

# Alcohol Screening and Brief Intervention (ASBI)

## IHS-Tribal Hospital Emergency Departments and Clinics

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Indian Health Summit Conference  
Denver, CO

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# Objectives

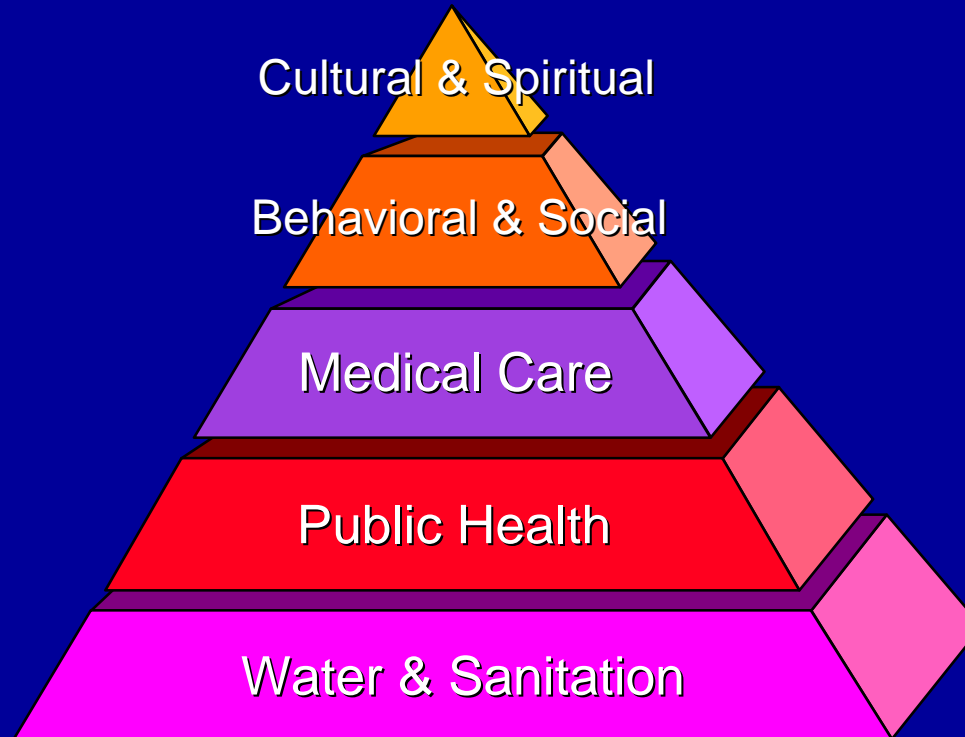
- **To know** the AI/AN demographics of trauma and non-intentional injuries
- **To learn** behavioral and motivational change models as applied to alcohol abuse
- **To understand** intervention strategies for reducing repeat injuries
- **To participate** the IHS-Tribal ASBI Program

Trauma, Emergency Care, Behavioral Health, Alcohol and Substance Abuse, and Injury Prevention: 2007



# Indian Health Service

# IHS Tribal-COMMUNITY ORIENTED PRIMARY CARE



The Indian health care system is built on a broad spectrum approach to health. It starts with a base of fundamental public health and sanitation infrastructure. It provides inpatient and ambulatory medical services. It also integrates community-oriented programs promoting healthy behaviors and lifestyles.

# IHS Director Grim's Initiatives

- Management of Chronic Disease
  - Hazardous/Harmful Drinking, Alcohol Abuse & Relationship to Injury
- Behavioral Health
  - Substance Abuse & Control
  - Motivational Interventions
- Health Promotion and Disease Prevention
  - Re-Injury Prevention, Reduce Trauma
  - Mortality, Morbidity & Costs

# Alcohol Screening and Brief Intervention Program

- Takes advantage of the “teachable moment” when an injury patient presents at a facility as a result of possible intoxication or drug abuse.
- Considered the largest “rural targeted injury-alcohol intervention” to date.
- Being implemented system-wide in all IHS and tribal hospitals.
- Six *Train-the-Trainer* conferences held so far.
- Next year the ASBI program will be introduced in IHS/tribal primary care



# Injury Terminology

- **Trauma=Injury**
  - Unintentional
  - Intentional
    - Suicide
    - Homicide
- Injury **Recidivism = Repeat Injury**
- Injury **Prevention**
- **Trauma Costs, Contract Care Funds\***

# ASBI Terminology

- **AS:** Alcohol Screening
- **BI:** Brief Intervention
- **BNI:** Brief Negotiated Interview (Yale)
- **ASBI:** Alcohol Screening & Brief Intervention
- **SBIRT:** Screening, Brief Intervention and Referral to Treatment
- **Counseling:** Intense, Prolonged Therapy

## ASBI Program Goal

***“ALCOHOL SCREENING AND A BRIEF NEGOTIATED INTERVIEW, DURING THE TEACHABLE MOMENT, AFTER INJURY, CAN BE EFFECTIVE IN REDUCING RE-INJURIES (RECIDIVISM) UP TO 50% FOR SEVERAL YEARS”***

DR Boyd MDCM, FACS

# ASBI Strategic Approach

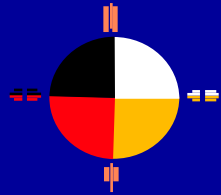
- Targeted Injury Control Initiative
- Alcohol Screening in Acute Care Settings; Trauma, ED and PC and BH Clinics
- Utilizes Multiple Providers
- Low Cost Implementation
- Cost Effective Intervention
- Universal Screening of other Substance Abuse and “Injurious Behaviors”

# Injury Mortality & Alcohol

- Trauma is the **fourth leading cause** of death in the United States and is the leading cause of death under 45 years of age.
- Alcohol Intoxication has been repeatedly associated with **over half** of trauma incidence and mortality.
- The Alcohol-Injury Relationship is **well known** throughout Indian Country

# FIVE LEADING CAUSES OF DEATH FOR DECEDENTS 15 TO 24 YEARS OF AGE

American Indians and Alaska Natives, IHS Service Area, 1996-98 and  
 U.S. All Races and White Populations, 1997  
 (Rate per 100,000 population)



	AI/AN Rate Adjusted <sup>1/</sup>	U.S. All Races Rate	U.S. White Rate	Ratio AI/AN to U.S. All Races	Ratio AI/AN to U.S. White
ALL CAUSES	193.4	86.2	77.5	2.2	2.5
Accidents	106.3	36.5	38.3	2.9	2.8
Motor vehicle	82.9	27.9	29.5	3.0	2.8
Other accidents	23.4	8.6	8.8	2.7	2.7
Homicide and legal intervention	37.4	11.4	11.9	3.3	3.1
Suicide	21.3	16.8	8.3	1.3	2.6

<sup>1/</sup>

Injuries had become the leading cause of death (30% of deaths).

