



REPORT & RECOMMENDATIONS

Substance Use Screening, Brief Intervention, and Referral to Treatment:

Landscape Scan and Recommendations to Increase the Use of SBIRT in Montana

MONTANA HEALTHCARE FOUNDATION

THE NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

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About the Montana Healthcare Foundation

The Montana Healthcare Foundation (MHCF) makes strategic investments to improve the health and well-being of all Montanans. Created in 2013, MHCF has approximately \$150 million in assets, making it Montana's largest health-focused private foundation. MHCF contributes to a measurably healthier state by supporting access to quality and affordable health services, conducting evidence-driven research and analysis, and addressing the upstream influences on health and illness. To learn more about the Foundation and its focus areas, please visit www.mthcf.org.

About the National Council for Behavioral Health

The National Council for Behavioral Health is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with 2,900-member organizations serving more than 10 million adults, children, and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. A not-for-profit 501(c)(3) association, the National Council for Behavioral Health's mission is to advance their members' ability to deliver integrated health care. They advocate for policies that ensure people who have mental health and substance use disorders have access to comprehensive, evidence-based health care services. To learn more, please visit www.thenationalcouncil.org.

About the Conrad N. Hilton Foundation

The Conrad N. Hilton Foundation was created in 1944 by international business pioneer Conrad N. Hilton, who founded Hilton Hotels and left his fortune to help the world's disadvantaged and vulnerable people. The Foundation currently conducts strategic initiatives in six priority areas: providing safe water, ending chronic homelessness, preventing substance use, helping young children affected by HIV and AIDS, supporting transition age youth in foster care, and extending Conrad Hilton's support for the work of Catholic Sisters. In addition, following selection by an independent international jury, the Foundation annually awards the \$2 million Conrad N. Hilton Humanitarian Prize to a nonprofit organization doing extraordinary work to reduce human suffering. In 2017, the Humanitarian Prize was awarded to icddr,b, an international health research institute dedicated to solving the most serious health issues facing low- and middle-income countries. Since its inception, the Foundation has awarded more than \$1.6 billion in grants, distributing \$114.9 million in the United States and around the world in 2017. The Foundation's current assets are approximately \$2.8 billion. For more information, please visit www.hiltonfoundation.org.

About the Montana Department of Public Health and Human Services

The Department of Public Health and Human Services (DPHHS) strives to improve and protect the health, well-being, and self-reliance of all Montanans. Through various public health programs, DPHHS monitors and responds to disease outbreaks, works with businesses to ensure food safety, assures clean indoor air and safe drinking water, and provides community programs to support healthy living. Agency human service programs help children, families, seniors, and people with disabilities. These programs ensure families in need have adequate food and health coverage, keep children and adults safe, and help heat and weatherize homes.



Introduction and Purpose of Report

The Montana Healthcare Foundation (MHCF) makes strategic investments to improve the health and well-being of all Montanans. MHCF contributes to a measurably healthier state by supporting access to quality and affordable health services, conducting evidence-driven research and analysis, and addressing the upstream influences on health and illnesses.

Montana has a high prevalence of mental illness and substance use disorders. Behavioral health workforce shortages and the state's rural geography compound the challenges involved in addressing these issues. MHCF, in partnership with the Montana Department of Health and Human Services (DPHHS) Chemical Dependency Bureau and the Hilton Foundation, contracted with the National Council for Behavioral Health (National Council) to explore the current use of screening, brief intervention, and referral to treatment (SBIRT) and develop recommendations for the increased uptake of this evidence-based approach. MHCF is looking to identify and support policies that enhance the use of SBIRT across the state in support of the following goals:

- Increasing access to effective care for substance use disorders (SUDs) by facilitating routine screening and early intervention in primary care and other medical settings.
- Facilitating the integration of primary and behavioral health care.
- Identifying high-risk substance use and addressing the need for referral in order to improve outcomes for SUDs in Montana.
- Alleviating the behavioral health workforce shortage by addressing substance use in general health care settings.

This report presents findings from information gathered over the past year, as well as actionable recommendations to support the uptake of SBIRT within Montana.

Montana passed a Medicaid expansion bill in 2015 and is receiving an enhanced federal match to support services for covered adults. As of January 2018, the state has enrolled 71,000 Montanans in Medicaid. The Medicaid expansion gives Montana's Medicaid program a unique, point-in-time opportunity to make meaningful progress in the SUD delivery system and payment policy to improve the health, well-being, and lives of Montanans.

For more information, click [HERE](#).

As the unifying voice of America's community mental health and addictions treatment organizations, the National Council, together with more than 2,900-member organizations, serves the nation's most vulnerable citizens, including more than 10 million adults, children, and families living with mental illnesses and addictions.

Integral to the National Council mission is facilitating opportunities for community behavioral health organizations, federally qualified health centers (FQHCs), and other health care organizations to practice upstream and preventative approaches such as SBIRT. This drives the National Council's commitment to accelerating the use of SBIRT for adolescents and adults through practice improvement initiatives, consulting services, and the dissemination of SBIRT resources to a national audience.

The National Council adopted a four-phased approach to understand Montana's current use of SBIRT, barriers to using SBIRT, and best practices when integrating SBIRT into clinical practice. The findings from this approach drive the recommendations included in this report.

SBIRT and SBIRT-A:

Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive, integrated public health model designed to provide universal screening, secondary prevention, early intervention, and timely referral to treatment for people with substance use disorders. SBIRT-A takes these principles and adapts them to the adolescent population.

SBIRT was developed for use by people who are working in non-SUD treatment settings and are not addiction specialists. The approach is important because general medical settings such as primary care practices and emergency departments now see more patients with behavioral health disorders than psychiatric or other mental health settings do.

Figure 1. Overview of National Council for Behavioral Health Activities

STEERING COMMITTEE	INFORMATION GATHERING AND DELIVERY	KEY INFORMANT INTERVIEWS AND SBIRT-FOCUSED SURVEY	POLICY LANDSCAPE
In partnership with MHCF, the National Council convened six Integrated Behavioral Health Steering Committee meetings, bringing together more than 25 stakeholders from across the state. Participants were selected by MHCF and DPHHS. SBIRT was discussed in the larger context of integrating primary and behavioral health, and the steering committee provided guidance on key aspects of the project.	Throughout the project year, the National Council produced several interim deliverables to provide context and background for SBIRT. These deliverables included: <ul style="list-style-type: none"> • Definitions of SBIRT and SBIRT-A • National models of SBIRT • The use of technology and SBIRT • Historical use of SBIRT in Montana 	The National Council conducted five interviews with key stakeholders across the state. These interviews gathered information about SBIRT uptake and barriers. Interviewees were drawn from organizations that do and do not provide SBIRT services, as well as state health officials. <p>The National Council developed a 25-item survey instrument for behavioral and primary health care providers in the state of Montana. The survey examined uptake, barriers, and factors that support the implementation of SBIRT and SBIRT-A in Montana.</p>	The National Council conducted a comprehensive policy analysis of the Montana health care system with a focus on Medicaid policies.

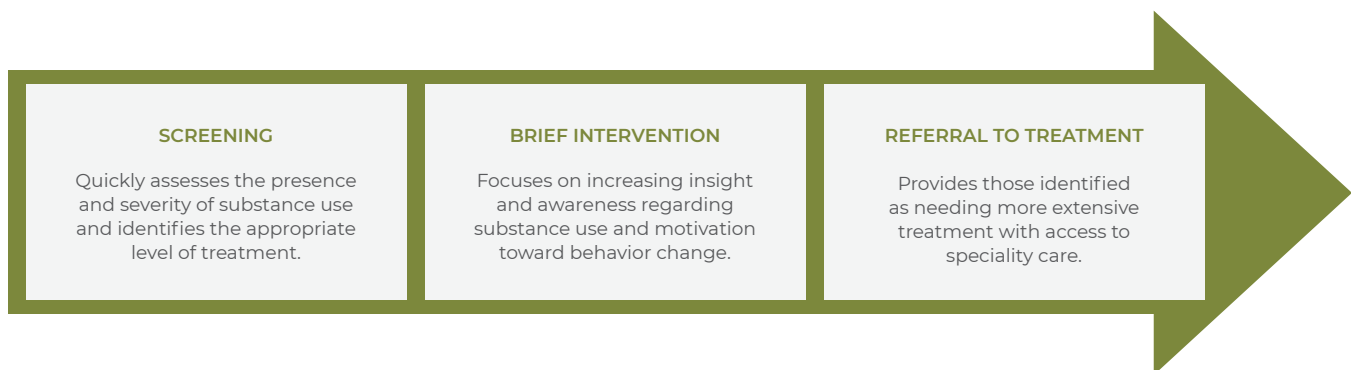
SBIRT and SBIRT-A Defined

Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive, integrated public health model designed to provide universal screening, secondary prevention (detecting risky or hazardous substance use before the onset of abuse or dependence), early intervention, and timely referral and treatment for people who have a substance use disorder.¹

SBIRT-A is a set of adaptations to the traditional SBIRT model to more effectively serve adolescents between the ages of 11 and 17 years in pediatric primary care settings.² Below is a graphic depicting the components of SBIRT and SBIRT-A. For more information, please see the references cited.

Components of SBIRT

Implementing the following components requires system changes that support reconceptualizing how substance use risks and misuse are defined and understood so they are delivered as part of the full continuum of services. Redesigning workflows, documentation standards, and data collection are necessary, in addition to clinical training and technical assistance.



Components of SBIRT-A

SCREENING ADAPTATIONS	BRIEF INTERVENTION (BI) ADAPTATIONS	REFERRAL TO TREATMENT ADAPTATIONS
<ul style="list-style-type: none">• Include caregivers• Use computer-administered screening due to generally high levels of familiarity and comfort with technology	<ul style="list-style-type: none">• Use risk algorithm to select BI• Deliver computer-based interventions• Emphasize psychoeducation• Involve caregivers	<ul style="list-style-type: none">• Enhance the physician-adolescent process• Enhance the physician-caregiver process• Enhance the physician-treatment provider process

Evidence for SBIRT

A large pre-post study of more than 450,000 people screened, including African Americans, American Indians, Hispanics, and Alaska Natives in multiple settings (primary care, community health centers, hospitals, school-based clinics), found SBIRT reduced heavy alcohol use by 38.6 percent and marijuana use by 67.7 percent.³ A more recent large (N=17,575) pre-post study of the Substance Abuse and Mental Health Services Administration's (SAMHSA) implementation grantees also found large decreases in substance use at six months (35 percent reduction in alcohol use, 43 percent reduction in heavy drinking, and 75 percent reduction in illicit drug use).⁴ *These study designs cannot confirm that SBIRT caused improvements, although they do support the association of SBIRT with changes in substance use. Furthermore, the U.S. Preventive Services Task Force recommends all adults ages 18 and over be screened for alcohol use and receive brief counseling to reduce misuse.* Two notable, smaller randomized controlled trials did not find brief intervention effects for illicit and prescription drug use.^{5,6} The complexity of drug use overall, along with the varying types of substances and severity of use, may limit the efficacy of SBIRT if approached as a cure-all.

Research to evaluate SBIRT in mental health centers and schools, with culturally diverse populations, and with youth is steadily increasing.⁷⁻¹⁰ Continuing to implement and evaluate SBIRT programming will be important for growing an evidence base in these areas. Youth SBIRT programs, such as those supported by the **Conrad N. Hilton Foundation's Youth Substance Use Prevention Strategic Initiative**, are especially promising opportunities to move upstream to reduce risky behavior and consequences of substance use.

Some SBIRT research finds associated gains in treatment system equity by extending services to disparate populations and in high-volume settings, the provision of continuous service between behavioral health and medical providers, and the best use of targeted resources to reduce costs.⁷ The opportunity to achieve greater system equity is particularly relevant for Montana in terms of equalizing health disparities based on socio-economic status, geographic location (rural), and other cultural factors. SBIRT was developed for use by people who are working in non-SUD treatment settings and are not addiction specialists. This has become extremely important as general medical settings see more patients with behavioral health disorders than psychiatric or other mental health settings do.¹²

For more information, see Appendix A. SBIRT Literature Review on page 21.

