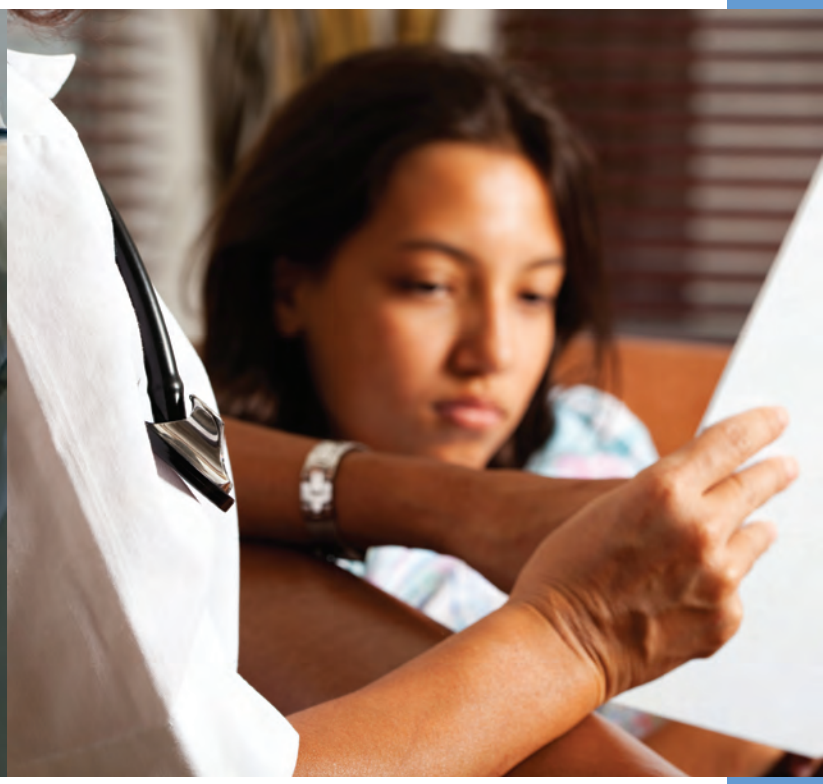
Implementation of Alcohol Screening, Brief Intervention and Referral to Treatment Policies in Pediatric Trauma Centers



Pediatric Trauma SBIRT Workgroup

Hasbro Children's Hospital
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1. Introduction

Adolescent Alcohol Use

Underage alcohol use is a significant public health problem. There are an estimated 10 million underage (12-20 years) alcohol users within the United States, 17% of whom engage in binge drinking and 5.1% of whom are heavy drinkers.[1] Similarly, in 2009, 41.8% of high school students nationwide reported having had at least one drink of alcohol on one or more occasions in the past 30 days[2] (Figure 1) and nearly one-quarter reported heavy episodic ("binge") drinking on one or more occasions in the past 30 days.[2] These national surveys find that rates of current, binge and heavy use increase throughout adolescence. A number of studies have also found strong relationships between alcohol use and other risky behaviors such as sex without contraception, delinquency, school failure, and school drop-out.[3, 4] Additionally, early onset of alcohol use in adolescence increases the risk of problems later in life due to alcohol misuse.[5]

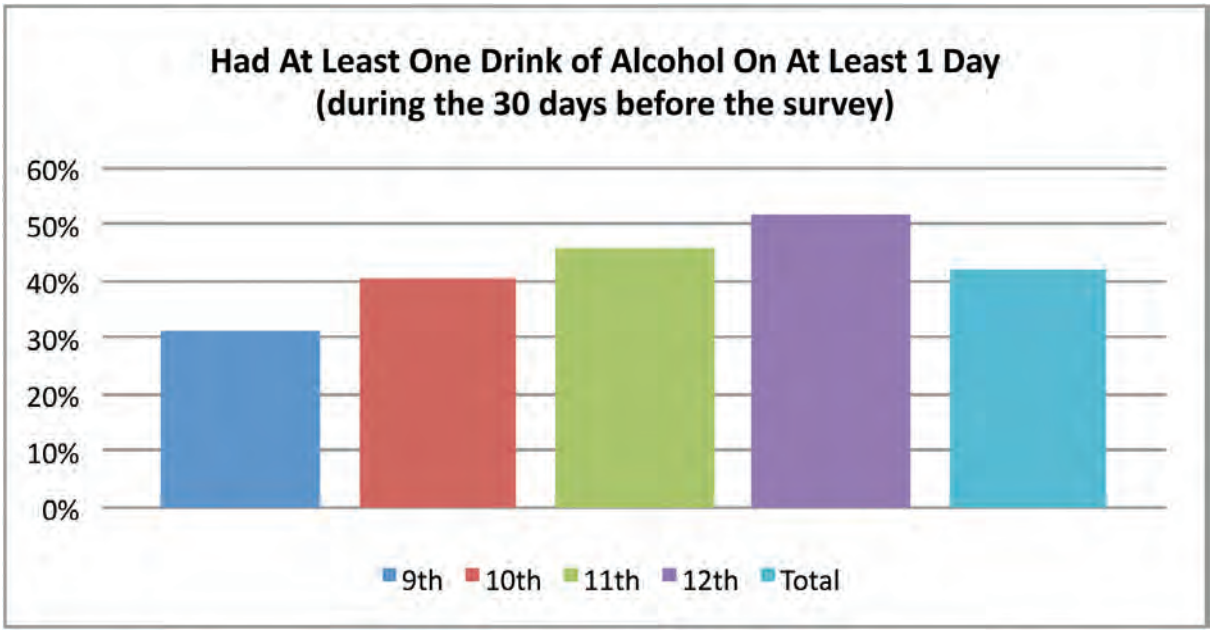


Figure 1: Current alcohol use among US high school students, Youth Risk Behavior Survey (2009)

Source: Centers for Disease Control and Prevention (CDC). 1991-2009 High School Youth Risk Behavior Survey Data. Available at http://apps.nccd.cdc.gov/youthonline. Accessed on April 18, 2012.

This high prevalence of adolescent alcohol use leads to many encounters with the health care system. An analysis of National Hospital Ambulatory Medical Care Survey for 2001 through 2004 indicates that, in the underage drinking population of 13-20 year olds, there were 858,828 alcohol-related emergency department visits.6 Studies have reported varied rates of alcohol use among adolescent trauma patients. One study of trauma patients reported that 34% of patients 13-19 years old were positive for alcohol or drug use.7 In a more recent study, Ehrlich, Maio et al.8 found that 30% of hospitalized trauma patients 11-17 years old screened positive for alcohol misuse.

Thus, the trauma service appears to be an opportune setting to identify and intervene with adolescents using alcohol to potentially decrease alcohol use and injury recidivism.

Screening, Brief Intervention and Referral to Treatment (SBIRT) Model

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive approach that utilizes universal alcohol screening to provide early intervention and treatment to those with risky alcohol use. This model is well researched in the adult population and to a lesser extent with adolescents. There is sufficient evidence regarding the use of screening instruments for adolescents[9] and demonstrating that brief interventions with both adolescents and adults in emergency departments have positive effects.[10-13] This recognition has led several national organizations to recommend screening and behavioral counseling interventions to reduce alcohol misuse among injured patients.[14-17] Further, now as part of the American College of Surgeons verification to be a level 1 trauma center, centers are required to have the capacity to identify trauma patients with risky alcohol use and provide an intervention.[16] While a number of SBIRT resources exist for health providers to promote the utilization of these services caring for injured patients,[18, 19] most are focused on the adult trauma center. A guide for implementation of SBIRT at trauma centers exists but again has a focus on the adult trauma population.

Creation of the Pediatric Trauma SBIRT Workgroup

With most evidence behind SBIRT being done within research protocols, translating it to routine care has led to challenges. Translation from clinical research protocol to routine clinical care has been especially challenging for the clinical environment caring for the injured inpatient adolescent as no guidance exists in the literature. For this reason, the Injury Prevention Center at Rhode Island Hospital formed the Pediatric Trauma SBIRT Workgroup. Members were solicited from sites of the Injury Free Coalition for Kids. Injury Free Coalition for Kids is a national organization of 44 pediatric trauma centers dedicated to the care and prevention of injury in children and adolescents. With funding provided by the Centers for Disease Control and Prevention's (CDC's) National Center for Injury Prevention and Control, the Injury Prevention Center at Rhode Island Hospital brought seven Injury Free Coalition for Kids sites together to work on translating SBIRT to the adolescent trauma patient. These sites include: Children's Hospital of Wisconsin; Children's Hospital of Michigan; Children's Hospital of Pittsburgh of UPMC; Cincinnati Children's Hospital Medical Center; Connecticut Children's Medical Center; Rady's Children's Hospital and Health Center and Riley Hospital for Children. It was a multi-year process that involved measuring what was already being done, participation in SBIRT technical assistance activities, creating institutional policy that is consistent with current best evidence, monitoring the opportunities and barriers to implementation and examining sustainability. We have utilized the experience and data accumulated from the seven sites to produce these recommendations for development and implementation of a SBIRT program at pediatric trauma centers.