# AI/AN TRAUMA DEATHS

**Three-Seven X's the General Population**

**New Mexico Deaths: (1999-2003)**

**Alcohol Related up (13- 20%)**

**Injuries up ( 7-12%)**

**ALASKA: Injuries are the leading cause of death (30% of all deaths).**

## ❖ Percentage of Deaths in AI/AN Related Alcohol-Related

❖ Motor Vehicular— 73%

❖ Pedestrian —75%

❖ Homicide —85 %

❖ Suicide —84%

Sources: May P, *The Epidemiology of Alcohol Abuse Among American Indians: the Mythical and Real Properties*. The Primary Care Provider, Volume 20, March 1995, Indian Health Service; . *Ethnicity and Alcohol-Related Fatalities, 1990-1994*, by Voas RB and Tipetts AS, National Highway Traffic Safety Administration, 1999. Courtesy of D. Wallace

# Injury Risk Factors for American Indians and Alaska Natives

- ❖ Median age of 24 vs. 33
- ❖ Below poverty level, 32%
- ❖ **Risky Environment:** Driving long distances on rural, isolated roadways.
- ❖ **Alcohol** involvement is higher than other racial groups.



Courtesy of Dave Wallace, MSEH; NCIP, CDC

# Trauma Center & ED Predictability

- ◇ **25-55% test+** for alcohol on TC-ED admission
- ◇ **25-50%** have a **diagnosable** alcohol use problem
- ◇ These are **3.5 times** more likely to be **re-admitted** for **another trauma episode**
- ◇ **Death** from repeat trauma is **6 times greater** than for the general population

# Trauma and EMS Systems

- Regionalization of Trauma/EMSS (1970)
  - Multiple/Spinal Injuries and Burn Centers/Systems
  - Adult and Children Programs
  - Clinical Modules; Cardiac, Poisonings, Perinatal & Behavioral,
- EMSS Act of 1973, amended in 1976 and 1979
  - “303 contiguous Regional EMSS Programs”
  - 15 Operational EMS Components
  - \$300 Million in Trauma EMS System Development
- Trauma & EMSS in IHS and Tribal EMS Programs (1975)
- EMS for Children Act of 1984 (Early Prevention Strategies)
- HRSA Trauma & EMS Program (1997-05)
  
- No Prevention Strategies

# Illinois Trauma-EMS System Data Alcohol Related–MVA Deaths

Blood Alcohol Content (BAC) for < 25 year olds  
were relatively low, many within legal limits

Every third MVA-Alcohol Related Death kills one  
other innocent passenger or bystander

DR Boyd MDCM, FACS Illinois Statewide Trauma Registry,  
Illinois Dept of Public Health, 1970-74

# R.A. Cowley STC

## Longitudinal Death Study

- **Not offering advice/intervention** to STC patients who test positive for alcohol misuse results in significant subsequent higher death rates from injury.
- **27,000 patients** discharged from the STC and followed for **1.5 to 14.5 years**.
- **A subsequent injury death occurred in 1,631 or (23%)** in those who tested toxicology positive at the initial STC admission.

Dischinger PC, Mitchell KA, Kufera JA, Soderstrom CA, et al: A longitudinal study of former trauma center patients: the association between toxicology status and subsequent injury mortality. *J Trauma* 2001;51:55-564.

# Billings Area Injury Death Study

- **Fatal Injuries** occurred after previous IHS Service Unit ETOH encounters without prevention counseling within;

**6 months (38%)**

## Recommendations:

- **Injury-Prevention** activities should be **initiated** at the time of any health-system contact in which alcohol use is identified.
- **Interventions** should be developed that convey the **immediate risk of death** from injury in these patients.

Analysis of Prior Health System Contacts as a Harbinger of Subsequent Fatal Injury in American Indians. TL Sanddal, J Upchurch, ND Sanddal and TJ Esposito; Journal of Rural Health, 2005

# 'Controlling Alcohol Problems among Hospitalized Trauma Patients'

“To combat America’s injury epidemic, **trauma care systems** have steadily improved over the last 30 years; such improvements include the development of highly successful Level I and Level II Trauma Centers.”

“These improvements in care have not reduced the incidence of trauma-related **scene deaths (~ 50%)**.”

