



# CARE FOR SUBSTANCE USE DISORDER

HOW-TO GUIDE

This how-to guide offers actionable, evidence-based best practices on substance use disorder, enabling primary care physicians and other members of the care team to overcome key barriers to operationalizing integrated behavioral health (BH) care in their practice. This resource is reflective of the generous time and direction provided by numerous substance use disorder subject matter experts with firsthand experience effectively integrating BH care within practices.



## TERMINOLOGY:

- When “primary care physician (PCP)” is utilized in this document, it is inclusive of physicians across specialties—including family medicine, internal medicine, pediatrics, and obstetrics and gynecology. While not trained in primary care, non-primary care specialties, such as cardiology, gastroenterology, neurology, and oncology, can also benefit from integrating behavioral health into their practices to support their patients.
- While “patient” will be used throughout, note that this also encompasses the families and caregivers, who play an important role in integrated care.



## CHILD AND ADOLESCENT

### A Developmental Approach to Child and Adolescent Mental Health Care

PCPs who serve children and adolescents have a unique opportunity to promote healthy mental and emotional development and safe, stable, nurturing relationships in families. Mental health (MH) concerns manifest differently in children than in adults; as such, pediatric approaches to behavioral health integration (BHI) can differ compared to adult practices. To that end, we have included guidance specific to child and adolescent MH care where appropriate. This type of information will be noted with the icon above.

# Introduction

Like other chronic diseases, substance use disorder (SUD) disrupts the healthy function of the body and increases an individual's risk of developing other health conditions. And yet, because of the stigma that is often associated with SUD, individuals may be reluctant to seek care, and therefore, their SUD may be untreated and unmanaged. As the first and frequently only connection a patient has to the health care system, PCPs are uniquely positioned to identify and address unhealthy substance use or misuse in their patients. Those in specialty care settings are also in a position to identify and intervene in SUD cases, as people with SUD often experience comorbid chronic physical health conditions, including chronic pain, cancer, and heart disease.<sup>1</sup>



## CALLOUT:

Adolescence (defined as 11 through 21 years of age) presents a crucial window of time for early intervention and prevention of SUDs. Early identification of those at risk presents an opportunity for youth to then go on to lead healthy and productive lives. The American Academy of Pediatrics (AAP) provides [tools and resources](#) to ensure a sustainable system of care for adolescents at risk.



# Align the Team

Each team member has a role to play in creating a safe environment for patients with SUD.

The entire care team must adopt and demonstrate a nonjudgmental approach that recognizes [SUD as a disease](#) and treats patients with compassion.

To foster a culture that makes your practice a place where patients are willing and able to disclose the details of unhealthy substance use/misuse and seek help, consider providing education and building team competency in the following ways:

## Adjust language to reduce the stigma often associated with addiction:

- Eliminate any language that portrays those with SUD in a negative way to avoid creating shame or discouraging them from seeking treatment.
- Use person-first language such as “person with a substance use disorder” rather than terms such as “addict,” “drug user,” or “alcoholic” to separate the person from their condition.

- Replace the term “abuse” with “use” (for illicit drugs) and “misuse” (for prescription medications used other than as prescribed) to reduce negative associations.

For further guidance, see the National Institutes of Health’s (NIH’s) [Words Matter: Preferred Language for Talking About Addiction](#) and the American Medical Association’s (AMA’s) recommendations for [compassionate SUD language](#).

## Implement a trauma-informed approach to care to create a safe context for treatment:

- The Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) [Concept of Trauma and Guidance for a Trauma-Informed Approach](#) outlines six key principles and 10 implementation domains of an organizational trauma-informed approach.
- The AAP’s [Trauma-Informed Care](#) resources provide information and guidance on implementing trauma-informed care in pediatric settings.
- The BHI Collaborative’s [“Addressing Childhood Trauma Through Trauma-Informed Care \(TIC\)”](#) webinar shares how to develop engagement strategies and techniques to address trauma symptoms in pediatrics.



