Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

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Keys to Implementing and Abstracting the Substance Abuse Measure Set

Minutes

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Operator: This is Conference #: 9188973

Matt McDonough: Good afternoon and thanks for joining today's webinar. My name is (Matt) and before we get started today, I'd like to cover a few housekeeping items with you before we turn this over to our presenters.

First off, there are a limited number of dial-in lines that are available. If you need them, please send us a Chat message and we'll send that out to you. Also, as you can see here, this event is being recorded.

Now you may have some troubleshooting issues that you need to resolve with your audio today, and I am going to refer you to the link that we've been posting in the Chat window. It does talk about how to address audio that is breaking up from your speakers or if it suddenly stops, as well as how to deal with echoing audio. So, please do visit the link that's been

pasted in the Chat window, qualityreportingcenter.com/audio to help to resolve those issues, and we'll post that again here in just a moment.

Now, our attendees are in a listen-only mode today but that doesn't mean you can't send your questions in. On the left side of your screen there's a Chat window. Please type your question in that "Chat with the Presenter" box and click the **Send** button. When you click that, all of our presenters that are online today will see your question, and as time and resources allow, they will be answered. We will be archiving all questions for addressing, being addressed in the future, as well. That's going to do it from my very brief introduction. So, without further ado, I'll hand it over to our first speaker of the day.

Evette Robinson: Hello everyone and welcome to today's IPFQR program webinar. My name is Evette Robinson and I am the project lead for the Inpatient Psychiatric Facility Quality Reporting Program.

Today I will be presenting our topic, *Keys to Implementing and Abstracting the Substance Use Measure Set*, with our guest speakers, Dr. Eric Goplerud and Dr. Lauren Broyles. Dr. Goplerud is the vice president and senior fellow at NORC at the University of Chicago. He has more than 25 years in senior federal and non-governmental leadership, directing numerous studies and task forces on behavioral health. At the Substance Abuse and Mental Health Services Administration he led the Agency's Policy and Planning Office; directed the Agency's Managed Care Quality and Finance Office; and served as the first director of SAMHSA's Science to Service Program, to speed the transmission of evidence-based practices into everyday clinical practice. In the 15 years since leaving federal service, he has directed major government and foundation-supported programs to integrate behavioral health into acute and primary care settings, including hospitals, FQHCs, and workplace programs. Dr. Goplerud led the successful efforts to secure new substance use screening and brief intervention CPT codes from AMA and new SBI HCPCS II codes from CMS and was instrumental in getting Medicare to cover primary care SA screening and brief intervention as a preventative service.

Dr. Lauren Broyles is an addiction health researcher at the VA Pittsburg Healthcare System, and an Assistant Professor of Medicine, Clinical and Translational Science and Nursing at the University of Pittsburg. At the VA she serves as a Director of the Advanced Inter-professional Fellowship in Addictions Treatment and a Director of the National Coordinating Center for that Fellowship, as well. Her clinical background is in nursing and includes working on the Inpatient Substance Abuse Liaison Service at the University of Maryland Medical Center in Baltimore.

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We also have in attendance with us from CMS, the IPFQR Program Lead, Dr. Jeff Buck, as well as our IPFQR Program Technical Advisor, Rebecca Kliman.

As many of you know, the slides for this presentation were posted to the *Quality Reporting Center* website prior to the event. If you did not receive the slides beforehand, please go to qualityreportingcenter.com, and on the right side you will see a list of upcoming events. Click on the link for this event; scroll down to the bottom of the page; and there you will find the presentation slides available for download.

Due to the volume of the content that we will cover in this presentation, we will not have a Q&A session at the end of the presentation. However this session, as Matt mentioned, is being recorded, and the slides, transcript, webinar recording, and question and answers from this presentation will be posted on the *QualityNet* and *Quality Reporting Center* websites at a later date.

The purpose of this presentation is for our participants to learn about the history and significance of the SUB-1 and SUB-2/2A measures, as well as the data reporting requirements, and keys to implementing the measures in their own facility.

And this slide shows you an outline of the learning objectives for today's presentation, which I hope all of you were able to read prior to this event.

This slide shows all the acronyms that will be referenced during today's presentation.

And now, at this time, I would like to turn the presentation over to our first guest speaker for today's webinar, Dr. Eric Goplerud.

Eric Goplerud: Thank you very much. Hello, this is Eric Goplerud and I am really delighted to be able to speak with you today. What I'll try to very briefly go through is an awful lot of material about the relevance and the importance of screening and managing alcohol problems in Inpatient Psychiatric Facilities, and in some ways, more generally, address substance use and particularly alcohol issues in acutely medically ill and injured patients who are coming into general hospitals or into acute psychiatric hospitals.

