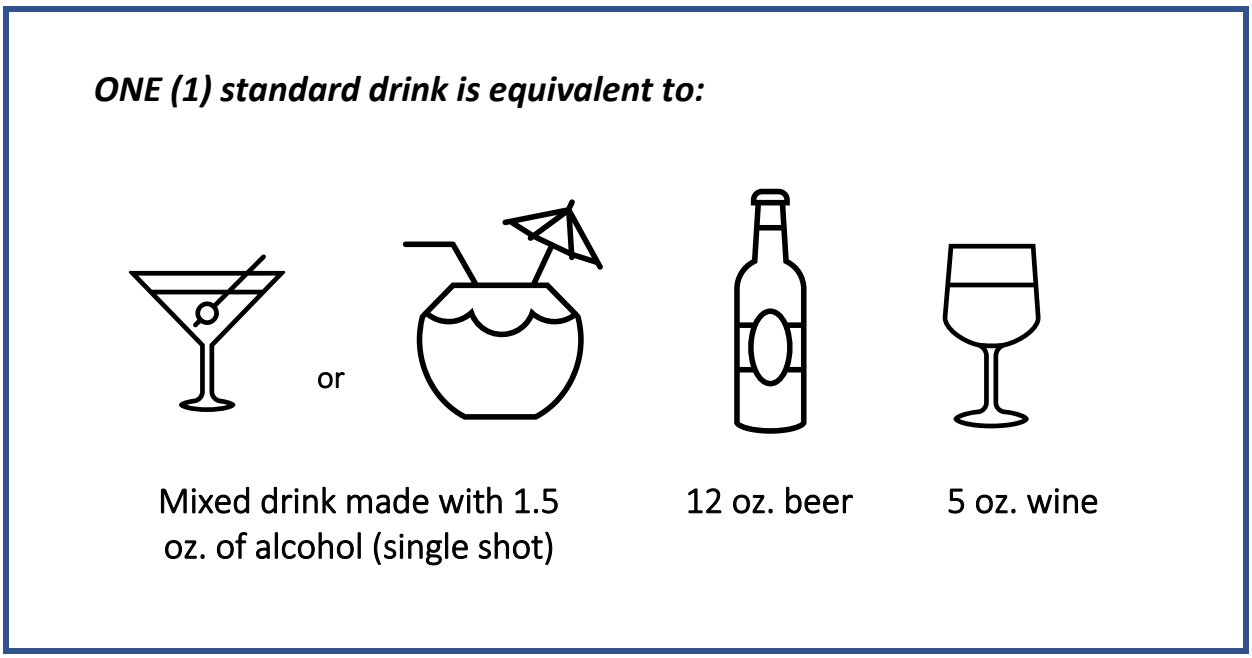

Table 3. Recommended Full Screen Tools for SUD

Name	Population	Description	Link
TAPS – 2 (Tobacco, Alcohol, Prescription medication, and other Substance use)	Adults, including pregnant people	Full screen for tobacco, alcohol, and specific illicit and prescription drugs that is adapted from the NIDA-modified ASSIST. If the TAPS-1 is positive, the online version automatically flows to TAPS-2.	Online version: https://nida.nih.gov/taps2/ PDF: https://cde.nida.nih.gov/sites/nida_cde/files/TAPS%20Tool%20Parts%20I%20and%20II%20V2.pdf
CRAFFT 2.1 (Car, Relax, Alone, Forget, Friends, Trouble)	Ages 12-26, including pregnant people	Full screen is available in numerous languages and validated for adolescents from diverse socioeconomic and racial/ethnic backgrounds. The latest version, 2.1, includes vaping as a method for using marijuana, and version 2.1+N contains questions about tobacco and nicotine use. If the tool is self-administered before seeing the healthcare professional, it is more likely to elicit honest responses.[11]	Version 2.1 PDF (self-administered): https://crafft.org/wp-content/uploads/2021/07/CRAFFT_2.1_Self-administered_2021-07-03.pdf Version 2.1+N PDF (self-administered): https://crafft.org/wp-content/uploads/2021/07/CRAFFT_2.1N-HONC_Self-administered_2021-07-03.pdf

[11] Boston Children's Hospital. (2018). Use the CRAFFT. CRAFFT. Retrieved 2023, from https://crafft.org/use-the-crafft/#faq

Brief Intervention

BI is an effective tool to help a subset of patients identified as engaging in moderate to risky substance use. It's a way to provide guidance and education to increase the patient's insight and awareness about risky substance use. BI can be a short, five-minute conversation addressing screening results or can take on a more focused approach using motivational interviewing techniques and eliciting considerations for change. BI also can be done over multiple visits. Taking a few minutes during each visit to address risky substance use through motivational interviewing techniques can help patients identify reasons for change.