## Promote cultural and structural competency to increase engagement:

- Increase sensitivity and acceptance around [cultural, structural, and linguistic factors](#) to help patients feel more comfortable obtaining treatment. Obtain guidance from the U.S. Department of Health and Human Services Office of Minority Health (OMH) and SAMHSA’s [Advancing Behavioral Health Equity: National CLAS Standards in Action webinar](#).
- Provide SUD intervention and education materials in patients’ preferred language.
- Link patients to culturally and linguistically appropriate community SUD resources.
- Train clinicians and staff in cultural and structural humility, cross-cultural communication, cultural and structural influences on unhealthy substance use/misuse, and appropriate [culturally/racially aware language](#) to use.
- Recruit PCPs and BH clinicians from culturally and linguistically diverse populations.
- Consider including individuals with lived experiences with substance use/misuse in the development of practice policies and protocols to ensure credibility and empathetic design.
- Integrate culturally appropriate screening, treatment, and case management with guidance from SAMHSA’s protocol on [Improving Cultural Competence](#).



## MOVING FORWARD:

The Agency for Healthcare Research and Quality (AHRQ) has developed topic briefs to address [Stimulant Use Disorders and Behavioral Health Integration](#), [The Role of Low-Threshold Treatment for Patients with OUD in Primary Care](#), and [The Role of Primary Care and Integrated Behavioral Health in Polysubstance Use](#).

In addition to the resources referenced in this guide, community-based outreach services and local universities’ addiction research centers can be excellent training resources for staff. Beyond the orientation and training stages, embed these practices into daily operations to ensure that PCPs can deliver quality care and promote patient engagement.

## Primary Roles + Responsibilities

The list below includes examples of potential responsibilities related to unhealthy substance use/misuse identification and intervention that each care team member may have:

### Primary Care Physicians:

- Deliver brief intervention using [motivational interviewing \(MI\) techniques](#) for patients who screen positive for unhealthy substance use/misuse
- Perform ongoing assessment at future visits
- Identify patients for further examination by BH clinician
- Consult with BH clinician on treatment plan
- Prescribe and manage pharmacotherapy (if deemed appropriate)
- Manage cases through team case conferences

### Medical Assistants or Nurses:

- Administer pre-screen and screening tools
- Flag any concerning responses to the PCP and/or BH clinician