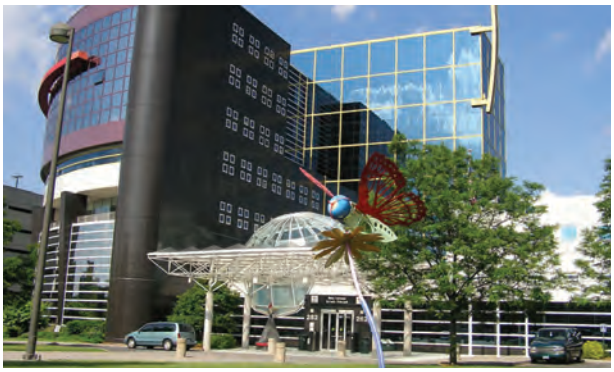
2. SBIRT Site Leader & Support Team

The first step to successful development and implementation of a SBIRT program is to identify a SBIRT site leader to help the trauma center adopt alcohol screening and brief intervention into routine institutional clinical practice. Past research and the experience of our pediatric trauma SBIRT workgroup demonstrate that this key individual plays a critical role in making institutional level policy and practice change.

A trauma program manager is an ideal SBIRT site leader. Firstly, integrating SBIRT into practice aligns with this individual's primary job responsibilities. A trauma program manager is responsible for the development, implementation and evaluation of systems related to the care of trauma patients. He/she also plays a significant role in assuring that the department meets trauma center verification requirements. Since having the capacity to perform an alcohol screening and brief intervention is a verification requirement for level 1 trauma centers, a trauma program manager is especially vested in building this capacity. Secondly, a trauma program manager is very familiar with the structure and staffing of the trauma center and knows best what activities/approaches are most realistic for their particular institution.

A SBIRT site leader must guide their institution through four distinct phases: 1) Adoption of SBIRT by key constituents as an organizational/institutional priority; 2) Development of multidisciplinary consensus for adapting SBIRT Policy/Protocol; 3) Implementation of SBIRT Policy/ Protocol and 4) Monitoring of SBIRT Policy/Protocol and Quality Improvement. The details of these phases will be further discussed in later sections of this manual.

To develop and effectively implement an alcohol screening and brief intervention policy, a SBIRT site leader needs institutional support. No assumptions should be made regarding workloads and collaboration with other disciplines in establishing a SBIRT program. If the workload for the SBIRT program cannot be assumed by the workforce under the auspices of the trauma program/service, collaboration and negotiation is key to success. Many of the participating institutions formed a multi-department working group to assist with the project. Be prepared to encounter barriers and delays in integrating processes. If one solution doesn't work out, try another with another group or discipline.



At Connecticut Children's Medical Center, the SBIRT workgroup included the trauma program's medical director, manager, registrar, and Injury Prevention Center director. In addition, the social service director and inpatient nurse managers were active participants. A key activity developed by the trauma program manager included a monthly chart audit to track SBIRT compliance, which allowed the workgroup to identify issues and seek solutions.

Last, cross institutional networking is of great importance when putting the SBIRT model into practice. Speaking with SBIRT site leaders from other pediatric level 1 trauma centers through existing networks such as Injury Free Coalition for Kids and the Society of Trauma Nurses will help staff and institutions to develop, share and implement effective policies. While this manual provides a solid framework for putting SBIRT into practice, others in the field have and will deal with the similar challenges with implementing and sustaining a new policy. Maintaining a cross institutional network will help maintain momentum when challenges arise. Further, your institutional successes can be shared to motivate others who may need support getting their policy off the ground.

3. Target Population

There are no formal trauma center guidelines specifying which patients must be screened, nor at what age patients must be screened, but it is expected that the number of excluded patients will be as few as possible. The guidelines do recognize situations where screening may not be practical or appropriate, e.g. very young patients, institutionalized patients (as they are unlikely to be using substances), or patients requiring emergent medical, surgical or mental health care. It is important to clearly define the target population for the SBIRT program.

While the onset of substance abuse can occur at any age, it is very rare in young children. Screening young children is likely to be unproductive. Given that substance use initiation begins to rise in mid-adolescence (15% of 14-15 year old adolescents), it is clear that at a minimum screening needed to include these ages. The pediatric trauma SBIRT workgroup decided that age 12 was a reasonable lower age limit to capture early substance initiators (3-5% of 12-13 year old adolescents).

Consensus by our pediatric trauma SBIRT workgroup was also achieved on which injured adolescents would be approached for screening. The natural starting point was adolescents who received a trauma evaluation. All patients would need to be medically stable and cognitively able to participate in screening. While there was brief discussion about screening injured adolescents who do not receive an evaluation by the trauma surgery service, it was decided not to universally screen this population throughout each institution. First, the American College of Surgeons only requires screening of patients admitted to the trauma service. Second, screening all adolescent patients presented several logistical problems as not all institutions had the capacity to screen for non-injured adolescents. Finally, given the large number of injured adolescents who present to emergency departments and are not evaluated by the trauma surgery service, extensive resources would also be required to screen all these patients. For these reasons, the pediatric trauma SBIRT workgroup decided to operationally define "injured adolescents" as those patients who received an evaluation by the trauma surgery service.

Location for SBIRT: Inpatient Hospital vs. Emergency Department

All pediatric trauma SBIRT workgroup institutions screened admitted injured adolescents. When the in-patient setting is utilized, specific time can be arranged for patients to undergo the SBIRT process, frequently coordinated to mesh with their trauma care and the adolescent life style. For example, visiting friends, late-sleeping adolescents and medical procedures need to be taken into consideration when developing a SBIRT system. Even with these considerations, ample time exists for these screening processes to be completed and, if necessary, a BI done. Another benefit of the inpatient setting is that follow-up to the brief intervention can be accomplished and information validated. Some screened only trauma surgery service, others screened irrespective of the admitting hospital unit (e.g. intensive care unit vs. standard inpatient acute care unit) or the admitting service (e.g. trauma surgery, orthopedics, neurosurgery, etc). Patient confidentiality is also more likely to be better protected in the inpatient setting when appropriate private time can be found.

A few sites opted to extend the reach of their SBIRT program and screen both admitted adolescents as well as those evaluated in and discharged from the emergency department. The one main benefit of utilizing the emergency department as the SBIRT setting is the potential to reach a larger number of

adolescents in a short period of time. However, implementing SBIRT, particularly in acute care oriented settings like emergency departments, poses many challenges. For an injured adolescent who is scared or in pain the SBIRT process may not be appropriate. Competing priorities, staff attitudes, privacy issues and lack of time are just a few of the additional barriers for implementing SBIRT in the emergency department. Currently, innovative methods for SBIRT are being developed for use in the emergency department, including computer-based approaches, which may assist with the process.[20] Lastly, patient flow issues through the emergency department setting are of vital importance to the success of every hospital. Care needs to be taken to ensure that implementing the SBIRT process in the emergency department does not hinder the patient flow regarding discharge or admission or utilize valuable emergency department space while other patients wait for care.

Type of Patient: Trauma Service vs. Injured Patient

Adolescent patients who are injured may be admitted specifically to the trauma service or, if the injury is isolated, to another service within the hospital. The decision on whether to implement the SBIRT process for trauma service or for all admitted injured patients depends on two factors: 1) the identified screening process and 2) the presence of resources available to accomplish both the screening and BI process.

The screening portion of SBIRT only takes approximately 5 minutes; however, working around the other issues that occur within the hospital setting is always complicated. One major aspect that needs careful consideration when deciding the population to screen is that the institution must have an adequate staff to address the increased population of positive findings from the screening process. The larger the number of individuals screened, the more individuals who will require a brief intervention.

Defining Ineligible Patients

Within each hospital, the definition of an "ineligible patient" must be determined. Possible exclusion criteria include the following:

- Patients with severe head injury who require inpatient rehabilitation
- Patients with a psychiatric history who are already under the care of a mental health professional

Ultimately, institutions will need to determine how best to comply with the American College of Surgeons' SBIRT mandate. Given what is known about the age of substance use initiation, the presumed benefits of early intervention, as well as the age at which adolescents are developmentally able to participate and benefit from individual intervention, screening adolescents age 12 and above is appropriate. Universally screening patients who receive a trauma surgery evaluation is a reasonable, realistic goal. However, the decision on whether to screen injured adolescents in both the inpatient and outpatient settings is based on each institution's available resources and goals.