BI is an efficient way to motivate patients to change their behavior. When delivered properly, interventions should focus on increasing peoples' understanding of substance use and behavior change. The goal of BI is to help motivate people toward behavioral change.

BI includes three components:[12,13]

- **Understanding the patient's view of their substance use, such as:**
    - How the person thinks about their substance use and what role it plays in their life
        - *"I'm curious, what role do you feel alcohol plays in your life?"*
    - Asking the patient to develop a pro and con list.
- **Giving information and feedback**
    - Ask for permission to give feedback.
        - *"Is it okay if I provide some feedback about your alcohol use?"*
    - Providing information and education about the health risks
- **Giving advice and negotiating a change plan**
    - Upon receiving permission, provide clear advice to the patient to change.

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[12] *SBIRT: A Step-by-Step Guide*. Massachusetts Screening, Brief Intervention, and Referral to Treatment. https://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf

[13] TAP 33: System level implementation of Screening, Brief Intervention and Referral to Treatment: https://store.samhsa.gov/product/TAP-33-Systems-Level-Implementation-of-Screening-Brief-Intervention-and-Referral-to-Treatment-SBIRT/SMA13-4741

        - *"What do you think about reducing your alcohol use? What would that look like to you?"*
    - Goals should be patient-generated.

Motivational interviewing (MI) techniques and skills are an essential part of brief intervention. MI is a collaborative conversation style for strengthening a person's own motivation and commitment to change. A brief intervention doesn't have to take long or be elaborate. It is about being collaborative and tapping into a person's own reasons to change. The acronym OARS, below, can help to support motivational interviewing techniques.

- **OPEN-ENDED QUESTIONS:** Patients don't need to worry about providing the wrong answer. Open-ended questions are an invitation to open up.
- **AFFIRMATIONS:** Everyone needs validation. Demonstrating you are happy for your patient's success, even small wins, helps keep them motivated and moving forward.
- **REFLECTIVE LISTENING:** Patients often have their own answers, and providers should support finding them with guidance and support.
- **SUMMARIZE:** Capture the key, actionable steps and allow the patient to correct or affirm them; Based on these, ask open-ended questions to support goal setting.

Referral to Treatment

Referral to treatment is necessary when a patient is identified as having a high or severe risk and will likely meet diagnostic criteria for moderate to severe SUD. Of those screened, only around 5 percent will likely need a referral for level of care assessment and treatment (Figure 1). Using motivational interviewing techniques can improve the likelihood that the patient will decide to seek treatment. Start where the patient is and be collaborative, not confrontational. Often, we may feel a patient needs inpatient or residential services; however, if the patient is willing to consider outpatient care, make the referral for outpatient SUD treatment.

Referral to treatment best practices:

- Refer to services available in your community and make connecting to treatment as barrier-free for the patient as possible.
- Have a referral process in place, set the patient up with a referral to treatment before leaving. Don't just provide the patient with a list of places to call with their discharge paperwork.
- Develop an enhanced referral network with behavioral health providers, including memorandums of understanding (MOUs), care coordination, and a process for closing the referral loop.
- Refer to an ADAD-contracted treatment provider. That list can be found at: https://health.hawaii.gov/substance-abuse/files/2022/09/2022-2024-Treatment-Provider-List-rev-9.20.22.pdf
- Call HI CARES, a free 24/7 mental health and substance use call center that will triage and direct patients to appropriate services. Call (808) 832-3100 or (800) 753-6879 (toll-free)
- Suggest self-help groups such as Smart Recovery, AA, NA, etc., for patients who may be noncommittal about formalized treatment services.

Table 4. Suggested Self-Help Groups and Contacts

Name	Island	Phone	Link
Alcoholics Anonymous	Oahu	(808) 946-1438	http://www.oahucentraloffice.com
	Hawai'i (West)	(808) 329-1212	http://www.westhawaiiaa.org
	Hawai'i (East)	(808) 961-6133	http://www.easthawaiiaa.org
	Maui	(808) 244-9673	http://www.aamaui.org
	Kauai	(808) 245-6677	http://www.kauaiaa.org

Narcotics Anonymous	Oahu	(808) 734-4357	www.Na-hawaii.org
	Kauai	(808) 828-1674	
	Maui, Molokai and Lanai	(808) 214-1239	
	Big Island (West)	(808) 769-6016	
	Big Island (East)	(833) 624-7463	
SMART Recovery	Statewide		https://meetings.smartrecovery.org/meetings/?coordinates=250&location=hawaii

Billing

Effective billing for SBIRT is critical for the sustainability of substance use screening and intervention. Billing for SBIRT is like billing for any other services provided to patients and can be billed on top of any other services provided during the same visit. Inpatient SBIRT services will be carved out from APR-DRG payments, please refer to guidance on APR-DRG payments for further information.

