

More patients or more competition?

A physician believes widespread substance use screening in primary care will boost specialty treatment

BY LARRY M. GENTILELLO, MD, FACS

It wasn't too long ago that addiction treatment specialists were the only source of professional help to those suffering from problems with alcohol and drugs. But in recent years, screening, brief intervention and referral to treatment (SBIRT) of patients with potential alcohol- and drug-related problems has increasingly become a part of mainstream medicine.

First introduced in the late 1990s, SBIRT addresses the entire spectrum of substance use disorders, from early symptoms that are identified and addressed before the patient has exhibited signs of addiction to addicted patients who need long-term chronic treatment. The approach is evidence-based, and has demonstrated a small but proven impact on daily and weekly alcohol consumption, DUI arrests, injuries, car crashes and other complications associated with alcohol and drug misuse.

Now, physicians and healthcare providers of all stripes (those in trauma centers, emergency departments, primary care and college campus health clinics, general surgical and medical wards, and employee assistance programs) increasingly are using formal screening methods to detect the potential harmful use of alcohol, prescription drugs, or illicit drugs. And physicians and other hospital and clinic staff are also counseling patients who screen positive for substance use and are referring some on for treatment by addiction specialists.

There is a great deal of other evidence that the momentum for the SBIRT approach continues to grow:



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- A new medical specialty board, the American Board of Addiction Medicine, was established in 2007 and already has certified nearly 3,000 physicians from various disciplines as specialists in addiction medicine.
- Medicare, and in some states Medicaid, is reimbursing clinicians for these services. New CPT codes

for reimbursing brief intervention activities were adopted. Effective in January 2007, the Centers for Medicare & Medicaid Services (CMS) allowed reimbursement for alcohol- and drug-related screening and brief interventions.

- Barriers to SBIRT are falling. For instance, many states have

repealed insurance laws that discourage blood alcohol test screening in emergency departments. A widely adopted state insurance law recommended in 1947 by the National Association of Insurance Commissioners (NAIC) allowed health insurance companies to deny payment to physicians and healthcare providers for medical care to persons injured as a result of being under the influence of alcohol or a non-prescribed narcotic. As a result of these laws, one in four trauma surgeons were experiencing denials of reimbursement and only half of trauma surgeons surveyed were screening patients for blood alcohol content. Fortunately, progress has been made in repealing these laws. In 2001, the NAIC unanimously recommended that states repeal the laws, and since then 14 states and the District of Columbia have done so.

The leading question now for “traditional” addiction treatment professionals is how much this trend will affect public health and their livelihoods. Will there be fewer referrals to addiction treatment specialists? Will these specialty providers have to compete with doctors for patients? Or will they receive more referrals and develop closer ties and stronger relationships with physicians?

Those are legitimate questions, but first it might be helpful to place this trend into some historical perspective.

What’s behind the SBIRT trend?

The mainstreaming of SBIRT reflects a growing acknowledgement that alcohol and drug use can endanger the health of people who do not have, by definition, an addiction.

Although alcohol and other drugs cause or complicate the treatment of at least 70 medical conditions for which patients frequently seek care, medical schools and residency training programs traditionally have provided very little practical training for doctors on how to screen for substance use and intervene when necessary.

As a result, in any given year, 22 million Americans are in need of substance use treatment, yet only two million patients each year receive it. Why is that? The

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main reason is 94 percent of patients simply don't know they need treatment. Four percent know they need treatment but don't want it, and two percent know they need help and are actively seeking it or wanting to engage in it.

When it comes to addressing alcohol or drug use problems, one of the most important developments in the past 20 years has been the recognition that only a relatively small fraction of the patients who use alcohol or drugs in quantities that can damage their health meet the criteria for having alcohol dependence syndrome or alcoholism, or are drug addicts.

This was shown by the largest study on SBIRT, a 2009 analysis that screened 459,599 patients in general medical settings (including emergency departments, family practice clinics, trauma centers and general medical surgical wards).

The study found that 22.7 percent of patients had a positive screen for some type of alcohol or drug problem. The two most commonly identified problems were binge drinking (getting drunk to the point of intoxication) and regular use of alcohol in amounts that might not lead to intoxication, but that over time can cause chronic health problems. These two types of drinking patterns were found in 15.9 percent of patients. However, the severity of the problem was at a level that most patients were judged to need only one skillfully delivered counseling session.

The study found that an additional 3.2 percent of patients had problems that were more advanced but still did not meet the definition of addiction or dependence. However, it was felt that these individuals would benefit from more than one counseling session, and should be seen at least two or three more times. The patient's primary physician, regardless of specialty, can provide these sessions if he/she receives the proper training.

The SBIRT trial found that only 3.7 percent of patients who present for general medical care—about one in six of those who screened positive—met the definition of addiction, or suffered from the alcohol dependence syndrome. These patients need to be referred to an outpatient or inpatient center for treatment by an addiction treatment specialist or someone with similar professional credentials.