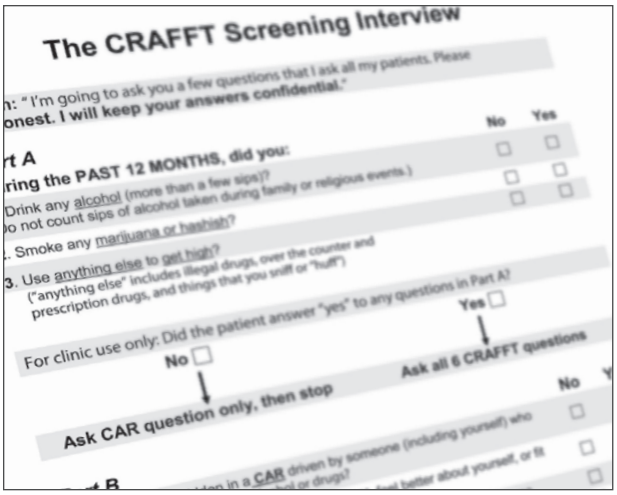
Rady Children's Hospital of San Diego, a participant in the Pediatric Trauma SBIRT Workgroup

4. Alcohol Screening

It is necessary to utilize a standardized brief questionnaire that is easily administrated and scored to assess an adolescent's alcohol use and related problems. All institutions from the pediatric trauma SBIRT workgroup decided to administer the CRAFFT screening instrument which assesses both alcohol and drug use.[21] The CRAFFT has been found to be a valid screening tool, and has acceptable sensitivity and specificity for adolescent substance-related problems.[22] Several members of the workgroup identified adolescent drug use as a substantial problem among their target populations. Thus, the ability to screen for both alcohol and drugs was favored.

The CRAFFT is easily scored (each yes answer is given 1 point) and has a well established cut-off score of 2 or more indicating a positive alcohol screen.[21, 22] Some chose to lower the cut-off score to 1 or more. Realizing the vulnerability of this age group in developing a problem with alcohol and drugs, some institutions decided that those with a negative screen would be presented with some verbal and/or written information on the prevention of alcohol and drug abuse. This is also an opportunity to provide information to the parents on the parental role in prevention.

During the course of this study, after the pediatric trauma SBIRT workgroup sites developed and implemented their policies, the National Institute for Alcohol Abuse and Alcoholism (NIAAA) released "Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide" which presented a new two-question alcohol screen for youth asking about the patient's drinking frequency and friends' drinking.[9] Drinking frequency represents an empirically supported brief screen to identify adolescents with alcohol related problems.[23] Having substance abusing and deviant peers is linked to adolescents' substance use.[24-27] Some studies demonstrate that the presence of alcohol-using friends is the best predictor of an adolescent's alcohol use.[28, 29] For these reasons, this brief alcohol screen represents another alternative for use in the pediatric trauma center. To further gauge alcohol risk this manual also recommends the use of formal alcohol screening tools such as the CRAFFT or Alcohol Use Disorders Identification Test (AUDIT) to gather additional alcohol risk information about a patient screening positive with the two-question screen and requiring a brief intervention. Information about other adolescent alcohol screening tools is available on our project's website.[30] The pediatric trauma SBIRT workgroup acknowledged that an adolescent may not always be truthful when asked about their alcohol and drug use. Therefore, routine collection of blood alcohol level via breath and/or blood samples would indicate recent alcohol use and would serve as a way to partially validate the self report of the patient. It was recognized that despite a negative breath/blood screen, it is very possible that an adolescent could be a regular problem user who simply had not used recently. Thus, a negative breath/blood screen does not usurp the need for having routine standard screening questions assessing past alcohol use. It is important to train staff (nurses at pediatric trauma SBIRT workgroup institutions) responsible for alcohol screening about the importance of alcohol screening, including who should be screened and how to administer and score the screening tool.


The CRAFFT Screening Interview

onest. I will keep your answers confidential."

No Yes

ring the PAST 12 MONTHS, did you:

Drink any alcohol (more than a few sips)?

o not count sips of alcohol taken during family or religious events.)

. Smoke any marijuana or hashish?

3. Use anything else to get high?

("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")

For clinic use only: Did the patient answer "yes" to any questions in Part A?

Yes

No

Ask all 6 CRAFFT questions

Ask CAR question only, then stop

No

Nurses from Children's Hospital of Wisconsin administer the CRAFFT tool to their admitted patients and have found their adolescents understand their alcohol screening questions. When adolescents are screened alone, they are willing to honestly share their personal experience with drugs and alcohol. There are times during the screening process that young adults surprise the screener with their answers to some of the CRAFFT questions resulting in a positive screen.

5. Electronic Medical Record

Integrating the standardized alcohol screening instrument into the hospital's electronic medical record system (EMR) is a highly efficient way of screening trauma patients. The SBIRT site leader and other institutional partners should first meet to delineate the current or desired clinical process. Then the team will have the information necessary to request the changes in the existing electronic documentation or to ensure that the necessary information is identified as a priority in the transition to the electronic medical record. Ideally, integration within the electronic medical record also includes rules to prompt nursing documentation and to consult social services with positive screens. Integrating these changes within the EMR system can be time consuming. It is necessary to alert Information Services early on in the project so they may anticipate the project's needs within their workload and priorities.

The "triggering" question to begin the screening should be based on the age of the patient. Ideally, the required questions are automatically generated by the system, which calculates the patient's age. Alternatively, the clinician doing the screening responds to a question asking if the patient is older than a specified age and if the answer is yes, then the required questions are generated. This allows, however, for incorrect answers to the age question and the potential for bypassing the screening questions. A task to complete the screening questions is generated for those who fall within the required target population for alcohol screening.

Once the screener obtains a positive score to any of the questions, a brief intervention consult (all pediatric trauma SBIRT workgroup institutions utilized social workers) is automatically ordered by the system and a task is created within the EMR for the screener to notify social work for a positive alcohol screen. The social worker then knows to complete the brief intervention. Social work documentation should include the consult request and the intervention delivered.

While the alcohol screening instrument is embedded within the EMR, screening training should still be provided to all staff responsible for screening. This training should cover the importance of alcohol screening, who should be screened and how to administer the screening tool.

The workgroup at Children's Hospital of Pittsburgh of UPMC recognized that for this process to work, it had to be fully integrated within the EMR. As the center is extremely proud of its longstanding continuous accreditation as a level 1 pediatric trauma center and takes compliance with the standards of accreditation quite seriously, linking the integration of SBIRT within the EMR with the requirements for trauma center accreditation advanced this project to the top of the priority list for EMR projects. After the informatics nurse collated the information necessary, she completed the request for service for the changes and the additions to the EMR. A standing committee of directors, managers, and lead analysts reviews all requests for prioritization. Because this request was related to a certification requirement it was given high priority and an analyst was quickly assigned to work with the workgroup to assure appropriate building and testing until SBIRT functions were finalized within the EMR.

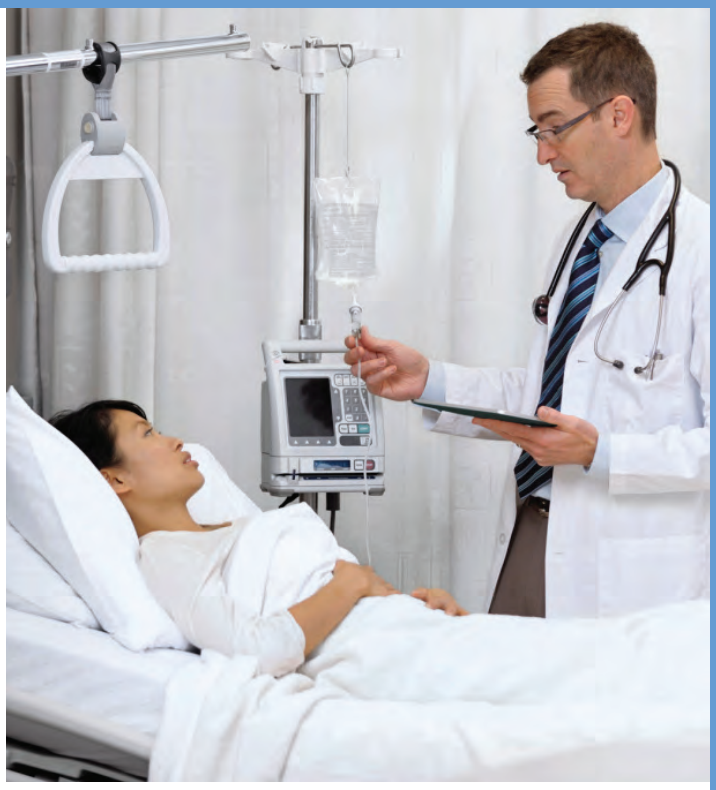
6. Brief Intervention

Interventions targeting hazardous drinking and alcohol use disorders among adolescents in trauma settings vary on a continuum. At one end are very brief interventions that consist of screening and brief advice, lasting up to 5 minutes. At the other end are more intensive and lengthy interventions that can include up to 12 weeks of counseling. There are many intervention models within this continuum. Motivational Interviewing is a counseling style developed for use with a substance abusing population.[31, 32] As such, pure forms of motivational interviewing typically occur only in outpatient or residential treatment settings. However, because it has been found that motivational interviewing is most effective with non-treatment seeking individuals, it has been successfully adapted for use in diverse medical and mental health settings.[33-35] One reason for its effectiveness with non-treatment seeking populations is hypothesized to be its non-confrontational approach, which helps to enhance patients' intrinsic motivation to change and increases the likelihood of behavior change.[36-38]

In a busy pediatric trauma setting, brief interventions, brief motivational interventions, or motivationally enhanced interventions, characterize most approaches. Any single approach is appropriate depending on available staff and resources.