E/M Billing Codes

Billing for SBIRT services is based on the time spent providing the screening, brief intervention, and referral services. Commercial plans may have different requirements for billing, but the most common billing codes are shown below. These codes should typically be billed using modifier 25 to signify a "significant, separately identifiable" additional service was provided in addition to the primary billing code for the visit.

Table 5. Billing Codes

Description	Time Requirement	HI Medicaid Code
Negative Screening		H0049
Alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention *5-14 minutes*	5-14 minutes	G2011
Alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention *15-30 minutes*	15-30 minutes	G0396
Alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention *31+ minutes*	31+ minutes	G0397

Settings

Individuals present for healthcare in various settings, therefore SBIRT should be provided in numerous settings to reach the largest number of people. SBIRT services can be provided in multiple outpatient and inpatient settings. These include, but are not limited to:

Outpatient

- School
- Outpatient office
- FQHC
- Rural Health Clinic

Hospital

- Outpatient hospital clinic
- Emergency Department **
- Inpatient

**For SBIRT services in the emergency department, either the provider or the hospital, but not both, may bill for the provided service.

Diagnosis Codes

Assigning an accurate diagnosis code when performing SBIRT services is important to facilitate payment for providing the service and to allow for accurate tracking of individuals screened for substance use. The two codes below are recommended for use when screening for substance use. If a diagnosis of a substance use disorder is ultimately made, that specific SUD diagnosis should also be added.

Table 6. Recommended Diagnosis Codes

ICD-10 Code	Description
Z71.41	Alcohol abuse screening, counseling, and surveillance
Z71.51	Drug abuse screening, counseling, and surveillance

Who Can Bill for SBIRT?

A range of professionals can bill for providing SBIRT services. Whether a professional can bill for SBIRT is determined by the individual payer (Medicare, Medicaid, or commercial). The following professionals can independently bill Medicaid for providing SBIRT services if they are participating providers:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Licensed Clinical Psychologists
- Licensed Clinical (Master) Social Workers
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists
- Certified Nurse Midwife

Other non-licensed clinical staff are also able to provide SBIRT services. These individuals, known as delegates, act under the direct supervision of an independently licensed professional (listed above) and may bill under the NPI number of that licensed professional if they are appropriately trained to provide the SBIRT service and directly supervised. Some of these professions include but are not limited to:

- Certified drug and alcohol counselors
- Nurses
- Medical assistants
- Community health workers

Additional Information and Questions

Please contact SBIRTInquiries@dhs.hawaii.gov with further questions.

Appendices

Appendix A – Frequently Asked Questions (FAQs)

How frequently should I screen my patients for SUD?

The *US Preventative Services Task Force* recommends universal screening for adults 18 years and older, including those who are pregnant and postpartum. They do not specify a screening frequency.[14] We recommend screening at least every 12 months.

The *American College of Obstetricians and Gynecologists* recommends screening all patients at their first prenatal appointment.[15,16]

The *American Academy of Pediatricians* recommends that primary care providers perform universal screening for SUD in adolescents. Performing this screening each time an adolescent receives medical care will increase the likelihood of identifying an issue if one exists.[17]

Who can perform the screening?

Any staff member who has been adequately trained to introduce screening in a trusting, nonjudgmental way can perform the screening. Self-administered, as opposed to clinician-administered screenings, elicit more honest answers in adolescents.

How do I bill for screening?

Billing for screening is done by submitting accurate Current Procedural Terminology (CPT)® code, diagnosis, and other billing codes for the same visit, and a modifier 25 is often used to signify a separate, additional service. Additional details are available in the Billing section of this handbook.

Who can perform and bill for brief interventions?

Many licensed medical and behavioral health professionals have previous BI training. Clinicians who have not previously participated in this training can use online or in-

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[14] US Preventive Services Taskforce. (2020, June 9). Unhealthy drug use: Screening. Recommendation: Unhealthy Drug Use: Screening | United States Preventive Services Taskforce. Retrieved 2023, from https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening

[15] American College of Obstetricians and Gynecologists. Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. Obstetrics and gynecology. 2017;130(2):e81–e94

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person trainings as recommended earlier in this manual. Please see the Billing section of this manual for individuals who can provide and bill for SBIRT services.

If brief intervention is done over multiple visits, how do we bill for this? By each visit or just once at the initial screen and BI?

Brief intervention could be provided over multiple visits, with each visit resulting in a claim for the time spent providing the BI.

Appendix B – Definitions

ASAM: American Society of Addiction Medicine, the organization that developed patient placement criteria based on six dimensions to determine the most appropriate substance use disorder treatment level.

Assessment: Also referred to as a clinical or biopsychosocial assessment. An assessment provides a more holistic view of the patient and is used to help determine a diagnosis.

