Alcohol *or* Other Drug
Provider Toolkit

Lisa Pasillas-Le,
Health Net
We help you with medication adherence efforts.

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We help your patients access public health services.

Overview

The information in this toolkit can assist providers in screening and interacting with patients who use alcohol or other drugs (AOD). This toolkit also provides information to appropriately engage patients based on their stage of change, provides resources to effectively screen and address this chronic condition in the primary care setting, and includes current recommendations based on the findings of a brief screening.

Enclosed is information on the following topics:

- facts about and prevalence of AOD use
- managing AOD use in a primary care setting
- behavioral health and primary care coordination
- topics for primary care physician (PCP) and patient discussion
- clinical guidelines and resources for providers

With proper screening and subsequent intervention or referral, providers can help improve the chances of patients initiating and engaging in positive steps to manage their AOD use. Interventions for AOD use are largely dependent upon the patient's needs, readiness to change and ability to commit to a plan of action.

Facts about AOD use

AOD-related deaths have more than doubled since the early 1980s. According to the National Institute on Drug Abuse (NIDA), there are more deaths, illnesses and disabilities from AOD use than from any other preventable health condition.[1]

It is normal for adults and adolescents to experiment with AOD use. Some people are even able to use alcohol, recreational drugs or prescription medications without ever experiencing negative consequences or lack of control. For many others, AOD use can cause problems at work, home, school, and in relationships. Often, AOD use ends up leaving users feeling isolated, helpless or ashamed.

A person that uses any substance might have physical, behavioral or psychological warning signs that indicate their use is problematic. Key signs to look for when working with patients include the following.

- Physical warning signs
  - bloodshot eyes, pupils larger or smaller than usual
  - changes in appetite or sleep patterns
  - sudden weight loss or weight gain
  - deterioration of physical appearance or personal grooming habits

[1] NIDA. www.drugabuse.gov/related-topics/medical-consequences-drug-abuse/mortality.

- unusual smells on breath, body or clothing
- tremors, slurred speech or impaired coordination

Statistics show that there are more deaths, illnesses and disabilities from AOD use than from any other preventable health condition.

- Behavioral signs
  - drop in attendance and performance at work or school
  - unexplained need for money or financial problems; may borrow or steal to get money
  - engaging in secretive or suspicious behaviors
  - sudden change in friends, favorite hangouts and hobbies
  - frequently getting into trouble (fights, accidents, illegal activities)
- Psychological warning signs
  - unexplained change in personality or attitude
  - sudden mood swings, irritability or angry outbursts
  - periods of unusual hyperactivity, agitation or giddiness
  - lack of motivation; appears lethargic or "spaced out"
  - appears fearful, anxious or paranoid for no reason

Prevalence of AOD use

According to data from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), globally, alcohol is the third leading risk factor for premature death and disability. Costs associated with alcohol abuse, alone, in the United States were $223.5 billion in 2006. More than 70 percent of total costs were attributed to lost productivity. It is estimated that 15 percent of the workforce or about 19.2 million workers consume enough alcohol to lead to workplace impairment and 9 percent of them reported heavy use[2] (defined as five or more drinks on the same occasion on five or more days in the past 30 days, per MHN clinical guidelines).

Despite the growing diversity of treatment options, only 14.6 percent of individuals with alcohol abuse or dependence receive treatment, according to the data from the NIAAA's *2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions.*[3]

Recent statistics indicate that an estimated 24.6 million Americans ages 12 or older – or 9.4 percent of the population – had used an illicit drug in the past month. This number has increased since 2011, mostly due to marijuana use.[4]

Prescription Opioid use

In 2013, nearly two million Americans abused prescription medications, more than the number using cocaine, heroin, hallucinogens, and inhalants combined. Non-medical use of prescription medications is a growing health problem in the United States. Annually, more people die from prescribed opioids than all illegal drugs combined.[5]

[2] NIAA. www.niaaa.nih.gov.

[3] National Epidemiologic Survey on Alcohol and Related Conditions: Selected Findings. Alcohol Research and Health. Vol 29; No. 2; 2006.

