Screening, Brief Intervention, and Referral to Treatment (SBIRT) Manual

A Guide for Healthcare Providers to Effectively Use SBIRT in the Clinical Setting

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

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Why SBIRT?

Introduction: The "WHY"

Why has Med-QUEST created this Statewide Provider Manual on Screening, Brief Intervention, and Referral to Treatment (SBIRT) for you?

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,
- Five (5) percent experienced Alcohol Use Disorder and
- Two (2) percent experienced a substance use disorder (SUD) involving illicit substances.
- Of those with an alcohol or other SUD, 30 percent had Med-QUEST insurance (Figure 1).

Hawai'i's Med-QUEST (MQD) Primary Care Physicians (PCP) and Emergency Department (ED) providers address many patient issues. The problems providers see every day include the use of tobacco, alcohol, and illicit drugs. Addressing these problems is crucial, but they compete with other pressing clinical issues.

Since the pandemic, the use of illicit substances, such as fentanyl and methamphetamines, has grown in Hawai'i and around the country. SUD screening works and is a recognized best practice.

Figure 1. Individuals with SUD and Med-Quest Insurance

Why is screening for SUD so important?

Yes. Screening is a motivator. It helps reinforce concepts like safer or no use, mitigates risky behavior, or encourages seeking specialized care for severe SUD. That's why the US Preventative Services Task Force recommends universal screening for substance use for any person 18 years and older, and the American Academy of Pediatrics recommends universal screening for all adolescents.

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

From asking about bike helmets to sexual activity, healthcare providers routinely screen patients for risky behaviors. **Screening for SUD(s) is just as easy and important.** Patients often don't reflect upon their circumstances or readily offer information about their substance use unless asked by an interested, non-judgmental clinician.

Is screening really the most important motivator for patients?

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

Why SBIRT?
Because it's Evidence-based

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 with a solid evidence base developed over the past two decades. It provides a broad approach to addressing substance use, including early diagnosis and treatment for patients developing a SUD or already having one.

Big Goals!

To encourage early intervention, MQD set a goal of an annual SBIRT **screening for 90 percent** of its beneficiaries 12 years and older presenting for care in a primary care office, clinic, or ED **by 2028**

Performance will be measured by the number of **unique MQD SBIRT claims** compared to the number of beneficiaries 12 years and older.

Hasn't MQD tried to implement SBIRT before?

You may have heard of SBIRT and used it with your patients because MQD and other Hawai'i state agencies have tried to make it a standard of 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 not affiliated with a federally qualified health center (FQHC). Providers were incentivized in a pay-for-performance (P4P) program to screen at least three (3) percent of their maternity patients.

In 2019 the program launched the next iteration in partnership with 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 day-long Motivational Interview training, and in-person SBIRT training, totaling 16 hours of education.

Following the TtT MCOs led in-person training for providers using the SBIRT curriculum. Most recently, the 2022 Substance Use State Plan from ADAD named SBIRT a focus area to "integrate substance use disorder screening in primary care settings and develop referral and entry system into a continuum of care."

So why has SBIRT yet to become a standard clinical practice in Hawai'i?

Med-QUEST heard various reasons from providers about why they do not use SBIRT with every patient, but the overarching theme is "It takes too much time."

We recognize the burden many providers are experiencing since the pandemic; you've probably been busier than ever. Screening for a SUD may feel impossible when there are many problems to address and document.

SBIRT can be administered by other clinical staff and should take little time.

The prescreen takes one (1) to two (2) minutes to complete, and roughly 75 to 85 percent of patients will have a negative prescreen.

For patients who initially screened positive, administering **a full screen takes three (3) to five (5) minutes**.

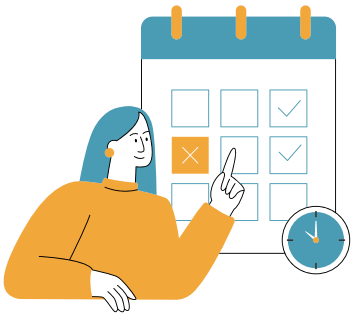
For patients who could benefit from **a brief intervention, it takes five (5) to fifteen (15) minutes**.

"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 provider 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 or resources to train my staff in SBIRT."



The training section in this Statewide Provider Manual will help you find training resources.

Training clinical and non-clinical staff is critical to gaining competency in SBIRT and making SBIRT an integral part of primary care or EDs.

Fortunately, more SBIRT training is free and accessible online and can be self-paced so staff can complete training during lulls in the office or ED.

