

SBIRTCOLORADO

Evidence-based approach FOR BETTER HEALTH.

SBIRT COLORADO MID-PROJECT REPORT EXECUTIVE SUMMARY DRAFT

PREPARED BY OMNI INSTITUTE

Screening Brief Intervention and Referral to Treatment (SBIRT) is a public health approach to preventing risky substance use behavior. SBIRT Colorado is a statewide initiative of the Office of the Governor and is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The program is co-administered by the Colorado Department of Human Services Division of Behavioral Health and the Colorado Department of Public Health and Environment/Prevention Services Division/Interagency Prevention Systems Program and managed by Peer Assistance Services, Inc.

The overall goal of SBIRT Colorado is to improve the lives and health of people by providing early substance use screening and intervention. Patients are assessed for levels of substance use risk behaviors using standardized screening tools. Patients showing risky substance use behaviors are provided a brief intervention, a short conversation incorporating feedback and advice, by a healthcare professional. Patients who screen in need of additional services are also provided a referral to brief therapy or additional treatment.

SBIRT Colorado services are currently being implemented across Colorado using multiple models. First, SBIRT Colorado sites use health educators to deliver services and collect data according to SAMHSA funding requirements. Findings presented herein are primarily from data collected from SBIRT Colorado sites. Second, with support from SBIRT Colorado, the Colorado Clinical Guidelines Collaborative (CCGC) developed the SBIRT Clinical Guideline and the Clinical Preventive Services Recommendations Guideline. CCGC works to disseminate and implement the two guidelines in primary care settings across the state. Finally, SBIRT Colorado collaborates with the Colorado Department of Public Health and Environment (CDPHE), utilizing Ryan White Part B funding, to expand SBIRT to clinics and AIDS Service Organizations that service people living with HIV.



tel 303.369.0039 x245
toll-free 1.866.369.0039 x245

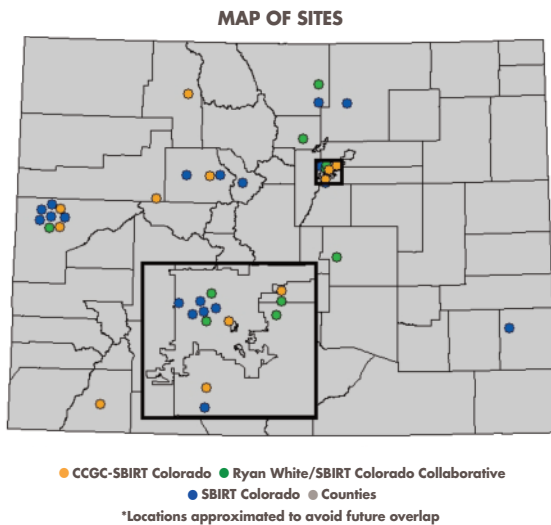
www.improvinghealthcolorado.org

Improving health. Changing lives.

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SBIRT Colorado began screening patients in April 2007. In the first two years of implementation, patients were screened in 18 SBIRT Colorado sites located throughout the Denver metropolitan area, along the I-70 mountain corridor, and in and around Grand Junction. At intake, data were collected on patients' demographics and substance use behaviors, and other indicators depending upon the level of patients' risky substance use behaviors. A random subsample of patients who showed risky use was targeted to participate in a follow-up study. Patients were contacted about six months after receiving services and asked additional questions about their substance use and their experience with the SBIRT Colorado. Using data collected at intake and follow-up, the goal of this mid-project report is to address the following evaluation questions for the period April 2007 through April 2009:

- 1) Who was served by the SBIRT Colorado program?
- 2) What were the patterns of substance use risk among those served by SBIRT Colorado?
- 3) What is the evidence of SBIRT Colorado's impact on patients to date?



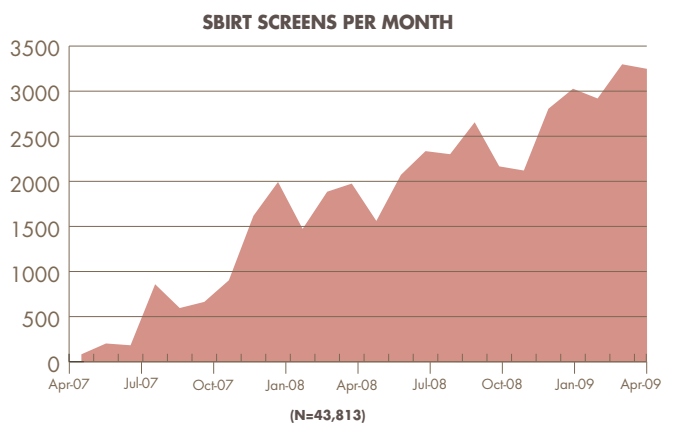
RESULTS

WHO WAS SERVED BY THE SBIRT COLORADO PROGRAM?