**“These numbers will change only when prevention efforts are increased.”**

# Content Review

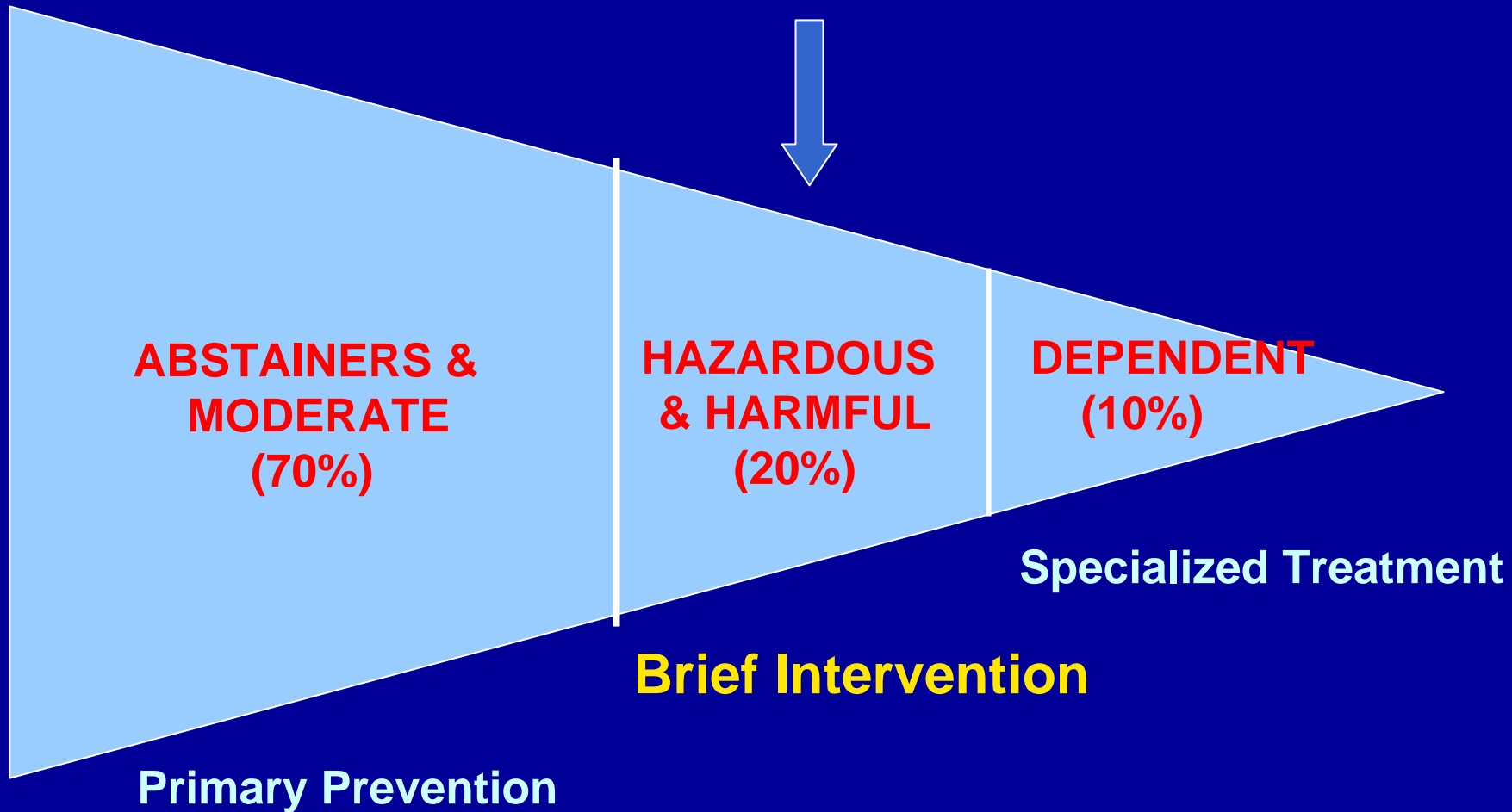
- Scope of Alcohol-Related Injury
- Scientific Background of ASBI
- Psychology of Behavioral Change
- Target Population
- Alcohol Screening (AS)
- Brief Intervention (BI)
- IHS-Tribal ASBI Plan
- Resources and References
- Documentation

# ASBI Literature Review

- Prochaska and DiClemente\* (1983)
- Bien et al (1993)
- Gentilello\* (1999)
- D'Onofrio\* and Degutis\* (2002, 2005)
- Dischinger\* and Soderstrom\* (2001)
- Moyer et al (2002)
- Soderstrom\* and DiClemente\*, (2005)
- Sanddal(s)\* and Upchurch\*, (2005)
- Schermer\*, (2006)

\*Assisting this IHS-Tribal ASBI Program

# The Spectrum of Alcohol Use: Who Are We Targeting in ASBI?



# ASBI Conceptual Rationale

- Provided in the **Acute Care Setting**
- **Window** of Opportunity
- Teachable **Moment**
- **Readiness** for Change
- **Non-Judgmental** Environment
- **Multiple** Health Care Providers
- Reinforcement “**Boosters**” are Helpful
- **Behavioral Health** Follow On
- **Diminish Loss** of Limb, Life and Trauma Dollars

# BEHAVIOR CHANGE: TAKING ADVANTAGE OF TEACHABLE MOMENTS as in THE SMOKING CESSATION STRATAGY

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[www.umbc.edu/psych/habits](http://www.umbc.edu/psych/habits)

# ASBI is derived from the Smoking Cessation **Transtheoretical Model**

- **Feedback** from the results of screening (AS)
- **Information** about the hazards of drinking
- Discuss how to choose a **Goal (BNI)**
- Give **Advice**
- Give **Encouragement**

Source: Prochaska, JO and DiClemente, CC. Stages and Process of Self-Change of Smoking: Toward an Integrative Model of Change . *J Consulting and Clinical Psychology* 51(3): 390-395, 1983.

# ACUTE CARE INTERVENTIONS

Provide a “**WINDOW OF OPPORTUNITY**” to intervene for problem identification and harm reduction.

Hazardous drinking patients are:

- **MORE OPEN** TO SEE DRINKING THE PROBLEM
- MORE VULNERABLE TO **LINKING CONSEQUENCES** TO THE DRINKING
- MORE **MOTIVATED** TO CHANGE
- HAVE A **MORE MOBILIZED** FAMILY SYSTEM