Brief Interventions usually consist of screening and some form of brief advice, usually given by a medical professional, on the need to either avoid the use of alcohol/drugs or to cut down. Referral to further services may be provided.

Brief motivational interventions are an adaptation of motivational interviewing and its principles, and are predominantly used in medical or health care settings targeting a non-treatment seeking population.[33-35] These brief motivational interventions are characterized by the presence of key motivational interviewing principles—valuing patient autonomy, collaboration, eliciting the patient's perspectives, building intrinsic motivation to change, and highlighting the discrepancy between where the patient is now and where he or she wants to be.[31, 32]



Although informed by motivational interviewing principles, brief motivational interventions are distinct from motivational interviewing as they are: 1) time limited (usually single session), and 2) include structured strategies, such as the use of personal feedback reports, discussion of pros and cons of use, and change plan completion[34, 39] to help deliver an intervention using a motivationally enhanced approach.[34, 40]

A motivationally enhanced intervention invokes motivational interviewing principles in delivering the brief intervention. There may not be any structured strategies. However, the intervention approach utilizes underlying motivational interviewing principles.

*Children's Hospital of Wisconsin trained their staff in **brief motivational intervention**. Those responsible for performing the brief interventions felt the training was easy to complete. Though they felt some anxiety conducting the brief interventions at first, they felt it became easier the more times it was completed. Patients are generally receptive to the brief intervention and treatment recommendations. Teens were willing to disclose their current use of drugs/alcohol and discuss their willingness to change. Importantly, the majority of the time adolescent patients were willing to disclose their alcohol screening results with their parents.*

A standardized brief intervention protocol was not developed by the workgroup. More research is necessary to determine the most effective intervention approach for this population. Existing resources for brief interventions include:

SAMHSA TIP #34 Brief Interventions and Brief Therapies for Substance Abuse
http://kap.samhsa.gov/products/tools/cl-guides/pdfs/QGC_34.pdf

SAMHSA TIP #35 Enhancing Motivation for Change in Substance Abuse Treatment
http://kap.samhsa.gov/products/manuals/tip35c/index.htm

Mid Atlantic Addiction Technology Transfer Center
www.attcnetwork.org/midatlantic

7. Referral to Treatment

During the SBIRT process there are several scenarios that may require the trauma staff to refer the adolescent to additional resources. The following is not an exhaustive list, but gives some perspective around when and why trauma staff may refer the adolescent to other resources, and what types of resources they may need to have information about to make the referral.

- During screening for alcohol and other drug use the adolescent patient severity level suggests more intensive treatment is needed.
- During the brief intervention the adolescent patient indicates that their alcohol use or drug use is more severe than was indicated during screening.
- As part of any change plan during the brief intervention the adolescent patient indicates that they need further help in decreasing their alcohol or drug use.
- During the brief intervention or change plan the adolescent patient indicates that they need help or resources in other areas of their life. This could be resources around mental health, school problems, family or peer relationships, or sexual health needs.
- The parents or guardians of the adolescent patient may independently of the patient ask for help to deal with the alcohol, drug use or other problems of the patient.

Children's Hospital of Pittsburgh at UPMC developed a SBIRT discharge instruction topic within its discharge instructions program to provide teens and families with a variety of potential resources. This topic is selected and added to the discharge instructions for patients receiving a brief intervention.

Deciding to Refer

The cut-off scores of standardized alcohol screening instruments can help a clinician identify a patient's need for referral. For example, all institutions participating in this pediatric trauma SBIRT workgroup administered the CRAFFT. A CRAFFT score of 3 or more indicates being at risk for substance dependency. If the adolescent patient has a score of 3 or more on the CRAFFT a referral to a treatment resource for alcohol or other drug use should be considered by the clinician and discussed with the patient during the BI. The NIAAA guide[9] also has guidelines for when a referral should be considered.

Treatment Resources

The treatment resources may be within the hospital (e.g. a psychologist, social worker or psychiatrist) or a community treatment resource that will be part of the patient's discharge plan. The adolescent patient may identify other needs but may have no knowledge about what resources could meet those needs. Providing accurate and relevant information about resources is one of the greatest challenges in implementing the 'RT' component of SBIRT. Clinical staff may be more knowledgeable about resources

within the hospital than they are regarding services in the patient's community. The following is a list of possible considerations and suggestions to help staff identify community resources.

- Does a local community agency have a resource directory that is frequently updated and that the clinical staff could use? It is important that such a directory be frequently updated, have information relevant to these patients (i.e. resources for adolescents and young adults), provide information about health insurance needs, languages that the services are offered in, and any qualifying factors needed to obtain the services. These may be services for alcohol and drug treatment, mental health care, sexual health, social services and educational resources.
- Does the school that the adolescent attends provide resources that could support the adolescent? This may be school counseling support or educational resources.
- Are there local community self-help agencies that can help the adolescent? These may be groups such as Al-Anon and local teen alcohol and drug support groups. The adolescent patient needs to know where and when the group meets, what the group will be like, and if it is possible to have someone who will 'buddy' them when they first attend.

Developing a community referral resources directory that is easily accessible to clinicians providing the brief intervention is an important component of a SBIRT program.

Involving Parents

There are many issues to consider in deciding how best to assist adolescent patients to get the help they need for their alcohol or drug use problem and to get help for other health and social issues that may be related to the substance use. There are confidentiality policies that determine how a parent/guardian can be informed or involved in clinical decisions of the adolescent patient. The adolescent likely lives with their parent/guardian and has health insurance through their parent/guardian. States also differ in the laws governing when an adolescent can seek substance use or mental health counseling independently without parental consent.

For most adolescents a change plan they develop to address their alcohol use or other behaviors may involve their parents/guardians, especially if a referral for treatment is made. It is likely the parent/guardian will have to organize getting them to the treatment site, be involved with motivating them to attend, and help them to make and sustain changes. Parent involvement with any aspects of the BI change plan or referral to treatment involves negotiation with the adolescent patient about how much they want to involve or inform their parent about what their plan for change is and about the treatment resources they will be attending. Also, most adolescents in the United States are covered by their parent's health insurance policies, and there is the possibility that confidential information may be provided on claims that are sent to the parent.

A 16 year old male who sustained a 31% TBSA burn from throwing gasoline on a wood burning stove was transferred to one of our participating hospitals from another facility. His urine drug screen came back positive for cannabinoids but no alcohol level was available as he was a transfer patient. When the CRAFFT was completed, he had related that he was drinking and smoking weed in the afternoon before the accident. With the alcohol and weed on board, most likely impairing his judgment, he decided to throw the gasoline on the stove. During this he also related that he was a binge drinker and had tried previously to obtain a prescription for medical marijuana. His parents were divorced; he shared that his father was aware that he drank and smoked, but his mother only knew that he drank alcohol. A brief intervention was completed in the hospital and he was also referred to outpatient treatment. He was a patient who fell outside of the institution's usual criteria for SBIRT in that he was not a trauma code patient at the facility, but was captured when his case was discussed in a patient peer review and someone stated that he had a positive drug screen at the referring hospital.

8. Confidentiality Issues

The SBIRT process involves a dynamic tension between the adolescent's right to privacy and confidentiality and the parent's right to know of safety risks to their children. Not surprisingly, many adolescents are concerned that disclosing their alcohol use to parents may result in negative consequences. In fact, clinicians' reassurance that confidentiality will be protected has been demonstrated to enhance adolescents' readiness to disclose their substance use. However, at times, parents expect that health care providers will reveal adolescent alcohol or drug use, and in some cases state laws may mandate such disclosure.