### BH Clinicians:

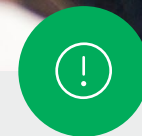
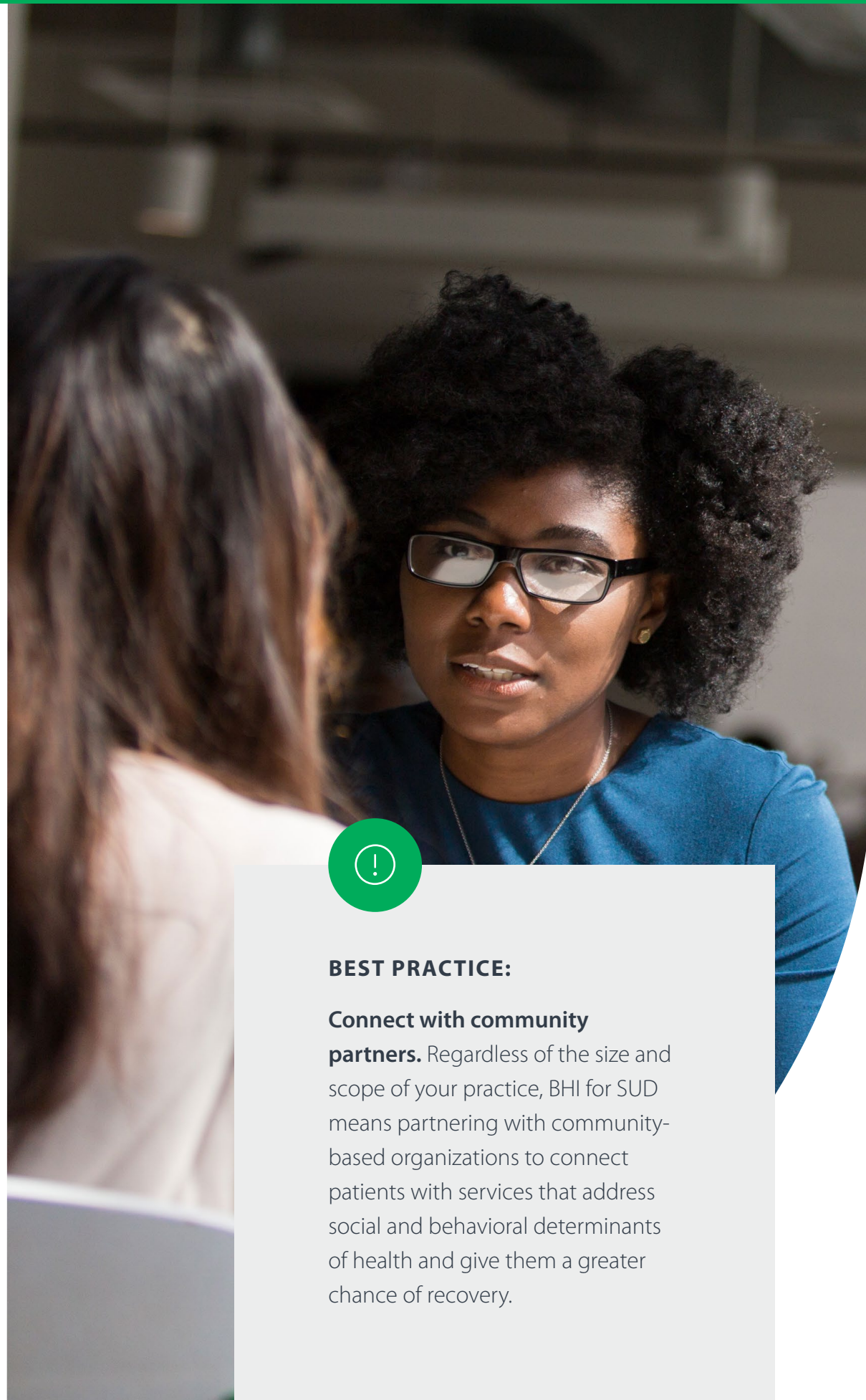
- Deliver care on-site in the practice, or off-site in an on-call or virtual capacity
- Conduct further assessment if unhealthy substance use/misuse is suspected
- Determine and facilitate changes in treatment plan with PCP and patient as clinically indicated
- Provide brief interventions for patients (MI, goal setting)
- If licensed, offer behavioral therapy to patients in one-on-one or group settings
- Facilitate and oversee referrals to specialty services

*Note: Depending on the state in which you practice and your practice's needs, this person could be a Licensed Clinical Social Worker, a Licensed Clinical Professional Counselor, or another licensed professional who specializes in SUD.*

### Psychiatric Consultants (MD/DO):

- Review complex cases and assist with diagnoses as needed
- Consult on treatment plan for complex MH issues/co-occurring disorders that may fuel addiction

*Note: Ensure this consultant has specialized training in addiction.*



### BEST PRACTICE:

#### Connect with community partners.

Regardless of the size and scope of your practice, BHI for SUD means partnering with community-based organizations to connect patients with services that address social and behavioral determinants of health and give them a greater chance of recovery.

## Secondary Roles + Responsibilities

### Case Managers or Community Health Workers:

- Maintain records and connect patients to care
- Serve as system navigator for patients
- Provide patient advocacy, such as helping patients communicate with their PCPs and insurance companies
- Connect patients to social support services, such as housing or transportation

### Peer Support Specialists:

- Mentor patients and help with goal setting
- Model recovery and hope
- Help patients navigate the health care system and advocate for themselves
- Can take on case manager responsibilities in some instances



### MOVING FORWARD:

For best practices and recommendations on how to increase access to care for SUDs while navigating current challenges in health care, reference the [AMA's information on physicians' progress toward ending the nation's drug overdose epidemic](#).

# Evaluation

Before screening begins, establish an environment of trust by sharing appreciation for the patient being there and describing your commitment to providing integrated care:

- Discuss your policy of screening all patients for a variety of conditions.
- Assure them they are welcome to answer, elaborate on, or not answer any of the screening questions.
- Express gratitude and appreciation for responses shared and remind them that sharing information helps you work together to ensure the best care.
- Assure the patient that the confidentiality of their information will be protected in compliance with federal and state laws.