As of April 30, 2009, SBIRT Colorado screened 43,813 patients for risky alcohol and other substance use. The number of patient screens performed each month has steadily climbed since the start of the program. Over 3,000 screens were performed each of the last six months of 2009.

Summary of findings

- A roughly equal number of patients were screened in hospital and clinic settings.
- A much higher proportion of screens were in urban (85%) than in rural (15%) locations.
- A higher proportion of female patients (56%) were screened than male (44%) patients.
- Patient age ranged from 18 to 85 with a mean age of 41 and a median age of 39.
- Patients in hospital settings were on average nine (± 0.2) years older than patients in clinic settings; patients in urban locations were slightly older (2 ± 0.2 years) than patients in rural locations.
- The three most common race/ethnic groups identified by patients screened were White (59%), Hispanic (33%), and Black (12%).
- It was more likely for screened patients to identify as Black in urban than rural locations.
- It was more likely for screened patients to identify as Hispanic in clinic than hospital settings.



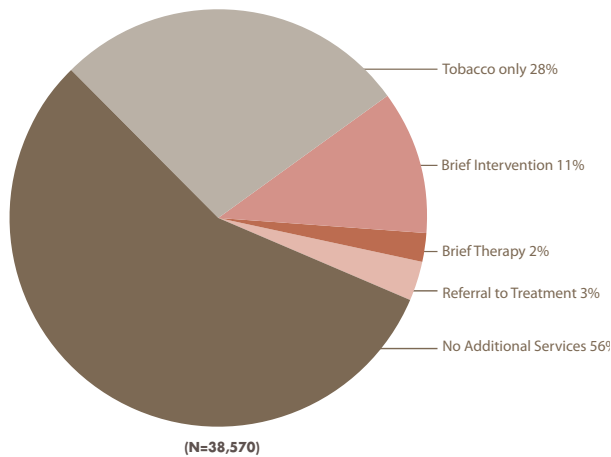
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WHAT WERE THE PATTERNS OF SUBSTANCE USE RISK AMONG THOSE SERVED BY SBIRT COLORADO?

Screening in SBIRT Colorado sites begins with administering the brief screen to each patient. Patients who screen positive on the brief screen for possible risky substance use are then administered further screening/assessment using the ASSIST and a service delivery plan is generated based on ASSIST scores. According to screening guidelines, there are four categories of overall risk patterns for alcohol or illicit substance use: low or no risk, moderate risk, moderate-high risk, and high risk. Patients who screened negative on the brief screen or low or no risk on the ASSIST are classified as needing no additional services. Patients who screened at moderate risk or higher on the ASSIST were identified as needing a brief intervention (BI). Patients who screened at moderate-high risk were also identified as needing a referral for brief therapy (BT) and patients who screened at high risk were identified as needing a referral to more intensive treatment (RT). Note that ASSIST data were available for 38,570 patients and were missing for 5,243 (14% of the overall sample). Missing ASSIST data were from the early period of the grant before the on-line data collection system was implemented.

RISK CLASSIFICATION ACROSS ALL SUBSTANCES



Summary of findings

Overview of risk

- About 16% of all patients screened were identified as engaging in risky alcohol or illicit substance use.
- Male patients were more than twice as likely to screen at-risk than female patients.
- Hispanic patients were less likely than non-Hispanic patients to screen at-risk. Hispanic females were the least likely race/ethnicity and gender group to screen at-risk.
- Patients were more likely to screen at-risk for tobacco than any other substance. About 38% of all patients screened at-risk for tobacco and 27% of all patients screened at-risk for tobacco only and no other substances.
- Following tobacco, patients screened at-risk for alcohol and cannabis (9% and 8% of all patients, respectively) more than three times more frequently than the next highest substance, cocaine (2%).
- Overall, less than a third of at-risk patients were in need of additional services. Need varied by substance: patients at-risk for cannabis showed the lowest rates (7%) of needing additional services, compared to more than half of all patients at-risk for opioids.

Binge drinking

- About 68% of at-risk patients who used alcohol one or more days in the 30 days prior to screening reported binge drinking (having five or more drinks in a single sitting to intoxication) one day or more in the 30 days prior to screening.
- At-risk female patients were more likely than at-risk male patients to report zero days of binge drinking.
- Binge drinking varied considerably with respect to age. Patients aged 18 to 24 were the most likely age group to binge drink on one to five days in the 30 days prior to screening. Patients aged 45 to 54 were the most likely age group to binge drink on 26 to 30 days in the 30 days prior to screening.

Poly-substance use

- Most patients (78%) at-risk for alcohol or illicit substances were at-risk for only one substance (excluding tobacco).
- Of those at-risk for two substances, the majority (53%) were at risk for both alcohol and cannabis.