During the screening process, adolescents are more likely to be forthcoming with regard to substance use if screening questions are asked when their parents are not present. In the health care setting, this can, at times, be a challenge, since in some cases, parents may be reluctant to leave the room or to permit the adolescent to be screened in private. In these instances, screening methods such as paper or computerized questionnaires may present the greatest degree of privacy.

It is important to note that the confidentiality considerations that pertain to SBIRT may be dictated by a number of considerations, including HIPAA regulations, federal and state statutes, type of health care setting, and by local, institution-specific policies. While all states currently have laws that permit minors to consent for particular health services without parental notification, these generally pertain to issues around reproductive health. However, with regard to substance abuse, state laws differ significantly with regard to the types of services for which adolescents can consent without parental permission or notification. Some states require reporting to parents of adolescent substance use that constitutes a safety risk; others prohibit parental notification even when the adolescent is being referred to substance abuse treatment. Consequently, familiarity with state and local regulations is imperative.

In health care settings, SBIRT screening is subject to HIPAA regulations. Additionally, if the health care practice specializes in substance abuse disorders or is a substance abuse treatment facility, the program will be subject to the federal statute pertaining to confidentiality of alcohol and drug abuse patient records, 42CFR Part 2. While this law addresses the release of information of minors from substance abuse treatment programs, it does not necessarily pertain to the SBIRT process in hospitals or emergency departments. In fact, as it currently appears to be interpreted, the confidentiality of hospital-based SBIRT may only be protected when SBIRT is being performed by individuals whose primary role is to screen for substance abuse, followed by referral to treatment.

Ultimately, respectful recognition of adolescent confidentiality during the SBIRT process needs to be considered within the context of a variety of factors. A few general principles may help guide the development of the process in the health care setting.

- Parents and adolescents should be well informed about the confidentiality policy, including what will be kept confidential from whom as well as specific instances in which confidentiality will be broken. When confidentiality is to be broken, the specifics of the process (who will be told, what action will be taken, etc.) should be clear to the adolescent.
- A familiarity with state and local regulations, as well as federal regulations, is imperative. States differ markedly with regard to what substance abuse information disclosed by an adolescent may be shared with the adolescent's parent.
- Prior to implementing adolescent SBIRT, discussions should be conducted with hospital risk management and hospital attorneys to confirm consensus agreement among all institutional groups.
- In many instances, a considered discussion with both parent and adolescent will permit an open dialogue that circumvents the need for undue concealment.

Riley Children's Hospital for Children, a participant in the Pediatric Trauma SBIRT Workgroup

9. Growth and Sustainability of SBIRT Services

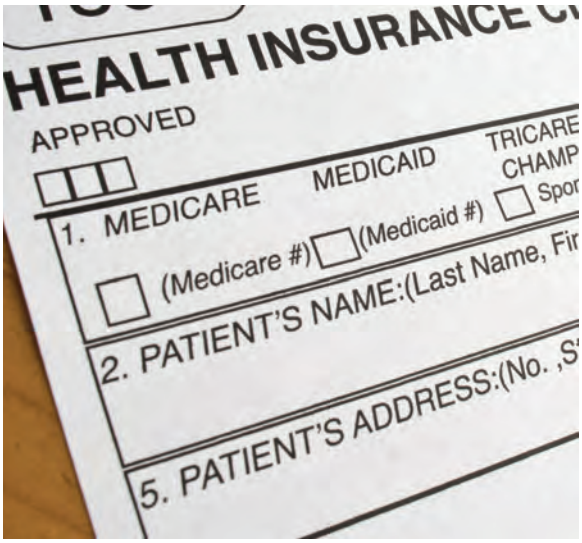
Our working group's goals included development of SBIRT policy, implementation of SBIRT services for admitted trauma patients, and sustainability of these SBIRT services. There are multiple forces that can negatively impact the sustainability of SBIRT services at pediatric trauma centers and eventually could lead to a retraction of it. But counter strategies exist for not only having sustainability of SBIRT services but also its expansion within the institution.

As SBIRT services are implemented, the site leaders responsible for establishing the program may move to other positions within the institution or leave the institution. To maintain services it is essential to have these programs truly institutionalized and not only thought of as a certain person's assigned task. This requires leadership from all disciplines involved to accept SBIRT service as the standard care for injured patients. Having this leadership from the top will allow key facets needed for sustainability to be incorporated into institution policy and culture.

When new clinical staff is hired for positions responsible for screening or delivery of brief interventions, there needs to be a training curriculum that is part of the new hire's orientation and training for the designated tasks. Clinical staff needs to be continually assured of the institution's commitment to these services. Strengthening this can be accomplished by having quality improvement markers associated with SBIRT tasks and providing this feedback to clinical staff. Examples of this include percentage of eligible patients screened, percent of those screening positive who are referred for a brief intervention, and percentage of brief interventions delivered to qualifying patients. Incorporation of screening and delivering brief interventions into designated clinicians' formal job descriptions embeds those functions into that position so that future hires will be trained and perform those skills. Scheduled supervision for clinicians delivering interventions, either by direct observation or by review of taped interventions, can provide ongoing quality improvement that can be incorporated into clinical staff's annual performance evaluation metrics.

Another strategy for sustainability of alcohol SBIRT services is to link it with other screening that the institution is mandated to complete. The American College of Surgeons has a requirement for alcohol screening but other certification, regulatory or licensing agencies (e.g. JCAHO, state department of health) may have other mandated screening (e.g. domestic violence, depression). All of these could be incorporated into one screening process with delivery of the intervention and appropriate referrals by a designated clinician.

There are costs associated with delivery of SBIRT. There is the cost of each screening by a clinician. Although the alcohol screens are brief, taking only one to three minutes to complete per patient, in total for the entire institution's yearly trauma volume it can have a modest cost. More time is needed to address a positive screen including initiation of a brief intervention, frequently notification of another individual to deliver the intervention, the actual brief intervention, arrangement of any needed referrals and documentation of the encounter. Although it is not unlike many other consults for social issues that are frequently utilized within the pediatric center, it still will require additional staff time and have those associated costs. There is good news in that Medicare



billing codes exist for brief intervention services. Although these are for Medicare, a few states have also adopted them within their Medicaid program and commercial insurers are also slowly adopting them as well. The codes are only for the delivery of the brief intervention however, not for screening, and are based on the length of time for the intervention.

Growth within Institution of SBIRT Services

Our working group was focused on delivery of SBIRT services for injured adolescent admitted to the trauma service. Some institutions have expanded that narrow focus while others have chosen to optimize delivery of SBIRT within the trauma service before attempting diffusion into other areas of the institution. Potential areas for expansion would include injured adolescents who are not admitted to the trauma service, such as an adolescent with an isolated orthopedic injury admitted to the orthopedic service. A natural extension is also delivery of SBIRT services within the emergency department for the injured adolescent. This is a much larger patient population that would require availability of more resources to deliver all components of SBIRT. Growth of SBIRT could also occur beyond just applying it to injured patients but also to those adolescents being treated for medical illnesses. There is no research on SBIRT's effectiveness with adolescents admitted for medical illness but extrapolating from the primary care research gives it credible potential. NIAAA recommends considering screening as part of emergency department visits or other acute care visits.[9]

After successfully implementing SBIRT services for pediatric trauma inpatients, Riley Hospital for Children decided to expand their SBIRT policy to emergency department patients. These activities are currently being implemented and are well received by staff and patients.

Future directions

Creation and implementation of SBIRT services at pediatric trauma centers is only the start. The evidence for SBIRT effectiveness has been demonstrated in other environments and research is needed to see if adapting it to the inpatient trauma setting has the desired results of decreasing alcohol use and injury recidivism. Furthermore, research must define developmentally appropriate interventions in this setting and determine whether certain groups are more responsive to interventions, and if behavior changes can be sustained. These recommendations are an important start but more work is needed to fully realize the potential SBIRT may have to offer in the opportune setting of the pediatric trauma center.

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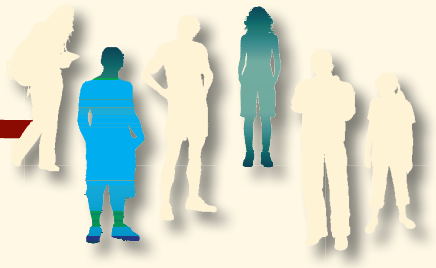
Appendix A: Alcohol Screening Tools

Alcohol Screening and Brief Intervention for Youth:
A Practitioner's Guide NIAAA 2 Question Screen



STEP 1: ASK THE TWO SCREENING QUESTIONS

Research indicates that the two age-specific screening questions (about friends' and patient's drinking) are powerful predictors of current and future alcohol problems in youth. Fit them into your office practice in whatever way works best for you, whether by adding them to a pre-visit screening tool or weaving them into your clinical interview. In either case, take steps to protect patient privacy and, if at all possible, conduct an in-person alcohol screen when you are alone with your patient. See page 25 for more information about confidentiality.