**Sentinel Publication** of the  
American College of Surgeons (ACS)  
Committee on Trauma (COT)

***The Journal of TRAUMA***

***Injury, Infection, and Critical Care***

**Alcohol and Other Drug Problems Among Hospitalized Trauma  
Patients:**

Controlling Complications, Mortality, and **Trauma Recidivism**

**Volume 59 Number 3 • September 2005 Supplement**

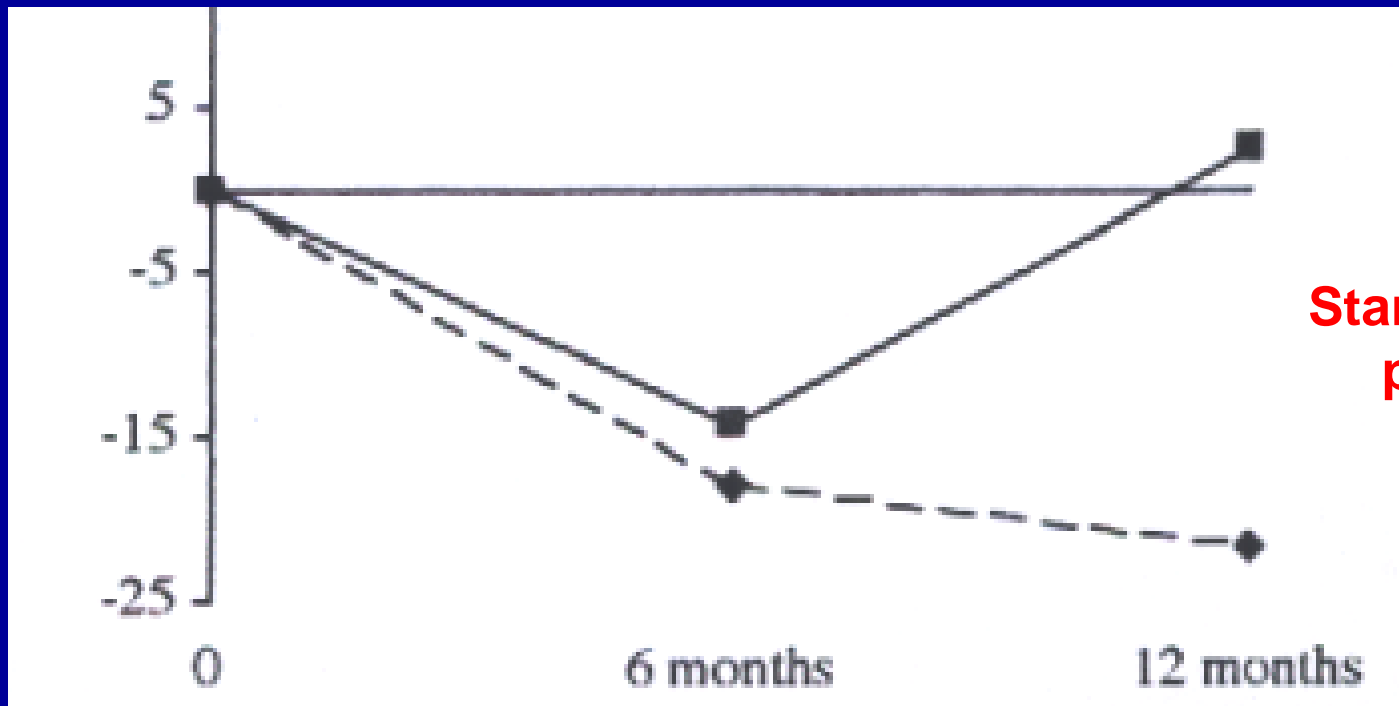
# Key Trauma Center Study

Showed the beneficial results achieved with a **Brief Intervention (BI)** in TC patients demonstrating **decreases in drinking** at 6 months and at one year in the.

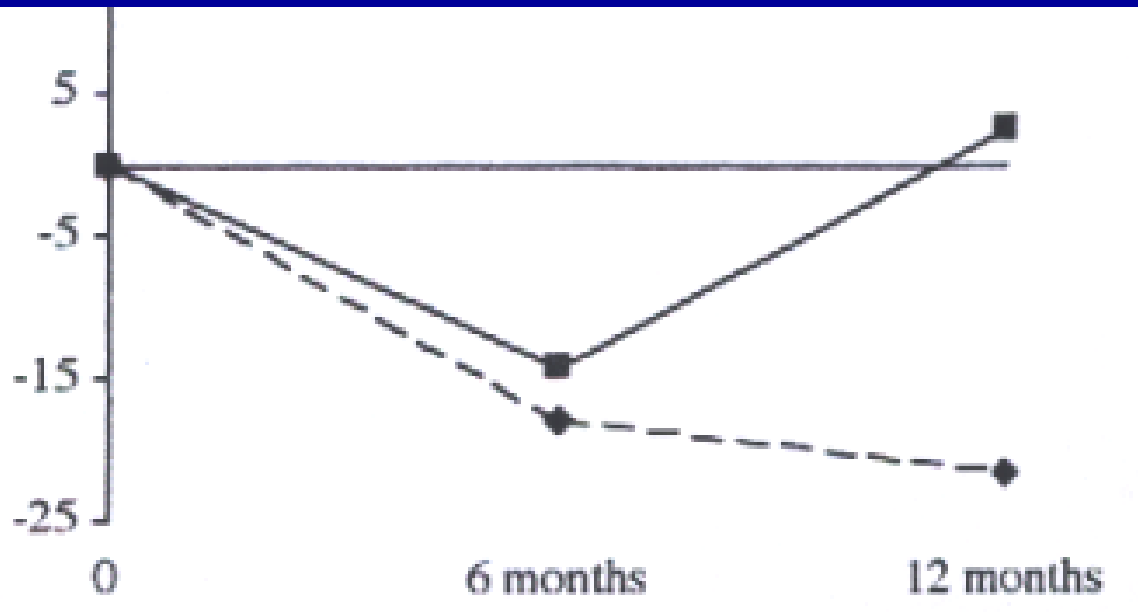
- The control group returned to pre-injury level (or higher) at one year.
- **The experimental group had a 47% reduction in injuries requiring emergency department care or trauma center admission.**

Gentilello LM, Rivara FP, Donovan DM, Jurkovich GJ, et al: Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Ann Surg*, 1999;230: 473-483.

**Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence**  
**Gentilello LM (Dunn CW) et al: Ann Surg 1999;230:473-483**



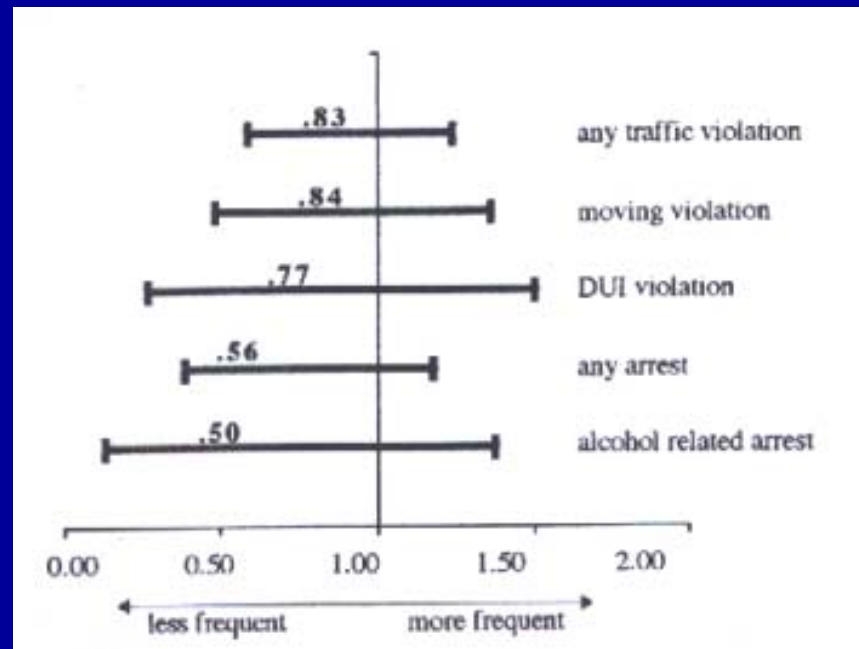
**Standard drinks  
per week**



**Standard drinks  
per week**

**Adverse Outcomes  
Controls vs. BI  
at 1 year**

**Gentilello et al *Ann  
Surg* '99**



## **Brief interventions for alcohol problems:**

**A review** ,Thomas H. Bien, William R. Miller & J. Scott Tonigan

*Addiction* 1993;88:315-336

**32 controlled trials in drinking behavior in Non-Emergency/Acute Care populations**

***“These studies indicate that brief interventions are more effective than no counseling, or often as effective as more extensive treatment.”***