Cost Considerations and Funding

The cost of implementing SBIRT has been raised as a potential barrier to effective utilization. In 2009, the total estimated social cost of substance abuse in the United States was \$510.8 billion.⁸ SBIRT, when implemented correctly, can be an effective tool to reduce overall health care costs. SBIRT has demonstrated Medicaid cost reductions ranging from \$3.66 to \$5.42 per member per month while simultaneously reducing inpatient utilization.⁹ A recent study of Medicaid beneficiaries in health clinics who received SBIRT services showed a net annual savings of \$391 per Medicaid adult beneficiary compared to those receiving treatment as usual.¹⁰

Billing codes exist for commercial insurance, Medicare, and Medicaid to allow for SBIRT services to be reimbursed, although code accessibility varies by state and insurer. Federal funding does not guarantee code activation at the state level.¹¹ Even when SBIRT codes are made available, utilization may be limited because of fee schedules, licensure-level requirements, lack of training, and service setting. In Montana, SBIRT codes are accessible through G codes and CPT codes, although not for H codes. Code utilization was reported to be low among members of the Integrated Behavioral Health Steering Committee for reasons consistent with the limitations noted above. This is relevant to clinicians and administrators because the lack of clear and consistent guidance regarding reimbursement for SBIRT can inhibit practice adoption. State policymakers should work to align existing coding options for SBIRT services with common practice settings and the workforce delivering SBIRT services to mitigate confusion and enhance adoption of SBIRT as a common practice.

The Conrad N. Hilton Foundation, a philanthropic trust providing funds to nonprofit organizations since 1944, has become the single largest private U.S. funder in the substance use disorders field, with significant investment in youth SBIRT grant making, convening, research, and advocacy.¹² SAMHSA and the Health Resources and Services Administration (HRSA) also provide SBIRT funding, such as through capacity expansion grants.

For more information, see Appendix B. Historical Use of SBIRT in Montana on page 32.

National Models of SBIRT

The National Council focused on four SBIRT models, deriving lessons learned that could be applied in Montana to expedite the uptake of SBIRT. For the purposes of this report, the following is a highlight of information found in Appendix D.

For more information, see Appendix D. National Models of SBIRT on page 38.

Breakout 1. National Model: Colorado

Colorado: Colorado has received two SBIRT implementation grants from the SAMHSA, and SBIRT is currently being implemented across the state. SBIRT Colorado is a collaborative effort of the Office of Behavioral Health, Colorado Department of Public Health, and Environment and Healthcare Policy and Financing. It supports the integration of behavioral health into medical care broadly and seeks to standardize substance use screening as a routine practice by defining and accepting Medicaid procedure codes 99409, 99408, and H0049 for eligible trained licensed and non-licensed providers. CPT codes were also available through the involvement of private payers, the insurance commissioner's office, and the Colorado Association of Health Plans. SBIRT Colorado partnered with HealthTeamWorks to devise SBIRT training materials and disseminate them across the state. SBIRT Colorado helps organizations throughout the state implement SBIRT by linking them to educational resources through HealthTeamWorks, which provides the educational training for SBIRT.

Breakout 2. National Model: Wisconsin

Wisconsin: In 2006, the Wisconsin Department of Health Services (DHS) Division of Mental Health and Substance Abuse Services (DMHSAS) was awarded a five-year SBIRT grant by the SAMHSA. To execute the grant, titled the Wisconsin Initiative to Promote Healthy Lifestyles (WIHPL), several organizations came together in partnership: DMHSAS, the University of Wisconsin's Department of Family Medicine, Wisconsin Medical Society, and the University of Wisconsin Population Health Institute. To achieve the overall goal of improving the systematic delivery of SBIRT in health care settings beyond the grant period, an SBIRT ad-hoc committee was formed from the Wisconsin State Council on Alcohol and Other Drug Abuse Planning and Funding Committee. This SBIRT committee worked to forge partnerships among federal, state, tribal, county, and local governments; health care financing organizations; health care provider organizations; health care professionals; mental health and substance abuse treatment providers; private payers; employers; and patients.

Breakout 3. National Model: Oregon

Oregon: Following a five-year SAMHSA implementation grant and the creation of state Medicaid SBIRT codes, an analysis of SBIRT code use showed there was very low code utilization. In 2011, Oregon faced deep Medicaid cuts and in 2012 received a waiver to transform Medicaid in the state to be more cost effective. The State Legislature created coordinated care organizations (CCOs) that were held accountable by the Oregon Health Authority (Public Health, Addictions and Mental Health; Medicaid; and Public Employees Benefits Board all under one roof) for 17 performance measures, one of which was SBIRT for all Medicaid patients age 18 and above. (In 2015, that expanded to age 12 and above.) More recently, this measure is on hold until 2019, when it will be based on electronic health records (EHRs).

SBIRT is often misunderstood as an add-on rather than a part of normal health care delivery. Their programming demonstrated that just having codes available didn't significantly increase uptake. The boost in use of billing codes came from having a performance measure. Starting in 2013, when the performance measure took effect, monthly counts of SBIRT codes submitted to Oregon Medicaid increased from virtually none to more than 5,000. Oregon advises that performance metrics need continual review and tweaking as needed to best match clinical processes. Hospitals that do not meet the benchmark can still meet their improvement target and earn quality funds by making sufficient progress towards the benchmark.

Example findings from Oregon's analysis of code use based on claims data include the following: a) Brief screening is not billable. Only if a person is positive and needs a full screen is there a billable code. b) Codes require a minimum of 15 minutes for the brief intervention. There is no evidence that shows a certain amount of time is necessary to be effective. In fact, they found there is a code for tobacco BI for three minutes. c) Codes are limited to a relatively short list of provider types. d) There is no code for billing for the referral to treatment. To date, Oregon has not changed the coding structure for Medicaid. Oregon continues to do advocacy work for SBIRT policy changes among Centers for Medicare and Medicaid Services (CMS), White House Office of Drug Control Policy, American Medical Association, SAMHSA, and local legislators.

Breakout 4. National Model: Cherokee Tribe

Cherokee Tribe: The Prevention Trial in the Cherokee Nation is a partnership between prevention scientists and Cherokee Nation Behavioral Health to create and implement an integrated community-level intervention designed to prevent underage drinking and associated negative consequences among Native American and other youth. This community-based participatory research approach contains two components. The first is an updated version of Communities Mobilizing for Change on Alcohol, a community-organizing intervention to reduce alcohol access and use among youth, and the second is CONNECT, a newly developed population-wide intervention based on SBIRT research. The new CONNECT intervention expands traditional SBIRT to be implemented universally within schools. Coaches conduct brief, 15-minute, one-on-one health consultations in a private school office with each student once each semester. The results from the randomized community trial published in 2017 included a significant reduction in the probability over time of 30-day alcohol use and heavy episodic drinking compared to students in the control condition.

Historical and Current Use of SBIRT in Montana

SBIRT is a relatively new practice in Montana and has the potential to address several challenges the state faces. Through the Integrated Behavioral Health Steering Committee established in 2016, SBIRT is being discussed as a conduit for integrating primary and behavioral health care, directing early identification of SUD to where it is most likely to be successful, and relieving the provider shortages in rural and frontier areas across the state. The Montana DPHHS Provider Manual defines SBIRT specific to chemical dependency programs contracted with the Chemical Dependency Bureau as follows:

It must include an alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST, CRAFFT), and brief intervention (SBI) services. The brief intervention utilizes motivational interviewing techniques. Mental health screenings are not included in this service.

The Montana DPHHS Chemical Dependency Bureau has included SBIRT as a reimbursable service under federal block grant funds for contracted SUD treatment programs serving individuals who do not meet Medicaid eligibility but are at or below 200 percent of the federal poverty level.

A completed screening can be billed regardless of the result of the screening, and it should be billed to all payment sources. It is a billable service for providers under the contract and Medicaid (Provider Type 32). Financial information needs to be completed to determine payment sources. This service cannot be billed on the same day as an assessment or any treatment services.

Breakout 5: SBIRT in the Substance Use Disorder Program Manual, 2018

Montana operates a primarily fee-for-service delivery or primary care case management system in the delivery of behavioral health services, including outpatient substance use. Billing and reimbursement for all services, including SBIRT, are built on codes submitted to commercial insurance, Medicare, and Medicaid. CPT codes 99408 and 99409 are available for commercial insurance and Medicaid, while four G codes are available for Medicare. H codes, available only through Montana Medicaid and block grant-funded contracts, are not yet widely available for use. Reimbursement amounts are listed in Appendix B.

Integrating SBIRT into practice appears to be impacted by several factors: billing and reimbursement, provider training, and low numbers of substance use providers in the state. This leads to hesitancy to use SBIRT if there are limited resources for people needing treatment. Further information from survey and interview findings is below.

For more information, see Appendix B. Historical Use of SBIRT in Montana on page 32.

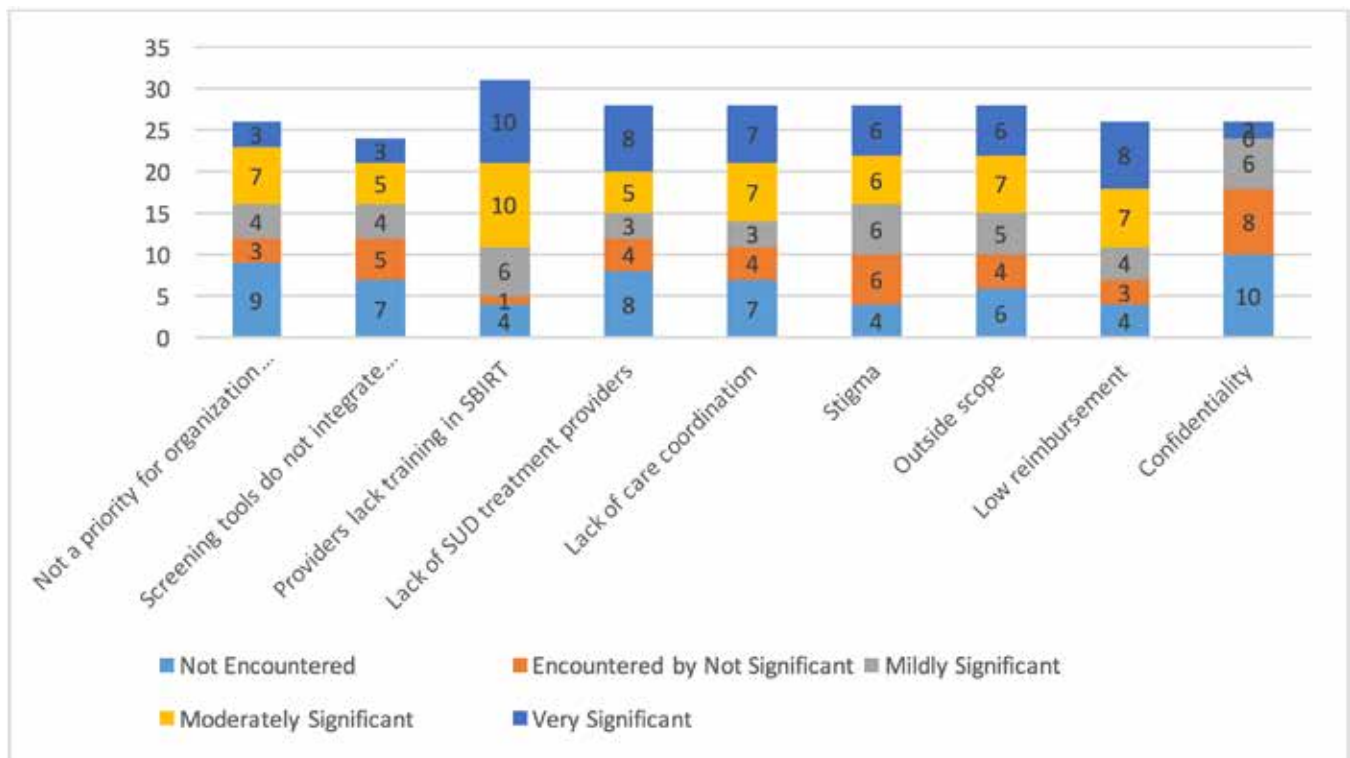
SBIRT Survey of Providers

The National Council developed a 25-item survey instrument for behavioral and primary health care providers in the state of Montana. The survey was disseminated via Survey Monkey to 110 potential respondents and garnered a response rate of 48 percent (N=53). Respondents came from contacts through MHCF and spanned FQHCs, community mental health centers, substance use disorder treatment centers, hospital-based practices, and Indian Health Services/Tribal/Urban (I/T/U) health centers.