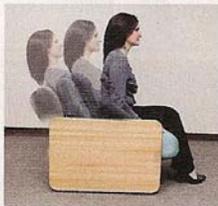
Proven value in trauma

What addiction professionals have learned is that "the setting" often plays an important role in the effectiveness of the screening and brief intervention. SBIRT has proven to be especially valuable in trauma centers, because nearly 50 percent of the time, alcohol or drugs played a key role in the event that led to the patient's injuries.

SBIRT appears to be particularly effective in trauma centers.

One study showed that a year after a trauma center intervention, patients reduced their alcohol consumption by an average of nearly 22 drinks per week (a control group that did not have an intervention reduced their drinking by only six drinks per week).¹ Over the following year

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More patients who require the services of addiction treatment professionals will be identified, and referred.

there was a 48 percent reduction in return visits to an ER for treatment of another major or minor injury. There was still a benefit three years later, as the intervention group had a 47 percent reduction in injuries that were serious enough to require readmission to the hospital.¹

Another study showed that by reducing the risk of reinjury, each time it provides an intervention it saves \$330 in healthcare costs over the next three years. The return on investment was \$3.81 saved for every \$1 spent on screening and intervention.²

The role that SBIRT could play in transforming healthcare was underscored when the American College of Surgeons Committee on Trauma (COT), the primary organization responsible for developing trauma center requirements, added a new

criterion for Level 1 trauma center verification. Starting in the spring of 2007 the COT required all Level 1 trauma centers to have a mechanism to screen for substance use problems for all patients who sustained injuries serious enough to require admission to the trauma center. And all Level 1 trauma centers had to have a mechanism in place to provide an intervention to those who screened positive.

The American College of Surgeons was the first professional medical society that had regulatory authority to pass a requirement that patients receive treatment for a substance use problem. For that matter, it became the first medical society that mandated any type of mental health benefit for patients receiving medical care.³

Prior to this mandate, screening for alcohol problems in trauma centers was far from routine.⁴ A 1999 study based on a random sampling of 241 members of the American Association for the Surgery of Trauma reported that more than half of trauma surgeons screened fewer than one in four of their patients.⁵

Given the rarity of screening, and lack of interventions and referrals prior to the new COT ruling, it is anticipated that the currently required use of SBIRT in trauma centers will increase the number of patients screened. More patients who require the services of addiction treatment professionals will be identified, and referred. However, the big payoff will come when the practice of screening and interventions spreads from trauma centers, and begins to involve hospital settings in general.

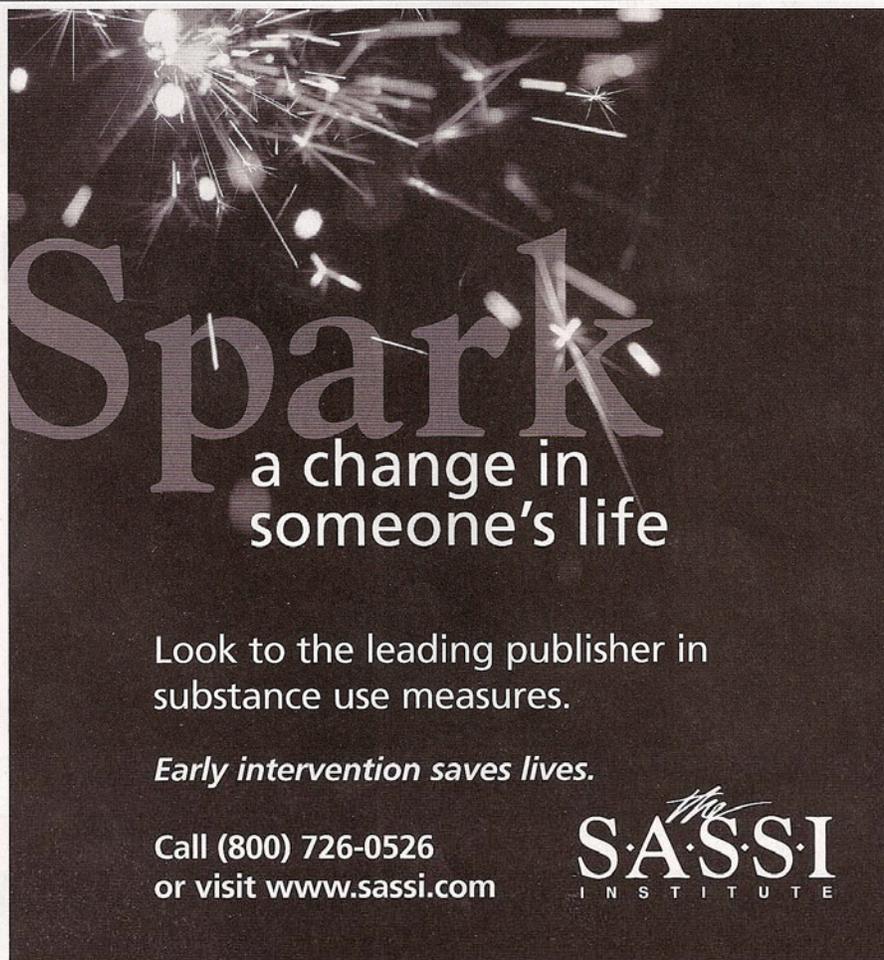
The trauma center mandate for use of screening and brief intervention has ignited the fuse that we hope will eventually lead to the spread of screening, intervention and referral to specialty care for those who need it, to many other types of general medical practices.