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

Documentation matters. Suppose SBIRT is separate from the EHR template and is more challenging to document. In that case, providers may be less inclined to use it. We hope SBIRT is of enough clinical value to justify an EHR optimization—primarily if screening identifies growing problems early enough to prevent higher utilization and costs.

In summary, SBIRT is simple, but it requires some know-how. Most of all, screening needs organizational and provider commitment.

In the rest of this manual, we lay out the nuts and bolts of SBIRT, including how to bill for the service, and answer other important questions about SBIRT in practice.

Clinical Directors, Consider This First

Before your primary care or emergency department decides to commit the time and resources to implement SBIRT within the workflow, 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 you refer to are culturally sensitive to patient needs?
- To what degree do you need to address the stigma around SUD, and how will you build empathy?

Regarding workflow:

- How often will you screen, and at what types of visits?
- Who will perform the prescreen & screen?
- How will EHR documentation occur?
- How will you bill for SBIRT?
- Who in your organization needs SBIRT training, 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 for a higher level of SUD treatment?

Everyone Needs 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 in support of SBIRT to change nay-sayers to supporters?

These talking points will help you reassure clinical and non-clinical staff who may be hesitant to screen. They include facts 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 substance use disorder (SUD) do not require referral to a SUD treatment center.

Screening is impactful. It prompts a patient to reflect on their use of substances and the impact of using.

Clinicians must be aware of substance misuse and SUDs because they impact other behavioral and physical health conditions.

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

BI can be helpful for those waiting for admission to SUD treatment centers.

One more thing...

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

Pro Tip

Integrating behavioral health and SUD treatment into the primary care settings is easier with an evidence-based model such as collaborative care.

Training & Workflow

SBIRT Training

MQD is NOT mandating SBIRT training for reimbursement. However, MQD recommends that clinical and non-clinical staff take advantage of free virtual training to support quality and fidelity to the SBIRT model.

MQD recommends two SBIRT trainings developed with funding from SAMHSA:

- **University of Missouri Kansas City** created free online training for medical and behavioral health clinicians that includes 3.5 hours of continuing medical, nursing, and social work education credit. Access the training **HERE**.
- **Pacific Southwest Addiction Technology Transfer Center Network**, created a four-hour, self-paced online course. It provides 4.0 hours of continuing education credits for behavioral health clinicians, including psychologists. Access the training **HERE**.

In addition to these recommended SBIRT training, Table 1 outlines other resources on addiction and early-life trauma. These trauma-informed training programs include best-practice approaches for many SUD patients who have experienced early-life trauma. Increased knowledge of both will help staff better understand the value of SBIRT.

Trauma-informed care approaches patients with sensitivity because we know most patients with SUD have experienced early-life and ongoing trauma. Increased knowledge of both will give staff a better understanding of the importance of SBIRT. Suggested training for staff who want to learn more can be found in Table 1.