Alcohol use is associated with more than 80 illnesses and a large number of injuries. If you take a look at this slide, this is the result of a large number of independent disease data analyses finding what the proportion of these diagnoses or these conditions are in which alcohol plays either a causative or complicating role. As you can see on the left hand column,

things like alcohol psychosis, alcohol dependence obviously alcohol plays a 100 percent role in those, but if, as you look down others on the left which are often the kinds of things that come in through the emergency department. For example, accidental falls for females 65 years of age and older, approximately four percent of those are associated directly with alcohol use. Others such as alcoholic gastritis or accidental falls for males over – accidental falls for males over 65, about 12 percent of those have alcohol involvement. But these are primarily on the left-hand side, other than a few exceptions, primarily conditions that are likely to be affecting younger people. Those conditions that are showing up on the right-hand side are often those conditions which are the result of a lifetime use of alcohol. For example, gastro-esophageal hemorrhages or malignant gum neoplasms, these are very often the kinds of conditions that are coming into acute general hospitals and are also likely to be coming in with substantial co-morbidities of psychiatric conditions.

Now, the role of Substance Use Screening and Treatment in Healthcare Systems – this slide demonstrates that for the – a large majority of adults, somewhere in the range of about 70 percent either drink at levels below the guideline levels set by the NIAAA and U.S.D.A of what is low-risk drinking or do not drink at all. However about 26 percent of adults are drinking at levels that are above, at least occasionally, high risk, that increase their risk of alcohol-related health, social, or work-related consequences. The NIAAA guidelines, down there in the asterisk and the lower left-hand column–four drinks per day, 14 per week, are at the – above – that is considered a higher increased risk for women, greater than three or more drinks per day seven days per week. Seven drinks per week is–above that is considered riskier drinking. Also, for persons over age 65, males and females, drinking more than two drinks a day or seven drinks within a week is considered at risk or higher risk alcohol use. Now this slide also shows that about three percent of the adult population would meet the criteria of dependence but are functioning, functioning in their everyday activities, and are not visibly impaired by their alcohol dependence. And the acute severe dependent individuals are only about one percent of total U.S. population.

Now where we're likely to find people who have unhealthy or at higher risk alcohol consumption–This slide summarizes quite a bit of, of epidemiological research, and what you can see is the purple bar and the light green bar are trauma center admissions. Those are patients who are coming in dramatically injured into the hospital. Anywhere between 40 and 60 percent of adults who are coming in traumatically injured through the emergency department into trauma care are – have alcohol on board. Alcohol likely contributed to or caused the injury or the traumatic event that brought them in. But, in addition if you take a look at the light green bar, the next highest most frequent co-morbidity or complication of

alcohol use is associated with psychiatric inpatient units. Now this would include those inpatients – units which are explicitly co-occurring – treating co-occurring disorders, as well as those that are exclusively substance use where we have often a very high co-morbidity of psychiatric conditions. But also pointing out that a very large proportion of patients who are coming into a psychiatric or primarily general hospital psychiatric facility, also either have a primary or a complicating alcohol–alcohol use.

Screening and treating acutely ill and injured patients with co-morbid substance use has been fairly extensively studied. A recent Cochrane collaborative review of 14 randomized control trials that included adults and adolescents found that the outcomes favor brief intervention. That's what BI is, brief interventions for non-treatment seeking patients, i.e., these are not patients who are coming in acutely intoxicated or in withdrawal. These are patients who were coming in for other conditions. Brief interventions administered to non-treatment seeking inpatients report a significant drop in alcohol consumption at six months; significant drop in alcohol consumption at nine months; through self-report, a reduction in alcohol use at one year; and significantly fewer deaths at six months and one year. Now there have been several recent well-designed studies, including one by Dr. Rick Sakes from Boston University, published in JAMA, that has shown that brief interventions for patients – hospitalized patients with a drug use disorder is either, not affective or is a weak intervention, and far more study needs to be done on that. However, the research, at least from the Cochrane collaboration review, indicates that opportunistic screening and brief intervention of medically ill or psychiatrically ill acute inpatients is–is effective in reducing both alcohol risks and alcohol consumption.

Screening and brief intervention in hospital emergency departments similarly has been found through systematic reviews, including a large number of randomized control trials to reduce alcohol intake, risky alcohol use practices, and injury frequency.

Now the – this–this slide shows the prevalence of co-morbid mental health and substance use conditions for several chronic illnesses that are likely to be showing up in hospital inpatient units, whether this is psychiatric services or in general hospital services. And what you can see is, while the blue bars on the left-hand column show approximately a third–a quarter to a third of patients have no mental illness or drug abuse, drug or alcohol abuse, that mental illness with no drug or alcohol use may represent as much as 50 percent or a little more of a co-morbid condition for patients with these conditions. And then, the co-morbidity of either alcohol alone or mental illness and alcohol represents anywhere from about 15 percent up to as much 25 percent for patients. And this, this is really stressing the importance that the co-morbidities of the patients

coming in through–in psychiatric units or in general hospital units are not coming in with singular conditions. They're coming in with multiple co-morbidities.