In addition to information gathered through pre-screens and screening tools, additional clues that could indicate substance use may surface during a patient's visit:

- Social factors such as inability to maintain employment
- Interpersonal and financial problems
- Repeated legal offenses
- Poor adherence to treatment



## BEST PRACTICE:

**Communicate confidentiality and privacy** through frank conversations with patients. Be prepared to answer questions about how their information will be accessed and/or shared. Let them know the practice is committed to confidentiality and has policies and training in place to ensure their information stays private. Also, consider engaging your electronic health record (EHR) vendor about establishing pathways to ensure patients' preferences can be tracked and validated.

## Screening

All patients should complete single-question pre-screens that ask about alcohol and drug use at each visit.

### ALCOHOL:

Men: *How many times in the past year have you had five or more drinks in a day?*  
 Women: *How many times in the past year have you had four or more drinks in a day?*

### DRUGS:

*How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons (for example, because of the experience or feeling it caused)?*

If a pre-screen is positive, the following evidence-based screening and assessment tools can be administered by a nurse or medical assistant when rooming the patient to direct at-risk patients to BH clinicians.

### SCREENING TOOLS

TOOL	SUBSTANCE TYPE		PATIENT AGE	
	Alcohol	Drugs	Adult	Adolescent (12–17)
Screening to Brief Intervention ( <a href="#">S2BI</a> )	x	x		x
Brief Screener for Tobacco, Alcohol, and other Drugs ( <a href="#">BSTAD</a> )	x	x		x
Tobacco, Alcohol, Prescription medication, and other Substance use ( <a href="#">TAPS</a> )	x	x	x	
National Institute on Alcohol Abuse and Alcoholism (NIAAA) Youth Alcohol Screen ( <a href="#">Youth Guide</a> )	x			x
Opioid Risk Tool – opioid use disorder (OUD) ( <a href="#">ORT-OUD</a> )		x	x	



### ASSESSMENT TOOLS

TOOL	SUBSTANCE TYPE		PATIENT AGE	
	Alcohol	Drugs	Adult	Adolescent (12–17)
Alcohol Use Disorders Identification Test ( <a href="#">AUDIT-C</a> ) or ( <a href="#">AUDIT</a> )	x		x	x
Drug Abuse Screening Test ( <a href="#">DAST-10</a> )		x	x	
Car, Relax, Alone, Forget, Friends, Trouble ( <a href="#">CRAFFT 2.1+N</a> ) or the ( <a href="#">CRAFFT+N</a> )	x	x		x
Global Appraisal of Individual Needs ( <a href="#">GAIN</a> )	x	x		x



For a comprehensive list of substance use screening and assessment tools, reference the National Institute on Drug Abuse's (NIDA's) [Screening and Assessment Tools Chart](#).



**TIP: The AMA's [Practice guide: Integrated behavioral health care for older adults](#)** contains detailed information for PCPs on SUD and misuse, signs, and treatments when caring for older adults.



**E-cigarette use is widespread among youth today**, with adolescents turning to e-cigarettes over other tobacco products. The AAP's [E-cigarette and Vaping Curriculum](#) provides youth e-cigarette prevention based on current evidence and best practices.

### BEST PRACTICE: Integrate screening tools into the EHR.

The ability to track patients from screening to treatment via the EHR is necessary for documenting care, analyzing program impact, and billing accurately. To improve data collection and increase the number of patients screened, consider imbedding screening assessments that score results and recommend next steps to ensure proper interventions are recommended. The Institute for Research, Education and Training in Addictions (IRETA) has compiled an [EHR Toolkit](#) to assist in implementing and improving your workflow.



**TIP: Ask probing questions during standardized BH screenings** (such as the [PHQ-9](#)) to determine if alcohol and/or substance use/misuse could be contributing to other BH symptoms. The effects of certain substances can mimic psychiatric symptoms, especially anxiety, depression, insomnia, hyperactivity, irritability, and hallucinations.