Guidelines for asking the screening questions: (1) For elementary and middle school patients, start with the friends question, a less threatening, side-door opener to the topic of drinking. (2) Because transitions to middle or high school increase risk, choose the question set that aligns with a patient's school level, as opposed to age, for patients aged 11 or 14. (3) Exclude alcohol use for religious purposes.

Elementary School (ages 9–11)
*Ask the **friends question** first.*

Friends: Any drinking?
"Do you have any friends who drank beer, wine, or any drink containing alcohol in the ***past year***?"
ANY drinking by friends heightens concern.

Patient: Any drinking?
"How about you—have you ***ever*** had more than a few sips of beer, wine, or any drink containing alcohol?"
ANY drinking: Highest Risk

Middle School (ages 11–14)
*Ask the **friends question** first.*

Friends: Any drinking?
"Do you have any friends who drank beer, wine, or any drink containing alcohol in the ***past year***?"
ANY drinking by friends heightens concern.

Patient: How many days?
"How about you—in the ***past year***, **on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol?"
ANY drinking: Moderate or Highest Risk
(see chart on page 10)

High School (ages 14–18)
*Ask the **patient question** first.*

Patient: How many days?
"In the ***past year***, **on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol?"
Lower, Moderate, or Highest Risk
(see chart on page 10)

Friends: How much?
"If your friends drink, **how many drinks** do they usually drink on an occasion?"
Binge drinking by friends heightens concern.
(3 to 5+ drinks; see page 15)

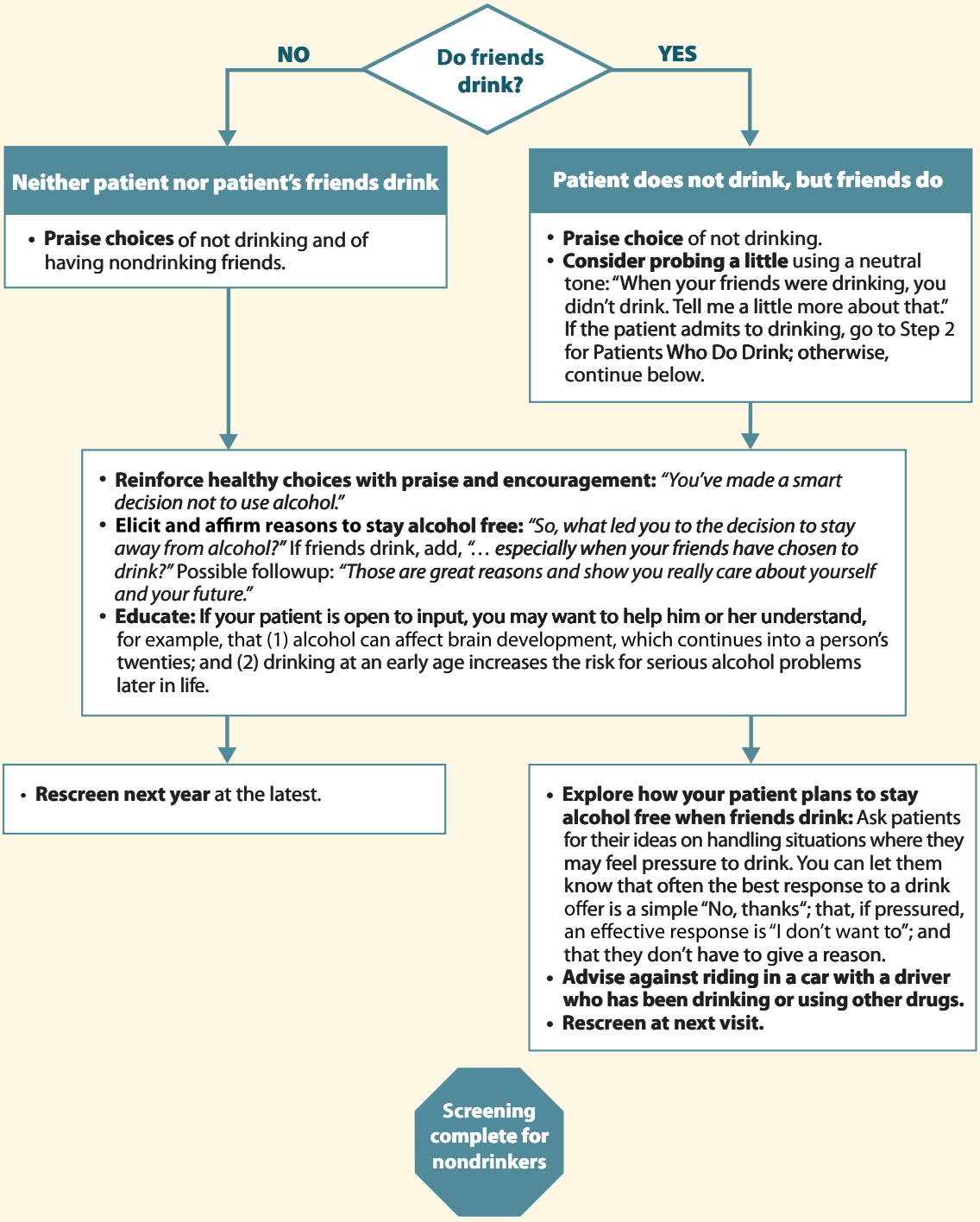
Does the patient drink?

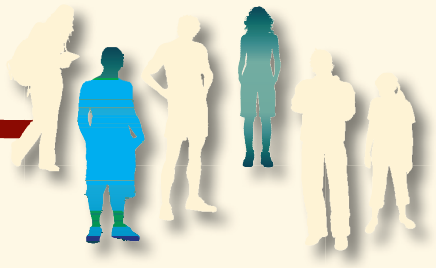
NO → **GO TO STEP 2: GUIDE**

YES → **GO TO STEP 2: ASSESS RISK**

STEP 2: GUIDE PATIENT

*For patients who **DO NOT** drink ...*

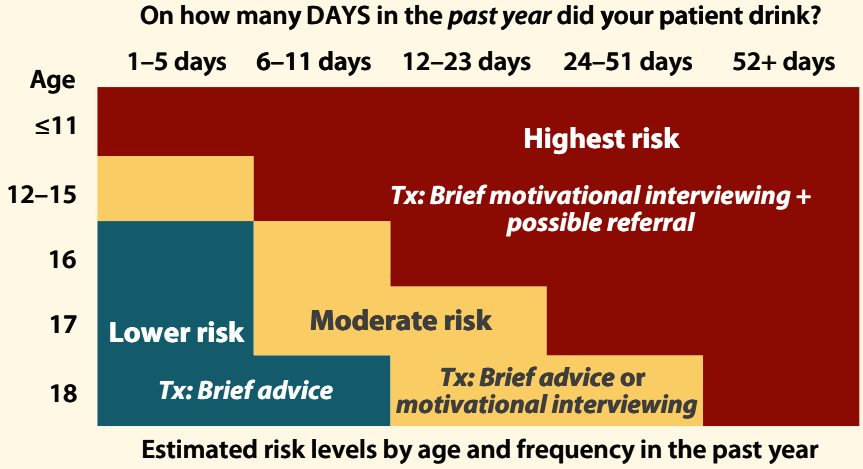




STEP 2: ASSESS RISK

*For patients who **DO** drink ...*

For a broad indicator of your patient's level of risk, start with the chart below, which provides empirically derived population-based estimates. Then factor in what you know about friends' drinking and other risk factors, ask more questions as needed, and apply your clinical judgment to gauge the level of risk.



Estimated risk levels by age and frequency in the past year

In the chart, see where your patient's age and drinking frequency intersect: If your patient responds to the screening question with a per-month or per-week frequency, convert the answer to days per year to see where the drinking falls on the risk chart. As an example, a 15-year-old who reports drinking about twice a month, or 24 days in the past year, is at "highest risk" for adverse consequences. (This chart is also in the Pocket Guide; see page 19 for tips on remembering the risk level cut points.)

Factor in friends:

- **For elementary and middle school students:** Having friends who drink heightens concern. Because having more drinking friends means more risk, ask how many friends drink, if your patient didn't offer this detail when answering the screening question.
- **For high school students:** Having friends who binge drink heightens concern. Recent research estimates that binge drinking levels for youth start at 3 to 5 drinks, depending on age and gender (see page 15).