[4] Http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

[5] Hhttp://drugabuse.com/library/drug-abuse-statistics/

Opioid use and pregnancy

Opioid use in pregnancy is not uncommon and includes the use of heroin and the misuse of prescription opioid analgesics. Recent studies show that an estimated 0.1 percent of pregnant women used heroin within the past 30 days, while one percent reported non-medical use of opioid medications. Some studies have shown that there is a strong correlation of opioid use with an increased risk of birth defects, low birth weight and developmental deficits. Chronic heroin use is associated with fetal growth restriction, fetal death and preterm labor.

Prior to pregnancy and in early pregnancy, all women should be screened and asked about their use of alcohol and other drugs, including prescription opioids. Research has shown that pregnant women with mood or anxiety disorders are more likely to have a substance use disorder. The presence of opioid use during pregnancy requires that providers be aware of the implications of opioid abuse in pregnant women and utilize appropriate management strategies. Any pregnant woman who screens positive for substance use should be co-managed by the obstetrician and an addiction medicine specialist.[6]

Binge drinking

Binge drinking has become the number one form of alcohol misuse. Binge drinking is defined as a pattern of drinking, resulting in a blood alcohol level of 0.08 percent or higher within two hours. For men this is about five or more drinks and for women about four or more. Statistics indicate that most binge drinkers are not alcohol dependent, are over age 26 and have incomes of $75,000 or more. Binge drinkers are 14 times more likely to report alcohol-impaired driving than non-binge drinkers.[7]

Vulnerability to AOD

As with many other conditions and diseases, vulnerability to AOD use differs from person to person. One's genes, behavioral health status, family, and social environment all play a role in whether AOD use becomes problematic. Risk factors that increase vulnerability include:

- early use of drugs
- family history of addiction
- behavioral health disorders, such as depression and anxiety
- abuse, neglect or other traumatic experiences in childhood
- method of use – smoking or injecting – can increase addictive potential

Conditions occurring with AOD use

As many as 30 percent of individuals with mental illness and 50 percent of individuals with severe mental illness also have substance use disorders. Alcohol is the most commonly used drug, followed by marijuana and cocaine.[8] Rates for concurrent psychiatric conditions in persons with problematic AOD use are approximately two to four times higher than the general population. The most common mood disorders are anxiety and depression.[9] Such a high prevalence among these groups indicates their particular vulnerability.

Approximately seven thousand people are treated in the emergency department daily for using prescription medication in a manner other than as directed.

[6] Opioid abuse, dependence, and addiction in pregnancy. Committee Opinion No. 574. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012; 119:1070-6.

[7] http://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm

[8] National Alliance on Mental Illness (NAMI). www.nami.org/Learn-More/Mental-Health-Conditions/related-conditions/dual-diagnosis.

[9] NIAAA. niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/other-psychiatric-disorders.

PCP Management of AOD *Using Screening, Brief Intervention and Referral to Treatment (SBIRT)*

As health care gatekeepers, PCPs play an important role in the screening and management of AOD use.

SBIRT is an approach to early intervention and treatment for individuals who have or are at risk for a substance use disorder. A study of interventions in primary care settings noted that approximately 20 percent of male patients and 10 percent of female patients who visited their physicians met the criteria for at-risk behavior or dependent alcohol use.[10]

As such, one of the most effective methods to manage AOD use is routine screening in the primary care setting. PCPs are health care gatekeepers and, as such, are in the position to take action against substance abuse. PCPs play a pivotal role in the screening and subsequent management of AOD use because they occupy a special place of trust and confidence in our society. By recognizing warning signs, AOD use problems can be detected earlier.

Deciding whether AOD use is problematic is a several-step process. The information in this toolkit compiles the latest information on using evidence-based screening tools, brief interventions and referring patients to treatment in the primary care setting when a patient is either high-risk or experiencing AOD overuse. The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends the following SBIRT steps for the PCP to manage AOD use:

1. **Screen using an evidence-based tool.**
2. **Conduct brief intervention using risk-level.**
   Schedule a follow-up appointment within 14 days of diagnosis. The 14-day follow-up appointment is a Healthcare Effectiveness Data and Information Set (HEDIS®)[11] measure that is tracked and reported annually by the Health Net HEDIS team.
3. **Refer for treatment according to risk-level if patient requires a higher level of care.**

PCPs can use the table on page 5 to refer to these steps in more detail, in addition to the PCP's role, tools for the PCP to use and handouts for patients. Instructions for accessing the tools and handouts are also included.