**A review of screening and brief intervention (SBI) for alcohol problems:  
Implications for Emergency Medicine Practice. Gail D'Onofrio & Linda C. Degutis**

**Evidence-based review of SBI from 39  
studies including trauma center &  
emergency departments showed:**

**Positive Effects in 32 studies or 82%**

# Brief *Opportunistic* Interventions

- *Brief Interventions (BI)* that use *Motivational Principles* have been found to be very effective in producing significant and lasting changes
- *Opportunistic Interventions “seize the moment”* when individuals may be more open to these motivational principles moves the change process along, improves quality of life, and save lives

# Lasting Effect on DUI Recidivism

- Patients who received **BI** during a trauma center admission are **less likely** to be arrested for **DUI within 3 years** of discharge.
- **BI** represents a **viable intervention** to reduce DUI after trauma center admission.

Trauma center brief interventions for alcohol disorders decrease subsequent driving under the influence arrests. [Schermer CR](#), [Moyers TB](#), [Miller WR](#), [Bloomfield LA](#). J Trauma. 2006 Jan;60(1):29-34.

# ASBI COST-EFFECTIVENESS

- **“Cost-Benefit”** analysis for injured patients demonstrated a savings of nearly four dollars in direct injury related medical costs for every dollar invested in screening and intervention for injured patients”.
- **4 Trauma \$ vs. 1 ASBI \$**
- ***“Prevention Pays”***

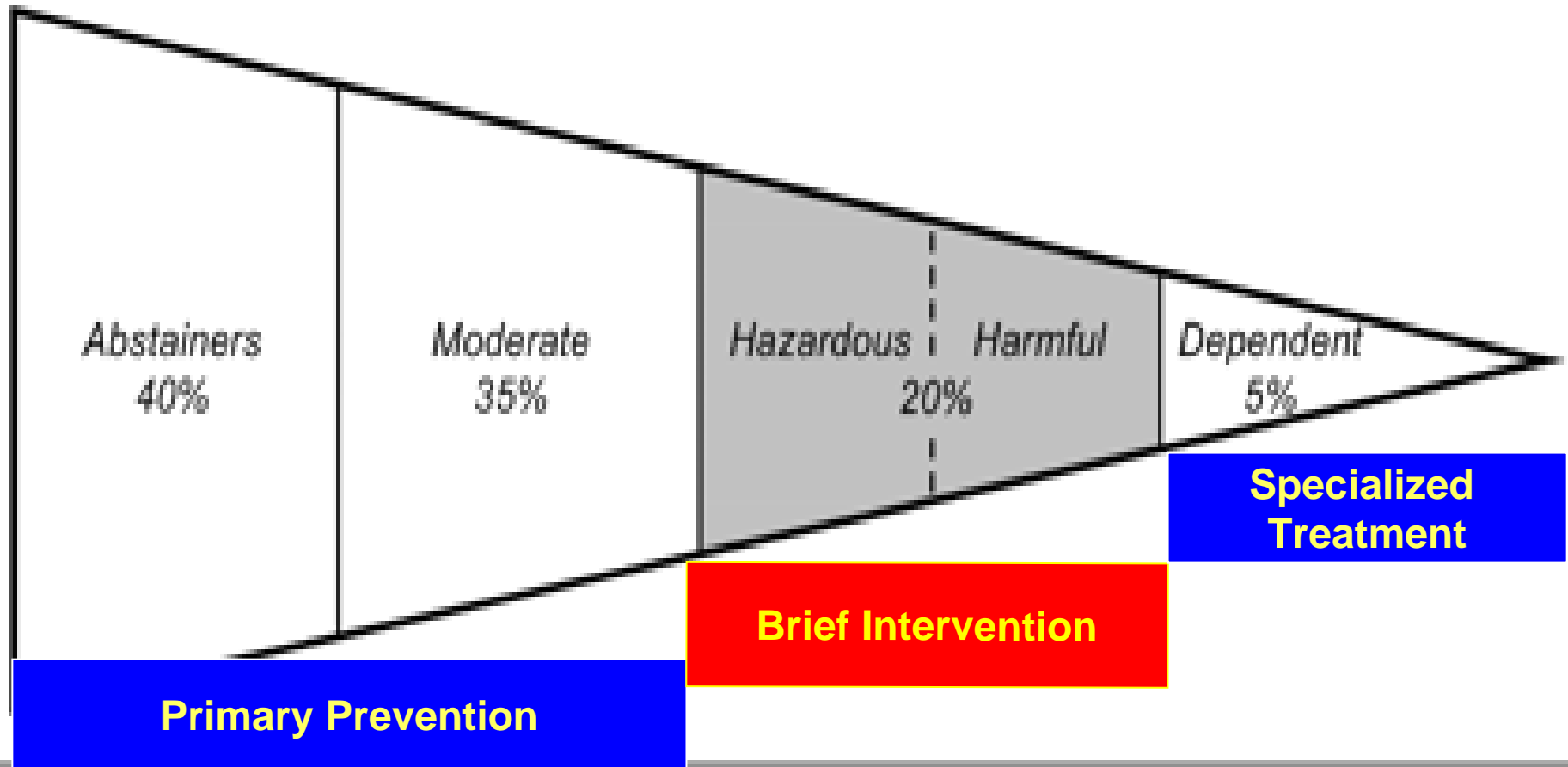
Gentilello. Lm. Et al, Alcohol interventions for trauma patients treated in emergency departments and hospitals: a cost benefit analysis.  
*Ann. Surg.* 2005;241:541-550

# Content Review

- Scope of Alcohol-Related Injury
- Scientific Background of ASBI
- Psychology of Behavioral Change
- **Target Population**
- Alcohol Screening (AS)
- Brief Intervention (BI)
- IHS-Tribal ASBI Plan
- Resources and References
- Documentation

