**NC INSTITUTE OF MEDICINE**
**TASK FORCE ON SUBSTANCE ABUSE SERVICES**
**January 14, 2007**
**10:00-3:00**
**NC Hospital Association**

**Meeting Summary**

**Attendees:**
*Task Force/Steering Committee:* Martha Alexander, Bert Bennett, Sonya Brown, Robert Bilbro, Sherry Bradsher, Carl Britton-Watkins, Anthony Burnett, Spencer Clark, Chris Collins, Grayce Crockett, Debra DeBruhl, Leah Devlin, Anne Doolen, Tony Foriest, David Friedman, Robert Gwyther, Paula Harrington, Verla Insko, Larry Johnson, Jinnie Lowery, Mary McAllister, Kevin McDonald, Sara McEwen, Phillip Mooring, Mike Moseley, Paul Nagy, Martin Nesbitt, Will Neuman, Marguerite Peebles, Janice Petersen, Martin Pharr, William Purcell, Thomas Savidge, Jane Schairer, Starleen Scott-Robbins, DeDe Severino, Gregg Stahl, Anne Thomas, Wendy Webster, Cynthia Widford

*Interested Persons*: Thomas Babor, Jeremy Bray, Sheila Davies, Lindsey Deere, Scarlette Gardner, Kathleen Gibson, Alan Hampton, Denise Harb, Trish Hussey, Shawn Parker, Paul Savery, Wes Stewart, Shealey Thompson, Mike Vicario, Helen Wolstenholme, David Zell
*Staff*: Kimberly Alexander-Bratcher, Thalia Fuller, Jennifer Hastings, Mark Holmes, Christine Nielsen, Pam Silberman, Daniel Shive, Alex Tilley

**WELCOME AND INTRODUCTIONS**
**Senator Martin L. Nesbitt, Jr., JD**
NC Senate

Senator Nesbitt welcomed the Task Force members to the meeting. He informed the group of the need to come up with interim recommendations to include in the interim report to the General Assembly.

## SCREENING, BRIEF INTERVENTIONS, REFERRAL AND TREATMENT (SBIRT)

**Thomas F. Babor, PhD, MPH**
Professor
Physicians Health Services Chair in Community Medicine
& Public Health
University of Connecticut Health Center

Screening, Brief Intervention and Referral (SBIRT) is a set of interventions developed over the past 25 years. SBIRT was developed to get the mainstream medical community to pay attention to substance abuse. It is an approach to substance abuse for alcohol, illicit drugs, prescription drugs, and tobacco as well. There is now a federal initiative called SBIRT sponsored by SAMSHA, providing large demonstration grants to several states and tribal groups. Jeremy Bray, from RTI, is conducting the evaluation of the first 6 states and 1 tribal group.

Substance use screening tests have been around since the early 1970's, but substance abuse treatment and education have been practiced since the early 18th century. In the 1980's, the World Health Organization developed the Managing Hazardous and Harmful Alcohol Use in Primary Care program. The program was designed to fit both developing and developed countries for substance abuse. Ultimately the program broadened the base of treatment into mainstream medical care. The 1990's brought a second generation of screening tests (AUDIT and ASSIST) and an explosion of research into brief intervention and risk identification. The SBIRT concept was introduced in the early 2000's with a national demonstration project and in other countries.

Dr. Babor discussed the need for a public health approach to screening and early intervention and certain preconditions necessary to facilitate such an approach . Specifically, there must be an adequate definition of the problem and an understanding of risk factors and the at-risk population. Validated and reliable screening tests must also be readily available for use, especially tests that are brief and easy to administer. In addition to the screening instrument, effective interventions and treatment options must also be available. Ultimately, screening instruments need to have sufficient penetration to affect the rate of alcohol and other substance use in the population.

The SBIRT model represents a public health approach to screening and early intervention. The model screens to find at-risk users and cases of substance dependence. Brief intervention is time limited and provides a low cost, easy to use early substance use detection mechanism. This mechanism is large scale rather than individual specific. The model refers more serious cases to further diagnostic assessment and specialized care. Overall, the SBIRT model represents coordination, integration, and dissemination of activities across the patient encounter.