What it means for the addiction professional

Now that SBIRT has been adopted in trauma centers, it is hoped that screening, intervention and referral will become standard medical care. Studies have shown that SBIRT is one of the most beneficial and cost-effective preventive healthcare measures available (more than screening for cholesterol, cervical cancer, diabetes and depression—preventive measures that already *are* standard medical practices in many settings).

There are reasons to believe that the trend to adopt SBIRT will accelerate. More and more doctors are becoming board-certified in addiction medicine; hospitals are increasingly developing expertise in performing SBIRT; and young, new physicians are beginning to accept that addressing substance use problems is a part of their core responsibilities.

There has never been a better opportunity to break down the barriers between mainstream medicine and substance use treatment, and to make sure patients with problematic alcohol or drug use are identified and get the help they need. After all, healthcare reform will now require most Americans to have health insurance coverage, and the new federal Mental Health Parity and Addiction Equity Act will increase accessibility to insurance coverage for treatment of addiction and mental health problems.



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The bottom line is that SBIRT is a welcome addition in the fight against dangerous use of alcohol and other drugs. It has the potential to alert an increasing portion of the more than 20 million people who may have a potential problem and need to seek help. And while patients with mild problems will receive counseling from their doctor, those with complicated or severe problems will be referred to addiction treatment specialists.

As screening becomes routine in general medical care, physicians who identify patients in need of more than brief intervention or counseling will have to have arrangements with addiction treatment specialists who possess the skills and who work at facilities that can provide the more extensive treatment and ongoing care that these patients require.

As adoption of SBIRT into medical care increases, early identification and intervention might result in fewer patients developing the need to be seen by an addiction treatment professional. On the other hand, 90 percent of patients who require help don't even know it. The adoption of SBIRT in healthcare settings will identify these patients and result in *more*, not fewer, patients being referred for the type of addiction treatment that most general medical doctors cannot provide. Society will need *more* addiction professionals, not fewer. Ultimately, that's good not only for patients, but also for society at large—and for those who treat them. ■

Larry M. Gentilello, MD, FACS, is a Professor of Surgery at the University of Texas, and Adjunct Professor in Management, Policy, and Community Health. He is a director of the American Board of Addiction Medicine. He is a leader in the area of general medical screening and brief intervention for substance use problems and has conducted a number of clinical trials designed to incorporate psychosocial healthcare interventions, especially those involving substance use problems, into the trauma and acute care arena. His e-mail address is lgenti@gmail.com.

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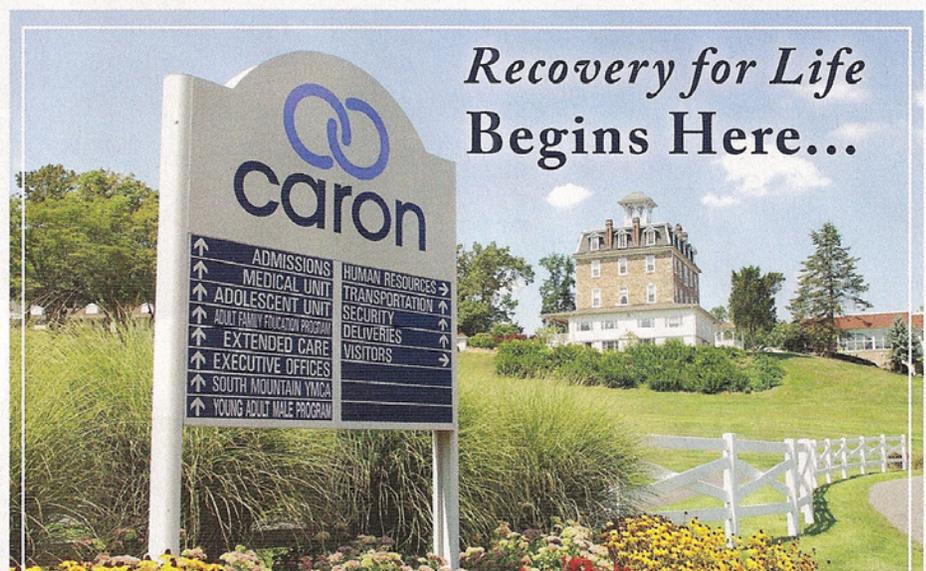
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