Fifteen of the respondents (28%) currently use SBIRT, while another four (8%) are planning for future use. There was no discernable difference in organization type among those implementing SBIRT. A cumulative 32 respondents (60%) are neither using SBIRT nor planning on using SBIRT in the future. A total of eight respondents (18%) utilize CPT codes to bill for SBIRT services. Of the organizations that are using SBIRT, 99408 was the most common CPT code used (six respondents or 33%) followed by 99409 (four respondents or 22%).

Respondents were then asked detailed questions about barriers related to using SBIRT (Figure 2). Providers lacking training in SBIRT was the largest barrier, followed by the limited specialty care workforce and uncoordinated care. These barriers can be addressed by working to integrate primary and behavioral health care and providing SBIRT trainings through pilot programs.

Figure 2. Barriers Related to SBIRT Implementation



For more information, see Appendix C. SBIRT in Montana - A Survey of Providers and Administrators on page 35.

Key Informant Interviews

The National Council performed five key informant interviews with various stakeholders across the state, including four providers and one public health representative. Overall, barriers to implementing SBIRT noted by interviewees were similar to those noted by survey participants. In particular, staff shortages and staff competencies were cited as SBIRT barriers. For these providers, engaging in SBIRT billing and coding was variable, dependent on documentation of client interactions. More detailed provider interview results can be found in Table 2.

Table 2. SBIRT Provider Interview Results

Interviewee	SBIRT Status	Funding	Barriers	Telehealth
Medical Center	Currently engaged in SBIRT, medical director is very supportive. Now also performing referral to treatment (RT) onsite. Electronic health record prompts AUDIT C and DAST are administered by medical assistants as clients are roomed. Positive flags are passed to behavioral health care manager (BHC), who is a layperson.	Most clients are Medicaid or uninsured. Coding is variable.	Most clients are Medicaid or uninsured. Coding is variable.	Adjusted internal infrastructure to support telehealth in a meaningful way.
Community Health Center	Currently engaged in SBIRT, even screening in dental clinic. Has some integration between primary and behavioral health care. Has brought SBIRT into schools, which helps engage the community.	Currently engaged in SBIRT, even screening in dental clinic. Has some integration between primary and behavioral health care. Has brought SBIRT into schools, which helps engage the community.	Organizational culture around asking screening questions, training staff in motivational interviewing, and brief interventions.	Difficult to get clients bought into using telehealth.
Medical Center	Screening is expected, however SBIRT is not formally used. Staff have been trained in SBIRT and have the skills.	Not formally using SBIRT codes	Tracking the use of SBIRT, aligning reporting, engaging clients in self-reporting use.	Not applicable.
Indian Health Service	Not currently using SBIRT, screening clients	Indian Health Service provides an all-encompassing code. Using SBIRT codes is not "favorable."	Buy-in from clinicians when all-encompassing code exists, changing workflows are difficult.	Not applicable.

The Case for SBIRT in Montana

Montana has alcohol and other substance dependence and abuse rates higher than the national average across all age ranges (12-18+).¹³ Embedded in those numbers is another statistic: nearly 90 percent of those counted receive no treatment.¹⁴

A recent report by Manatt Health commissioned by the Montana Healthcare Foundation outlines the serious social, economic, and public health impact of Montana's high prevalence of substance abuse disorders. Substance disorders are causing significant increases in the number of foster care placements due to parental use, neonatal abstinence syndrome (NAS), spending on law enforcement, criminal justice, lost productivity, and costs for treatment. Alcohol misuse and abuse in Montana has created one of the highest rates of binge drinking and alcohol-related deaths in the United States.

All 56 of Montana's counties are designated as health professional shortage areas (HPSAs) in mental health.¹⁵ Fifty-two of 56 counties are designated HPSA in primary care.²⁰ Meanwhile, Montana has the highest suicide rate in the 48 contiguous states.¹⁶

Health disparities among I/T/U populations, compounded by often severe limitations in access to prevention and treatment, can make the consequences of SUDs even more apparent.¹⁷ In the pursuit of care coordination and integrated care, there are strengths and challenges in both state and Indian Health Services systems. The co-occurrence of mental and physical health problems with substance use disorders drives costs and burnout in a system already strained for capacity.

SBIRT has been associated with improvements not only to efficiency and economy, but also to treatment access.¹⁸ In multiple studies, SBIRT demonstrated the ability to increase awareness, improve cost benefit, advance care integration through deployment in primary care settings, and reduce harmful behaviors associated with substance use disorders. This makes it an essential component in Montana's efforts to relieve suffering, engender community connection among care providers, and advance behavioral health care innovation.



Recommendations

The following recommendations were informed by the state provider survey, stakeholder interviews, and discussions with the Integrated Behavioral Health Steering Committee, along with the results of a recent analysis of five years of SBIRT implementation by SAMHSA grantees that identified several key factors for sustainability.¹⁹

Sustainability and Diverse Funding

1. Hold an SBIRT Business Model Virtual Roundtable session to identify local best practices, such as use of standardized and valid instruments, and fidelity to brief intervention and coding practices. Speakers should represent diverse health centers using SBIRT, with representation from those using billing codes and those not using codes, as well as commercial and government payers.

Discussion topics should include:

- a. Use of existing G codes and CPT codes and the pros and cons of making H codes available (e.g., eligible providers, time requirement, fee schedule).
- b. Advantages and disadvantages of using “dummy” codes or other documentation to track use of SBIRT when codes are not available, and how this practice might influence payment models.
- c. Rate setting factors, using data on cost savings from other states, code schedules, and coverage.²⁰
- d. Exploring the benefits of establishing an SBIRT private payer and Medicaid and performance measure similar to the experience of SBIRT Oregon to incentivize uptake of SBIRT and recognize/reward high performers.

2. Explore avenues for SBIRT startup funding for early adopters (see recommendations #8-9 below) and partner with state associations to make SBIRT a standard of care for integrated behavioral health. With the support of startup funding, implementation projects have a stronger foundation for demonstrating SBIRT as a higher-quality and lower-cost service, and thus engage payers in conversations about value-based arrangements.

Funding support considerations include:

- a. Electronic health record adaptations to support meaningful data collection and analysis to assess progress, challenges, and opportunities for continuous improvement.
 - b. Staff training on clinical delivery of the model, operational efficiencies with workflows, and establishing a quality improvement process.
 - c. Engaging private payers and reaching out regarding continued inclusion of SBIRT in their payment structures.
 - d. Transition to value-based outcomes, drawing from relevant quality metrics (e.g., Physician Quality Reporting System measure for alcohol screening, counseling, and initiation of treatment; National Quality Forum measure for Unhealthy Alcohol Use Screening and Brief Counseling).
3. Establish an SBIRT Advisory Group. Membership would benefit from some overlap of participants with the Integrated Behavioral Health Steering Committee to continue driving integration across the state.

The role of the advisory group would be:

- a. Review progress and data of SBIRT implementation projects (see recommendations #7-9 below) and provide recommendations for moving beyond the pilot phase to statewide implementation.
- b. Invite presenters from other Montana data-driven prevention initiatives and those with Strategic Targeted Response grants to glean lessons learned for enhancing Health Information Exchange activities that may support SBIRT tracking.
- c. Advocate through group bargaining to relevant professional associations the need for EHR responsiveness and consistencies that will allow health systems to provide data-driven care and value-based outcomes.

Workforce Staffing

4. Pursue a rule change to allow paraprofessionals (e.g., certified peer support specialists, community health workers, health educators) to bill under another qualified provider (e.g., physician) for SBIRT services and establish training programs for these staff along with supervisory training to operationally and clinically support SBIRT services as part of a care team. Criteria and training development should include representatives from DPHHS and the Washington, Wyoming, Alaska, Montana, and Idaho

(WWAMI) Regional Medical Education Program, as well as consultation from subject matter experts from peer-delivered SBIRT programs, such as Project ASSERT, Wisconsin Initiative to Promote Health Lifestyles, SBIRT Colorado, and SBIRT Oregon.

For more information, see Appendix D. National Models of SBIRT on page 38.

5. Form a Telehealth “Tiger Team” (time limited, focused group) to address barriers and opportunities for both remote consultation and direct care. Focus areas should include disparities, patient uptake and stigma; use of ECHO/psychiatric consultation and newly established partnerships; and a review of the data on true referral needs compared to those that could be managed in a non-specialty setting with the SBIRT model. Adults with likely substance use disorder and need for referral to treatment is approximately 5 percent nationally, whereas about 75 percent of the population are low risk or abstinent and require no intervention beyond screening. Establish guidelines for consistent and efficient processes that will virtually connect health care organizations with specialty SUD providers so that a lack of referral resources does not hinder SBIRT adoption. This may also include considerations for utilizing in-state providers, ensuring wraparound services, or creating an online directory or “real-time” way to locate available counselors, such as Outlook Calendar’s scheduling assistant.
6. Increase primary care substance use treatment team capacity through Medication Assisted Treatment (MAT) training opportunities. Non-prescriber staff (e.g., LPN, LCSW, CHW) should also receive training on engagement and activation strategies toward the benefits of MAT and how these medications can enhance traditional treatment services for substance use disorders. Explore partnerships with the hub and spoke system underway in Montana through the Opioid State Targeted Response grant, which is also looking at workforce development, such as having higher education require SBIRT and MAT to be part of curricula.

System Adaptability

7. Implement an adolescent risk reduction SBIRT pilot using SAMHSA’s Strategic Prevention Framework (SPF) to maximize DPHHS funding for early intervention with request for proposals (RFPs) estimated for later in 2017. SPF is a planning process for preventing substance use and misuse involving community members in all stages of the planning process. As the Partnership for Success (PFS) discretionary grant

and the Substance Abuse, Prevention, and Treatment (SAPT) Block Grant Prevention contracts come to the end of their five- and seven-year terms, respectively, there is an opportunity to develop new contracts that incorporate a priority focus on SBIRT infrastructure development within community-level prevention activities. Funding from the SAPT block grant will support new prevention contracts beginning in state fiscal year 2019 and will prioritize strategic SBIRT infrastructure development as provided through training, technical assistance, and other supportive resources.

8. Through an inclusive process with I/T/U leadership, implement a pilot of project CONNECT (an evidence-based strategy for adolescent SBIRT intervention and prevention) or a similar evidence-based and culturally appropriate pilot, as a public health model in I/T/U communities identified as being in a workforce shortage area. This model is focused on high school students and involves training family, school staff, and community members. Start-up funding in recommendation #2 should be available to the pilot sites as incentive for informing broader I/T/U community and school-based best practices.

9. Establish a two-year learning community for primary care implementation of SBIRT for adolescent and adult populations. The learning community would be comprised of primary care organizations seeking to implement SBIRT as a strategy for risk reduction in a group learning and consultative environment. Start-up funding in recommendation #2 should be provided as an incentive to support workforce training, workflow development, establishing common data points, technical assistance from subject matter experts, data submission and analysis for establishing best practices, and recognition as change leaders informing statewide implementation efforts.