An algorithm puts all the pieces together. The model distinguishes between people who may have a problem and those who do not, as well as those with different levels of risk for substance use. The majority of patients receive the brief intervention because they do not have a treatable problem. The use of the brief intervention in these cases is to deter the patient from an abusive path. Those patients who continue to be at risk after the brief intervention receive brief treatment. Brief treatment includes 4 to 5 sessions with a patient in a setting other than the treatment facility. This helps patients to accept the intervention in beginning stages. Those patients not responding to brief treatment or motivational counseling are then referred to substance abuse treatment facilities.

SBIRT will pick up many end-stage users, but also a large number of people who are at risk. Social settings encourage drinking and driving. We must remember to focus on the people at risk as well as those end-stage users. Dr. Babor referred to the Drinkers' and Illicit Drug Use pyramids. The Drinkers' pyramid shows that only about 5 percent of people are dependent drinkers and an additional 20 percent are at-risk drinkers. Only 40 percent of the population is termed an alcohol abstainer. The same pattern emerges when looking at illicit drug use. Only three percent of the population abuses illicit drugs to the point of needing treatment, but another 14 percent are current drug users.

Most current screening tests are either self-reported or biological. Self-reported screening instruments usually cost very little to administer and score. Techniques exist to detect and minimize response bias tied to self-reported screening tools. Biological tests (liver function, corpuscular volume, urine screens, etc.) are more expensive and resource-intensive than self-reported screening tools, but are useful in employment and medical settings.

Self-reported screening tools are the best instruments to use in a public health approach due to the relative ease of use and interpretation and low cost. The Alcohol Use Disorders Identification Test (AUDIT) and Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) are two commonly used self-reported screening tools. Many health care professionals believe that self-reported screening tools are inaccurate due to reporting bias. Reporting bias may be less of an issue in identifying at-risk users compared to those with a current substance abuse problem. However, surveys show that patients are comfortable with substance use screenings and believe that these screenings are very important to providers.

The appropriate brief intervention stems from the screening test results. Brief intervention, by definition, is time-limited behavioral counseling that it is targeted at specific health behaviors (e.g., at-risk drinking or drug abuse). These interventions can range from 5 minutes to 5 brief counseling sessions. Each session should be guided by the results of the screening test and should facilitate two-way communication between the patient and provider to help identify patient-centered goals and provide encouragement to reach set targets. The goal of these sessions is to reduce substance consumption and to help engage patients in treatment should it be needed. The evidence base for alcohol brief intervention is growing. A clinical trial of at-risk drinkers found a 13 to 34 percent reduction in the average number of drinks per week for those patients receiving a brief intervention compared to a control group. Those receiving brief interventions also had an increased likelihood of having a safe or moderate drinking condition compared to controls.

Other studies have found that decreased alcohol consumption leads to an improved quality of life. In the long term, brief intervention has been shown to decrease alcohol consumption and reduce hospital days. However, research is mixed on the long-term effects on morbidity or mortality. Fewer studies have been conducted for brief intervention and drug use.

Recent research is focused on brief intervention and multiple risk factors. For example, smoking is common among heavy drinkers and drug users. The relationship between smoking, drinking, and drug use makes it difficult to change one behavior without modifying the others. The Vital Signs Project was designed to evaluate the efficacy of brief interventions for smokers and risky drinkers when delivered separately and in combination. The project targeted Medicaid recipients at community dental clinics. Preliminary results show an overlap of behavior change between intervention groups, showing that focus on a single substance use issue affects other risk behaviors as well.

Recent advances in brief treatment have centered on manual-guided brief psychotherapies (cognitive-behavioral, motivational enhancement) and new pharmacotherapies for general practitioners (e.g., buprenorphine and naltrexone). The Marijuana Treatment Project (MTP) is a multi-site study of the effectiveness of brief treatment for cannabis-dependence funded by the SAMHSA Center for Substance Abuse Treatment (CSAT). The MTP involved 250 chronic cannabis users who were randomly assigned to 1 of 3 treatment groups: delayed treatment control, brief treatment, and extended treatment. Those users assigned to the brief treatment group saw a one-third reduction in cannabis use after two sessions and a two-thirds reduction in use after 9 sessions.