And the impact of co-morbid diseases on 30-day readmission–you can see from this slide, this comes from work by Boyd et al., finds that substance use disorders represent a much higher risk. Patients who have these substance use disorders are at a much increased risk of 30-day rapid re-admissions. And when you put together the combination of substance use disorder plus schizophrenia, the risk increases by 73 percent over either of these conditions separately.

The most common diagnoses according to – for 30 day readmissions, according to the 2012 HCUP studies, you can see here. Of these conditions, clearly, the greatest – the diagnoses with the greatest number and likelihood of readmission for any cause, are patients coming in with mood disorders, followed by schizophrenia, if the patient has a mood disorder. However, number three for patients with mood disorders, they have a co-morbid alcohol use disorder, their risk of re-hospitalization is significantly higher. For patients who have a schizophrenia diagnoses, their risk of re-hospitalization, the fourth most common co-morbidity associated with increased risk, is an alcohol-related disorder.

This has not been, this has clearly been recognized as a risk condition by a number of accrediting groups. The, the American College of Surgeons Committee on Trauma, the accrediting body for trauma centers, has required since 2008 that level one trauma centers and level 2 trauma centers be able to demonstrate that they can screen and provide brief interventions or referral for injured patients who have an alcohol – who have "at risk" alcohol use. CMS, for the Inpatient Psychiatric Incentive Program in 2014, has been requiring the substance use screening performance measure SUB-1, and in 2016, starting in January, SUB-2, which is the brief intervention or the initiation of treatment. The – also I have a picture here of The Joint Commission. The Joint Commission developed a set of core performance measures for alcohol and drug screening, brief intervention, and treatment.

Those measures were developed by a technical advisory panel on global alcohol and tobacco measures. These are the individuals who were, and who continue to be, members of that expert panel. I was fortunate to be co-chair with Dr. Michael Fiore; and the individuals who had alcohol and drug expertise include: Katharine Bradley, Steve Bernstein, Connie Weisner, and Larry Gentilello. That's an ongoing group.

Now, the identification of substance use disorders on admission and discharge from general hospitals tends to be pretty mediocre. These are

two studies that have looked at the rates of identification of – of alcohol use disorders or alcohol or drug disorders of patients who, through research, diagnostic interviews, have been identified as having problems, and yet, there's no notation in the chart of a diagnoses on admission or on discharge. Also, the final set of bars on the right-hand side, show what on discharge are the rates of attendance at a – you know, a substance use treatment program, either in a psych unit or in a specialty substance use program.

Now there a whole lot of hospitals that have been implementing – this is just a list of about eight of them – that have implemented routine screening of medically ill and psych inpatients in their – in their general hospitals.

A good example of that is a hospital in, in Falmouth Massachusetts, a 100-bed general hospital. There was a 50-bed addiction treatment center that was on the same campus. But, while they were courteous, they were distant neighbors. They saw each other as sort of mutually necessary, but did not collaborate. The substance use program, Gosnold, was quote, "the place to send those people." They now have implemented an integrated program. What changed? What changed was that they nearly had a patient dying going into withdrawal who was medically ill and who was admitted for a medical issue risk. The CFO and risk managers clearly identified this, not as something necessarily – that hospital felt that it was – the hospital felt that it was necessary to do this for risk management purposes, as well as it would mean, for good medicine. And what did they find?

Well, what they found was that prior to implementing an integrated service, about half of the patients who were identified as having a co-morbid alcohol use disorder went to the ICU. Once the intervention program was implemented, only 10 percent of those patients went to the ICU. The overall costs for the hospital were 30 to 40 percent lower for patients who were in – in the – in the med surg programs. But perhaps even more important to the hospital was that prior to this collaborative effort, the average length of stay for patients who had an unidentified prior identified alcohol use disorder was about 14 and a half days. After intervention, it was less than six and a half days. The difference becomes really important when hospitals are paid on a DRG basis, and the average length of stay declines. It begins to not only be good medicine, but also good business.

A similar program has been developed – it's called Project Engage – at Christiana Hospital in Delaware, and what they did was, and what they are continuing to do is, targeting hospitalized substance users who are withdrawal risk or who have a significant co-morbid addiction. They

provide bedside peer-to-peer interventions using motivational interviewing, and they have an addictions community social worker who assists in removing the barriers to transition to care, and to help with integrating the patients into the hospital milieu.

Just a couple of, again, non-randomized control trials simply assessing pre/post Medicaid costs for the – for our first small cohort. They found that they had substantial savings to Medicaid with a small number of patients. But what is particularly important, I think, is that in the post period you had fewer medical inpatient admits, fewer emergency department visits, but more primary care and behavioral health ambulatory care.

Two successive cohorts that they followed had similar patterns and similar savings reductions in medical inpatient admits, reductions in ER visits, and what's not shown in here but it occurred is, increases in ambulatory care when the substance use was or alcohol use was identified and managed in an acute setting.