Additional Training Resources

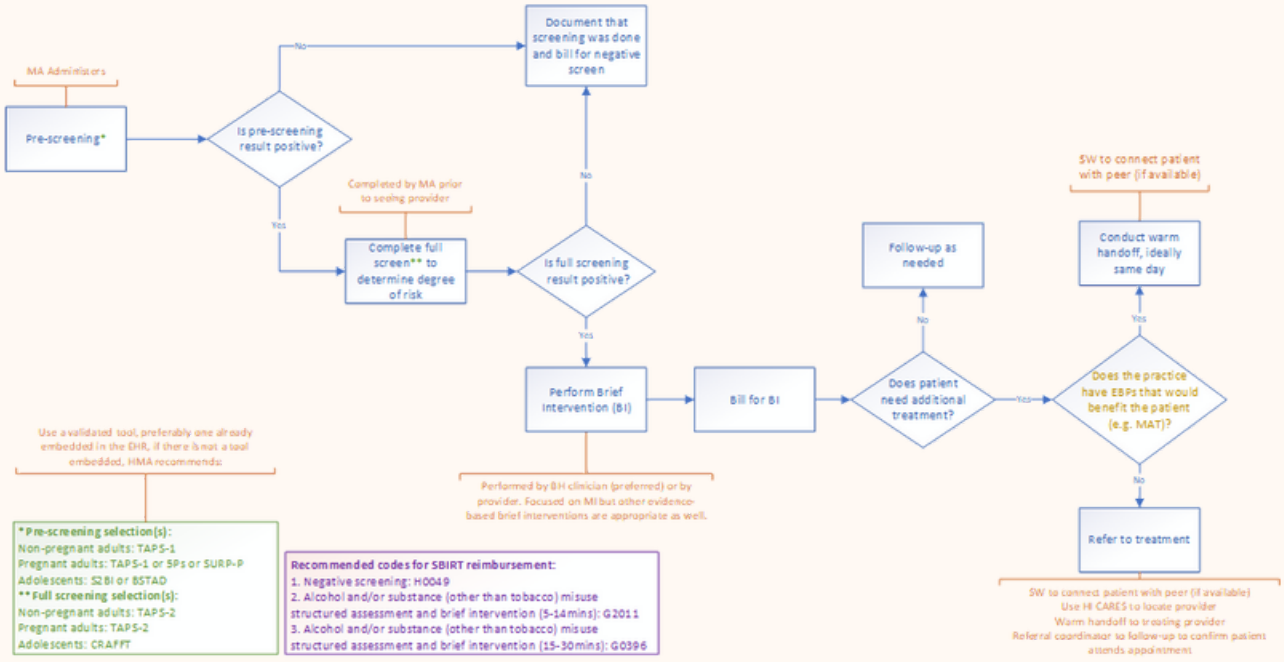
COURSE	DESCRIPTION
Health Knowledge Substance Use Disorder Basics	Courses cover introductory topics in the substance use disorder field
The Science of Addiction Addiction Neuroscience 101	An overview of the neurobiology of addiction.
TED MED – How childhood trauma affects health across a lifetime by 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.

Recommended Workflows

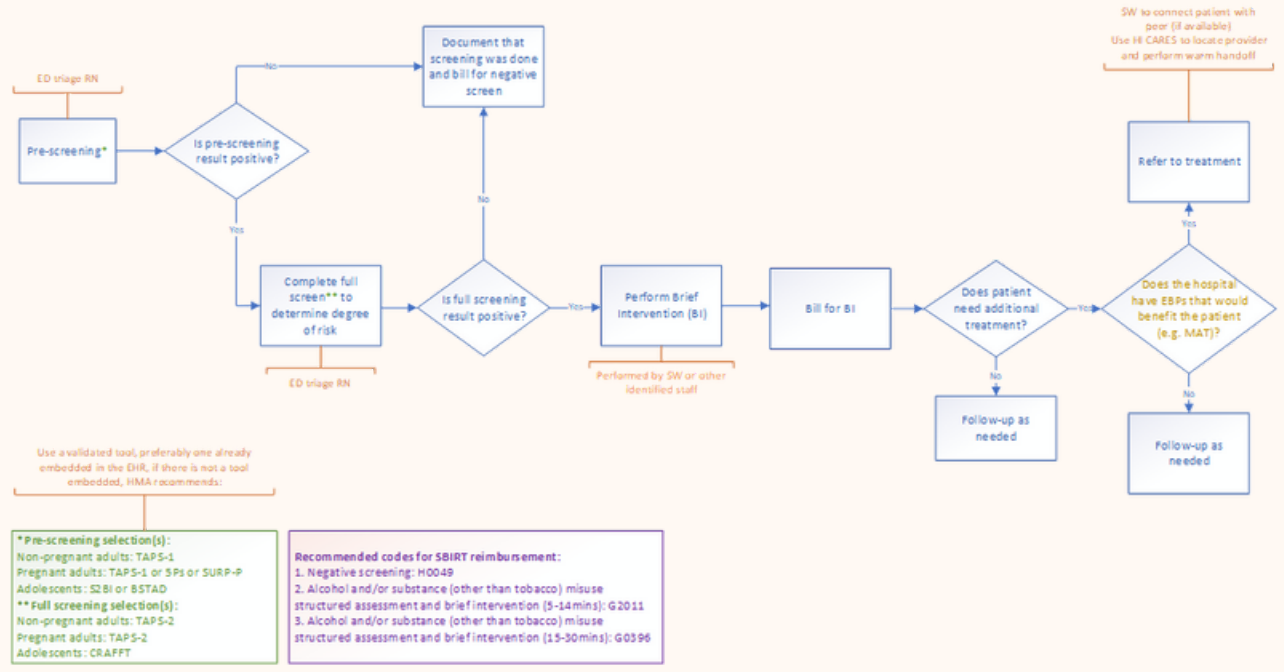
In planning for SBIRT implementation, workflow development is crucial for any primary care office or emergency department. Each facility has its resources and operations, requiring workflow to be customized to be facility-specific.