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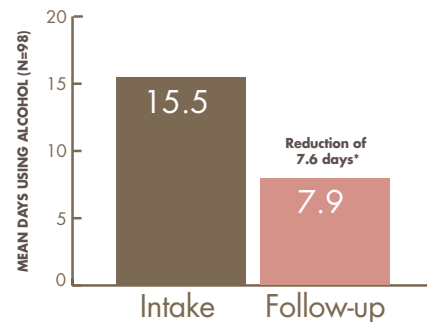
WHAT IS THE EVIDENCE OF PROGRAM IMPACT ON PATIENTS TO DATE?

A total of 193 patients who showed risky alcohol or illicit substance use at intake completed follow-up interviews between five and eight months after their intake interview. Use was measured as the number of days using alcohol or illicit substances in the 30 days prior to intake or follow-up.

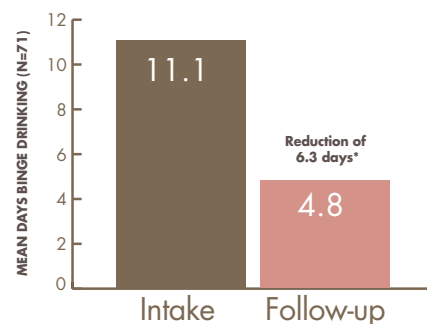
Summary of findings

- At the follow-up interview, more than 90% of patients reported that they remembered their health educator and described him or her as both very respectful and very friendly.
- Most follow-up patients also reported that the health educators were 'very helpful' and that the screening 'made them think'.
- The following figures show the results of analyses examining reduction in four risky substance use behaviors: days of alcohol use, binge drinking, illicit substance use, and cannabis use.
- When sample sizes permitted, analyses were also conducted to examine reductions in use for various subgroups:
- Patients experienced a significant reduction in use for each substance analyzed across site setting and location, and as a function of patient demographics.
- Patients with moderately risky substance use (i.e., in need of a brief intervention) and patients with higher levels of risk (i.e., in need of a referral for brief therapy or treatment) also showed declines in patterns of risky substance use.

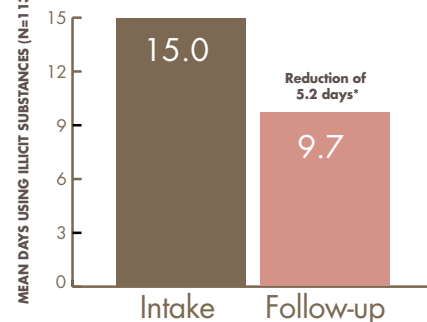
MEAN DAYS USING ALCOHOL AT INTAKE AND FOLLOW UP



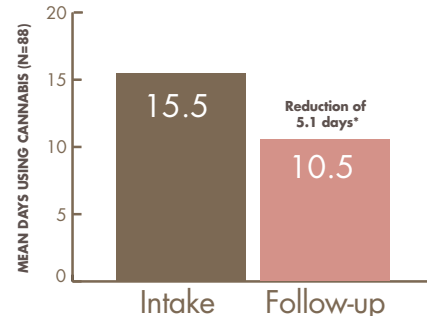
MEAN DAYS BINGE DRINKING AT INTAKE AND FOLLOW UP



MEAN DAYS USING ILLICIT SUBSTANCES AT INTAKE AND FOLLOW UP



MEAN DAYS USING CANNABIS AT INTAKE AND FOLLOW UP



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MEAN DAYS OF USE OR ACTIVITY AT INTAKE AND FOLLOW-UP DATA LIMITATIONS

Limitations to the evaluation design need to be considered when interpreting the results presented.

- Data were not collected from a comparison group of patients who needed, but did not receive, SBIRT services. Thus, it is not possible to ascertain whether similar changes in substance use behavior would have occurred even if SBIRT services were not provided.
- It is possible that individuals who have reduced their risky alcohol or illicit substance use were more likely to complete follow-up interviews than individuals who continued to use alcohol and illicit substances at risky levels—results may be biased due to over-representation of individuals who reduced their use in the follow-up sample.
- Sample sizes in the follow-up study were relatively small at the time of this report. All findings should be considered preliminary.
- Patient age was not considered when assigning a service delivery plan based on ASSIST scoring. For example, patients aged 18-21 did not have different risk criteria for alcohol than patients over 21, even though alcohol use is illegal for that age group.