Summary

The National Council for Behavioral Health, in partnership with the Montana Healthcare Foundation and the Montana Department of Public Health and Human Services, conducted a yearlong exploration into the current use of SBIRT to develop recommendations for the increased uptake of this evidenced-based approach. Activities included engaging a steering committee comprised of diverse stakeholders; background research in the form of a comprehensive review of the SBIRT literature and scan of national models; key informant interviews; an SBIRT-focused landscape analysis; and a policy analysis. Through this work, the National Council recommends focusing efforts on the following areas: pursuing diverse funding to sustain current and future SBIRT work; engaging in health care system changes to support and enhance the SBIRT workforce; and implementing early adopter SBIRT learning opportunities, with a focus on primary care and community settings and youth and I/T/U populations.

Appendix A. SBIRT Literature Review

In 2012, SAMHSA reported that nearly one in five Americans lives with a mental health or substance use disorder.¹ Inadequate access to behavioral health (BH) services has the potential to cause great personal and economic challenges.

- The National Alliance on Mental Illness (NAMI) noted that untreated mental illnesses cost the American economy more than \$100 billion in lost productivity.²¹
- SAMHSA estimates that untreated substance use disorders result in 500 million lost workdays annually.²²
- More than 90 percent of the 42,000 people who commit suicide each year lived with a mental illness or substance use disorder.²³

SBIRT in Primary Care

Numerous studies show alcohol screening and brief counseling interventions reduce unhealthy alcohol use in primary care patients.²⁴ Even with promising results, there are several barriers to implementing SBIRT in a primary care setting: knowledge of substance use problems/disorders, time requirements, reimbursement, accepting a change in the structure of the care team, and lack of faculty mentors. These barriers can be overcome easily with SBIRT training and having mentors for providers who can offer assistance.

Gryczynski, J. et al. “A Randomized Trial of Computerized vs. In-person Brief Intervention for Illicit Drug Use in Primary Care: Outcomes Through 12 Months.” *Journal of Substance Abuse Treatment* (March 2015).

- Use of AUDIT (> 8) and single yes/no screener for illicit drugs or illicit use of prescription drugs in the last year; positive screen = referral to behavioral health counseling (BHC).
- Brief intervention (BI) or behavioral therapy (BT) delivered by behavioral health counselors (psychologists, social workers, chemical dependency counselors) integrated into the medical team.
- Six-month follow-up: BI/BT associated with decreased frequency of illicit drug use, alcohol use, and alcohol intoxication.

Madras, B. et al. “Screening, Brief Interventions, Referral to Treatment (SBIRT) for Illicit Drug and Alcohol Use at Multiple Healthcare Sites: Comparison at Intake and 6 Months Later.” *Drug and Alcohol Dependence* (October 16, 2008).

- Primary care, FQHCs, hospitals, community health centers, trauma centers, emergency departments, school-based clinics.
- Peer health educators, substance abuse professionals, general health care staff, licensed BH counselors, community health workers, case managers.
- More than 450,000 people screened.
- Alaska Natives, American Indians, African Americans, Caucasians, Hispanics.
- Self-report at six months: Heavy alcohol use was 38.6 percent lower, drug use was 67.7 percent lower (marijuana biggest decrease).

Fleming, M. et al. “Brief Physician Advice for Problem Alcohol Drinkers. A Randomized Controlled Trial in Community-Based Primary Care Practices.” *JAMA* (April 1997).

- 17 community-based primary care clinics in 10 Wisconsin counties, randomized clinical trial with 12-month follow-up.
- Two BIs of 10-15 minutes each, done by physicians.
- Alcohol use reduced from 19 to 11.5 average drinks in previous seven days.
- Binge drinking episodes reduced from 5.7 to three in past 30 days.
- Excessive drinking (percent in previous seven days) decreased from 47.5 percent to 17.8 percent at 12 months.

Barbor, T. et al. “Brief Interventions for At-Risk Drinking: Patient Outcomes and Cost-Effectiveness in Managed Care Organizations.” *Alcohol and Alcoholism* (November 2006).

- Randomized trial with three conditions: intervention with licensed practitioners, intervention with mid-level providers, no intervention.
- Two intervention groups had a greater decline in drinking over a three-month period.
- Costs of interventions were \$4.16 with licensed providers and \$2.82 with mid-level specialists.
- Interventions delivered to a common protocol by mid-level specialists are as effective as those delivered by licensed providers at about two-thirds the cost.

SBIRT in the Emergency Department

The emergency department (ED) is the health care point of contact for millions of Americans. Forty percent of ED visits are due to trauma and 50 percent of these are alcohol-related.²⁵ Patients presenting to the ED, as compared to those in primary care, are more likely to report heavy drinking and alcohol dependence.²⁶ As of 2006, all Level I trauma centers are required to be SBIRT-capable and offer brief screenings and interventions to patients.²⁷

The Academic ED SBIRT Research Collaborative, 2007

- 14 institutions: Training of ED staff (n=402) (MDs, nurse practitioners, physician assistants, nursing staff, social workers): 74 percent reported having < 10 hours of alcohol education during graduate or post-graduate training; 78 percent < 2 hours alcohol education in the previous year. Participants given:
 - Two-hour interactive workshop with case simulations, or
 - Web-based program
- At three months post-training:
 - Significant increase in belief that SBIRT would make a difference to patients
 - 72 percent reported use of SBIRT intervention in their clinical practice
 - Predictors of use: more years of practice, no differences by profession

- At 12 months post-training:
 - Increased confidence in ability to perform SBIRT
 - Greater sense of responsibility to screen
- Barriers: Lack of belief in effectiveness, lack of role models among faculty, concern of angry response from patient, lack of reimbursement, lack of referral sources.
- Underscores need for institutional support and continued supervised clinical practice of SBIRT and system change that supports this intervention.

The Academic ED SBIRT Research Collaborative, 2010.

- Companion study of 7,751 patients screened; 2,051 exceeded National Institute on Alcohol Abuse and Alcoholism NIAAA low-risk limits; 1,132 consented to study where patients received SBIRT/BI or control (written advice/referral list) from providers.
- At three months: Those receiving brief intervention reported significantly fewer drinks/week and were more likely than controls to be drinking under the NIAAA low-risk limit.
- ED intervention can directly benefit patients by reductions in alcohol consumption, as well as decreases in alcohol morbidity, mortality, and cost (the Academic ED SBIRT Research Collaborative, 2007).
- Six- and 12-month follow-ups: Effects seen at three months were no longer evident.

Desy, P. et al. "Alcohol Screening, Brief Intervention, and Referral to Treatment Conducted by Emergency Nurses: An Impact Evaluation." *Journal of Emergency Nursing* (November 2010).

- Patients were screened for alcohol use, and those with risky drinking behaviors were randomly assigned to intervention or usual care group.
- Intervention group received a brief motivational intervention and referral to appropriate follow-up services.
- Nurses delivering SBI in EDs point to decreased alcohol consumption and decreased ED use in three-month follow-ups.

Vaca F. et al. "The Basics of Alcohol Screening, Brief Intervention, and Referral to Treatment in the Emergency Department." *Western Journal of Emergency Medicine* (August 2007).

- Emergency departments are the health care safety net for the nation.
- Most models of SBIRT in the ED rely on emergency physicians/nurses or specially trained health promotion/education paraprofessionals.
- Availability to administer SBIRT in the ED is the largest constraint.
- Comfort level of staff implementing SBIRT is also a constraint but can be combatted with training programs.
- Savings are great and include less recidivism and avoidance of alcohol-related medical issues, injury, and fatality.

SBIRT in the Criminal Justice System

There is limited literature regarding screening and brief interventions within the criminal justice system. However, in 2002, 40 percent of admissions to alcohol treatment and 34 percent of admissions to treatment programs for alcohol or other drugs were accounted for by criminal justice/driving while intoxicated (DWI) referrals.²⁸ About two-thirds of convicted DWI offenders are alcohol dependent; and 85 percent of female and 91 percent of male DWI offenders met the criteria for alcohol use or dependence at some point in their lives.²⁹

Court-ordered screening misses many people with alcohol use disorders and can, at times, be coercive. There is a need for standardized SBI, particularly in the impaired driver population.

Brown, T. et al. "Brief Motivational Interviewing for DWI Recidivists Who Abuse Alcohol and Are Not Participating in DWI Intervention: A Randomized Controlled Trial." *Alcoholism: Clinical and Experimental Research* (February 2010).

- Male and female recidivists with drinking problems who were not currently engaged in DWI intervention were recruited, evaluated, and randomly assigned to receive one of two manualized interventions:
 - 30-minute brief motivational interviews (BMI) session, or
 - Information advice
- There were significant declines in risky drinking with both interventions.
- BMI resulted in a 25 percent reduction in risky drinking days at the 12-month follow up.

Brown, T. et al. "The Role of Demographic Characteristics and Readiness to Change in 12-Month Outcome from Two Distinct Brief Interventions for Impaired Drivers." *Journal of Substance Abuse Treatment* (2011).

- A nonclinical, community-based sample of 184 male and female recidivists were randomly assigned to receive one of two brief interventions: BMI or an information advice session.
- Recidivists who were younger, male, and exhibited more negative consequences and ambivalence toward their problem drinking improved more on alcohol-related outcomes, irrespective of intervention type.
- The results do not convincingly indicate specific intervention responsiveness based upon participant characteristics but provide preliminary guidance about which recidivists are most apt to benefit from these brief approaches.

Chang, I. et al. "Alcohol Use Inventory: Screening and Assessment of First-Time Driving-While-Impaired Offenders." *Alcohol and Alcoholism* (March 2001).

- Evaluated the use of the Alcohol Use Inventory (AUI) in a drunk driving offender population.
- When using AUI screening for offenders, consider:
 - Screeners place more emphasis on second- and third-order scales than primary scales.
 - Lower cut points can be used for identifying problem drinkers.
 - Counselors conduct in-person interviews with clients to develop rapport and encourage self-disclosure.

Lapham, S. et al. "Screening and Brief Intervention in the Criminal Justice System." *Alcohol Research & Health* (2004/2005).

- Large proportion of offenders in the criminal justice system have alcohol-related problems.
- Implement SBI programs for impaired drivers who are likely to be dependent on alcohol.
- More standards need to be created to address national screening programs for impaired drivers.

Ouimet, M. et al. "A Randomized Controlled Trial of Brief Motivational Interviewing in Impaired Driving Recidivists: A 5-Year Follow-Up of Traffic Offenses and Crashes." *Alcoholism: Clinical and Experimental Research* (November 2013).

- A 30-minute BMI was more effective at reducing the percentage of risky drinking days in drunk driving recidivists than a control information advice intervention at the 12-month follow-up.
- A BMI was better at delaying DWIs and other dangerous traffic violations in at-risk younger drivers.

SBIRT for Adolescents

Alcohol and drug use is a leading cause of injury and death in children and adolescents. The 2013 National Survey of Drug Use and Health found that 8.8 percent of 12- to 17-year-olds consumed alcohol within the past 30 days.³⁰ Binge drinking is common in adolescents: 8 percent of 8th graders and 19 percent of 12th graders consumed five or more drinks in the past 30 days.³¹ An additional 47 percent of adolescents try an illicit drug by the time they are in high school.

Cunningham, RM. et al. "Alcohol Interventions Among Underage Drinkers in the ED: A Randomized Controlled Trial." *Pediatrics* (October 2015).

- Adolescent patients were randomized into three groups:
 - Intervention, therapist intervention, control
- Therapist BI was most successful at reducing alcohol consumption, prescription drug use, and alcohol-related injury.
- Computer BI was successful at reducing the frequency of DUI.
- A single session BI, delivered by a computer or therapist in the ED, shows promise for underage drinkers.

Levy, S. et al. "An Electronic Screen for Triaging Adolescent Substance Use by Risk Levels." *JAMA Pediatrics* (September 2014).

- An electronic screen and brief assessment tool triages adolescents into five actionable categories regarding their experience with nontobacco substance use.
- No significant differences were found in the sensitivity or specificity between the full tool and the SBI.
- A single screening question assessing past-year frequency use for eight commonly misused categories of substances appears to be a valid method for discriminating among clinically relevant risk categories of adolescent substance use.

Ozechowski, T. et al. "SBIRT-A: Adapting SBIRT to Maximize Developmental Fit for Adolescents in Primary Care." *Journal of Substance Abuse Treatment* (March 2016).