Following are recommendations for workflows for primary care and emergency department settings. Please note that the primary care workflow can be adapted to other ambulatory practices, and the emergency department workflow can be adapted to other hospital departments. Larger images are located in Appendix D: Handouts and Resources.

Primary Care SBIRT Workflow



Hospitals Emergency Department SBIRT Workflow




Screening
& Referral

Screening Works!

Universal screening is a holistic approach to prevention and treatment that can reinforce healthy behaviors and behaviors that lead to health. For example, screening for SUD can lead a patient to:

- Engaging in interventions before dependence.
- Safe use of substances (harm reduction) and abstinence.
- Better decision-making, such as not driving under the influence.
- Mitigating health problems that arise from complications related to substance misuse and abuse

Adopting SBIRT is easier for staff when they understand that screening for all substances positively impacts patients' health. They are also more likely to incorporate SBIRT when combined with other screening questions patients typically expect to be screened for, like tobacco use, alcohol use, and illicit and prescription drug misuse.

Introduction to Screening

How screening is introduced and discussed is critical for the patient's comfort. Your tone and body language influence a patient's openness to answering questions honestly, which impacts your ability to determine the severity of risky behavior. Figure 2 is an example introduction you can customize based on the setting and patient.

Hi, I'm _____. Nice to meet you. If it's okay with you, I'd like to ask you a few questions to 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 not prescribed.

I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you. Everything we talk about is confidential.

Figure 2. SBIRT Script for staff and clinicians.

Approach and Validated Tools

Once you introduce screening to the patient, prescreening can be performed. Prescreenings are brief screens with 2 – 4 questions identifying individuals with risky substance use. Validated prescreening tools are highly sensitive, so you can quickly rule out risky behavior for those who screen negative.

However, prescreening tools are less specific, so those who screen positive will require a full screening to determine where they are on the spectrum of substance use—from risky behavior to severe use to dependence.

Patients with no or low risk benefit from positive reinforcement of their behavior and primary prevention services.

Patients with moderate risk are referred for brief intervention.

Patients with high-risk benefit from brief treatment, medication-assisted treatment, or referral to a more appropriate level of care.

Using validated tools for the prescreen and the full screen is important because they have been well-researched and shown to capture an individual's risk accurately.

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

Organizations should determine which validated screening tools are already embedded in their electronic health records (EHR) to facilitate SBIRT implementation and data tracking. Suppose the EHR does not have SUD screening tools already embedded. In that case, we recommend those listed in Table 2 because they are concise and screen for alcohol, illicit and prescription drugs, and in some cases, tobacco.

Note: The TAPS-1 screening tool in Table 2 asks about the number of drinks but does not specify the volume of alcohol considered to be one drink.[10]

Please see Appendix D: Handouts and Resources for the CDC's recommendation for standard drink size.

Table 2. MQD recommended Prescreen Tools for SUD

Name	Population	Description
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.
5Ps (Parents, Peers, Partner, Pregnancy, and Past)	Pregnant people	Five-item screen for alcohol and drug use. Integrated version (PDF): An integrated version also screens for tobacco use, depression, and violence.
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.

Table 3. Recommended Full Screen Tools for SUD

Name	Population	Description
TAPS – 2 (Tobacco, Alcohol, Prescription medication, and other Substance use)	Adults, including pregnant people	Full screen PDF 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.
CRAFFT 2.1 (Car, Relax, Alone, Forget, Friends, Trouble)	Ages 12-26, including pregnant people	Full screen PDF 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]

Brief Interventions (BI)

Brief Intervention (BI) is an effective tool to help patients identified as having moderate to risky substance use during screening. It's a way to provide guidance and education to increase the patient's insight and awareness about risky substance use. The ultimate goal of BI is to motivate a person toward behavioral change.

BI can be a short, 5-minute conversation addressing screening results or a focused intervention using motivational interviewing techniques to elicit considerations for change. BI can happen over multiple visits. During each visit, the screener can take a few minutes to address risky substance use and help the patient identify reasons for change using motivational interviewing techniques. BI is an efficient way to help motivate patients to change their behavior. When delivered correctly, interventions focus on increasing a person's insight about substance use and behavior change.

Motivational Interviewing (MI)

Motivational interviewing (MI) skills are essential to brief intervention. MI is a collaborative conversation style to strengthen a person's motivation and then tapping into that motivation to support change.