DISCUSSION

The goal of this mid-project report is to provide stakeholders of SBIRT Colorado with information about individuals screened, patterns of risky substance use among those screened, and preliminary outcome findings on the impact of SBIRT services on individuals who were contacted six months after receiving a screening and intervention. It is important to stress that of the total number of individuals screened for risky substance use (38,570), only 11% screened in need of an intervention (excluding tobacco) and only 5% were in need of a referral to brief therapy or to treatment. The findings summarized above and presented with more detail in the full mid-project report (www.improvinghealthcolorado.org/about_newsletter.php) are in line with findings of a multi-state SBIRT study that screened 459,599 patients in general hospital and medical settings. In the multi-state study, 23% of patients screened at-risk (compared to 16% in Colorado). Of these, 16% used alcohol or drugs above safe limits (compared to 11% in Colorado), an additional 3% were very heavy users and only 4% had an addictive use pattern (compared to 2% and 3% in Colorado, respectively) (Madras, Compton, Avula, Stegbauer, Stein, & Clark, 2008; National Drug Control Strategy, 2009 Annual Report).

Data in the SBIRT Colorado Mid-Project Report are based on a health educator service delivery model of SBIRT in which health educators administered the ASSIST, brief interventions, and provided referrals to additional services. Health educators for SBIRT Colorado are not required to have clinical or master's level degrees and most have a bachelor-level education. When possible, analyses were conducted separately as related to site setting (screenings conducted in hospitals or clinics), site location (screenings conducted in urban or rural counties), and patient demographic characteristics (gender, age, and ethnicity). This strategy was employed to assess whether there were differences in screening patterns, substance use behaviors, or program impacts due to these factors. Although patterns in the data sometimes differed as a function of patient and site characteristics, decreases in risky substance use behaviors were observed for most groups and for most substances. Despite limitations to the evaluation design, these preliminary findings provide support for the positive impact of SBIRT on reducing patients' risky substance use behaviors.

Among the most important factors for sustainability of SBIRT as a standard of care is to help practices train clinical support staff on brief intervention techniques, and to help practices integrate alcohol, tobacco, and other substance screening and interventions as part of overall prevention services. Some of the tools that support integrated prevention services consist of intake forms that include brief screening on substances and depression, standing orders/standing protocols to promote service delivery by medical assistants and nurses for efficiency, and electronic registries and electronic medical record templates that guide integrated prevention services carried out by an entire practice team.

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The mid-project results of SBIRT Colorado are encouraging. Across the nation, substance use screening in healthcare settings is gaining broader acceptance as an effective approach for mitigating the health and social impact of substance use and abuse on individuals, the healthcare system, and communities. New requirements are being put in place by the American College of Surgeons' Committee on Trauma (ACS-COT) to address the need for substance use screening and brief intervention. The ACS-COT requires that Level I and Level II trauma centers have a mechanism to identify problem drinkers and, in addition, requires Level I trauma centers to have the capability to provide brief interventions for patients that screen at-risk. There are four Level I trauma centers and four Level II trauma centers currently in Colorado.

The efficacy of SBIRT is also recognized by The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which accredits over 17,000 healthcare organizations and programs in the United States, hospitals in particular. A majority of state governments recognize Joint Commission accreditation as a condition of licensure and receiving Medicaid reimbursement. The Joint Commission is currently piloting measures for assessing and treating tobacco, alcohol, and other drug use and dependence for all hospitalized patients.

In 2008, 58% of 150 health plans responding to an annual survey indicated they would pay for substance use screening and brief intervention services as defined by the medical billing codes approved by the American Medical Association and the Centers for Medicare and Medicaid Services. In the State of Colorado, the passage of House Bill 09-1204 mandates that health plans operating in the state must provide health insurance coverage for alcohol and tobacco misuse screening and intervention as a preventative service beginning January 1, 2010.

A new report published by National Center on Addiction and Substance Abuse at Columbia University (CASA-Columbia) titled, *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets* (May 2009), identifies the total amount spent by federal, state and local governments on substance abuse and addiction—the first time such an analysis has ever been undertaken. In the state of Colorado in 2005, for every dollar spent on substance abuse and addiction, 97 cents went to shoveling up the wreckage and only three cents were spent on prevention, treatment, and regulation/compliance.

In that same year, 15% of Colorado's state budget was spent on paying for the burden of substance abuse and addiction, representing \$1.616 billion. This included spending in justice, education, health, child/family assistance, mental health/developmental disabilities, public safety and state workforce.

The *Shoveling Up II* report emphasizes that intervening early is essential to prevent addiction and its consequences and that substance use screenings and brief interventions have proven efficacy. Because the costs of untreated addiction are so high and the human consequences so great, CASA Columbia recommends that every person entering a government funded health service, criminal justice or social welfare setting should be screened for substance use disorders and offered effective interventions and treatment where indicated.

Physicians and other healthcare professionals are often in the best position to address substance misuse in patients. By spotting substance misuse early, risky use of substances can be prevented from progressing to addiction, reducing healthcare costs and potentially saving millions of dollars in other social areas.

REFERENCE LIST

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tel 303.369.0039 x245
toll-free 1.866.369.0039 x245
www.improvinghealthcolorado.org

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