- Adolescents are less likely to attend preventative visits than adults and younger children.
- Adolescents are more likely to screen positive for substance use during acute care visits than well-child exams.
- American Academy of Pediatrics (AAP) guidelines: Universal substance use screening for adolescents during both routine preventative appointments and non-preventative visits.
- 2011 AAP guidelines recommend the routine use of the six-item CRAFFT screener.
 - Single question screening is as effective as the full CRAFFT in triaging adolescents into four risk categories.

Schweer, L. et al. "Pediatric SBIRT: Understanding the Magnitude of the Problem." *Journal of Trauma Nursing* (July – September 2009).

- Survey to assess SBIRT in pediatric populations.
- 242 hospitals responded.
- 18 percent screen all adolescents in ED (screening tools: AUDIT, CRAFFT, CAGE).
- 26 percent screen adolescents admitted to trauma service.
- 52 percent use blood alcohol concentration (BAC) as an indicator for whether to screen; who gets BAC is the decision of the clinician (i.e., health care professionals decide who is at risk and will exclude many likely to have at-risk behaviors).

Robinson, R. et al. "The Advanced Practice Nurse Role in Instituting Screening, Brief Intervention, and Referral to Treatment Program at the Children's Hospital of Pennsylvania." *Journal of Trauma Nursing* (2010).

- Children's Hospital of Philadelphia study of SBIRT implementation for patients 12-18 years with trauma (n=209).
- Use of CRAFFT screener by trauma nurses using pencil and paper.
- Positive response to any screening question: referral to social worker or trauma advance practice nurses (APN) to assess; specialty treatment referral if needed.
- Charting in "Specially Protected Information" part of record.
- Positive screens in 25 percent; 81 percent answered one to two questions affirmatively.

Cultural Adaptations

Several minority groups, such as American Indians and Hispanic men, are more likely to engage in heavy drinking and experience alcohol-related problems but are less likely to obtain treatment.³² SBIRT is a tool with which providers can reach a diverse group of individuals. The model is adaptable and, as such, can be applied to many different cultural groups effectively.

Manuel, J. et al. "Adapting Screening, Brief Intervention, and Referral to Treatment for Alcohol and Drugs to Culturally Diverse Clinical Populations." *Journal of Addiction Medicine* (September – October 2015).

- SBIRT offers a useful set of tools to help reduce risky or problematic substance use.
- Appropriate screening questions are key to accurate identification of substance use problems.
- Minority patients may be more likely to experience treatment delays.
- Minority patients are less likely to report that they are uncomfortable with provider interactions.
- Populations studied included Native American/Alaska Natives, Latinos, African Americans, and Asian Americans.

Leonardson, G. et al. "Validity and Reliability of the AUIDT and CAGE-AUDT in Northern Plains American Indians." *Psychological Reports* (August 2005).

- 50 individuals participated.
- Assessment took 25-30 minutes, given by two experienced therapists.
- Substance use scales were internally consistent and valid measures of substance use in this sample.

SBIRT for Drug Use

In 2013, an estimated 24.6 million Americans ages 12 and older were current illicit drug users.³³ Yet, it is estimated that the vast majority of this population does not seek treatment.³⁴ The evidence of the effectiveness of screening and brief interventions for heavy alcohol use is extensive, but the evidence for effectiveness of SBI for illicit drug use is sparse and conflicting.

Madras, B. et al. "Screening, Brief Interventions, Referral to Treatment (SBIRT) for Illicit Drug and Alcohol Use at Multiple Healthcare Sites: Comparison at Intake and Six Months." *Drug and Alcohol Dependence* (January 2009).

- Largest SAMHSA study of SBIRT for illicit drug use to date.
- Covered many diverse populations: Alaska Natives, American Indians, African Americans, Caucasians, and Hispanics.
- 459,599 patients screened: 22.7 percent screened positive for a spectrum of use; 15.9 percent of those were recommended for a brief intervention; of those, 3.2 percent were recommended for a brief treatment or referred to specialty treatment.
- Among those recommended for brief treatment or referral to specialty treatment, self-reported improvements in general health, mental health, employment, housing status, and criminal behavior were all significant.

Bernstein, J. et al. "Brief Motivational Intervention at a Clinic Visit Reduces Cocaine and Heroin Use." *Drug and Alcohol Dependence* (2005).

- Single, structured encounters conducted between peer educators and out-of-treatment cocaine and heroin users who were screened in the context of a routine medical visit.
- Randomized clinical trial in inner-city teaching hospital outpatient clinics with three- and six-month follow-up.
- Cocaine levels in hair samples were reduced by 29 percent for the intervention group.

Humeniuk, R. "A Randomized Controlled Trial of a Brief Intervention for Illicit Drugs Linked to the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) in Clients Recruited from Primary Health-Care Settings in Four Countries." *Addiction* (May 2012).

- Brief intervention for illicit drugs using ASSIST.
- Intervention lasted an average of 13.8 minutes.
- ASSIST intervention was effective.
- Effective in the short term.

Roy-Byrne, P. et al. "Brief Intervention for Problem Drug Use in Safety-Net Primary Care Settings: A Randomized Clinical Trial." *JAMA* (August 2014).

- Adapt brief interventions for drug use instead of alcohol use.
- Single brief intervention using motivational interviewing, a handout with substance abuse resources, and an attempted 10-minute telephone booster within two weeks.
- Primary outcomes: Self-reported days of problem drug use in the past 30 days and Addiction Severity Index-Lite (ASI) drug use composite score.
- No significant difference at three months between enhanced care and care as usual.
- No significant difference at six or 12 months.

Saitz, R. et al. "Screening and Brief Intervention for Drug Use in Primary Care: The ASPIRE Randomized Clinical Trial." *JAMA* (August 2014).

- Test the efficacy of two brief counseling interventions for unhealthy drug use, a brief negotiated interview, and an adaptation of motivational interviewing compared with no brief intervention for illicit drug use.
- Primary outcome: Number of days of use in the past 30 days at six months.
- Brief interventions did not have a significant effect on decreasing unhealthy drug use in primary care patients identified by screening.
- In primary care, there were no differences from getting BI for cocaine, opioids, or marijuana among low- and high-risk users.
- Encouraged further study isolating specific drugs of use.

Implementing SBIRT

The SBIRT model can be effectively implemented in a variety of health care settings, including FQHCs, community behavioral health centers, primary care offices, and emergency departments. Successful implementation relies on the training of staff and availability of staff support.

Dwinnells, R. "SBIRT as a Vital Sign for Behavioral Health Identification, Diagnosis, and Referral in Community Health Care." *Annals of Family Medicine* (May 2015).

- Implemented SBIRT in one Ohio FQHC, used another FQHC as a control.
- Trained clinicians how to effectively implement SBIRT.
- Referral rates were higher at the intervention site; however, kept appointment rates were similarly low at both clinics.

Glass, J. et al. “Specialty Substance Use Disorder Services Following Brief Alcohol Intervention: A Meta-Analysis of Randomized Controlled Trials.” *Addiction* (September 2015).

- Meta-analysis of 13 randomized controlled trials.
- There is a lack of evidence that brief alcohol interventions have any efficacy for increasing the receipt of alcohol-related services.
- In some cases, there could be a gap in the referral process where individuals do not actually access treatment.

AHRQ. “With Support from Collaborative, Primary Care Practices Identify and Address Behavioral Health Issues, Reducing Binge Drinking, Marijuana, and Depression Symptoms.” (2013).

- Behavioral screening and intervention programs offer formal screening and assessment, intervention, and specialty referrals for behavioral health conditions.
- These programs have been shown to reduce illicit drug and alcohol use, injuries, inpatient and ED use, and total care costs.
- They are rare in primary care practices due to inadequate staff resources and training.
- The Wisconsin Initiative to Promote Healthy Lifestyles supports primary care practices in identifying and addressing behavioral health issues in patients.
- Patients complete a screening form each year, and an educator conducts a formal assessment using validated tools.
- The program has reduced binge drinking, marijuana use, and symptoms of depression and has generated high levels of patient satisfaction and a small positive financial return.

Spear, S. et al. “Another Way of Talking About Substance Abuse: Substance Abuse Screening and Brief Intervention in a Mental Health Clinic.” *Journal of Human Behavior in the Social Environment* (December 2009).

- ASSIST is currently used in SAMHSA-funded grant programs, but it is assumed it can be used in a variety of settings by a range of professionals.
- Implemented SBI on college campuses.
- Challenges implementing ASSIST in a primary care setting include lack of time, lack of training, low self-efficacy in delivering interventions, lack of psychiatric referral sources, attitudes about substance users, and views that substance use counseling is a part of the physician's role.

Cost Savings of SBIRT

Many organizations cite the cost of implementing SBIRT as a major barrier to effective utilization. However, the total estimated social cost of substance abuse in 2009 in the United States was \$510.8 billion.³⁵ SBIRT, when implemented correctly, can be an effective tool to reduce overall health care costs for this population. Additionally, after the up-front cost of training staff, overall costs will be reduced and savings realized.

Fleming, M. et al. "Brief Physician Advice for Problem Drinkers: Long-Term Efficacy and Benefit Cost Analysis." *Alcoholism: Clinical and Experimental Research* (January 2002).

- Control or intervention groups.
 - Intervention: Brief physician advice for the treatment of problem drinking. Two physician visits and two follow-up phone calls.
- Subjects in the intervention group experienced significant reductions in seven-day alcohol use, number of binge drinking episodes, and frequency of excessive drinking.
- Effect was maintained six months post-intervention.
- \$43,000 reduction in future health care costs for every \$10,000 invested in early intervention.

Maciosek, M. "Greater Use of Preventive Services in U.S. Health Care Could Save Lives at Little or No Cost." *Health Affairs* (September 2010).

- Estimated cost of adopting a package of 20 preventative services, including substance use screening.
- Increasing the use of preventive services could result in health care savings of \$3.7 billion.

Estee, S. et al. "Evaluation of the Washington State Screening, Brief Intervention, and Referral to Treatment Project: Cost Outcomes for Medicaid Patients Screened in Hospital Emergency Departments." *Medical Care* (January 2010).

- Washington State Medicaid Cost Analysis:
 - Working age (18-64 years), disabled Medicaid patients
 - Screened (AUDIT/DAST)
 - SBI delivered by substance abuse counselors
- SBIRT is associated with a significant reduction in Medicaid costs of \$366 per month per member.

Gentilello, L. et al. "Alcohol Interventions for Trauma Patients Treated in Emergency Departments and Hospitals: A Cost Benefit Analysis." *Annals of Surgery* (April 2005).

- Cost-benefit analysis of injured patients treated in an ED or admitted to the hospital.
- An estimated 27 percent of patients are candidates for brief alcohol intervention.
- Net cost-savings of intervention was \$89 per patient screened or \$330 for each patient offered an intervention.
- SBIRT produced cost-savings in reduced health expenditures of \$3.81 for every \$1.00 spent; possible savings of \$1.2 billion annually.

Zarkin, G. et al. "The Costs of Screening and Brief Intervention for Risky Alcohol Use." *Journal of Studies on Alcohol and Drugs* (2003).

- Two models of SBIRT were implemented: practitioner model and specialist model.
- Identified participants were administered an AUDIT to determine an appropriate intervention.
- SBI start-up costs ranged from \$86,000 to \$115,000.
- Estimated ongoing cost of administering the health appraisal was \$0.25 per patient appraised.
- Median cost of performing the brief intervention was \$2.59 per patient in the specialist clinic and \$3.43 in the practitioner clinic.

Zarkin, G. et al. "Costs of Screening and Brief Intervention for Illicit Drug Use in Primary Care Settings." *Journal of Studies on Alcohol and Drugs* (2015).

- Per-person cost estimates were \$15.61 for screening, \$38.94 for a brief negotiated interview, and \$252.26 for an adaptation of motivational interviewing.
- Ongoing clinical supervision costs are the largest component of service support costs.
- Implementation cost estimates for illicit drug brief intervention vary greatly depending on the model.