Referral to treatment is the often overlooked, yet integral component of SBIRT. Research shows that the earlier patients are engaged in treatment, the better their long-term outcomes will be. Patient referrals are also effective in engaging both treatment-seeking and non-treatment-seeking patients in treatment. Patients who are referred to treatment are 10 times more likely to attend their first appointment compared to non-referred patients.

Brief interventions and brief treatments are effective with smokers and drinkers, and the results are promising with marijuana users. Over 2 decades of clinical research and program development supports wider SBIRT implementation; however, implementation barriers exist. Providers often cite a lack of time and insufficient screening and diagnostic skills as primary barriers to the adoption of SBIRT. A general sense of role incompatibility (i.e., “not my job”) and negative attitudes associated with substance abuse also prove hard to overcome. Compounding these problems is a lack of proven implementation models.

The Cutting Back Study is attempting to address some of these implementation barriers. Specifically, the study is looking at the feasibility of SBIRT implementation in primary care settings within managed care environments. The study also looks at whether the person who delivers the intervention (e.g., doctors, nurses, or health educators) affects the outcomes. The study found a significant reduction in the number of drinks per week in the group that received the brief intervention. There was no difference in affect whether the intervention was delivered by a doctor or specialist (nurses or health educators). The Cutting Back Study does provide insight into factors influencing success/failure of SBIRT implementation. A stable patient population and organizational structure are important predisposing factors for successful implementation. Factors that enable implementation include providing time for the intervention during the patient encounter, involving the staff in the planning process, and having a “champion” within the organization that can provide leadership. Top-down organizational support is an important reinforcing factor.

Ultimately, SBIRT focused on alcohol can be done, but it is not easy. There are numerous implementation barriers including lack of time during the patient encounter and competing organizational priorities. However, training can change organizational beliefs and build capacity, and practice will reinforce these changes.

**Comments/Questions:**

Currently 11 states are using SBIRT in federal demonstration projects. North Carolina is currently applying for part of this funding. Most of the current research is focused on implementation models such as through insurance companies; however, insurance companies are not showing much interest. Lack of reimbursement is commonly cited as a limiting factor to SBIRT integration, but the New Mexico Cutting Back study was piloted without specific billing. Additional costs were about $0.11 per member per month. While the per unit cost of screening is relatively low, the overall cost of screening an entire population can add up. As such, it is important to choose the appropriate intervention that proves most effective for your population. There is still concern that lack of billing codes for SBIRT will significantly limit integration into primary care.

The SBIRT model is not necessarily patient specific. So, SBIRT can theoretically be used in the uninsured population by integrating SBIRT into safety net organizations. Overall, 90 to 95 percent of people who screen positive are not addicted. SBIRT works best for those people who have some control over their substance use, but can prove effective in helping addicted people get treatment.

SBIRT can also be effective in the adolescent population. A study at Brown University found that adolescents that were identified and who received treatment had reduced substance use and hospital admissions in comparison to those who were not identified and did not receive treatment.

## INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH

**Chris Collins, MSW**
Program Consultant
Community Care of North Carolina

There are few evidence-based models for the integration of primary care and substance abuse. As such, this presentation will provide an overview of primary care and behavioral health integration models with the assumption that similar techniques could be used for substance abuse. Ms. Collins explained that there is a lot of overlap between the SBIRT discussion and the integration of care in behavioral health.

Data show that 1 in 5 people in the United States have a mental health diagnosis, and almost 50 percent of those receive treatment for their disorder in the primary care setting. Patients strongly prefer to get their behavioral health services from their regular medical provider. Because the vast majority of patients in primary care have either stress sensitive physical ailments, difficulty maintaining a healthy lifestyle, or a psychological disorder, it is clinically effective and cost effective to make behavioral health providers part of the primary care setting.

The Mountain Area Health Education Center (MAHEC) has experience with behavioral health care integration and has found that integrated care delivery can lead to increased treatment adherence, more effective and efficient care, increased patient function, and improved patient and staff satisfaction.