The acronym **OARS** can help you remember the MI technique:

- **O**PEN-ENDED QUESTIONS: Patients don't need to worry about providing the wrong answer. Open-ended questions are an invitation to open up.
- **A**FFIRMATIONS: Everyone needs validation. Even with small wins, demonstrating that you are happy for your patient's success helps keep them motivated and moving forward.
- **R**EFLECTIVE LISTENING: Patients often have their answers, and providers should support finding them with guidance and support.
- **S**UMMARIZE: Capture the main actionable steps and ask the patient to correct or affirm them. Based on the response, 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 of substance use disorder and will likely meet diagnostic criteria for moderate to severe SUD. Of those screened, about five (5) percent are likely to need a referral to assess level of care and treatment.

MI 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 only open to considering outpatient care, make the referral for outpatient SUD treatment.

Referral to treatment best practices:

- **Remove barriers by referring** your patient to services available in their community to make connecting to treatment as easy as possible.
- **Develop a referral network** with behavioral health providers that includes memorandums of understanding (MOUs), care coordination, and a process for closing the referral loop.
- **Have a referral process** with the your network. All staff must know the process to assure the referral for your patient is made before they leave. *Do not give the patient a list of places to call* when they leave the appointment or are discharged from the ED.
- Refer to an ADAD-contracted treatment provider. That list can be found **HERE**.
- 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. Support Groups

Name	Island	Phone	Website
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


Coding &
Billing

Coding and 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 the 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 the modifier 25 to signify a "significant, separately identifiable" additional service was provided in addition to the primary billing code for the visit.

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.

Table 5. Services and Billing Codes

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

ICD-10 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. Two ICD-10 codes (Table 6) are recommended for when screening for substance use. If a diagnosis of a substance use disorder is ultimately made, that specific SUD diagnosis should also be added to the patient's chart.

Eligible Providers

A range of licensed clinical professionals can bill for providing SBIRT services to patients, which is determined by payer (Medicare, Medicaid, or commercial). Non-licensed clinical staff who can provide SBIRT services are known as delegates.

Delegates must be appropriately trained to provide the SBIRT service and act under the direct supervision of a licensed healthcare professional (Table 7). Delegates may bill for providing SBIRT services under the NPI number of the licensed professional. Delegates providers include:

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

Table 6. ICD-10 Codes

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

Table 7. Eligible Providers

Licensed Providers Eligible for Medicaid Reimbursement
Physicians
Physician Assistants
Nurse Practitioners
Licensed Clinical Psychologists
Licensed Clinical (Master) Social Workers
Licensed Professional Counselors
Licensed Marriage and Family Therapists
Certified Nurse Midwife

Appendix

Hawai'i Department of Human Services
Med-Quest Division
2023

Appendix A: Frequently Asked Questions (FAQs)

Frequently Asked Questions

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. 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-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.

Appendix B: Definitions

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.

Definitions

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: References

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[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
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[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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Appendix D: Handouts & Resources

Resources

Conducting SBIRT Virtually – Prevention Technology Transfer Center (PTTC) Network. An Infographic for conducting SBIRT virtually, developed by Mountain Plains PTTC.

Massachusetts SBIRT Toolkit. Provides a step-by-step guide for implementing SBIRT at the provider level.

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.

SAMHSA TAP 33: Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment. Systems-level core elements for SBIRT program implementation.

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.

CRAFFT 2.1 Screening Tool Manual. Manual for health screening using CRAFFT for youth ages 12-21.

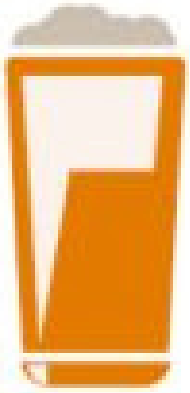
Adolescent SBIRT Toolkit for Providers – Massachusetts Child Psychiatry Access Program (MCPAP). A guide for adolescent SBIRT implementation for alcohol and other drug use.

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

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.

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

US Standard Drink Sizes



12 ounces
5% ABV beer

8 ounces
7% ABV malt liquor

5 ounces
12% ABV wine

1.5 ounces
40% (80 proof)
ABV distilled spirits
(gin, rum, vodka,
whiskey, etc.)

ABV = Alcohol by Volume

https://www.cdc.gov/alcohol/fact-sheets/moderate-drinking.htm

The Three Parts of Brief Intervention[12] [13]

Part 1. Understanding the patient's view of their substance use.

HOW does the person think 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?"

Ask the patient to develop a pro and con list.