# Who Are We Targeting With ASBI?

- The spectrum of alcohol use



# National Institute of Alcohol Abuse and Alcoholism: **Definitions**

TYPE	AMOUNT	AFFECTS
Abstainer	None	None
Moderate	Within NIAAA Guidelines	Health: None Problems: None
<b>Hazardous (At Risk)</b>	> NIAAA Guidelines	<b>At Risk for Injury/Illness, Social Problems</b>
<b>Harmful (Problem)</b>	> NIAAA Guidelines	<b>Experiencing Medical/Social Problems</b>
Dependent	Excessive	Physical Dependence

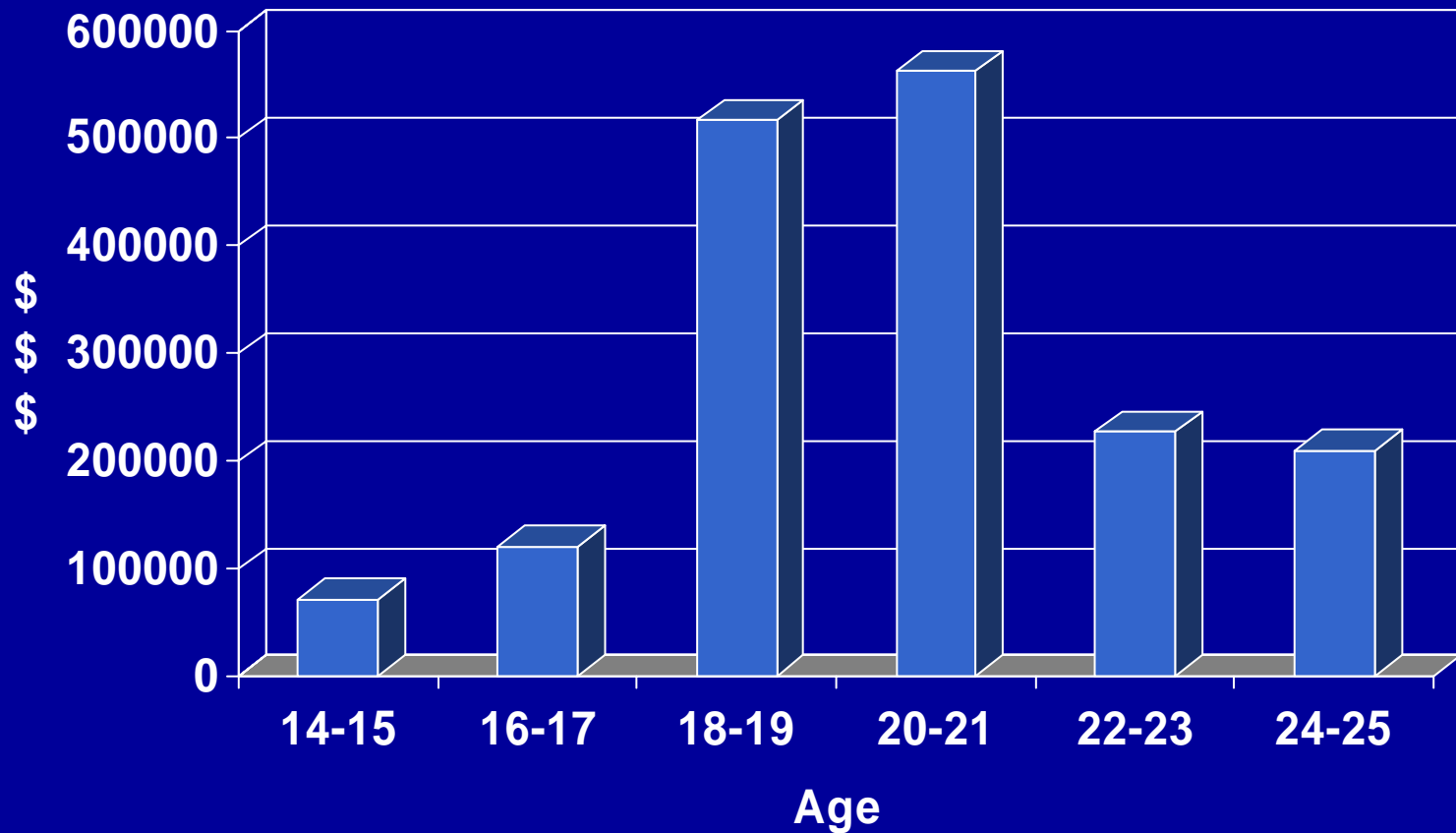
# ASBI Target Population

1. Young Adults and Teens
2. Non-dependent Alcohol Abusers
3. Hazardous or Harmful Behavior
4. Injury Causing to themselves or others
5. Injury Presentations to an IHS-Tribal  
Emergency Department, Urgent,  
Ambulatory and Primary Care
6. Are in the “Teachable Moment”

# ASBI TARGET PATIENT

- Acute Injury Related Patient Encounter
- Clinical Assessment
- Injury Related to Risky Behavior
- Risky Behavior has an Alcohol Basis
- Not a Diagnosis on “Alcoholism”
- Not an Assessment of “Intoxication.”
- Blood Alcohol (BAC) Not Required

# Billings Area CHS Injury Expenditures FY04 by Age



# Content Review

- Scope of Alcohol-Related Injury
- Scientific Background of ASBI
- Psychology of Behavioral Change
- Target Population
- **Alcohol Screening (AS) Several Methods**
- Brief Intervention (BI)
- IHS-Tribal ASBI Plan
- Resources and References
- Documentation

# Alcohol Screening (AS)

- Pre-Screen or Clinical Assessment
- CAGE
- Single Question
- AUDIT

# Alcohol Use Disorders Identification Test (AUDIT)

- Alcohol
- Use
- Disorders
- Identification
- Test
  
- Positive Hazard Score
  - Woman +7,
  - Man +8

# AUDIT

- Questions 1-3 **Hazardous Drinking**
  - *1. How often do you have a drink containing alcohol?*
  - *2. How many drinks containing alcohol do you have on a typical day when you are drinking?*
  - *3. How often do you have X or more drinks on one occasion? (X= 4 for females, 5 for males)*
- Questions 4-6 **Alcohol Dependence**
  - *4. Can't stop*
  - *5. Failed to do what's normally expected of you*
  - *6. First drink in AM (Eye-opener)*
- Questions 7-10 **Harmful Drinking**
  - *7. Guilt*
  - *8. Can't remember*
  - *9. You or someone else injured?*
  - *10. Cut down*

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- Scope of Alcohol-Related Injury
- Scientific Background of ASBI
- Psychology of Behavioral Change
- Target Population
- Alcohol Screening (AS):
- **Brief Intervention (BI): IHS-Tribal Methodology**
- IHS-Tribal ASBI Plan
- Resources and References
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# BI: WHO Definition & Implications

BI is a “practice to identify a real or potential alcohol problem and to motivate an individual to do something about it.”