Include what you already know about the patient's physical and psychosocial development in your risk evaluation, along with other relevant factors such as the level of family support, drinking and smoking habits of parents and siblings, school functioning, or trouble with authority figures.

For moderate and highest risk patients:

- **Ask about their drinking pattern:** *"How much do you usually have? What's the most you've had at any one time?"* If the patient reports bingeing (see page 15), ask: *"How often do you drink that much?"*
- **Ask about problems experienced or risks taken:** *"Some people your age who drink have school problems like lower grades or missed classes. Some do things and feel bad about them later, like damaging or stealing property, getting into fights, getting sexually involved, or driving or riding in a car driven by someone who has been drinking. Others get injured, have memory blackouts, or pass out. What not-so-good things related to drinking, if any, have you experienced?"*
- **Ask about other substance use and consider using other formal tools to help gauge risk** (see page 32). The majority of your lower risk patients will not have used illicit drugs (NIAAA, 2011), but ask them, too, about past-year use, time permitting.

After you assess risk ...
GO TO STEP 3

CRAFFT

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

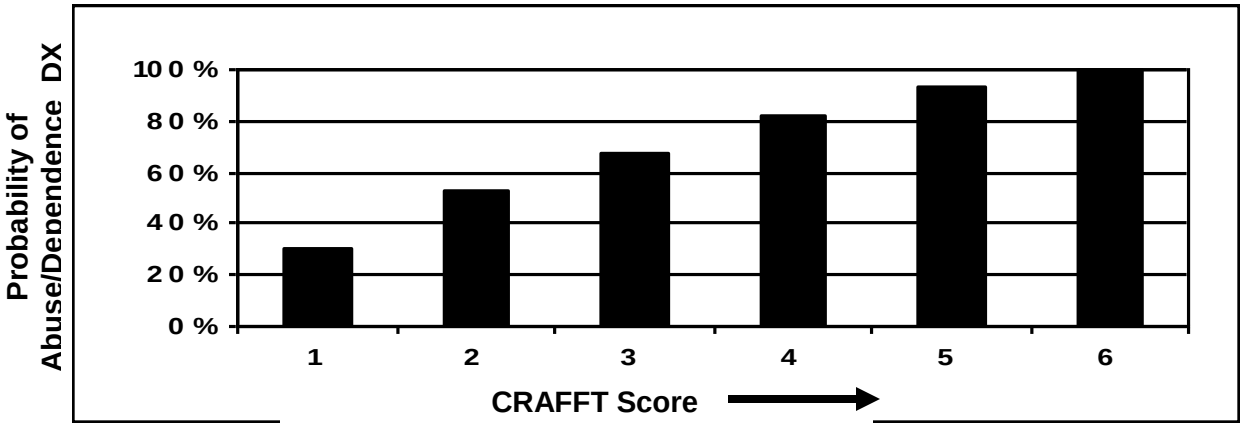
Yes ☐ → **Ask all 6 CRAFFT questions**

Part B	No	Yes
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each "yes" response in **Part B** scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score[1,2]



DSM-IV Diagnostic Criteria[3] (Abbreviated)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

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AUDIT

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol) =

8-9 oz. of malt liquor (about 7% alcohol) =

5 oz. of wine (about 12% alcohol) =

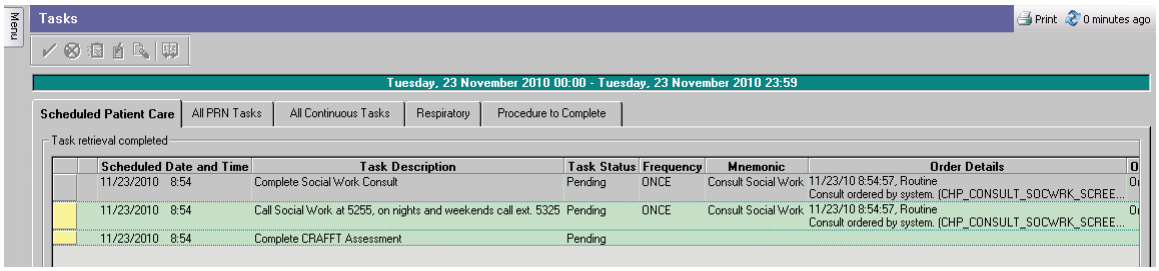
1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

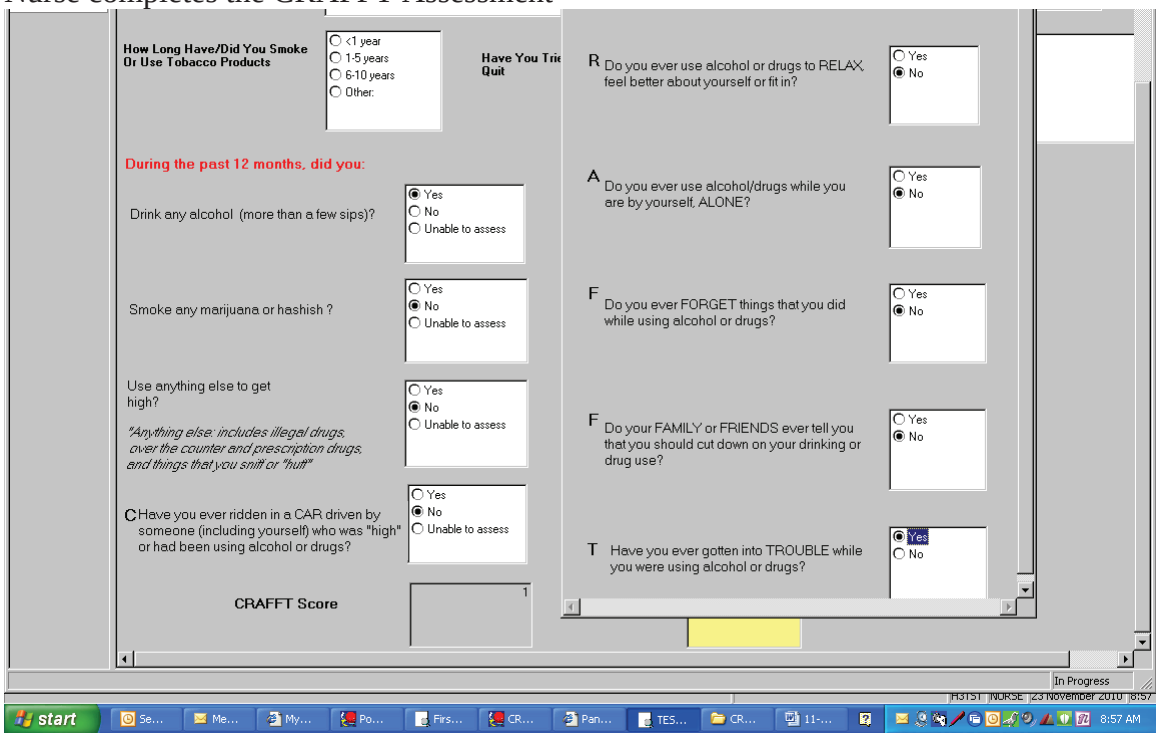
Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at ***www.who.org***.

Appendix B: EMR Screen Shots

CRAFFT Documentation completed…
Child is older than 12—task to complete the CRAFFT Assessment

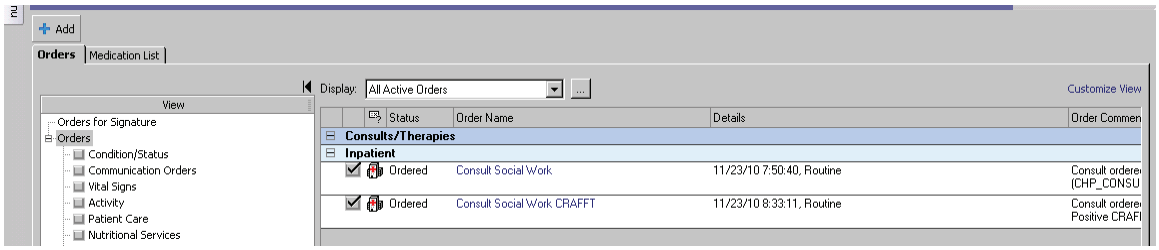


Nurse completes the CRAFFT Assessment



Both consults appear on the FirstNet tracking board (system generated and CRAFFT)

Both orders appear on the Order tab (system generated and CRAFFT)



Appendix C: Example SBIRT Policies

Children's Hospital of Pittsburgh of UPMC	TITLE: **SBIRT: Screening Brief Intervention and Referral to Treatment**		POLICY # **466**
	ORIGINATION DATE: 05/06/2010	REVIEW/REVISION DATE:	SECTION: II Patient Care
SCOPE: ☒ Children's Hospital of Pittsburgh ("CHP") Main ☒ Children's Hospital of Pittsburgh Satellites ☒ Children's Hospital of Pittsburgh Ambulatory Clinics ☒ Children's Hospital of Pittsburgh Ancillary Service ☒ CHP North Surgery Center ☒ CHP South Surgery Center	☒ **POLICY/PROCEDURE** ☐ **PLAN** ☐ **GUIDELINE**	**Approval Committee Review** ☐ Medical Executive Committee ☐ Patient Care Leadership ☒ Practice Council	

I. PURPOSE:

To identify patients at risk for substance abuse and to provide a brief intervention and referral to treatment when warranted.