Another program, this was in Salina, Kansas, a similar collaboration between a substance use treatment program and an inpatient unit. As the DRG substance use, or alcohol use, moved from the number two most frequent DRG for rapid re-hospitalization to the 13th [the] average length of stay was reduced, many of the patients were triaged and did not need to be admitted. And what I think is particularly significant, is that 60 percent – nearly 60 percent of patients who were referred to substance use treatment post-discharge, actually made it and made it to their first two appointments based on a warm handoff. Now this is not what is part of the SUB-2 measure, but it's part of what happens when you intervene with a co-morbid alcohol use condition. And for the substance use treatment program, what was a real positive to them was their detox admissions increased very substantially and their reimbursement from commercial insurance increased substantially.

So, investing in substance use treatment results in a significant return on investment. These are various figures that show, you know, what now has been achieved in – across the variety of studies, showing that for every additional dollar in substance use treatment for a co-morbid alcohol use condition reduces the cost to taxpayers, or the cost to help insurers, or to all the rest of us, by anywhere between $1.28 and $1.76.

So I am going to turn it over now to Evette to talk about the measure abstraction and data reporting requirements.

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Evette Robinson: Thank you doctor – thank you Dr. Goplerud. As you mentioned, the next section of the presentation will cover the measure description, abstraction, and the data reporting requirements for the IPFQR program.

As Dr. Goplerud described earlier, the measure set that we're addressing today consists of the SUB-1, the alcohol use screening, and SUB-2, alcohol use brief intervention provided or offered, as well as the subset of 2A, alcohol use brief intervention measure.

The SUB-1 measure is a chart-abstracted measure that describes hospitalized patients who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use. The numerator and denominator definitions are displayed on this slide for your reference.

This slide summarizes the excluded populations and the data elements for the numerator and denominator statements for the SUB-1 measure.

And since the SUB-1 measure alone does not provide a full picture of an IPF's response to screening patients for alcohol use, CMS believes that the addition of the SUB-2 and a SUB-2 a measure set to the IPFQR program will improve the overall quality of care that patients receive in IPF settings, as well as overall patient health outcomes. When the SUB-1 measure is linked to the SUB-2/2a measure, the IPF measure set depicts the rate at which patients are screened for potential alcohol abuse and the rate at which those who screen positive accept the offered interventions. Further the adoption of SUB-2/2a could alert IPF's to gaps in treatment or interventions if rates are low, which supports the development of quality improvement plans and better patient engagement and treatment. In addition data for the SUB-2/2a measure set, in combination with the SUB-1 measure, would afford consumers useful information in choosing among different facilities, particularly for patients who may require assistance with unhealthy alcohol use. In the next couple of slides I will review the chart-abstracted measure set of SUB-2 and the subset, SUB-2a.

The SUB-2 measure is reported as an overall rate, which includes all patients to whom a brief intervention was provided or offered and refused, and a second rate, which is the subset of the first, and it includes only those patients who received the brief intervention for the SUB-2a subset. On this slide it will – you can find the numerator and denominator definitions for the SUB-2 measure.

And on this slide, you can find also the numerator and denominator statements for the SUB-2a measure. And again, this particular subset describes those patients who actually received the brief intervention during the hospital stay.

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This slide summarizes the excluded populations and the data elements for the numerator and denominator statement for the SUB-2/-2a measure set.

The difference between the SUB-2 and SUB-2a is that SUB-2 includes all patients who screened positive for unhealthy alcohol use and were offered and received or were offered and refused a brief intervention during the hospital stay; whereas SUB-2a includes only those patients who were offered and actually received the brief intervention during the hospital stay. Patients who refused the brief intervention are not included in the subset of SUB-2a.

And now, in this slide, we have listed the three Allowable Values for the SUB-2 measure.

And some of you may be wondering what constitutes a brief intervention. A brief intervention is a single interaction conducted by a qualified healthcare professional or a trained peer support person with the patient following a positive screening result for unhealthy alcohol use or alcohol use disorder. Intervention components include: feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; a discussion of the overall severity of the problem. And all this corresponds directly with the five As: Ask, Advise, Assess, Assist, and Arrange, which is recommended for treatment of the alcohol – of alcohol dependence.

This slide – this slide lists the notes for abstraction for a brief intervention as it pertains to the SUB-2/2a measure set. Of particular note here are the individuals who are identified as qualified to provide the brief intervention, specifically: a qualified healthcare professional, such as a physician, nurse, certified addictions councilor, psychologist social worker, or a health educator with training in brief interventions. A peer support person who has received specialized training in brief intervention may perform the brief intervention in lieu of a qualified healthcare professional. If there is no documentation that a brief intervention was given to the patient, then one would select "three" which is the option that "a brief intervention was not provided to the patient." Selecting Value Three is appropriate if the documentation provided also is not explicit enough to determine if the intervention was provided, and whether it contained the specific component, or if it is determined that the intervention does not meet the intent of the measure.