[10] Fleming, M. and Baier Manwell, L. Brief Intervention in Primary Care Settings; a Primary Treatment Method for At-Risk, Problem, and Dependent Drinkers. Alcohol Research & Health. Vol. 23, No. 2, 1999.

[11] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

PCPs can also use the drinking level assessment on page 6, along with the Stages of Change Model on page 7, to further evaluate patients' levels of AOD use and identify appropriate interventions.

PCP Management of AOD

Step	*PCP Role*	*Provider Tools and Resources*	*Patient Handouts*
Step 1: Screening using an evidence-based tool	Universally asking patients brief, validated questions on entry into the primary care setting is most effective. Questions are designed to assess risk. One to two "yes" responses indicate education is appropriate while three or more indicate referral is appropriate. • Have you felt you should cut down or stop your alcohol or any kind of recreational or prescription drug use? • Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop your use? • Have you felt guilty or bad about how much you use? • Have you been waking up wanting to use?	CAGE-AID Questionnaire – available online at www.integration.samhsa.gov/images/res/CAGEAID.pdf	N/A
Step 2: Brief intervention using risk-level.	When screening indicates low risk, apply change interventions focused on raising awareness of use and consequences while motivating toward positive behavioral change. A typical intervention takes the time span of one visit to conduct. This works in two ways: 1. Educates about low risk to moderate drinking limits and health risks if limits are exceeded. 2. Encourages those at risk to think differently about use and make changes to improve their health. Schedule a follow-up appointment within 14 days of the diagnosis to discuss and review goals to reduce AOD use.	Stage of Change Tasks for PCPs – refer to Stages of Change Model on page 7	*Rethinking Drinking* – available online at http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/OrderPage.htm
Step 3: Referral to treatment using risk-level.	Following a screening result of moderate or high risk, the PCP refers the member to behavioral health care treatment. This is a proactive process facilitating access to specialty care for those requiring further assessment. Similar to brief intervention, referral for treatment involves a motivational discussion and empowerment. Treatment goals are assessment, education, problem-solving, coping mechanisms, and building a supportive social environment. This may be done over 4 to 6 sessions or more depending on individual needs.	Behavioral Health and Medical Care Coordination of Care Form[12]	N/A

[12] The Behavioral Health and Medical Care Coordination Form is specific to Health Net members with behavioral health coverage through MHN and is available on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Quality > Quality Improvement Corner.* The form can be used to communicate member information between the PCP and the behavioral health provider to facilitate coordination of care.

A drinking level assessment can help PCPs and patients determine whether patients should cut back on or abstain from alcohol.

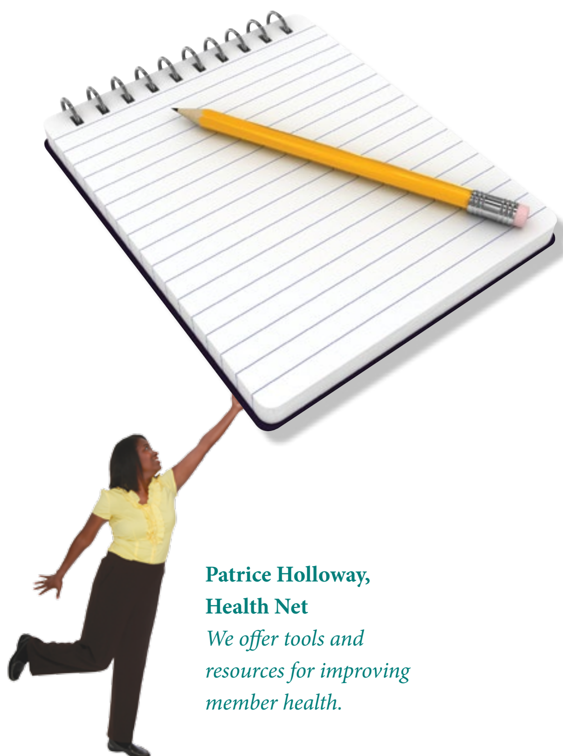
Drinking Level Assessment

PCPs can complete a drinking level assessment to further evaluate patients' drinking levels and advise on cutting back or abstaining from alcohol, as necessary. The following are information and criteria to evaluate low- and high-risk drinking behaviors.