II. POLICY:

All patients ≥ 12 years old who present as a trauma activation (Level I or II) will be screened for substance abuse. Those patients who are subsequently admitted to an inpatient unit for the treatment of a traumatic injury will have a brief intervention conducted and documented by a trained social worker. When indicated, a referral to treatment will be made.

III. PROCEDURE:

A. Level I and Level II trauma activations who are 12 years of age or older are to have a serum blood alcohol content level (BAC) and a urine drug screen (UDS) collected during their evaluation as required by the Trauma Service Guidelines. Additionally, they will be administered the CRAFFT questionnaire.
   1. The CRAFFT questionnaire will be administered by the ED nurses as part of completion of the ED Trauma Documentation form or the Trauma Flowsheet.
   2. The Trauma Nurse Practitioners and Trauma Social Workers will monitor completion of the tool for patients unable to be assessed in the Emergency Department. The form can then be completed in the PICU or on the acute care nursing unit.

B. Patients with a positive BAC or UDS or a CRAFFT score of 1 or higher will receive a brief intervention prior to discharge.
   1. A score of 1 or higher on the CRAFFT questionnaire will generate a task list in Cerner for the patient's nurse to page the social worker on call with the consult.
   2. The patient's nurse or other member of the treating team will notify social work of a positive BAC or UDS.
   3. Social work will provide the brief intervention.
   4. Behavioral Health and/or Child Advocacy may be consulted for further assessment/intervention if needed.
   5. Patient Confidentiality. Information regarding substance use and or abuse is to be treated as confidential medical information. Results of alcohol and drug testing can be shared with parents or guardians of minor patients without their consent unless the patient is actively "seeking" treatment and articulates that he/she does not want the information shared. In this case, the information can still be shared with the parents/guardians when:

      i. Testing was done for medical purposes
      ii. Patient is extremely young and/or lacks the capacity for rational choice
      iii. Situation poses a substantial threat to life or physical well-being

REFERENCES:

American College of Surgeons Committee on Trauma (2006). *Resources for Optimal Care of the Injured Patient.* Chicago, IL, American College of Surgeons.

OTHER POLICIES RELEVANT TO THIS POLICY

Policy #	Name of Policy
108	Alcohol or Substance Abuse: Guidelines for Evaluation and Medical Stabilization

Riley Hospital for Children
Indiana University Health

Manual:	Riley Trauma Services
Section:	Practice Guidelines
Approval Date:	September 2010
Revised Date:	May 2012
Effective Date:	May 2012

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT GUIDELINES

PURPOSE:

To identify adolescent patients (12 years and older) who are at risk for injury due to drinking or substance abuse and to provide intervention when warranted.

SCOPE OF GUIDELINE:

Trauma patients who are at least 12 years old. This includes all patients who meet inclusion criteria into the trauma registry.

DEFINITIONS:

- **Trauma**: Trauma is mechanical damage to the body caused by an external force.
- **Trauma Patient**: An injured person who requires timely diagnosis and treatment of actual or potential injuries by a multidisciplinary team of health care professionals
- **SBIRT:** Screening, brief intervention and referral to treatment. A three-step process for screening patients for alcohol and drugs to identify whether or not the patients' drinking or substance use places them and others at risk and hence warrants a brief intervention. Step one is to screen patients for alcohol or drugs. Step two is to conduct a brief intervention if warranted in order to reduce or eliminate at-risk behavior. Step three is to follow up or provide referrals if warranted for additional services in order to reinforce the intervention. Research evidence clearly shows that brief interventions for at-risk drinking result in health, social, and economic benefits for the individual and society.
- **BAC:** Blood alcohol content. The BAC threshold for impaired driving is 80 mg/dl (0.08 g/dl) in all 50 U.S. states. This threshold was set because research shows that driving ability is impaired at this level for everyone. The Indiana University Health laboratory technical limit is 10 mg/dl (0.01 g/dl).
- **UDS:** Urine drug screen. Tests for Amphetamines/Methamphetamine, Barbiturates, Benzodiazepines, Opiates, Cocaine/Metabolite, PCP (Phencyclidine), and THC (Marijuana). Technical limits vary with each class.
- **CRAFFT questionnaire:** A 6-item questionnaire specifically designed and validated for use with adolescents, ages 12 through age 21, to screen for high-risk alcohol and other drug use disorders simultaneously.
- **Trained SBIRT Provider:** A nurse, social worker or physician who has successfully completed an SBIRT training program and who demonstrates competency in implementing brief intervention.
- **Minor patient:** An individual who is less than eighteen (18) year of age.

GUIDELINE:

- Trauma patients who are 12 years of age or older will be assessed for alcohol and drug usage using biological markers (BAC and UDS), the CRAFFT assessment tool or both.
  - Trauma patients should have a BAC and a UDS collected during the initial workup when medically indicated.
    - It is not necessary to obtain consent for a BAC or UDS when it is medically indicated.
    - A BAC is collected in an unopened gray tube. Avoid using an alcohol swab when collecting the sample.
    - A UDS is collected in red top tubes. (50 mL is preferred, 10 mL is minimum)
  - The CRAFFT questionnaire should be administered to all **trauma/injured** patients who are 12 years to 21 years of age .
    - It is not necessary to obtain parental consent prior to administering the CRAFFT assessment.
    - The assessment should be administered in a confidential manner without the presence of parents, guardians or visitors. The patient should be advised that confidentiality may be broken in situations when the safety of the patient or others is a concern.
    - The CRAFFT assessment will be completed by the Emergency Department Nurse. Patients who are admitted and have not received screening within the ED, or who are cognitively unable to perform assessment during ED stay, will have the screening completed by the Trauma Advanced Practice Nurse as soon as appropriate during the hospitalization. The on-call social worker or SBIRT trained nurse will provide brief intervention as indicated.
    - Patients who are over 21 years of age should received the adult RAPS4 screening tool.
- Patients with a positive BAC, UDS or CRAFFT score of 2 or higher will receive a brief intervention prior to discharge.
  - Patients who test positive should receive a brief intervention when medically and psychologically appropriate and prior to discharge.
  - The brief intervention will be completed by the ED social worker if patient is in the ED, prior to discharge. The Trauma Advanced Practice Nurse will coordinate with Social Services to ensure intervention on all admitted trauma patients. Child Psychiatry or Adolescent Medicine should be consulted when indicated.
- Documentation.
  - The CRAFFT assessment will be filled out in the Electronic Medical Record (EMR) by the screening nurse. A screening score of 2 or higher indicates a brief intervention is indicated. Social Services or the Trauma Advanced Practice Nurse will provide documentation of the intervention within the patient's electronic chart. Documentation should be brief, indicating that the

assessment and intervention are complete and the duration of time with the patient.

- Reimbursement
  - Correct usage of CPT codes 99408 and 99409 requires that the screening and interventional components of this service be documented in the clinical record.
  - Services of 15 – 30 minutes duration receive a 99408 code.
  - Services great than 30 minutes duration receive a 99409 code.
- Patient Confidentiality. Information regarding substance use and or abuse is to be treated as confidential medical information.
  - Patients are to be informed of the confidential nature of this information prior to the interview.
  - Information regarding alcohol and drug testing can be released to parents or guardians of minor patients under the following circumstances:
    - Cases where testing was done for medical purposes
    - Extreme youth and/or lacks capacity for rational choice
    - Situation poses a substantial threat to life or physical well being
    - The patient provides consent.

REFERENCES/CITATIONS:

American College of Surgeons Committee on Trauma (2006). *Resources for Optimal Care of the Injured Patient: 2006. Chicago, IL,* American College of Surgeons.

RESPONSIBILITY: Riley Trauma Services, P-EMTC
Trauma Morbidity & Mortality Committee
Trauma Performance Improvement Committee

REVIEWS:

Medical Director, Riley EMTC	Date
Medical Director, Riley Trauma Services	Date
Clinical Director, Riley EMTC	Date
Trauma Services Program Manager	Date

DATE(s)

Approval Date:		Initial Approval Date	
Effective Date:		Initial Effective Date	
Review/Revision Date(s):		Ongoing List of Review Dates	

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