Brief Intervention: Brief intervention (BI) is a structured, client-centered, non-judgmental therapy by a trained interventionist using 1-4 counseling sessions of shorter duration (typically 5-30 minutes). Based on a harm reduction paradigm, BI aims to reduce a person's substance use to a safe level or complete abstinence.

Clinician: A licensed medical or behavioral health provider, i.e., physician, physician assistant, nurse practitioner, licensed independent (masters) social worker, psychologist, and licensed marriage and family therapist.

Enhanced Referral: Referrals that have shared agreements between organizations regarding appointment access and bidirectional information sharing, as well as follow-up as needed to complete successful referral connections.

Full Screen: While still intended to be completed quickly, a full screen has more focused questions regarding alcohol and/or drug use used to identify the risk of unhealthy substance use.

Harm Reduction: Set of evidenced based practices or strategies focused on improving the physical and social wellbeing of people with substance use disorders without judgement, discrimination, coercion, or requirement of abstinence. Harm reduction strategies focus on interventions, such as needle exchange programs, that reduce the negative effects of substance use.

Level of Care: Identifies the setting and intensity of substance use disorder treatment according to assessment using The ASAM Criteria: Prevention, Office based opioid treatment (OBOT), Opioid Treatment Program (OTP), Outpatient Treatment, Intensive Outpatient (IOP), Partial Hospitalization (PHP), Clinically Managed Residential, Medically Monitored Residential, Medically Managed Inpatient, and Withdrawal Management.

Other Clinical Staff: Healthcare professionals who require certification to practice but are not able to bill independently for services; including but not limited to medical assistants, registered nurses, registered social workers, community healthcare workers, peer specialists, and assistant coordinators. This has also been called a **delegate** historically in Hawai'i.

Prescreen: A brief screen, as defined by SAMHSA, as "a rapid, proactive procedure to identify individuals who may have a condition or be at risk for a condition before obvious manifestations occur." It's two or three short questions about alcohol and drug use.

SBIRT: Screening, Brief Intervention, and Referral to Treatment is an integrated public health approach for early identification and intervention with patients whose patterns of alcohol and/or drug use put their health at risk.

Validated Tools: Validated screening tools are screening instruments that have been scientifically validated to produce consistent results.

Appendix C – Resources

Resource	Description	Link
Conducting SBIRT Virtually – Prevention Technology Transfer Center (PTTC) Network	Infographic for conducting SBIRT virtually, developed by Mountain Plains PTTC.	https://pttcnetwork.org/centers/mountain-plains-pttc/product/conducting-sbirt-virtually-infographic
Massachusetts SBIRT Toolkit	Provides a step-by-step guide for implementing SBIRT at the provider level.	https://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf
SAMHSA TIP 34: Brief Interventions and Brief Therapies for Substance Abuse (2012)	Introduction for providers to brief interventions and therapy for mental illness (MI), SUD, or MI/SUD co-occurring disorders. The manual provides methods and scenarios for implementing brief interventions.	https://store.samhsa.gov/product/TIP-34-Brief-Interventions-and-Brief-Therapies-for-Substance-Abuse/SMA12-3952
SAMHSA TAP 33: Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment	Systems-level core elements for SBIRT program implementation.	https://www.samhsa.gov/resource/ebp/tap-33-systems-level-implementation-screening-brief-intervention-referral-treatment
National Institute on Alcohol Abuse and Alcoholism – Conduct a Brief Intervention	Step-by-step guide for providers to building motivation and a plan for change.	https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/conduct-brief-intervention-build-motivation-and-plan-change
CRAFFT 2.1 Screening Tool Manual	Manual for health screening using CRAFFT for youth ages 12-21.	https://crafft.org/wp-content/uploads/2018/08/FINAL-CRAFFT-2.1_provider_manual_with-CRAFFTN_2018-04-23.pdf
Adolescent SBIRT Toolkit for Providers – Massachusetts Child	A guide for adolescent SBIRT implementation for alcohol and other drug use.	https://www.mcpap.com/pdf/S2BI%20Toolkit.pdf

Resource	Description	Link
Psychiatry Access Program (MCPAP)		
Best Practices for Prenatal Substance Use Screening – University of Pittsburgh	Presentation by Assistant Professor of Obstetrics, Gynecology, and Reproductive Sciences at the Magee-Women's Research Institute at the University of Pittsburgh	https://www.whamglobal.org/list-documents/50-sud-screening-presentation/file
National Institute on Drug Abuse – Screening and Assessment Tools Chart	A chart to help providers choose evidence-based screening tolls and assessment resource materials based on substance and patient population.	https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

Additional **patient education** materials can be found at www.sbirt.care

Appendix D – References

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