At this time I would like to provide a few pointers regarding data reporting for the SUB-2/2a measure set. This measure set was adopted in the FY 2016 IPF PPF Final Rule for the Fiscal Year 2018 payment determination and subsequent years. Data reporting will begin with patients discharged

in Calendar Year 2016, meaning January 1 through December 31, 2016, and it will include patients discharged in the first quarter of 2016 who were admitted at the end of 2015 and having length of stay of less than 120 days. Sampling is allowed for this measure and per the Final Rule, The Joint Commission/CMS Global Initial Patient Population Sampling Methodology can be used when sampling for this measure. Data collected in Calendar Year 2016 will be submitted to CMS during the July 1 through August 15, 2017 data submission period and, again, this will impact the Fiscal Year 2018 payment determination.

As mentioned in the previous slide, IPFs will have the option to use global sampling for measures such as SUB-1/-2/-2a. From this point forward, CMS will only require that IPFs report annual aggregate measure values. The table on this slide shows the global population sampling standards, which can be found on page 46,718 in the Fiscal Year 2016 IPF PPS Final Rule in Table 26.

CMS recognizes that some IPFs may choose to sample data during the calendar year on a monthly or a quarterly basis, and then report that total number at the end at the time of data submission. For those purposes, IPFs should refer to the sampling tables listed on this slide, which can be found in The Joint Commission's specification manual. Again, as a reminder, data will be submitted as a single, aggregate annual number for the substance use measures. We will discuss the sampling options in more detail in upcoming webinars, but we encourage you to read the Fiscal Year 2016 Final Rule where you will find more information about the SUB-2/-2A measure set, the global sampling option, and other changes to the IPFQR program.

The next portion of the webinar will be presented by Dr. Lauren Broyles. Dr. Broyles the floor is yours.

Lauren Broyles: Thank you. My portion of the webinar today is going to be focused on implementation and operationalization of the measures, essentially where the rubber meets the road; and that being in the weeds of figuring out exactly who, what, when, where, and how all these processes of care are going to be handled, and how this is actually all going to fit into the real life setting. And so, quite honestly for us in the VA, this has involved three primary balancing act – acts: the first is the balance between good clinical care and just meeting the measures; the second is the balance between developing processes of care for these measures that are patient-centered but also efficient for staff; and then the third is the balance between getting as much stakeholder engagement and buy in as possible during the planning process with watching your time, so that you can get things in motion and then also not be deficient from a measure standpoint.

So with that as a backdrop, in this section of the webinar I am going to cover three main topics. First how and why screening and brief intervention implementation is unique in inpatient care settings; what some of the practical and logistical, as well as the philosophical, the ideological, the attitudinal issues are that make rolling this out in any inpatient care setting a little bit different than rolling it out in primary care, community health, or emergency and trauma. The second is tips and strategies from the existing implementation guides and literature that are already out there. So, what I want to do is show what the existing guides that are geared towards primary care and emergency trauma provide as a starting place or at least a skeleton for thinking about how to begin implementation, and then what some of this literature tells us about what works and what doesn't. I am going to feature some of my own research in this area, but the main thing that I want to convey is that there's no need to reinvent the wheel. A lot of that information in those guides is highly practical and it's highly applicable and adaptable. Additionally, having some of these published guides or articles in hand as you're doing your planning process can help make that case better to your partners or your stakeholders or your administrators. It shows that you've done your homework. It shows that there's been a precedence set somewhere else, and it also carries a little bit of caché or authority. It can serve as a starting point or a springboard that can make the whole process seem a little bit less daunting. And then third, I am going to cover some of the lessons that we've learned from mandated implementation of these measures within the VA healthcare system, specifically our experience at VA Pittsburg.

So, what we first need to think about is the fact that alcohol screening and brief intervention has primarily been implemented in primary care settings and to some extent, in trauma and emergency settings. But for the most part, we're talking about a set of clinical practices that are done with well patients coming into an outpatient setting with a relatively small number of staff, where a health promotion is already an accepted part of the package. And so, when we think about what this might look like in an inpatient setting, particularly in an inpatient psychiatric setting, we can't assume that we can just replicate the same way of doing things. We need to think about some very specific, important differences. First of all, patient acuity: so obviously, now, we're talking about doing screening and brief intervention with patients who are sick; who have an altered mental status; they're medicated; they're sedated; they're not necessarily those who are alert and oriented, walking in and out of a primary care appointment. Secondly, in the inpatient care setting, we simply have an exceptionally high number of people who need to see the patient. We have the staff nurse, the med student, the specialist, people who are being

taken on and off the floor for procedures, respiratory therapy, social work, physical therapy. All of these people are coming in and need to access that – that ill, medicated, or sedated patient making it a little bit even trickier to figure out when exactly screening and brief intervention is – is supposed to happen. It also raises a lot of questions about who amidst all of those people is best equipped or even available to do screening and brief intervention. All of – many of those individuals are theoretically able, but the question is, you know, most of them are likely to say they don't have the time or that someone else is more qualified to do it. And then finally we have this cultural issue that patients nor clinicians are typically thinking about health promotion in the acute care setting. It's a really different mindset. They're typically focused on the acute issues, and this will be a new orientation for them. So, although there are some unique aspects to doing this in the inpatient setting, we can use brief intervention guides from other settings, at least as a starting point.