Appendix B. Historical Use of SBIRT in Montana

In collaboration with DPHHS, the National Council was provided a list of organizations that are currently implementing SBIRT.

State-Approved Providers Utilizing SBIRT in SFY16 (July 1, 2015 – June 30, 2016)

- Alcohol and Drug Services of Gallatin County (Bozeman)
- Park County (Southwest CD) (Livingston) – Used in their outpatient setting and in the high school through their school-based intervention services.
- Bullhook Community Health Center (Havre) – Used in the FQHC clinic and the junior high/high school through the school-based intervention services. Bullhook is also the recipient of a SAMHSA grant for SBIRT and medication-assisted therapy.
- Western Montana Addiction Services (Missoula) – Used in the high school through the school-based intervention services.

Health Centers and Hospitals Using SBIRT

- RiverStone Health (Billings) – Implemented SBIRT for all patients at the main clinic in April 2017 and at the Health Care for the Homeless Clinics in May 2017. Training staff at satellite clinics occurred in September and October 2017. They are part of the Integrated Behavioral Health (IBH) Steering Committee.
- Barrett Hospital and HealthCare (Dillon)
- St. Vincent Healthcare (Billings) – Used in the emergency department and trauma program.
- Southwest Montana Community Health Center (FQHC) (Butte)
- Big Horn County (Hardin) – SAMHSA grant

There is a requirement for Level 1 and Level 2 American College of Surgeons-certified facilities to perform alcohol screenings and brief interventions. Montana doesn't have any Level 1 facilities, but there are four Level 2 facilities: St. Patrick Hospital and Health Sciences Center in Missoula, Benefis Health System in Great Falls, and Billings Clinic and St. Vincent Healthcare, both in Billings.

Planning for SBIRT

- Lewis and Clark County (Helena) – Planning grant through MHCF for integration and SBIRT was identified on the work plan. PureView Health Center (FQHC) is part of the IBH Steering Committee.
- State-approved programs intending to use SBIRT in school settings include Intermountain (Helena), SMART (Butte), and White Sky Hope (Rocky Boy).
- Western Montana Mental Health Center (Missoula) – Received training last year from DPHHS for all behavioral health staff and case managers in the Butte area.
- Sidney Health Center (Sidney) – Received staff training in April 2016 (nurses and licensed clinical social workers (LCSWs)).

Funding for SBIRT

Montana operates a primarily fee-for-service delivery system or primary care case management system in the delivery of behavioral health services, including outpatient substance abuse. Billing and reimbursement for all services, including SBIRT, are built on codes submitted to commercial insurance, Medicare, and Medicaid. The American Medical Association (AMA) designates Healthcare Common Procedure Coding System (HCPCS) codes for both public and private reimbursement of screening and brief intervention (SBI) for alcohol and drug use disorders.

HCPCS codes are divided into two levels. The first level codes are used by physicians and are known as Current Procedural Terminology (CPT) codes and can be both publicly and privately reimbursed. Level 2 codes are known as H codes and can only be reimbursed through Medicaid and block grant-funded contracts. Adoption of specific SBIRT codes in daily practice has been inconsistent. While SBI codes have been turned on in a majority of states, their adoption rate remains low. Anecdotal information from preliminary sources in Montana reveals similar low rates of adoption.

In Montana, the reimbursement rates taken from the Resource-Based Relative Value Scale Fee Schedule, effective January 2017, range as follows:

99408 – AUDIT/DAST	15-30 minutes	Physician	\$35.96-\$37.85
		Allied (including mid-levels)	\$24.09-\$25.35
		Behavioral Health (MH/SUD)	\$23.63-\$24.88
99409 – AUDIT/DAST	over 30 minutes	Physician	\$71.92-\$73.81
		Allied (including mid-levels)	\$48.17-\$49.44
		Behavioral Health (MH/SUD)	\$47.26-\$48.51

CPT 96150-95155 - Behavioral Health Assessment and Intervention (BHAI) codes are open to physicians, mid-levels, and social workers.

The range of amounts in this chart is due to facility versus office rates and the licensure of the professional providing SBIRT. The facility rate is paid to physicians/practitioners providing services at the following sites: hospitals; emergency rooms; ambulatory surgery centers; IHS provider-based and IHS 638 freestanding facilities; skilled nursing and nursing facilities; hospice, ambulance, inpatient psychiatric, and partial psychiatric hospitals; psychiatric residential treatment centers; comprehensive inpatient rehab facilities; birthing centers; and military treatment facilities. All other sites of service receive the office rate, inclusive of primary care.

It is also important to view the functions of SBIRT as something that can fit into similar services already provided. SBIRT activities can be incorporated into other, potentially more profitable codes, such as intake, assessment, or counseling. Hospitals, FQHCs, IHS, inpatient sites, and other sites may be receiving a bundled or encounter rate for services and may not be billing for individual SBIRT codes. Deploying SBIRT seamlessly enables providers to see more clearly the clinical needs of their populations and more quickly identify high utilizers. Knowing who the high utilizers are, providers can move to stem frequent ED admissions or other high-cost care episodes.

As of July 2014, Montana also has access to codes G0442 for annual alcohol misuse screen and G0443 for brief face-to-face counseling for alcohol misuse, in addition to the 99408 and 99409 codes that physicians and mid-levels are allowed to bill for under Medicaid. Also, behavioral health providers who have a contract with the Montana Department of Public Health, Addiction and Mental Disorders Division Chemical Dependency Bureau can bill codes 99408 and 99409, which are listed on the Medicaid and Non-Medicaid fee schedules.

While this information seems arcane, it is important to understand its implication when undertaking statewide creation and implementation of SBIRT policy. State associations, foundations, and change agents need to understand the specific barriers to implementation due to commercial and public reimbursement rates, aggregate facility types, and credentialing requirements. Individual Montana providers will need to understand their unit costs for providing SBIRT as they relate to reimbursement ranges, business overhead, and organizational financial and clinical change management.

Information on the role of licensed addiction counselors (LACs) in Montana can be found on the following Montana Healthcare Programs Provider Information webpages:

https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2016/provnoticeprov55_56LACaddedtoFQHCRHC.pdf

<https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2017/provnotice5556LAC02212017.pdf>

A more exhaustive look at specific codes used in integrated care settings, for SBIRT specifically and granularly in Montana, can be found in the following resources:

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS): CIHS has developed customized billing and financial worksheets for each state that identify existing billing opportunities for services provided in integrated settings. Each of the CIHS billing worksheets has been reviewed by the specific state's Medicaid office. It is important to note that these worksheets provide a point-in-time view, and information may change as states change their Medicaid programs.

<http://www.integration.samhsa.gov/resource/billing-financial-worksheets>

IRETA SBIRT Reimbursement by State: This tool allows organizations to determine whether SBIRT billing codes are listed on a state's fee schedule, and if listed, if they are open for reimbursement. This information is gathered from state Medicaid or other state health department websites and was last updated in 2014.

<http://my.ireta.org/sbirt-reimbursement-map>

Resource-Based Relative Value Scale (RBRVS) Fee Schedule - Montana: The Montana Fee Schedule is a complete listing of fees used by Medicare and Medicaid to pay doctors and other providers.

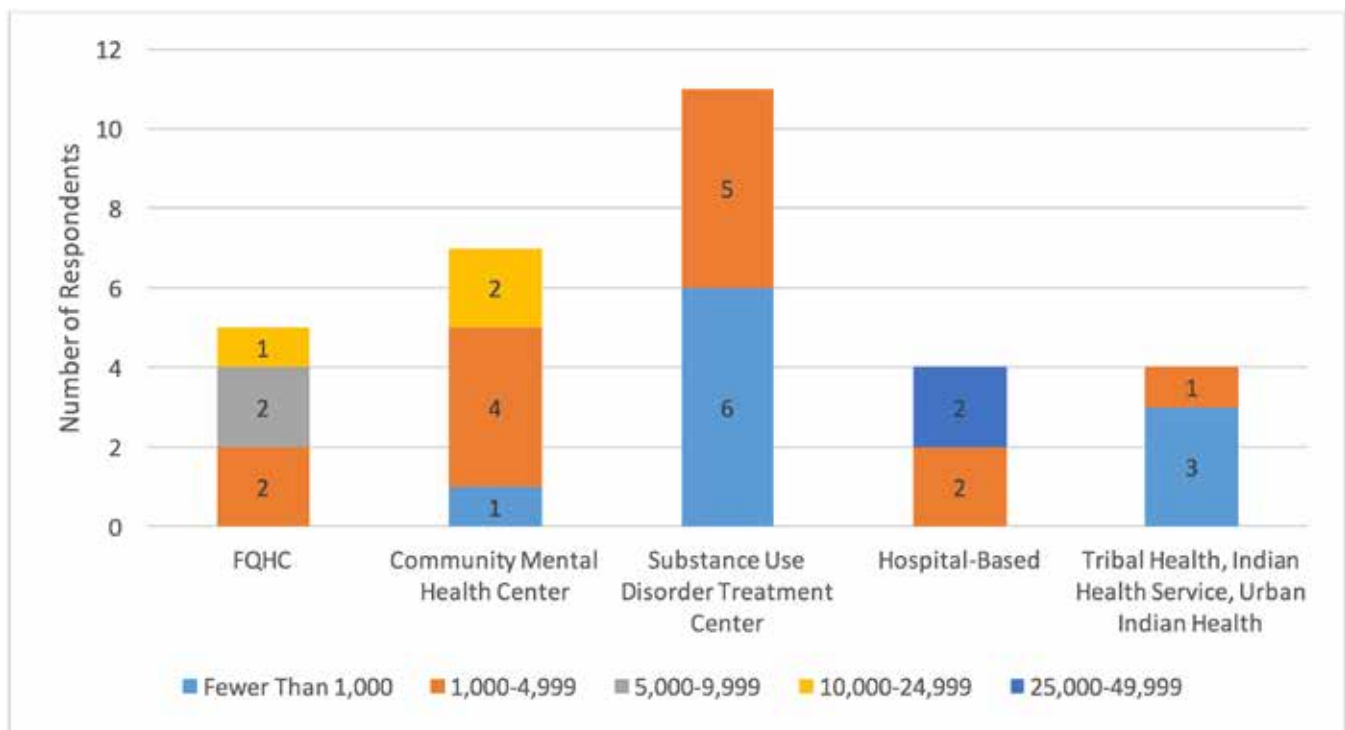
<http://medicaidprovider.mt.gov/enduserrbrvs>