Alcohol use at low-risk levels

Studies indicate that if the patient is not experiencing any immediate or long-term health-risk symptoms, the PCP may advise low-risk drinking. This option should not be considered for patients identified as using drugs regularly. The criteria for low-risk alcohol consumption includes not only that immediate or long-term health-risk symptoms not be present, but that the following criteria also be met:

- during the last year, use has consistently been at low-risk level
- patient has not suffered from early morning shakes
- patient would like to drink at low levels



Patrice Holloway, Health Net
We offer tools and resources for improving member health.

Cutting back or abstaining

High-risk – cutting back

Patients who are identified as adhering to either of the following are considered high risk and should be advised to cut back on their alcohol use.

- men who drink more than 4 drinks on any day or 14 drinks per week
- women who drink more than 3 drinks on any day or 7 drinks per week

These patients can be referred to *Rethinking Drinking* from NIAAA at http://rethinkingdrinking.niaaa.nih.gov for additional information. Providers may also order booklets to give to patients.

Abstinence

If the patient answers "yes" to three of the four key questions listed below, the PCP should encourage the patient to abstain from their alcohol use altogether. The PCP should also consider whether the patient should abstain from any regular use of non-prescription drugs or non-prescribed drugs.

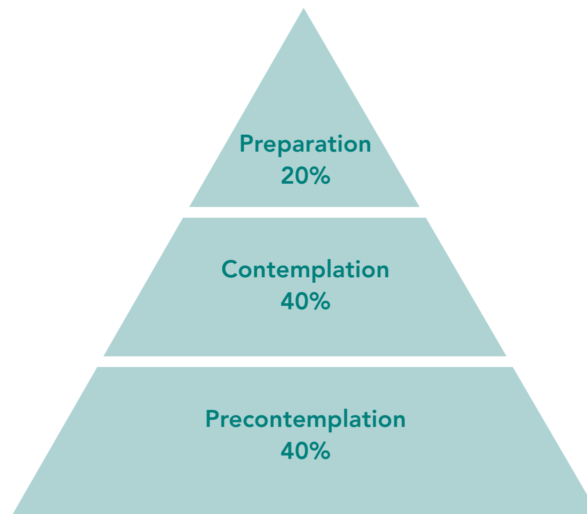
- Have you tried to cut down before, but were not successful?
- Have you suffered from morning shakes during a heavy drinking period?
- Do you have high blood pressure, liver disease or are you pregnant?
- Do you take medications that react with alcohol or other drugs?

Stages of change model

Health behavior change involves progress through the following six stages of change:

1. **Precontemplation**
2. **Contemplation**
3. **Preparation**
4. **Action**
5. **Maintenance**
6. **Recurrence**

Basic research has generated a standard model for at-risk populations, with 40 percent in precontemplation, 40 percent in contemplation and 20 percent in preparation. Applied research has demonstrated dramatic improvements in recruitment, retention and progress using stage-matched interventions. This following table provides a brief solution for PCPs to use with patients to identify change interventions appropriate to each stage of change.



PCP Interventions for Each Stage of Change

Stage of Change	*Patient's Stage of Change*	*Change Interventions*
Precontemplation	Not yet considering change or is unwilling or unable to change. Considered to be in denial.	Raise awareness and help patient define the problem as the patient perceives it.
Contemplation	Sees the possibility of change but is ambivalent and uncertain on how to change and whether he or she should change.	Resolve ambivalence; help patient to choose change by identifying pros and cons of making a change.
Preparation	Has decided that change is needed and has put a plan of action together to start to change.	Assist in building a change of action plan and suggest strategies to be implemented.
Action	Committed to a plan and taking steps toward change, but has not stabilized in the process.	Offer appropriate change strategies, help implement agreed-to ideas and motivate patient if regression occurs.
Maintenance	Has achieved goals and is working to maintain change using varied approaches.	Offer and help patient develop new skills for maintaining change.
Recurrence	Experiencing a recurrence of the symptoms and the problem changed has re-emerged.	Assist patient to cope with consequences and determine what to do next.