## Risk Severity

Assign a substance use/misuse risk severity based on screening and assessment results. Use the following risk categories to determine the degree of intervention required.<sup>ii</sup>

### ADULT SUBSTANCE USE/MISUSE SEVERITY TABLE

RISK SEVERITY	CRITERIA	RECOMMENDED LEVEL OF INTERVENTION
<b>Low Risk/Abstain</b>	Negative pre-screen or scoring in Zone I on the full screens (AUDIT score: 0–7; DAST score: 0–2) <i>Patient is likely not experiencing consequences related to unhealthy substance use/misuse and does not have risk for SUD</i>	<b>Positive health message</b> from the PCP reinforcing low-risk use and providing education
<b>Moderate Risk</b>	Negative pre-screen or scoring in Zone II on the full screens (AUDIT score: 8–15; DAST score: 3–5) <i>Patient is at risk of experiencing negative consequences because of their potential unhealthy substance use/misuse, such as falls, car accidents, or health issues later in life</i>	<b>Brief intervention:</b> a short, generally 5–15-minute conversation that offers feedback and advice using <a href="#">MI techniques</a> <b>As appropriate, hand off to BH clinician</b> for further assessment, diagnosis, and treatment plan execution
<b>Substantial or Severe Risk</b>	Negative pre-screen or scoring in Zone III on the full screens (AUDIT score: 16–19; DAST score: 6–8) or Zone IV (AUDIT score: 20–40; DAST score: 9–10) <i>Patient is likely experiencing negative consequences because of their unhealthy substance use/misuse and is more likely to have SUD</i>	<b>Hand off to BH clinician</b> for further assessment, diagnosis, and treatment plan execution Possible referral to specialized treatment



### ADOLESCENT SUBSTANCE USE/MISUSE SEVERITY TABLE

RISK SEVERITY	CRITERIA	RECOMMENDED LEVEL OF INTERVENTION
<b>No Reported Use</b>	No use in past 12 months and CRAFFT score of 0; BSTAD response: 0 days; S2BI response: never <i>Patient is likely not experiencing consequences related to unhealthy substance use/misuse and does not have risk for SUD</i>	<b>Praise and encouragement</b> from the PCP reinforcing low-risk use Prevention message to avert or delay initiation, keeping the advice medical
<b>Lower Risk</b>	No use in past 12 months and “yes” to car question only <b>OR</b> use in past 12 months and CRAFFT score < 2; BSTAD response: 1 day; S2BI response: once or twice <i>Patient is at risk of experiencing negative consequences because of their potential unhealthy substance use/misuse, such as falls, car accidents, or health issues later in life</i>	<b>Simple and direct cessation message</b> encouraging them not to use again <b>Provide information about risks</b> of substance use and substance use-related riding/driving Possible follow-up visit
<b>Higher Risk</b>	Use in past 12 months and CRAFFT score ≥ 2; BSTAD response: 2+ days (alcohol or other drugs) and/or 6+ days (tobacco); S2BI response: monthly+ <i>Patient is likely experiencing negative consequences because of their unhealthy substance use/misuse and is more likely to have SUD</i>	<b>Brief intervention:</b> a short, generally 5–15-minute conversation that offers feedback and advice using <a href="#">MI techniques</a> <b>Provide information about risks</b> of substance use and substance use-related riding/driving Follow-up visit Possible referral to specialized treatment



# Implementing Treatment

In an integrated health model, the PCP is responsible for opening the conversation about unhealthy substance use/misuse with patients and gauging their readiness to change and receptivity to engage with a BH clinician for further assessment and treatment. The BH clinician can then perform a holistic, biopsychosocial assessment of at-risk or high-risk patients to determine their needs and the level of care that will serve them best.

It is important to recognize that every patient is different, and treatment plans will need to be tailored to their willingness and ability to engage.

## Levels of Care

The [American Society of Addiction Medicine \(ASAM\)](#) broadly defines the five levels of care as follows.