- BI is a short health counseling technique designed to target alcohol non-dependent persons who engage in hazardous or harmful drinking.
- BI is not a quick fix treatment for alcohol dependence syndromes. Persons addicted to alcohol require specialist care or other treatment modalities.
- BI may help identify these persons with an alcohol dependence syndrome and facilitate referral to specialist care.



# Alcohol Screening and Brief Intervention (ASBI) Project

## BNI Training Manual

Gail D'Onofrio MD, MS<sup>1</sup>

Michael V. Pantalon Ph.D.<sup>2</sup>

Linda C. Degutis DrPH<sup>1</sup>

David Fiellin MD<sup>3</sup>

Patrick G. O'Connor MD<sup>3</sup>

<sup>1</sup>Department of Surgery, Section of Emergency Medicine, <sup>2</sup>Department of Psychiatry, Division of Substance Abuse & <sup>3</sup>Department of Medicine,  
Yale University School of Medicine  
New Haven, CT

# 4 Key Steps of the Yale BNI

- Raise The Subject
- Provide Feedback
- Enhance Motivation
- Negotiate And Advise

# Yale Brief Negotiated Intervention (BNI)

- The **BNI** is a **short, 5-7 minute**, counseling session that incorporates brief feedback and advice with motivational enhancement techniques to assist the patient in changing their drinking patterns.
- In most cases this means lowering their alcohol use to safe limits and thereby **reducing their risk of repeat illness/injury**.
- The **BNI** procedure is **patient-centered** and the skills used are based in large part on the patient's motivational **readiness to change**.
- The primary product of the **BNI** procedure is the **patient's agreement** to reduce either alcohol use and its ability to cause harm.
- The practitioner and patient make an **agreement through a process of negotiation**.
- **BNI for H&H drinkers** was successfully developed for **ED Providers** and who demonstrated proficiency in performing the BNI in **routine ED clinical practice**.
- **Development and implementation of an emergency practitioner-performed brief intervention for hazardous and harmful drinkers in the ED.** [D'Onofrio G](#), [Pantalon MV](#), [Degutis LC](#), [Fiellin DA](#), [O'Connor PG](#). Section of Emergency Medicine, Yale University School of Medicine

# ASBI-BNI Website & DVD

**A collaboration between Boston University  
School of Public Health and Boston Medical  
Center's Dept. of Emergency Medicine\***

**<http://www.ed.bmc.org/sbirt/index.htm>**

**\*Includes Excellent Teaching Case Scenarios**

# Efficacy of Brief Intervention (BI)

- Evidence-based review positive effect demonstrated in (82%).of studies
- USPHS Preventive Services Task Force an “alpha” rated procedure
- The effectiveness for risky drinking established in primary care & emergency department/ trauma settings.
- Brief interventions (5-10 minutes) by a physician, nurse or nurse practitioner as routine primary care significantly reduces alcohol use by high-risk drinkers for 12 months.
- **These data provide compelling evidence that ASBI can reduce alcohol-related injury recidivism (repeat injury).**

# Lessons from the BI Literature

**BNI is effective in non-acute care settings.**

Emerging evidence of **BNI** is also effective in **ED & Trauma Centers**

These benefits are in **non-dependent drinkers** after **“Brief”** non-judgmental questioning and advice

**“Booster Contacts”** after **BNI** are helpful

**BNI** can be **performed effectively by:**

- physicians - nurses
- social workers - psychologists
- substance abuse providers

# How Do I Implement the ASBI?

- **Hospitals/Service Units**  
Emergency Department  
Urgent Care/ Follow On Appointments  
In-Patient Areas
- **Primary Care & Behavioral Health Clinics**  
Injuries; Direct and Follow on  
Universal Screening

**Back Referrals from Trauma Centers**

# AS Positive Patient Triage to BNI

- Within the ED or PCC by MD or RN staff with BI prior to discharge
- Alert and Legally Sober During and After Treatments
- Outpatient Clinic follow-up after injury and within 7 days
- Admitted patients in the Service Unit within several days prior to discharge
- Trauma Center Transfers with a discharge “Back-Referral” to IHS-Tribal Primary Care and/or Behavioral Health
- Primary Care and Behavioral Clinic Injury Surveillance
- During “Universal Screening” for other Substances and/or Injurious Behaviors

# Behavioral Health BNI, Follow On, Boosters & Reassessment

- **Full AUDIT** Recommended
- Secondary Goals
  - Identify **Alcohol Dependent** Patient
  - Identify **Co-Morbidity (Dual Diagnoses)**
    - Other Substance Abuse
    - Other Mental Health Diagnoses
    - Introduce an Otherwise Resistant Referral
  - Perform **BNI** and establish a **Follow On BH Plan**
- **“Booster Shots”, When, Where, Who?**

# Hospital, SU & Clinic “Champions”

- Surgeon
  - ED Physician
  - ED RN
  - BH Provider
  - Substance Abuse Counselors
- 
- These are the “**Critical Mass**” essential for local SU and Clinic ASBI implementation and success.

# Content Review

- Scope of Alcohol-Related Injury
- Scientific Background of ASBI
- Psychology of Behavioral Change
- Target Population
- Alcohol Screening (AS)
- Behavioral/Brief Interventions (BI)
- **IHS-Tribal ASBI Plan**
- Resources and References
- Documentation

# IHS-Tribal ASBI Plan

- Phase I
  - Conceptualize and Develop Program February 2006
  - Incorporate as part of Dr Grim's Health Initiatives
  - Dissemination of Information to all IHS and Tribal Hospitals and EMS Systems
  - **Establish SU "Champions" and develop Hospital programs**
  - ASBI Leadership Conference, IHS-HQ 31Jan-1Feb 2007
- Phase II
  - Implementation in all Hospitals and Service Units
  - Collaboration with ACS-COT, introduction of IHS ASBI to distant receiving ED & Trauma Centers and "back-referral" program
  - **Train-The-Trainer (TTT) Conferences at Five (5) Sites; Aberdeen, Billings, Navajo, Phoenix. Oklahoma**
- Phase III
  - IHS-Tribal Leadership, Training, and Assessments
  - **Implement ASBI to all IHS-Tribal Clinics**
  - Implement in the Chronic Care Initiative Clinics
  - Research and Future Applications