Part 2. Giving the patient information and feedback.

Ask for permission to give feedback.

"Is it okay if I provide some feedback about your alcohol use?"

Provide information and education about the health risks

Part 3. Giving the patient advice and negotiating a plan for change.

When you receive permission, provide clear advice to the patient to change.

"What do you think about reducing your alcohol use? What would that look like to you?"

Goals should be patient-generated.

Figure 2. SBIRT Script for staff and clinicians.

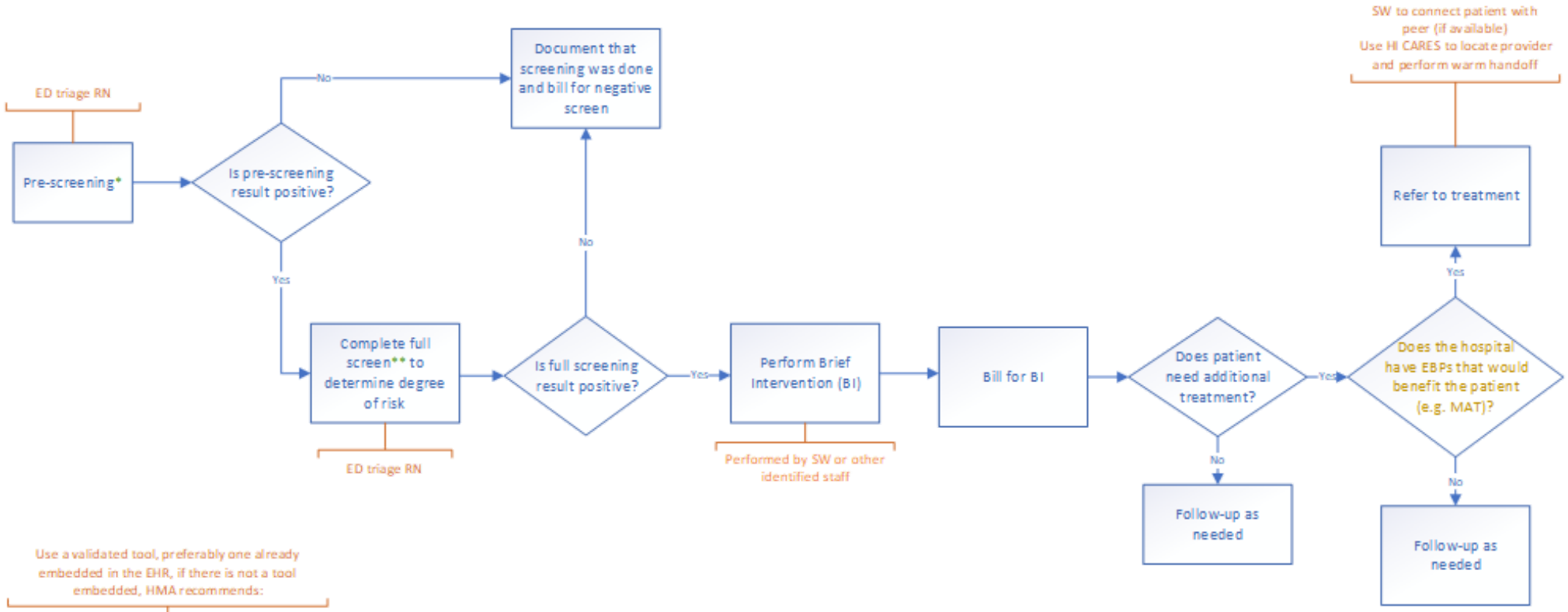
Hi, I'm _____. Nice to meet you. If it's okay with you, I'd like to ask you a few questions to help me give you better medical care.

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 not prescribed.

I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you. Everything we talk about is confidential.

Hospitals Emergency Department SBIRT Workflow



Use a validated tool, preferably one already embedded in the EHR, if there is not a tool embedded, HMA recommends:

*** Pre-screening selection(s):**
Non-pregnant adults: TAPS-1
Pregnant adults: TAPS-1 or 5Ps or SURP-P
Adolescents: S2BI or BSTAD
**** Full screening selection(s):**
Non-pregnant adults: TAPS-2
Pregnant adults: TAPS-2
Adolescents: CRAFFT

Recommended codes for SBIRT reimbursement:
1. Negative screening: H0049
2. Alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention (5-14mins): G2011
3. Alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention (15-30mins): G0396

Primary Care SBIRT Workflow