### Prevention/Early Intervention:

- **Brief Intervention:** For patients who screen in the low-risk or at-risk zones, brief intervention can be offered by PCPs, depending on their comfort level, or through a warm handoff to a BH clinician. This includes raising the patient's awareness of their unhealthy substance use/misuse and its consequences and using MI to drive behavior change. Techniques include asking open-ended questions, reflective listening, asking permission before offering advice, and eliciting statements from the patient about why they want to change. Brief interventions that are successful typically empower patients by setting goals using [shared decision-making](#).<sup>iii</sup>
  - For brief intervention goals for pediatrics, reference this [table from the AAP](#), which indicates goals along the substance use spectrum.
- **Primary Care Support for Self-Management:** Patients with SUD who are not ready for or interested in engaging in treatment should nonetheless be offered repeated brief counseling, MI, and shared decision-making at each appointment.
  - Treatment of comorbid MH and/or medical conditions may build rapport and engagement in treatment or can lead to changes in substance use/misuse.<sup>iii</sup>
- **Harm Reduction:** These interventions seek to minimize the negative consequences of drug use by meeting patients where they are in their unhealthy substance use/misuse and recovery journey. Tactics include:
  - Prescribing [Naloxone](#), the opioid-overdose-reversal agent, to those at risk of overdose.
  - Connecting patients to syringe services programs (SSPs), community-based prevention programs that facilitate access to sterile needles and syringes and safe disposal after use to reduce the risk of blood-borne infections.



### Outpatient Services:

- **Pharmacotherapy:** FDA-approved medications to treat alcohol and opioid use disorders (OUDs) and relieve withdrawal symptoms and psychological cravings. These medications are evidence-based treatment options and do not just substitute one drug for another.<sup>iv</sup>
  - **Alcohol Use Disorder Medications:** These medications can be prescribed in a primary care setting. Medication management focuses on assessing use and symptoms, progress toward goals, medication adherence, and participation in peer support groups (e.g., Alcoholics Anonymous).
    - › **Acamprosate** is for patients who have completed detox and want to avoid relapse. It reduces the brain's dependence on alcohol, preventing cravings, but it does not prevent physical symptoms of withdrawal.
    - › **Disulfiram** treats chronic alcoholism and is most effective in patients who have completed detox or are in the initial stage of abstinence. It discourages drinking by causing unpleasant effects when even small amounts of alcohol are consumed.
    - › **Naltrexone** blocks the euphoric effects of alcohol and feelings of intoxication and allows patients to reduce alcohol use by removing the perceived "reward" of consumption.



## Outpatient Services: (cont.)

- **Medications to Treat Opioid Use Disorder (MOUD):** These medications are used to treat OUDs attributable to short-acting opioids, such as heroin, morphine, and codeine, as well as semisynthetic opioids, such as oxycodone and hydrocodone.<sup>v</sup>
  - › **Buprenorphine** works similarly to methadone but only partially activates opioid receptors, often reducing drug use and protecting patients from overdose. Because buprenorphine is considered safer than methadone, less monitoring is needed, and it can be prescribed by PCPs.
    - PCPs are required to apply to the Drug Enforcement Administration (DEA) for a waiver to prescribe buprenorphine, and [waiver trainings](#) are available to PCPs at no cost, funded by the [Providers Clinical Support System \(PCSS\)](#) grant.
  - › **Methadone** works by activating opioid receptors in the brain and blocking the effects of heroin and painkillers. It is one of the most effective medications available. However, it is a potent medication and can cause sedation, even death. Therefore, dispensing methadone is highly regulated, and it can only be provided in Opioid Treatment Programs (OTPs).
  - › **Naltrexone** completely blocks opioid receptors and is used after detoxification to prevent relapse. It has no abuse potential and no overdose risk, and there is no withdrawal when it is stopped. Naltrexone can be administered in a PCP's office with single doses effective for up to 30 days.
- **Opioid Overdose Prevention Medication**
  - › **Naloxone** is a lifesaving drug that, when sprayed into the nose or injected, quickly reverses the powerful effects of opioids during an overdose. The FDA recommends [prescribing Naloxone](#) to all patients at risk of opioid overdose, regardless of whether they are being treated for OUD or not.<sup>vi</sup> See the AMA's brief step-by-step video demonstrating [how to administer naloxone](#).
- **Behavioral Therapy:** Often used as a stand-alone treatment for SUD or in combination with other modalities such as pharmacotherapy. Can take place in individual or group settings, teaching patients the skills they need to achieve and maintain sobriety and how to navigate various situations without relapsing to using substances.<sup>vii</sup>
  - **Cognitive Behavioral Therapy (CBT)** teaches patients to recognize and change maladaptive behaviors. CBT can help patients develop coping skills, identify situations in which the risk of relapse is heightened, and know what to do when they arise.
  - **Dialectical Behavior Therapy (DBT)** is used to reduce cravings, help patients avoid situations or opportunities that increase their risk of relapse, assist in giving up actions that reinforce substance use/misuse, and learn healthy coping skills.
  - **Rational Emotive Behavior Therapy (REBT)** helps patients understand their own thoughts and use that understanding to develop better habits, think in more positive and rational ways, and experience healthier emotions.
  - The **Matrix Model** was originally developed to treat individuals with stimulant addictions and combines various techniques that focus on rewarding good behaviors and promoting self-esteem, dignity, and feelings of self-worth.
- **Peer Support Groups:** Participation in peer recovery programs such as [Alcoholics Anonymous](#), [Narcotics Anonymous](#), or Self Management and Recovery Training ([SMART](#)) can help patients build support networks while in treatment, recovery, and maintenance.