There is no need to reinvent the wheel with respect to some basic guides that are already out there. I would encourage you to check these out. These guides are from the CDC, from SAMHSA, and others that are specifically designed for primary care. They weren't designed specifically for these measures, but they do have some very practical and pragmatic guidance for implementing alcohol screening and brief intervention that can be used as a skeletal framework for planning what you're going to be doing and figuring out all of those on the ground logistics.

So, for example, here are some very practical planning worksheets from the first guide that can really help you figure out the process of rolling out these measures, making sure that you're covering all the bases. All of these guides are available online. They're free, and you can just type the titles in and they'll come up.

So we can also turn to the literature, really briefly, for some guidance but honestly, these five articles are about it regarding screening and brief intervention implementations, specifically in any type of inpatient hospital setting. Two are from my work at VA Pittsburg, and the other three are from Australia and England and this literally it. These references are also at the end, and I encourage you to spend the time upfront reading them because they're all easy reads and they're all incredibly practical in their orientation. But I do want to quickly mention some of the basic themes that come from all sides.

So, across all articles we see the same recommendations emerge. From the get-go, have a solid infrastructure in place for training and processes of care that are going to support this over the long term. Second, they all call for a cultural shift that is focused on health promotion and attention to substance use in inpatient settings, and that that comes across not only

through staff education, workforce education, but also through designated clinical champions. And then, with respect to the third and fourth bullets, this notion that multidisciplinary involvement and collaboration are critical, but that ultimately there needs to be dedicated role effort for leading this initiative and keeping it together and moving forward. And then finally, somewhat related to number one, they all call for serious attention to recordkeeping procedures, needing to figure out what this documentation of these processes of care is going to look like.

So, what I'd like to do is spend just a couple of minutes also talking about what we've been doing at VA Pittsburg Healthcare System and what some of the issues have been for us. VA Pittsburg is a 661 academic bed medical, academic medical center in Southwestern Pennsylvania. We have over 10,000 admissions per year and 5,500 surgeries per year. We're a large center for training of students and fellows from all healthcare disciplines, and we're also a major research hub.

So in fall of 2013, VA Central Office mandated uptake of the new Joint Commission measures for substance use and tobacco use, and effective January 1, 2014, these went into – these went into effect for all VA medical centers nationwide. As you may know already, there are actually six measure sets for the substance use measures and six for the tobacco measures, which I've given just a snapshot of here. At VA we are mandated to implement both, the entire sets for both, but in line with today's presentation, I am only going to be focused on those in the red box there. Both of these measure sets are with already – they're very similar to what's already in place in terms of measures in VA primary care. But in our case, these measures are going to apply to all hospitalized patients admitted to any unit on any VA medical center nationwide, regardless of what they're admitting diagnosis is. I was asked by our chief of staff to direct implementation of the measures at VA Pittsburg because of my clinical background and my research background in addressing substance use in inpatient care settings.

So our first step here was the construction of a formal charter that outlined and formalized the goals and the responsibilities of the interdisciplinary workgroup that we had pulled together to decide on that who, what, when where, and how these measures were actually going to be put into place in our facility. And this charter, on the left, issued by our chief of staff, gave our initiative some legs. It gave it some meat and a little bit of authority. By formalizing what the goals were and what everyone's responsibilities were, it really helped create some accountability by naming people, specifically who was going to be assigned to serve, and it ensured, also, that all relevant stakeholders from all of the different service lines and disciplines were included. And you can see some of those there on the right-hand side, the different disciplines, service lines, and departments.

Support Contractor

Our guiding principles as a committee, from the get go, some of the things that we were truly committed to, echo the balancing act slide that I started out with. Everyone in VA is performance measured to death. We wanted to have meaningful metrics. We also wanted to be patient-centered. We wanted to develop ways of meeting the measures that were clinically and ethically right but also efficient for staff. We also wanted to be interdisciplinary so that there was shared responsibility, shared growing pains, and shared accountability, no single discipline being dumped on. And finally, we wanted a collaborative and participatory approach to developing this process so that it wasn't a top down dictum. And we spent about six months actually, determining which discipline or service line would be responsible for which measures in these complete measure sets, and I'll say more about that in a moment.

But, in a nutshell, all of the patients admitted to inpatient units at VA Pittsburg have to be screened for unhealthy alcohol use using the AUDIT-C screening tool within the first three days of admission. That's SUB-1. Patients were intubated, cognitively impaired, unresponsive, or on palliative measures only, or who refused, are exempted, and this has to be documented. At our facility we decided to have the admitting provider, the physician, nurse practitioner, or PA perform screening during the admission process. The AUDIT-C is electronically embedded into our electronic medical record admission orders for all service lines. Scores on the AUDIT-C range from zero to 12, and I'll show you that in just a moment, where patients with scores of five or greater are considered a positive screen. And they're required to have this brief mini-counseling session known as brief intervention which, you know, has the three parts that were alluded to earlier. It's usually considered about a 10 to 15 minute motivational conversation. I don't show it here, but we have some other processes of care for the remaining measures that I showed you or that I mentioned, SUB-3/-3a, and -4.