# ASBI Train-The-Trainer Sites(5)

- Crow- BIL, J. Upchurch, S. Wegner K. Masis
- GIMC-NAV , J Stone, J. Flaherty, P. Stuart
- PIMC-PHX, A. Dekker, G. Butler
- Rosebud-ABR, S. Two Hawk, D. Foster, D. LaRocque
- Tahlequah-OKL-J. Franklin, D. Harjo, D Carter, J Farris (17Oct)
- Several Other Service Units and Clinic

RESOURCES  
FOR  
OPTIMAL CARE  
OF THE  
INJURED  
PATIENT  
2006



COMMITTEE ON TRAUMA  
AMERICAN COLLEGE OF SURGEONS

CHAPTER 18

Prevention



Level I & II - Essential

**“Have a mechanism to identify patients who are problem drinkers”**

Level I – Essential

**“Must have the capability to provide an intervention for patients identified as problem drinkers.”**

2006 ACS Frequently Asked Questions (FAQ) website in development  
as of Jan 15, 2007 [facs.org/trauma/faq\\_answers.htm](http://facs.org/trauma/faq_answers.htm)

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- Resources and References

# Documentation and Reimbursement

- Chart Documentation, PCC and EHR
- Pre-Screen, Alcohol Screen (AS) & Brief Intervention (BI)
- Coding ICDA
- CPT-HCPCS Codes
- H-0049 Screening
- H-0050 Screening and Brief Intervention,
- RPMS
- CRS... GPRA
- Billing and Reimbursement

# Draft GPRA Indicator

- **Numerator #1:** Alcohol Screening and Brief Intervention (ASBI) done in ER, Trauma Center or Primary Care setting after a “hazardous” alcohol related accident or injury
- **Denominator # 1:** Active Clinical patients with an alcohol-related injury visit to Emergency treatment facility during the report period.
- **Numerator # 2:** Referred to a Behavioral Health Specialist or ASBI trained person for a Brief Intervention-Interview (BI) after initial Alcohol Screening (AS) in the ER, Trauma Center (TC) or PC Site
- **Denominator # 2:** Patients who were Referred after Alcohol Screening (AS) from the ER, TC or PC and seen in BH clinic by mental / behavioral health provider and / or trained nurse within 7 days of the ER,TC.PC visit and who received further alcohol screening and structured BI intervention.

# Office of Clinical and Preventive Services (OCPS)

Richard D. Olson MD, Director

**OCPS** is the “**Lead Agency**” for the ASBI Initiative includes Behavioral Health

Office of Emergency Services (OES)

- Supports the IHS Mission in;
  - EMS
  - Emergency Preparedness and Management
  - Trauma and Trauma System Development
  - ASBI Program

# Organizational Resources

- IHS HQ ES & OCPS
  - [David.Boyd@ihs.gov](mailto:David.Boyd@ihs.gov)
  - [jim.flaherty@tcimc.ihs.gov](mailto:jim.flaherty@tcimc.ihs.gov)
- IHS Chief Clinical Consultant, Substance Abuse
  - [Anthony.Dekker@ihs.gov](mailto:Anthony.Dekker@ihs.gov)
- American College of Surgeons, Committee on Trauma (ACS-COT)
- American College of Emergency Physicians (ACEP)
- National Highway Traffic Safety Administration (NHTSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Center for Disease Control CDC
- National Institute of Alcohol Abuse & Alcoholism (NIAAA)
- World Health Organization (WHO)

# ASBI Websites

- ACS  
[http://www.cdc.gov/ncipc/Spotlight/2003\\_Alcohol\\_Conference\\_Proceedings.htm](http://www.cdc.gov/ncipc/Spotlight/2003_Alcohol_Conference_Proceedings.htm)  
<http://www.mayatech.com/cti/sbitrain07>
- SAMHSA  
<http://sbirt.samhsa.gov>
- ACEP/ENA/NHTSA best practices re: alcohol use problems in the ED.  
[http://www.nhtsa.dot.gov/people/injury/alcohol/EmergCar/e/exec\\_summary.htm](http://www.nhtsa.dot.gov/people/injury/alcohol/EmergCar/e/exec_summary.htm)

# ASBI Recommendations

- WHO (1989, 1992, 2001)
  - Developed the **AUDIT** for screening, assessment, & intervention
- USPHS Preventive Services Task Force (2002)
  - established **ASBI as an “alpha” rated procedure**, that is, supported by Level I evidence (properly conducted, randomized, controlled trials) and recommended to be offered in the emergency department setting.
- ACEP (2002)
  - Promoted use of **ASBI in the ED**
  - Provided CD-ROM tool for Emergency Physicians, “Put the Brakes on the Next Drunk Driver”
- NHTSA (2005)
  - **ASBI was one of three priority initiatives** to help reduce driving while impaired (DWI) & focus greater attention on the impaired driving problem.
- ACS COT (2006)
  - **ASBI-SBIRT Program to be required for all Level I & II TC**
  - **ACS-COT SBIRT Program**

# Real Life in Your ED

- Time: 0200, full house
- 22 y.o. male, intoxicated driver in MVC, stable with non-life threatening injuries
- Stable, sutured, cast applied, neurologic checks negative, ETOH within Legal Limits
- Ready for Discharge
- Follow on Treatments Scheduled

# Should I do the ASBI on this Patient?

- **This Patient**, who maybe a “Frequent Flyer”, may have an “Attitude” and will cost me 5-7 minutes.
- **He/she could comeback** to my ED/Clinic with an **ETOH-Event (25-50%)**, with an **injury (50%)**, be **dead (25%)** or cause a **death of someone else,(1 in 3)** and within the next **6-12 months?**
- **Hmmmm? Let me think about this!**

## ASBI Goal

***“ALCOHOL SCREENING AND A BRIEF NEGOTIATED INTERVIEW, DURING THE TEACHABLE MOMENT, AFTER INJURY, CAN BE EFFECTIVE IN REDUCING RE-INJURIES (RECIDIVISM) UP TO 50% FOR SEVERAL YEARS”***

DR Boyd MDCM, FACS

# Thank You

- My colleagues and I are ready to help you establish an ASBI program in your hospital, service unit and/or clinic.
- ***Just give us a call,***

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