Topics for PCP *and* Patient Discussion

In order to better assist PCPs in educating patients about AOD, PCPs can discuss the topics below with patients about AOD abuse and addiction, inform them of potential consequences of their AOD use and help them reduce their AOD use. Whether or not AOD use is problematic, it is helpful for patients to understand their individual risk level. In furthering overall health, helping patients identify whether they should stop, or at least reduce, their alcohol use is an essential conversation.

Helping patients understand AOD abuse and addiction, along with risk levels of alcohol use, helps them identify whether they should reduce or stop use altogether.

AOD addiction

Although drug use may start out as voluntary, it can quickly become involuntary as the brain begins to physically change and craving increases. AOD changes the structure of the brain and how it works. This can lead to compulsive AOD-seeking behaviors, even though the user knows it is harmful. Areas in the brain affected by AOD abuse include decision-making, learning, memory, and behavior control.

Addiction is a treatable disease

With new discoveries in the field of addictions, research has led to advances in addiction treatment that can enable a person to live a productive life. Because addiction is a chronic disease, relapses are likely and occur at about the same rates as those with diabetes, hypertension and asthma. Successful treatment includes changing deeply imbedded behaviors with behavioral therapy. Treatment must also be tailored to address the needs of each individual and may include family therapy, staying connected with a treatment program, and reducing stress to reduce the likelihood of relapse.

Effects of high-risk alcohol use

The risks of alcohol use vary. There are immediate risks, ranging from injuries to violent behaviors, and long-term risks, such as diseases from excessive use over time. The following is a list of immediate and long-term health risks adapted from the Centers for Disease Control and Prevention (CDC).[13] For more comprehensive information, visit the CDC website at www.cdc.gov.

Immediate health risks

- unintentional injuries (traffic injuries, falls, drownings, burns, and firearm injuries)
- intimate partner violence
- child maltreatment and neglect
- risky sexual behaviors (unprotected sex, sex with multiple partners and increased risk of sexual assault)

[13] CDC. Fact Sheets: Alcohol Use and Health. www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm.

- miscarriage and stillbirth among pregnant women
- physical and mental birth defects among children that last throughout life
- alcohol poisoning

Long-term health risks

- neurological problems (dementia, stroke and neuropathy)
- cardiovascular problems (myocardial infarction, cardiomyopathy, atrial fibrillation, and hypertension)
- psychiatric problems (depression, anxiety and suicide)
- social problems (unemployment and family problems)
- cancer of the mouth, throat, esophagus, liver, colon, and breast
- liver diseases (alcoholic hepatitis and cirrhosis)
- gastrointestinal problems (pancreatitis and gastritis)

Adhering to a recommended drinking level

PCPs can use the following recommendations, as necessary, depending on the results of the drinking level assessment, as discussed under the PCP Management of AOD Use section.

Low-risk alcohol use limit

- no more than two drinks a day
- no more than two days of the week

Cutting back: high-risk drinking

- no more than 4 drinks on any day or 14 drinks per week for men
- no more than 3 drinks on any day or 7 drinks per week for women

Abstinence: times when even two drinks are too much

- when driving or operating machinery
- when pregnant or breastfeeding
- when taking certain medications
- when patient has certain medical conditions
- when patient cannot control his or her drinking

Carol Kim, Health Net
We work quickly to resolve your issues.

Behavioral Health and Primary Care Coordination

What is MHN and Who Does MHN Serve? MHN is Health Net's behavioral health division, which contracts with behavioral health practitioners throughout the United States. In addition, MHN has staff available to assist PCPs in providing care for Health Net members in need of behavioral health services. MHN provides services to eligible Health Net HMO, Point of Service (POS), EPO, and Medicare Advantage (MA) members in California.

PCPs can use the Behavioral Health Care Coordination of Care Form to help coordinate care with patients' behavioral health practitioners.

Physician Help Line

Contact the MHN Physician Help Line at 1-800-289-2040, Monday through Friday, 5:00 a.m. to 5:00 p.m. Pacific time (PT), for help finding appropriate care for members. Physician Help Line staff can answer questions regarding MHN, its network practitioners, the referral process, member eligibility, and benefits. PCPs can also schedule appointments for general consultations with experienced psychiatrists about treatment of depression or other behavioral health conditions for Health Net members.