But in general, this is the AUDIT-C. It was embedded – again, it's embedded in our electronic medical record. I saw someone's question earlier, it is not copy written. The AUDIT-C is a short version of the Outcall Use Disorders Identification Test, which was developed and validated by the World Health Organization, so it is not a problem to embed it into your – your electronic medical record. You can see it has each of the three questions here regarding frequency, quantity, and binge drinking, and the total score, in this case is difficult to see but it's a nine, which then drives our next screen…

…which looks like this. And in the first box you can see that the provider's next course of action, because the score was a nine, illuminates as a hyperlink. And the provider clicks on that and is prompted to the next screen, which is on the right, to order a social consult for brief intervention

since the AUDIT-C score was positive. And also, short consults must be answered before the patient is discharged. The social worker meets with the patient, conducts a brief intervention, which consists of those three components that Ms. Robinson mentioned earlier.

Additionally then, the social worker documents this. As you can see, the three brief intervention elements are listed here. And then we have a free text spot where the clinician can enter any additional information that may be helpful later on for follow up in primary care appointments.

So let's talk about some of the things that helped us launch this effectively. Developing these two processes and the processes of care for the rest of the measures took a lot of time. There were a lot of factors that were clear facilitators, though, that really helped us launch this. First we had immense administrative support and buy-in from our chief of staff who recognized the complexity of the measures, and he initiated the chartered and inter-disciplinary committee. Secondly we have a committee that's been dedicated to substance use issues, and we've also had buy-in from some folks in very unique roles, specifically that of the clinical nurse leader in the VA, which is a role that has dual responsibilities for both clinical education of staff, but also implementation issues at the unit level. We've also had some performance measurement and informatics partners who are engaged and invested not only in meeting the measures, but in doing what's right clinically and ethically. They really get it. We've also had some strong existing relationships on the units from some of my own research that had been conducted on the med search units where we were piloting. And we were also outsiders in the sense that we were from the research side of the house. I am actually a full time addiction health services researcher, so we had not been involved in a lot of the prior clinical politics or snafus, which actually helped. And then finally, we had some momentum at our facility because we were dually rolling-out the alcohol and tobacco measures at the same time, so it allowed us to think about how to roll things out synergistically.

But, that said, there were also some considerable barriers and hurdles that some of you may – may resonate with you also. First, in VA, this was an unfunded mandate, much like I am sure that it is for you. We had virtually no guidance or resources for strategy, for interpretation of the measures, for EMR templates, educational resources for clinicians or patients, et cetera. And the measures are really complex, at least in our case, in adopting the whole package with multiple subparts, there had been some initial aspects that made it – interpretation of them tricky. Plus, you know, these issues plus some overall performance measure and mandate burnout in the VA really diminished a lot of clinicians' psychological enthusiasm for this initiative, at least in some people and in some pockets. Because

the measures are so complex, as well, at least again with us implementing the whole package, they require the coordination of a lot of service lines and a lot of cooperation across departments and disciplines. Just the sheer number of services and stakeholders and disciplines involved, and all of the clinicians and researchers and staff – everybody's busy. So this really took a lot of coordination. Additionally, within VA at least, there were layers and layers of approvals that were required for lots of different actions based on various committee decisions or different entities like – like – the – the local bargaining unit, the union. Some of these things we're due in part to just VA bureaucracy, but others were also, you know, due in part to things that maybe analogous on the outside. For example, VA's commitment to shared governance models in nursing. And when these, these different committee meetings were held infrequently, then it meant that our getting approval to do certain things was often delayed. And then additionally, as in any organization, there are just general personalities and politics that can interfere with implementation of something new, particularly when the topic is something taboo or is something that's uncomfortable for many clinicians to deal with. But by and large for us, the largest barrier was the EMR and its limited, idiosyncratic capabilities and bugs. What we – what seemed that should be intuitive or what we thought should have been doable electronically, just simply wasn't.

So what did we learn in terms of rollout of these? Well first, people on the taskforce and committee and people on the frontlines really needed to be heard. They needed to feel valued. They needed to have their unit or departments or discipline's perspectives and concerns validated and understood before we moved forward in doing this process of – in developing these processes of care. It was critical for us to minimize these top down approaches in getting these things rolled out. But all of that initial and ongoing consensus building and trust building took a lot of time, a lot more time than we had anticipated, and so it felt often like we were spinning in the mud. We were going nowhere, rehashing the same ideas, talking about the same barriers, and we often worried that we weren't really moving forward. But in retrospect, it really was time well spent because, as I mentioned earlier, it gave us a firm foundation where everybody felt heard and had had – had a chance to again have their concerns validated. We had to trust in the process even when it felt like we were going nowhere. So once traction came, though, it often felt like we were riding a roller coaster, either things were speeding along faster than we could juggle, especially with all of our other clinical and research responsibilities, or it felt like we were creeping along up a strenuous hill. And so again, just knowing, just trusting in the process is really critical for us, knowing that it would be different the next week. As I mentioned earlier, top-level and mid-level support and buy-in were critical. We had