Several degrees of care integration exist. Co-location refers to behavioral health and primary care providers sharing the same work space, but not necessarily collaborating on individual cases. Collaboration models have specialty mental health services provided in close collaboration with primary care. In integration models, on the other hand, most behavioral health issues are managed by the primary care provider with consultation from behavioral health specialists. Integrated primary care combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to primary medical care. Integrated care models are not a replacement for specialty mental health as this would significantly overload the system.

The chronic care model serves as a guide for successful care integration. Studies show that integrated models are effective when they incorporate:

- Screening
- Treatment guidelines
- Patient education
- Physician education
- Tracking systems
- Treatment coordination
- Mental health specialists

As discussed earlier, proper screening improves the identification of patients with the target disorder in the primary care setting. Significant patient benefits have been observed in patients with depression when screening results are coordinated with effective follow-up and treatment.

The Buncombe County Health Center implemented an integrated care model in which care providers work together at the point of care to make treatment decisions. The Buncombe model incorporates the following components:

- Screening
- Assessment
- Brief supportive counseling
- Therapy
- Case management
- Medication monitoring
- Coordinated team care

The role of a behavioral health clinician in an integrated care model is five-fold. Clinicians must provide patient-focused support that addresses patient-specific issues and work to develop problem-solving skills and self-management techniques. Behavioral health clinicians must also be sure to follow-up with patients and foster open communication. This should include communication between the behavioral health

provider and the patient, as well as between the behavioral health provider and the primary care provider. In addition to patient support and active follow-up, behavioral health clinicians should also provide patient education, therapy, and medication management services. Successful integration models also require a certain degree of process education and supervision (both clinical and supportive). Education needs are especially important. Primary care providers need to be educated on various mental health topics, and behavioral health providers need to be educated on common medical and chronic conditions in addition to the language and operations of a primary care practice.

Significant cultural and professional differences may persist between primary care and behavioral health providers making integration difficult. The historical separation of physical and mental health care delivery also presents a significant barrier. Also of importance are the possible legal barriers to communication between providers about patient treatment.

The goal of co-location pilots in CCNC is to help improve mental health access in practices with a large percentage of Medicaid patients so that primary and behavioral health care can be better integrated. Grant funds will be used as a development grant to build the co-location infrastructure and provide a stipend to the practice until mental health provider billings can sustain the practitioner. Currently 12 of the 14 CCNC networks are participating, representing 44 primary care practices in 26 counties. Participating facilities include community health centers, rural health centers, health departments, family practices, and internal medicine and pediatric practices. There are also 2 examples of reverse co-location in which primary care providers are brought into behavioral health settings.

Key components of CCNC co-location models include primary care providers who use evidence-based screening tools to identify at-risk patients and refer those with positive screens to therapists. Therapists, in this model, provide initial care and refer more complex patients to mental health specialists. CCNC provides .25 FTE for a program consultant and about $25,000 per primary care provider (total of $1 million). The Division of Medical Assistance is tasked with resolving billing and coding issues. CCNC also partners with ICARE to provide training for both primary and behavioral health providers, to develop links to community resources, and to serve an advisory role in reviewing, posting and training on evidence-based tools.

There are several areas to consider when developing an integrated care model. There must be a solid internal infrastructure with a sustainable funding stream (Medicaid, private payers, providers, etc.) The funding of the model, particularly provider reimbursement, should be designed to support and incentivize care integration. Recruitment efforts should be made at the practice level. All stakeholders need training and education on program goals and tools. And finally, cross-discipline communication is essential to assure a shared plan of care.

**Comments/Questions**

The discussion that followed focused on other examples of integrated care practice, methods the Task Force could use to support the model for use with substance abuse, the basis of family practice on this type of model, and expanding the model to other providers including licensed clinical addiction specialists (LCAS), licensed professional counselors (LPC), and others

Primary care physicians have little or no time to deal with the complex problems of substance abuse. Currently, there is no standard for referrals, but most cases are routinely referred to mental health without regard to the patients' degree of substance use. Many people fall out of the system because they are referred to mental health providers before problems become chronic.