## Intensive Outpatient Program (IOP)/ Partial Hospitalization Program (PHP):

- Short-term, intensive day and/or evening treatment service for patients who do not require 24-hour care. May be ideal for patients who have complex symptoms or co-occurring disorders. Alternatively, IOP can be a step-down level of care for those who have completed inpatient rehab.



## Residential/Inpatient Services:

- This level offers the broadest spectrum of services to meet the unique needs of individuals, including those with severe mental disorders or cognitive impairments, those who are homeless, or those in the criminal justice system. While settings and services may vary, these programs are offered in a structured, clinically managed residential setting with 24-hour support and trained counselors.

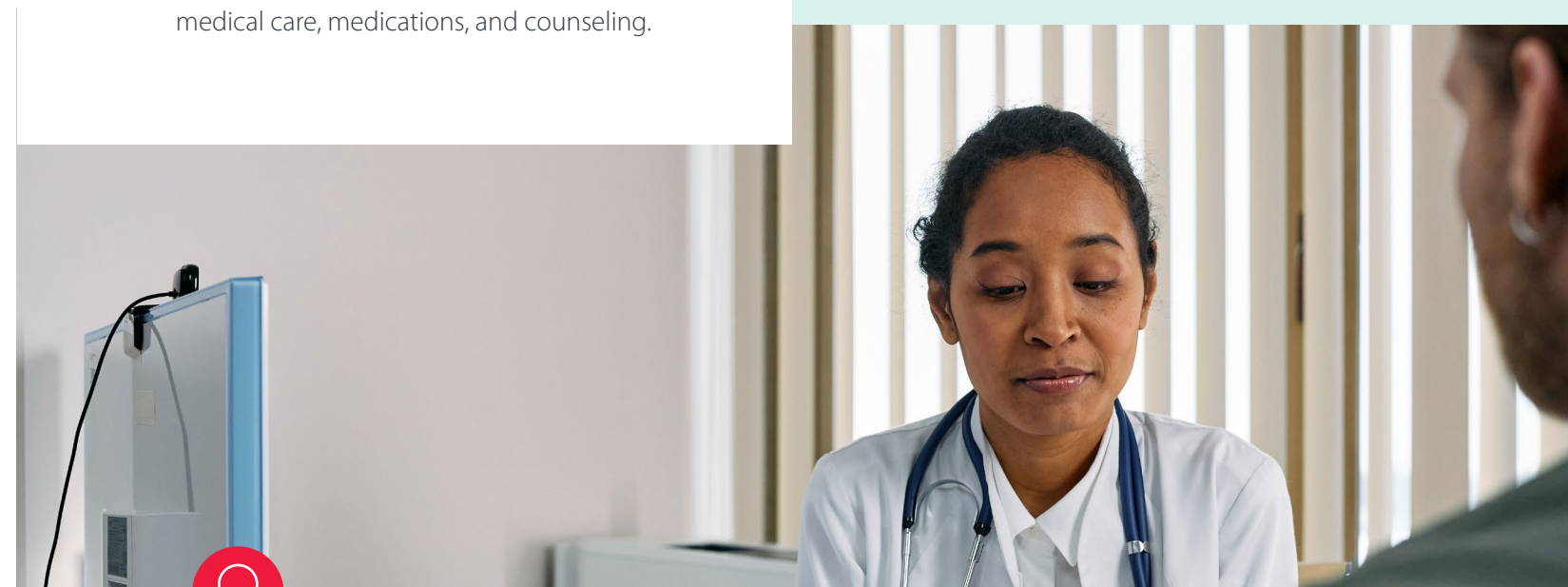


## Medically Managed Intensive Inpatient Services:

- Medical detoxification and stabilization services for adults who are at high risk of severe withdrawal symptoms. Patients receive 24-hour medical care, medications, and counseling.



**TIP: The AAP has partnered with the American Academy of Addiction Psychiatry (AAAP)** to provide several no-cost [Continuing Medical Education \(CME\) courses and other trainings](#) on treating OUD in adolescents.



### TIP: Leverage partnerships for consultation and referral.

As with all diseases and disorders, patients with SUD may present with complex medical issues beyond a PCP's expertise that complicate diagnosis and treatment. Adolescents may require specialty care, as may individuals who are pregnant or have co-occurring psychiatric disorders.<sup>ii</sup>

**For further resources on treating SUD,** visit the AHRQ's [primary care substance use resources page](#).





## Long-Term Management

SUD is a chronic health condition. Ongoing, regular follow-up is essential for support, encouragement, and modification of the treatment plan as needed. The recommended follow-up cadence is:<sup>ii</sup>



### WITHIN TWO WEEKS OF TREATMENT INITIATION:

Allows for tailoring of the treatment plan according to individual needs (e.g., change in dose of pharmacologic treatment, addition of support services).



### MONTHLY OR, AT MINIMUM, QUARTERLY:

As individuals stabilize on treatment, consistent follow-up allows for ongoing evaluation to ensure that the patient's goals are being met.



