



Expanding SBIRT to other Behavioral Risk Factors A Key to Improving Health and Reducing Costs

Richard L. Brown, MD, MPH



Need

Nearly half of all deaths, most chronic disease and disability, and over \$200 billion in health care costs could be averted every year if Americans had healthier lifestyles.¹⁻⁶

Research shows that implementing comprehensive behavioral screening and intervention in general healthcare settings would ...

- Increase smoking quit rates by three-fold⁷
- Elicit healthier diets and more physical activity^{8,9}
- Decrease binge drinking by 20% and reduce alcohol-related hospitalizations by 37%^{10,11}
- Reduce illicit drug use¹²⁻¹⁴
- Reduce car crashes and criminal justice costs^{11,15}
- Avoid and shorten episodes of depression¹⁶
- Generate tens of billions of dollars in net savings on health care every year^{3,17-19}

Barriers

New billing codes accommodate tobacco, alcohol, and drug screening and intervention, but other reimbursement barriers remain.²⁰

A major barrier continues to be provider time. In the average 15-minute visit, a primary care provider (PCP) addresses nearly three new clinical concerns.²¹ A PCP would need over 7 hours each day just to deliver all recommended preventive services to all patients.²² The Institute of Medicine has concluded that our current model of health care cannot address our current needs.²³ PCPs need help in delivering these critical preventive services.²⁴

A Solution

Consistent with the principles of the Patient-Centered Medical Home concept and the Future of Family Medicine Project, some SAMHSA-funded SBIRT projects have developed alcohol and drug screening and intervention models that can be expanded to address other behavioral risk factors:

- Receptionists hand out written screens^{7,25-27} when patients check in, or screens could be adminis-

tered at computer kiosks or on the Internet before a patient arrives.

- Nurses who check vital signs review the completed screens and have appropriate patients meet with an on-site Health Educator (HE).
- Dedicated, cost-efficient HEs administer all subsequent assessment, intervention, and (if needed) referral services.
- HEs receive specialized training²⁸ and ongoing support from an independent service agency.
- A computer system guides HEs in following evidence-based protocols and collecting data for quality improvement and evaluation.
- PCPs reinforce prevention messages and provide appropriate pharmacotherapy.^{7,29-31}
- A quality improvement team at each site optimizes work flow.³²

Recommendations for Implementation

White House and HHS leadership - Forge collaboration among multiple Federal agencies to implement this model over the next five years.

ONDCP, SAMHSA - Add other behavioral components to current and future alcohol and drug SBIRT programs.

CMS - Assure adequate reimbursement for services that are delivered by health educators on an "incident to" basis. Allow reimbursement when a PCP and HE deliver services at the same visit.²⁰

CDC - Administer educational and training programs to help healthcare organizations implement this model.

DOD, FEHP, HRSA, VA - Implement this model across all supported health systems and plans.

DOE - Assure implementation at all college health services.

Congress - All healthcare reform measures must ensure that comprehensive behavioral prevention services are delivered in all medical homes.



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