The co-location model can be very effective, but without referral services the model will fail. The community service system for substance abuse needs to have the capacity to accept the referrals that are currently being lost. If there is no parity between substance abuse and other mid-level providers, the system will struggle to succeed.

**NORTH CAROLINA DATA UPDATE**
**Spencer Clark, MSW**
**Shealy Thompson, PhD**
Community Policy Management
NC Division of MH/DD/SAS

Mr. Clark distributed two handouts in addition to the presentation. The first is an excerpt of a report on quality measures categorized by local management entity (LME). The other is a summary of substance abuse services provided to North Carolinians categorized by LME and ASAM service level. Service utilization and expenditure data, as well as overall public sector treatment penetration rates, are provided for adults and children separately at the state and LME level. The Division of MH/DD/SAS is currently working to capture these data at the county level. It is important to realize that data presented in these reports reflect state and federal claims that are captured in the Medicaid and the Division (IPRS) systems. Therefore, these data do not include private, self-pay, grant, partnership, or county expenditures, or expenditures for prisoners treated in jail treatment programs. Treatment for prisoners delivered outside of the prison setting is included as long as it is processed through Medicaid or the state IPRS. Overall public substance abuse expenditures may be underestimated, particularly in more urban LMEs. For example, Mecklenburg County spends approximately $42 million in local funds for substance abuse treatment, which is not captured in these data. The exclusion of private payer data is less limiting as private payer sources typically have fewer covered substance abuse services. Data from both reports are summarized in Mr. Clark's presentation.

As discussed in earlier meeting, North Carolina's continuum of substance abuse treatment services is based on a subset of the ASAM continuum of care. The North Carolina continuum consists of six levels of care: outpatient, intensive outpatient, residential low, residential high, inpatient, and crisis service treatment. Statewide,

substance abuse expenditures are weighted toward both ends of the continuum. Almost half of substance abuse funds were spent on outpatient services, and less than one-third on more intensive community services. Treatment rates follow a similar pattern with over three-quarters of patients treated by level 1 outpatient services. However, when looking at the average dollar expenditure per person treated, outpatient services are by far the least expensive ($531 per person treated). Of the 6 service definitions, residential-low services are the most expensive ($4,500 per person treated) due to the long-term nature of such treatment. The amount of money spent suggests some inadequacies in the system, particularly that outpatient services have not been provided in sufficient intensity to be effective.

The penetration rate presented by Mr. Clark is derived from the National Survey on Drug Use and Health (NSDUH) household survey. There is some concern that the survey under-represents the population. In North Carolina, it is estimated that the substance abuse treatment system is only reaching 7.2 percent of adults who are in need of services. This rate is standard and may include the number of people below the poverty line and the uninsured to estimate people receiving public services. The rate focuses on late-stage users of intensive service with a substance abuse diagnosis. There are other groups, including grants and other programs that may not be included in this data.

Mr. Clark presented the above data for four LMEs:

LME A is primarily rural and has a treatment penetration (5 percent) below the state average. Almost 90 percent of patients receive out-patient treatment with very low treatment prevalence for more intensive services. This LME has higher spending for outpatient services than the state average, but spending is not stable across other treatment levels. LME A does not provide the ideal model for service delivery and funding.

LME B focuses on extreme ends of continuum of services. The majority of expenditures are for the least and most intensive services with almost non-existent utilization of intermediate care. This LME may have challenges engaging and retaining clients as the continuum of services is not complete.

LME C is a mixed rural/urban service area. While more balanced than the previous two LMEs, LME C still treats three-quarters of its patients in the outpatient setting and treats less than 15 percent of patients in residential or inpatient facilities. The use of crisis services is almost non-existent. There are also large variations in the average cost per treated adult across the service levels. While only one percent of patients are treated in low-residential settings, they cost over $15,000 to treat compared to $2,000 for those treated in high-residential settings.

LME D represents a balanced approach, offering a combined continuum of care. Expenditures are more evenly distributed across services, and all levels of care are utilized.

The proportion of people served by treatment level varies significantly by LME. Those with many outpatient services tend to be lower in the utilization of other services. The ultimate goal for each LME is to achieve a balanced continuum of care. It is important not to just look at one factor to make a judgment. Instead, one must know the nuances of particular areas, and the system must be readily available to provide needed services for each area.