to be able to access resources, elevate these measures as a priority, and then help move some of those reluctant or obstructionistic individuals along. So what we had was not just an initial "yeah, yeah, yeah, sure go ahead" kind of approval, but a real commitment to sticking with us and in assisting us when we hit roadblocks. And I think, honestly, that we had – we had that investment from them because we spent that upfront time in all of those meeting and briefings. And then finally, as I mentioned earlier, substance use is often a very [inaudible] sensitive or stigmatizing topic, even in inpatient psychiatric settings. It's often something that clinicians and administrators are not familiar with; they're not comfortable with. They see it as not a real psych problem – quote, unquote. And there can be a lot of subtle or overt stigma or resistance around that topic and working with affected individuals. We found, for us, it was often easier to help people stretch and open up their minds to the population and the needs at hand, if we could use familiar examples of care or processes that had been applied to other disease conditions. For example, the chronic care model, recovery oriented care, and in one case we had CFS, CHF congestive heart failure education that the nurses were doing that we were able to draw some parallels between. We pointed out how the AUDIT-C was very similar to the history and physical, the social history that's typically done as a part of that, and drawing some of those parallels and analogies was really helpful for them.

And so in closing I'd like to just recap what some of our most practical suggestions are on the ground. Overall I would recommend that you read the existing screening and brief intervention implementation resources and literature. Again, they're all incredibly pragmatic and they're easy reads. I would encourage you to establish a charter. It helps with accountability and responsibility. Work on cultivating that leadership buy-in. Establish an interdisciplinary team with all potential stakeholders, and really think broadly about that. It's important to then also identify some additional champions who will help be the delegatees on the ground actually implementing the work and helping to monitor that, and to consider your EMR capabilities early while you're designing the processes of care. Those two things really have to go hand in hand or you'll end up with a process of care that you can't be – that can't document appropriately and then therefore can't be abstracted appropriately. And then, finally, if you have some time, do some test runs, some demos or some pilots so that you can work out the kinks. If you're able, start with one unit and then move forward from there. Our model is certainly not the only model for implementing these measures. A lot of my own research has focused on nurse-led models of SBI in inpatient care settings. And if you're interested in those models or if you have questions about nurse training or other expert related issues, I am happy to share literature and resources on

that, and my contact information is listed at the end, as are the references. Thank you.

Evette Robinson: Alright, thank you very much, Dr. Broyles, for that presentation. Our next section here will cover several helpful links and references that we hope will really help everyone on the call to launch their efforts to support capturing data for these measures.

And as Dr. Broyles mentioned earlier, this slide does provide contact information for her and for Dr. Goplerud. And you are welcome to, to use these links to follow-up with any questions. The questions and answer pairs that are received during this webinar will be addressed in the webinar Q&A transcript which will be available at a later date, and that will be posted on both the *Quality Reporting Center* and *QualityNet* websites.

This slide includes several links to various resources pertaining to the substance use measures including the Fiscal Year 2016 IPF PPF Final Rule, The Joint Commission specifications manual, the Hospital Experts Initiative which holds monthly conferences that facilities may find helpful as far as integrating SBIRT into routine practice, as well as a link to the Systems-Level Implementation of Expert Technical Assistance Publication from the Substance Abuse in Mental Health Services Administration. And these links all should be live in the .pdf that you're able to download from the Quality Reporting Center website.

For additional information concerning these topics we invite you to check out the literature references that are listed on slides 68, 69, and 70.

We do have several more upcoming IPFQR program educational webinars. We have listed here four of our dates that are coming up, the first being the Final Rule. We'll review that, as well as APU and the reporting period on September 17, and that is scheduled to occur at 2 p.m. on that day – 2 p.m. Eastern Time. Next month, on October 15, we will discuss New Measures and Non-Measure Reporting – Part 1, continuing with Part 2 of this topic on November 19. And finally, December 17, we will discuss Public Reporting and review the Follow-Up after Hospitalization for Mental Illness or FUH measure.

This slide includes active links that you can click on to send us your questions about the IPFQR program. We encourage you to use the Q&A tool in particular because it provides the best means by which we can track questions and answers and also delivers our responses directly to your email inbox. We also recommend that you sign up for the IPFQR program ListServe, if not already, so that you can receive communications that we send out to the IPFQR community pertaining to webinars, program

updates, and other announcements. And you can sign up for these notifications on the *QualityNet* Listserv Registration page.

On slide 73 through 78 contain information that you need to receive that you will need to reference in order to receive one CE credit for attending this webinar. Please read those slides carefully. And because we are now a national nursing provider, we ask that you please save your certificate for your nursing board once you've completed those steps described, again, in slides 73 through 78.

This concludes today's webinar for the IPFQR program. We thank you for your time and attention.

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