Appendix C. SBIRT in Montana: A Survey of Providers and Administrators

Results

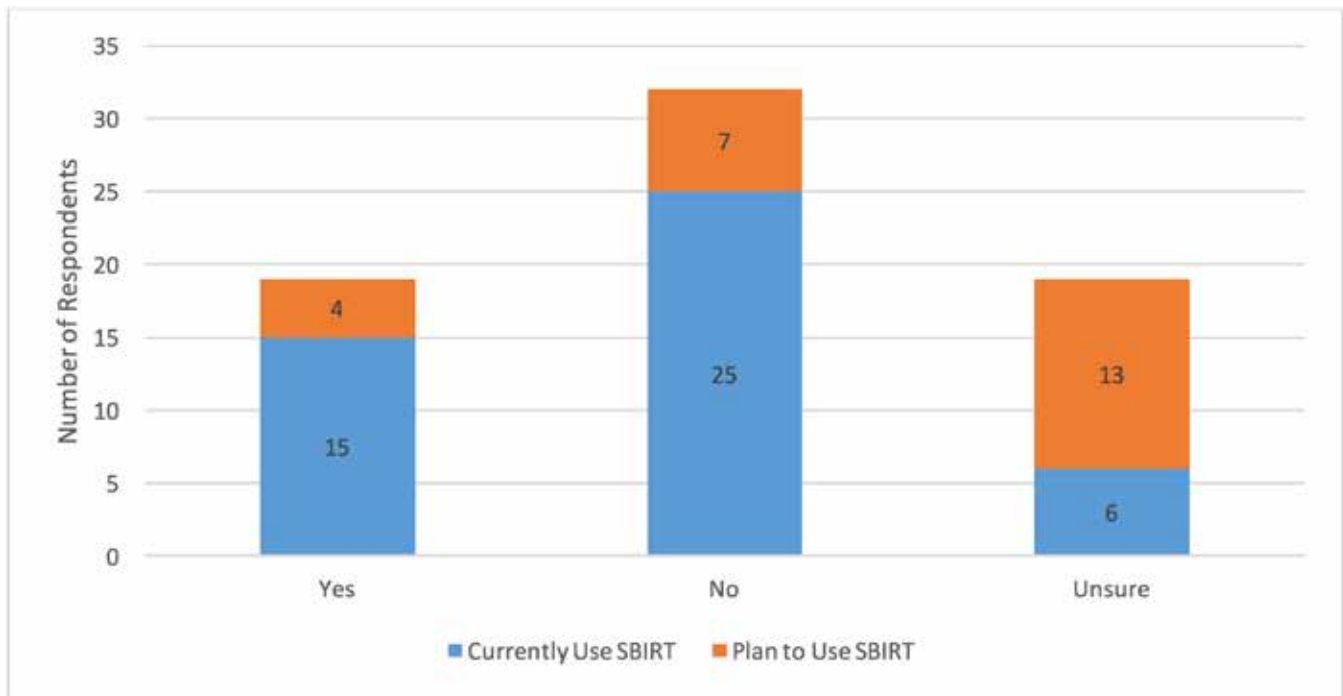
- The survey was disseminated to 110 potential respondents, and 53 (48%) responded.
 - Respondents came from contacts through MHCf and spanned FQHCs, community mental health centers, substance use disorder treatment centers, hospital-based practices, and I/T/U health centers (Figure 1).
 - Organizations ranged in size from fewer than 1,000 clients up to 25,000-49,999. There were no respondents with client populations greater than 50,000 clients per year (Figure 1).

Figure 1. Survey Respondents by Practice Setting and Client Population Size



- Respondents came from 18 different cities across Montana: Anaconda (1), Billings (3), Box Elder (1), Bozeman (5), Butte (2), Conrad (1), Dillon (2), Glendive (2), Great Falls (6), Hardin (1), Havre (1), Helena (10), Livingston (4), Miles City (2), Missoula (6), Polson (1), Poplar (1), Superior (1).
- Fifteen respondents noted they currently use SBIRT (33%, N=46). Of the 25 respondents who noted they do not currently use SBIRT, four (16%, N=25) plan to implement and seven (28%, N=25) have no plans (Figure 2).

Figure 2. Current and Future SBIRT Usage of Survey Respondents



- The most common screening tool is the AUDIT (12) followed by the DAST-10 (11), CAGE (9), and CRAFFT (8). No respondents noted using the NIAA, S2BI, DCUDIT, ORT, or TICS0, nor were there any un-validated instruments referenced.
- Twenty-nine (66%, N=44) respondents have formal partnerships for referral.
 - A majority of the respondents rely on client self-report (17, 55%, N=31) to follow up on referrals.
- Eight (18%, N=44) respondents utilize SBIRT codes to bill for SBIRT services.
 - Most common CPT codes used are 99408 (6) and 99409 (4).
- Thirty-six respondents provided information on data points collected related to SBIRT. Data include: number of individuals screened (10, 28%), number screened positive who received a brief intervention (8, 22%), screening score (6, 17%), number of referrals (6, 17%), outcomes of referrals (4, 11%), and SBIRT billing code utilization (1, 3%).
- Respondents were able to rate barriers to implementation of SBIRT (Figure 3).
- Eighteen respondents (50%, N=36) noted they utilize telehealth to provide behavioral health services. Barriers related to telehealth can be seen in Figure 4.

Figure 3. Barriers Related to SBIRT Implementation

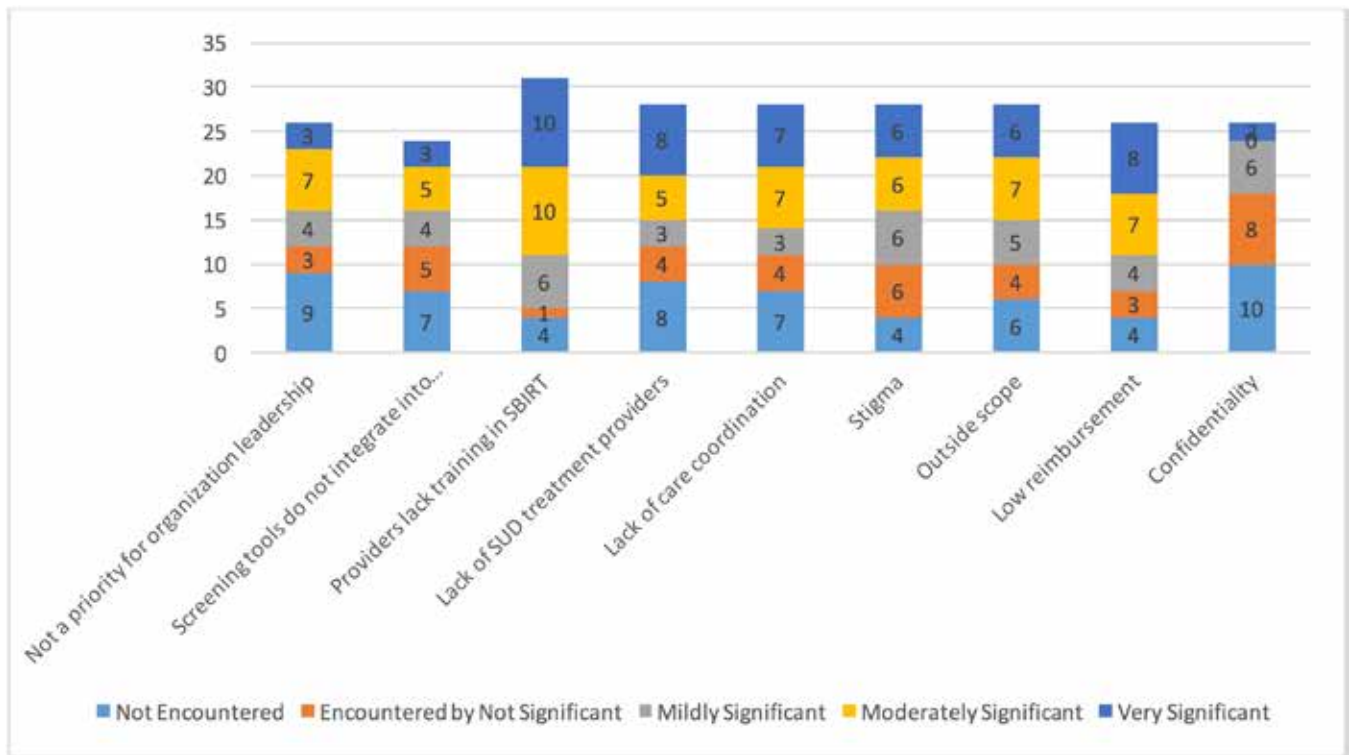
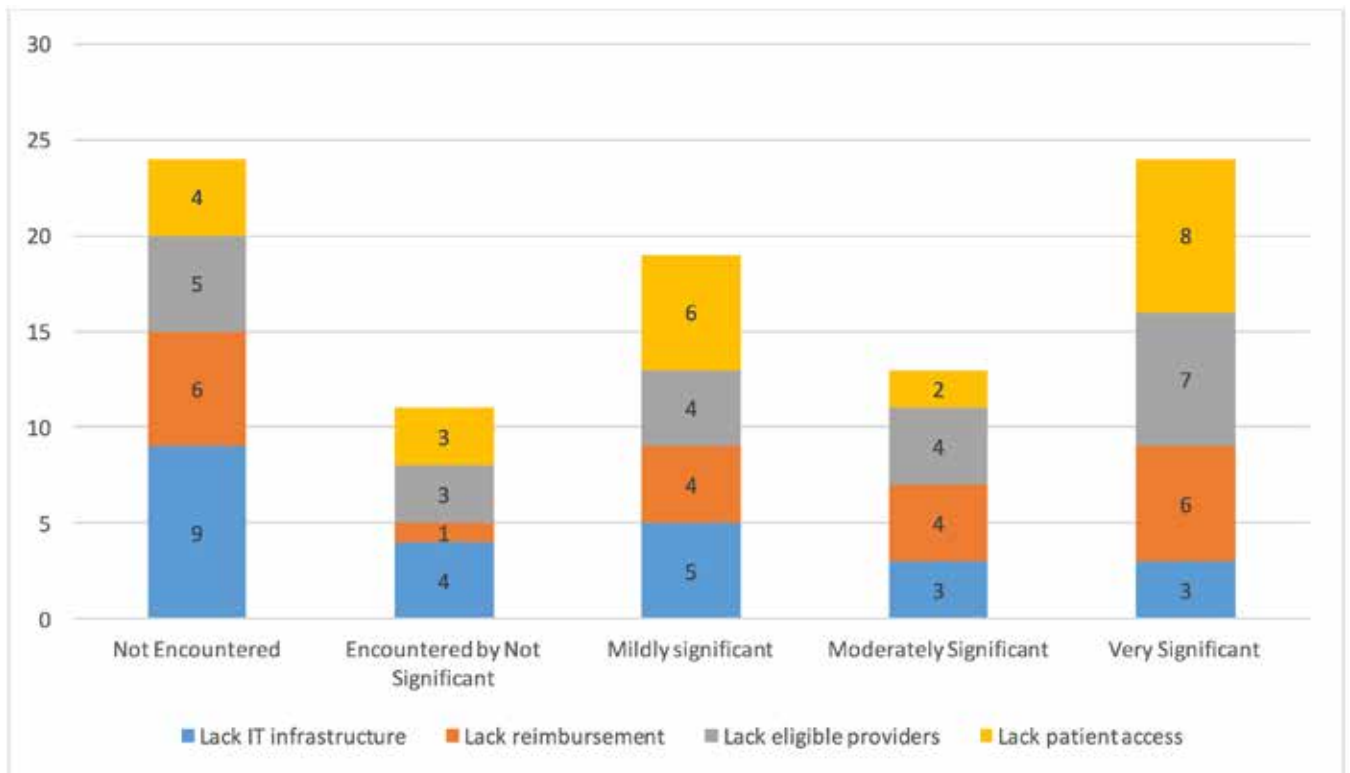


Figure 4. Barriers Related to Telehealth



Appendix D. National Models of SBIRT

Wisconsin

In 2006, the Wisconsin Department of Health Services (DHS) Division of Mental Health and Substance Abuse Services (DMHSAS) was awarded a five-year SBIRT grant by SAMHSA. To execute the grant, titled the Wisconsin Initiative to Promote Healthy Lifestyles (WIHPL), several organizations came together in partnership: DMHSAS, the University of Wisconsin's Department of Family Medicine, Wisconsin Medical Society, and the University of Wisconsin Population Health Institute. To achieve the overall goal of improving the systematic delivery of SBIRT in health care settings beyond the grant period, an SBIRT ad-hoc committee was formed from the Wisconsin State Council on Alcohol and Other Drug Abuse Planning and Funding Committee to forge partnerships among the federal, state, tribal, county, and local governments; health care financing organizations; health care provider organizations; health care professionals; mental health and addictions providers; employers; substance abuse treatment providers; and patients.