Initiation and engagement of treatment are important factors for successful treatment and continued recovery. The best chance of recovery involves prompt and continuing care. The quality measures used to assess initiation and engagement in services are taken from the Washington Circle Public Sector Workgroup, which states that "the standard for initiating consumers in care is to receive 2 visits within the first 14 days". The statewide goal for initiation of services is 71 percent. During state FY 2007, 5 LMEs met or exceeded that goal. On average 64 percent of those treated in the public treatment system received 2 visits within the first 14 days of care. The standard for consumer engagement in care requires an additional 2 meetings within the next 30 days, resulting in a total of 4 visits in 45 days. The state set its engagement goal at 50 percent. In SFY 2007, 10 LMEs met or exceeded this target. Overall, 47 percent of people who met the initiation standard also met the engagement standard.

In North Carolina, Medicaid pays 54 percent of adult substance abuse services and 77 percent of children's services. Many children have primary mental health diagnoses and are not included in these figures. Only primary substance abuse diagnoses are included in the data. Overall, Medicaid pays for more outpatient and inpatient services (e.g., residential high services) while the state IPRS pays for more half-ways houses (e.g., residential low services) and crisis services.

Comments/Questions:
Several participants asked about other data accessible through the division including treatment cost per day and services requested versus those that were provided and billed.

## POTENTIAL RECOMMENDATIONS FROM THE TASK FORCE

The Task Force is responsible for drafting an interim report for the General Assembly. As such, the discussion focused on which topics the Task Force feels ready to report.

Primary areas of focus for the report include: prevention, primary care integration, ASAM continuum of care, and existing and needed data. Specifically, the Task Force recommended:

- Prevention: We need to ensure a comprehensive system that includes evidence-based practices and accepted policies (as not all policies are evidence-based). The policies should clearly focus on early prevention and coordination of services, particularly who should manage these initiatives (DPI, DJJ, etc.) and how they should be funded. It was suggested that North Carolina publish a statewide prevention plan to include, among other things, a school curriculum for peer

health educators. Adolescents should be a primary focus of prevention activities given incomplete brain development and increased risk for greater abuse in adulthood. We need to develop a policy or program for children who are at increased risk for addiction, for example, children engaged in violence by the 4th grade. There are currently Safe and Drug Free Schools programs in every local education area through DPI; however, parents are not aware of what programs are offered. The Task Force must be careful not to use all funds for prevention purposes and risk leaving those people in current need of treatment without adequate services.

- Primary Care: If screening instruments are used in the primary care setting, we must be sure that adequate services are available to treat patients who screen positive. A successful screening program must bring 18 to 40 year olds into the primary care setting for screening. Interactions in emergency departments are not conducive to screening needs and do not offer "teachable" moments. There is also a problem with continuity of care among adolescents. After six years of age, adolescents are recommended to see a primary care physician every 3 years. These gaps in service represent lost time for early prevention and screening in this age group. There was also discussion of strengthening the safety net through Project Access models, community health centers, rural health clinics, school nurses, school-based health centers, data collection pilots, and child health family teams.

- Continuum of Services: A true continuum of substance abuse services requires the integration of primary care. Topics of discussion included workforce issues (reimbursement, licensed professional reimbursement other than LCSW, ex. Licensed Professional Counselor, etc.), inadequate information on barriers to care (appropriate mix of services, more information from division), incentive-based management of contracts and market forces, data from LSAC certification/licensure board, rural community models, and the need for county-by-county reports.

- Data: The topics discussed concerning data included county-level reports, driving distance to service, workforce, diagnostic data (incorrect coding), complete and appropriate reporting, funding/authorization patterns (requested versus delivered services, lengths of stay, etc.), the need for best practice/measurement tools for authorizers of care, the need for a model spread of care across continuum, the relationship between patient and program or resource provider, cost models, and the need for more information on patients that do not return for follow-up visits.

Other areas for further discussion include the administrative burden of paperwork and wait times for screening, triage, and referrals.