Locating an MHN Provider

Physicians can search for participating behavioral health providers (BHPs) using ProviderSearch on the Health Net provider website at provider.healthnet.com. The search feature locates BHPs as determined by the search criteria. Members can also search by using ProviderSearch through the member portal of the Health Net website at www.healthnet.com.

Obtaining a Referral

To obtain a referral, the participating provider may contact MHN's Physician Help Line at 1-800-289-2040 or visit the MHN website at www.mhn.com. Health Net members may contact MHN at the toll-free number on the back of their identification (ID) cards.

Coordinating Care

MHN strongly encourages regular, open communication between PCPs and behavioral health practitioners (BHPs). To facilitate this, MHN encourages the use of the Behavioral Health and Medical Care Coordination Form, which is available for download on the Health Net provider website at provider.healthnet.com, under *Quality* > *Quality Improvement Corner.* PCPs can give this form to Health Net members to take to appointments and have their BHP fill out the relevant information. With member permission, the BHP can send the information back to the PCP.

Screening, *Brief* Intervention *and* *Referral to* Treatment

Screening, Brief Intervention and Referral to Treatment (SBIRT) represents an innovative, evidence-based approach to addressing unhealthy Alcohol and Other Drug (AOD) use in patients. SBIRT is an approach to early intervention and treatment for people with or at risk for substance use disorders and is the recommended approach by the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA).[1]

Routine screening is the first step in identifying SUD in the primary care setting.

Why SBIRT in the PCP setting?

One of the most effective methods to manage substance use disorders (SUD) is routine screening in the primary care setting. Primary care physicians (PCPs), as health care gatekeepers, are in the position to take action against substance abuse. PCPs play a pivotal role in screening and subsequent management of SUDs because they occupy a special place of trust and confidence in our society. By recognizing warning signs, SUDs can be detected earlier. SBIRT has been shown to reduce:

- emergency department visits
- fatal injuries
- hospitalization
- arrests
- motor vehicle crashes

(continued)

[1] www.samhsa.gov/sbirt/about.

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Follow-up appointments after an SUD diagnosis

Follow-up care within 14 days of an SUD diagnosis is a Healthcare Effectiveness Data Information Set (HEDIS®) measure for commercial and Medicare members. The scores for the phases below are monitored and reported annually by the Health Net HEDIS team.

1. Initiation phase: The percent of members who receive a follow-up appointment within 14 days of an SUD diagnosis.
2. Engagement phase: The percent of members who have two additional follow-up appointments within 30 days after the first follow-up visit.

Referral to MHN

To obtain a referral, the participating provider may contact MHN's Physician Help Line at 1-800-289-2040 or visit the MHN website at www.mhn.com. MHN referrals are required when:

- A patient has a polysubstance use disorder.
- Brief intervention appears to be insufficient treatment.
- Patient has a co-occuring psychiatric disorder.
- Pharmacological treatments for addiction are needed and are beyond the scope of practice.

Brief intervention – PCP guide

Screen for alcohol or drug use

1. If screening results are positive:
   - Increase patient insight and awareness.
   - Set and agree on goals and motivate/assist change.
   - Discuss barriers to achieving goals and strategies to overcome these barriers.
   - Identify sources of support and engage in treatment activities necessary to recover from the effects of SUDs.
   - Schedule a follow-up appointment within 14 days.
2. At the 14-day follow-up appointment:
   - Review patient progress in changing behaviors.
   - Review reasons to cut back or abstain.
   - Review sources of support and programs for recovery.
3. Proceed with one of the following:
   - Schedule two more appointments within 30 days, or
   - Refer to behavioral health services, if appropriate.

Screening tools

AUDIT Screening Tool – Complete guide to implementation in the PCP Setting. http://apps.who.int/iris/bitstream/10665/67205/1/WHO_MSD_MSB_01.6a.pdf

Staying Healthy Assessment (SHA) questionnaire – DHCS: plans may use alternate screens with prior approval from Medi-Cal Managed Care Division. www.dhcs.ca.gov/formsandpubs/forms/Forms/DHCS_7098_H_ENGLISH_SHA_Adult.pdf

AUDIT, CAGE AID, AUDIT-c, DAST-10 – www.integration.samhsa.gov/clinical-practice/screening-tools

Opioid Risk Tool – www.opioidrisk.com/node/887

Resources

Patient resources

The following are resources that PCPs can recommend for patients regarding AOD use.