WIHPL had nine goals associated with the grant. Key findings and learnings from each goal are summarized below:

- Billing and reimbursement of services is a critical element of sustainable SBIRT implementation.
 - Defined as 1) reimbursement under national billing codes, 2) no out-of-pocket payments by patients, 3) reimbursement for paraprofessional-administered SBIRT, and 4) reimbursement when paraprofessionals and other providers deliver SBIRT and other services at the same visit.
 - To achieve this goal, WIHPL created the SBIRT Coding, Billing, and Reimbursement Manual.
- WIHPL created an interactive web-based SBIRT training for licensed providers and developed a 60-hour training curriculum for non-licensed providers to ensure all providers could deliver SBIRT services once codes were activated.
- When Wisconsin Medicaid activated the SBIRT codes, Wisconsin DHS simultaneously authorized a range of providers to bill for SBIRT services, including crisis intervention workers and prenatal care coordinators.
- WIHPL developed a partnership with the business community to ensure that health plans reimburse for SBIRT.
- WIHPL developed partnerships with key provider organizations to advance the support, dissemination, and sustainability of SBIRT. It also partnered with the state government to raise the profile of SBIRT across the state.
- WIHPL enhanced networking and connections between the primary care and specialty treatment settings. SBIRT is now listed as a referral source option in the Human Service Reporting System.
- WIHPL created an SBIRT program coordinator position within DMHSAS that will outlive the life of the grant to ensure SBIRT continues past funding.
- WIHPL created a website clearinghouse of information on SBIRT for health care professionals, employers, insurers, and advocates.
- WIHPL created a continuing education course for SBIRT incorporating theories of motivational interviewing (MI) to ensure fidelity of SBIRT delivery and develop a continuous quality improvement loop.

- Lack of clinic buy-in was identified as a significant barrier to implementing SBIRT. To address this, the WIPHL team clearly defined, addressed, and discussed the following areas: the importance of alcohol and drug screening; the health educator roles and responsibilities; the benefits of SBIRT; program parameters established by SAMHSA; and addressing staff's discomfort about screening for patient substance use. After these discussions, clinic buy-in increased.
- Successful implementation hinged on assembling a multidisciplinary health care team. Health educators were crucial to the success of SBIRT because 1) they received the most in-depth SBIRT training (per the Wisconsin model), and 2) they are dedicated to ensuring SBIRT is implemented correctly and making the appropriate linkages between providers.
- Patients who participated in SBIRT showed the following selected outcomes:
 - A 21 percentage point decrease in risky drinking among females under age 65, from 84 percent at intake to 63 percent at follow-up.
 - A 17 percentage point decrease in risky drinking among males under age 65, from 87 percent at intake to 70 percent at follow-up.
 - A 16 percentage point decrease in overall binge drinking, from 87 percent at intake to 71 percent at follow-up.
 - 65 percent of patients reported that the WIPHL program helped them change or modify their lifestyle, and 94 percent reported that they were currently working on continuing these changes.
 - The Health Educator model was integral to the program's success, with greater reductions in drinking for patients who participated in the program.
- Integrating depression screening into SBIRT can be feasible and effective.
- SBIRT works with a variety of patient populations.
- Medicaid reimbursement for SBIRT occurs under HCPCS codes H0049 and H0050.

For more information:

SBIRT Coding, Billing and Reimbursement Manual: http://www.wiphl.org/media/SBIRT_Manual.pdf

SBIRT Report to the State Council on Alcohol and Other Drug Abuse, Planning and Funding Committee: <https://scaoda.wisconsin.gov/scfiles/docs/SBIRTReport2013FINALforprinter.pdf>

Colorado

Colorado has received two SBIRT implementation grants from SAMHSA, along with Ryan White Part B funds to implement across the state. SBIRT Colorado also supports the integration of behavioral health into health care through a collaborative effort of the Office of Behavioral Health, Colorado Department of Public Health, and Environment and Healthcare Policy and Financing to standardize substance use screening as a health care practice by defining and accepting Medicaid procedure codes 99409, 99408, and H0049 for eligible, trained, licensed and non-licensed providers. CPT codes were also available through the involvement of private payers, the insurance commissioner's office, and the Colorado Association of Health Plans. SBIRT Colorado partnered with HealthTeamWorks, a nonprofit collaborative, to devise SBIRT training materials and disseminate them across the state. SBIRT Colorado helps organizations throughout the state implement SBIRT by linking them to educational resources through HealthTeamWorks, which provides the educational training for SBIRT.

- SBIRT Colorado uses health educators to deliver services. This helps integrate SBIRT into diverse settings, including primary care clinics, hospitals, emergency departments, trauma centers, urgent care clinics, and dental clinics. Sites are located in rural, frontier, and urban locations.
- SBIRT Colorado partners with HealthTeamWorks with the goal of redesigning the health care delivery system and promoting integration.
- HealthTeamWorks developed SBIRT guidelines for implementation and training tools. These documents are disseminated throughout the state to primary care clinics and public health departments.
- Patients in Colorado reduce their substance use after receiving SBIRT services. Reductions were found for all subgroups examined, including geographic setting, gender, service setting, ethnicity, and age.
- Providers identified improved quality of care as the primary motivator of participating in SBIRT. Improved quality of care was considered one of the greatest successes of SBIRT.
- Patients appreciated the SBIRT process.
- SBIRT is changing perceptions about substance use and its place in health care. SBIRT Colorado was noted as providing a standardized, evidence-based method to intervene before the point of addiction, bringing a new group of at-risk, non-dependent users to the forefront in primary care.
- Staff support of SBIRT was critical to the program's success. This was achieved through education, training, and outreach with providers, staff, management, and the broader community about the purpose, effectiveness, and evidence that supports the SBIRT approach.
- It is essential to establish clear protocols for clinic workflows to reduce demands on staff that will help eliminate confusion and strengthen sustainability.
- SBIRT Colorado was implemented with continual trainings in mind to ensure the success of the program.
- Funding remains a challenge due to state budget cuts and underfunded health care systems. Recommendations from SBIRT Colorado include leveraging discretionary SAMHSA grants and Medicaid dollars from health care reform, and also seeking opportunities through private insurance and foundations.

For more information:

SBIRT Colorado Lessons Learned: http://improvinghealthcolorado.org/wp-content/uploads/2014/02/SBIRTColoradoLessonsLearned_July2012.pdf

SBIRT Colorado Sustainability Interviews: http://improvinghealthcolorado.org/wp-content/uploads/2014/02/SBIRT_CO__Sustainability_Interviews_FinalReport.pdf

Colorado Medical Assistance Program, SBIRT: [https://www.colorado.gov/pacific/sites/default/files/Screening,%20Brief%20Intervention%20and%20Referral%20to%20Treatment%20\(SBIRT\)_0.pdf](https://www.colorado.gov/pacific/sites/default/files/Screening,%20Brief%20Intervention%20and%20Referral%20to%20Treatment%20(SBIRT)_0.pdf)

Oregon

Following a five-year SAMHSA implementation grant with subsequent availability of state Medicaid codes, an analysis of SBIRT code use showed there was very low utilization. In 2011, Oregon faced deep Medicaid cuts and in 2012 received a waiver to transform Medicaid in the state to be more cost effective. The State Legislature created coordinated care organizations (CCOs) held accountable by the Oregon Health Authority (Public Health, Addictions and Mental Health; Medicaid; Public Employees Benefits Board all under one roof) for 17 performance measures, one of which was SBIRT for all Medicaid patients age 18 and above. (In 2015, that expanded to age 12 and above.) SBIRT is often misunderstood as an add-on rather than a part of normal health care delivery. Their programming demonstrated that just having codes available didn't significantly increase uptake. The boost in use of billing codes came from having a performance measure. Oregon advises that performance metrics need continual review and tweaking as needed to best match clinical processes.

Example learnings from Oregon's analysis of code use based on claims data include:

1. Brief screenings are not billable. Only if a person is positive and needs a full screen is there a billable code.
2. Codes require a minimum of 15 minutes for the brief intervention. There is no evidence that shows a certain amount of time is necessary to be effective. In fact, they found there is a code for tobacco BI for three minutes.
3. Codes are limited to a relatively short list of provider types.
4. There is no code for billing for the referral to treatment. Oregon continues to do advocacy work for SBIRT policy changes within CMS, the White House Office of Drug Control Policy, American Medical Association, SAMHSA, and local legislators.

For more information:

"By Itself, Reimbursement Doesn't Expand SBIRT": http://ireta.org/2017/03/08/by-itself-reimbursement-doesnt-expand-sbirt/?utm_source=all+IRETA+communications&utm_campaign=a5003b3aa1-EMAIL_CAMPAIGN_2017_03_13&utm_medium=email&utm_term=0_5cec8dc768-a5003b3aa1-102826561&mc_cid=a5003b3aa1&mc_eid=662b225ce3

"How Oregon Dramatically Increased SBIRT in Primary Care": <http://my.ireta.org/node/1351>

Federal Funding and Implications

- SBIRT is a public health model that is deployed in clinics, emergency departments, primary care organizations, and FQHCs. If fully deployed in Montana, SBIRT would bring those at risk of substance use disorders to the attention of health care providers. On average, 9 percent of Medicaid enrollees screened would exhibit at-risk substance use, which would trigger a brief intervention.
- For comparison, Montana is one of nine states that operate a primarily fee-for-service delivery system or primary care case management system for behavioral health care, including outpatient substance abuse services. The others are Alabama, Alaska, Arkansas, Connecticut, Oklahoma, North Dakota, South Dakota, and Wyoming. These state delivery systems could be examined for lessons learned regarding SBIRT financing. Their reimbursement rates vary, in some cases significantly, like Alaska, but can be used as a starting point.
- Wisconsin is one of six states that carve out three behavioral health care categories, including outpatient substance abuse. Similarly, Colorado is one of eight states that carve out four categories, including outpatient substance abuse. Since both of these states have a more managed approach to service, analysis of different processes could prove useful in terms of streamlining SBIRT activities into care and managing high utilizers of service.
- Depending on the site of SBIRT deployment and the level of the professional, screening alone would cost Montana Medicaid between \$23.63 and \$73.81 per person. This can be used to project estimated costs and does not consider Federal Medical Assistance Percentage (FMAP) or Enhanced Federal Medical Assistance Percentage (EFMAP). These figures are drawn from the resource-based relative value scale published in Montana (resource link attached). Physicians generally bill 200 percent to 400 percent above the relative value unit (RVU).
- Data from Montana as of July 2016 show Medicaid expansion enrollment is nearly double initial projections. While only 25,000 citizens were expected to enroll, 47,399 had already done so, with an estimate of nearly 60,000 additional enrollees within one year.
- Average unit costs among four previous SAMHSA grantees for prescreening, screening, brief intervention, brief treatment, and referral to treatment were \$0.61, \$6.59, \$10.48, \$22.63, and \$12.06 in emergency departments. (Barbosa, et al., 2015.)
- Average unit costs among four previous SAMHSA grantees for prescreening, screening, brief intervention, brief treatment, and referral to treatment were \$0.86, \$6.33, \$9.07, \$27.61 and \$8.03 in inpatient settings. (Barbosa, et al., 2015.)
- Average unit costs among four previous SAMHSA grantees for prescreening, screening, brief intervention, brief treatment, and referral to treatment were \$0.84, \$3.98, \$7.81, \$27.94, and \$9.23 in outpatient settings. (Barbosa, et al., 2015.)
- Support activities comprise nearly half of all costs involved with SBIRT. These costs are primarily represented by salary and benefits within a particular program.
- Multiple studies indicate cost savings between \$3.81 and \$5.61 for each dollar invested in screening for risky use. (Adkins, et al., 2013.) These data come from MarketScan and cover ED use of patients that screen positive for SU/SUD, as well as Project TrEAT. MarketScan data looks at Medicaid, Medicare, and private insurance use.
- Project TrEAT encompassed 64 family physicians/general internists working in clinics in rural and urban Wisconsin. Cost savings arise from reduced trauma and medical care, auto accidents, and incarceration.

- CMS has expanded the types of service providers who may screen for risky substance use behaviors to include community health workers and other non-licensed practitioners when recommended by a physician or other licensed practitioner of the healing arts within the scope of practice under state law. Such expansion could shift costs to less expensive providers.
- Under Medicaid rules, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits allow age-appropriate mental health and substance abuse screening. EPSDT payments will be a consideration for SBIRT implementation in youth populations.
- States studied in the past have shown the need for infrastructure (a supportive legislature, funders, collaboration) to adequately train physicians, train screeners for motivational interviewing, prepare SBIRT curricula, and provide technical assistance on the use of proper billing codes. These costs should be taken into account in dissemination planning.

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