### ONGOING SUPPORT:

Peer Support Specialists can be a beneficial and accessible recovery resource in between treatment visits.



### BEST PRACTICE:

**Establish referral networks** of specialty care (e.g., IOP, PHP, inpatient services) to successfully manage more complex SUDs. Good care requires close tracking to confirm patient adherence and response to treatment. Primary care practices that refer patients with SUD to specialty care should stay abreast of the patient's engagement and participation in treatment, most easily ensured by obtaining a release of information from the patient, especially as this may affect treatment of the patient's general medical conditions.<sup>viii</sup>

# Financial Considerations



Understanding how to bill for alcohol- and/or other drug-related care will help ensure its sustainability in your practice.

[Screening and Brief Intervention \(SBI\) codes](#) can be used by integrated BH clinicians after screening, assessment of symptoms, and a warm handoff for unhealthy substance use/misuse or SUD if counseling lasts 15–30 minutes. Under the Affordable Care Act (ACA), they should not result in patient copays.

Alcohol- and/or other drug-related care may also improve performance on Center for Medicare & Medicaid Services (CMS) quality measures for accountable care organizations (ACOs) and the Merit-based Incentive Payment System (MIPS). Implementing SUD care may qualify as an innovative practice under MIPS and may generate shared savings for ACOs and improve cost-measure performance.<sup>iii</sup>

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## CALLOUT:

The [requirements for EHR documentation for Screening Brief Intervention, and Referral to Treatment \(SBIRT\)](#) have been expanded to include those at risk of developing these disorders. Screeners can be scanned into the EHR or a template can be created. In doing so, responses to all questions must be included, not only the scores/results to meet documentation requirements.

With patients who have tried vaping or any type of tobacco, ensure to use specific tobacco cessation counseling codes (99406 (3–10 minutes) and 99407 (>10 minutes)). For further billing information on pediatric substance use/abuse, reference the AAP's [Substance Use/Abuse Coding Fact Sheet for Primary Care Pediatrics](#).