Online health education

- **Substance Abuse and Addiction Health Center** *(WebMD website)* **–** www.webmd.com/mental-health/addiction/default.htm
- **Drugs, Brains, and Behavior: The Science of Addiction** *(National Institute of Drug Abuse)* – www.drugabuse.gov/sites/default/files/sciofaddiction.pdf
- **National Institute on Alcohol Abuse and Alcoholism** *(NIAAA)* – brochures and fact sheets for patients. Includes topics on risky drinking, cutting back, college drinking, pregnancy and drinking, driving and drinking, alcohol and women, alcohol and the Hispanic community, and alcohol and older adults. www.niaaa.nih.gov/publications/brochures-and-fact-sheets
- **National Institute on Drug Abuse –** www.drugabuse.gov/Infofacts/Infofaxindex.html

Self-help and community support groups

- **Alcoholics Anonymous** *(AA)* – www.aa.org
- **Narcotics Anonymous** *(NA)* – www.na.org
- **Rational Recovery for Alcohol and Drugs** – www.rational.org
- **American Lung Association Freedom from Smoking Program** – http://ffsonline.org
- **Self-Management and Recovery Training** *(SMART)* – www.smartrecovery.org
- **Women for Sobriety** – www.womenforsobriety.org

Hotlines

- **24-Hour Help Line from SAMHSA** – 1-800-662-HELP (4357)

Informational booklets

- ***Commonly Abused Drugs*** – www.drugabuse.gov/drugs-abuse/commonly-abused-drugs/commonly-abused-drugs-chart
- ***Rethinking Drinking*** – http://rethinkingdrinking.niaaa.nih.gov
- ***Pregnancy and Drinking*** – http://pubs.niaaa.nih.gov/publications/DrinkingPregnancy_HTML/pregnancy.htm
- ***Tips for Cutting Down on Your Drinking*** – http://pubs.niaaa.nih.gov/publications/tips/tips.pdf
- ***Harmful Interactions: Mixing Alcohol with Medications*** – http://pubs.niaaa.nih.gov/publications/medicine/harmful_interactions.pdf

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Provider resources

The following online resources can help PCPs assess and manage patients' AOD use.

- **CAGE-AID Screening Tool** – www.integration.samhsa.gov/images/res/CAGEAID.pdf
- **Screening, Brief Intervention, Referral to Treatment** *(SBIRT)* – A comprehensive PowerPoint presentation about SBIRT for providers is available on the Health Net provider portal at *Working with Health Net > Quality > Behavioral Health Resources for Health Net Providers.*
- **National Institute on Alcohol Abuse and Alcoholism** *(NIAAA)* materials for providers and patients – www.niaaa.nih.gov/guide – *A Clinician's Guide for Helping Patients Who Drink Too Much*
- **National Institute of Drug Abuse** – http://drugabuse.gov
- **Department of Health and Human Services – Centers for Medicare & Medicaid Services** *(CMS)* – www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf
- **DHCS website document on SBIRT** – www.dhcs.ca.gov/services/medi-cal/Documents/SBIRT%20Fact%20Sheet%20Dec%2016%202013.pdf
- **Overview and materials for PCPs about SBIRT** – www.integration.samhsa.gov/clinical-practice/SBIRT
- **Talking with Your Patients about Alcohol, Drugs, and/or Mental Health Problems – A guide for PCPs** – http://store.samhsa.gov/shin/content//SMA12-4584/SMA12-4584.pdf
- **Institute for Research, Education and Training in Addictions** – www.integration.samhsa.gov/clinical-practice/SBIRT.pdf

Provider training

- **Online SBIRT PCP training** – approximately four hours with CME credits and certification of completion. Cost is $50. www.sbirttraining.com
- **Webinar and online training for PCPs and non-PCPs** – www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx
- **SAMHSA SBIRT webinar and online information** – www.integration.samhsa.gov/images/res/SBIRT%20Webinar,%20PPP%20final.pdf

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