Welcome!

- **Audio for this event is available via ReadyTalk® Internet Streaming.**
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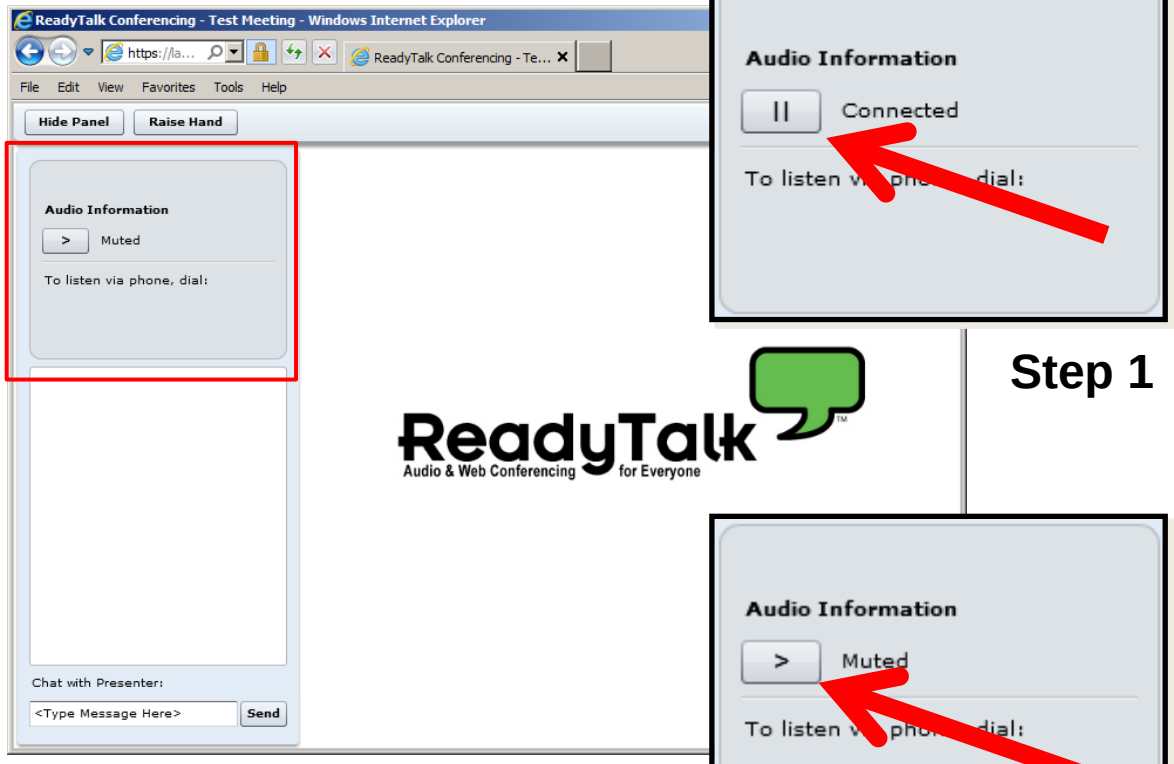
- **This event is being recorded.**

Troubleshooting Audio

Audio from computer speakers breaking up? Audio suddenly stop?

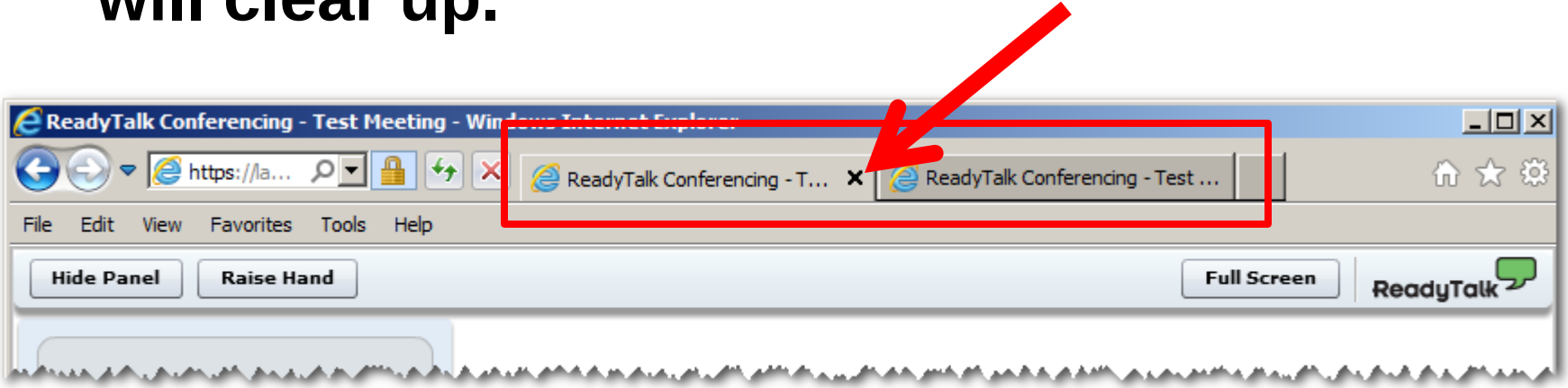
- **Click <u>Pause</u> button**
- **Wait 5 seconds**
- **Click <u>Play</u> button**



Location of Audio Controls

Troubleshooting Echo

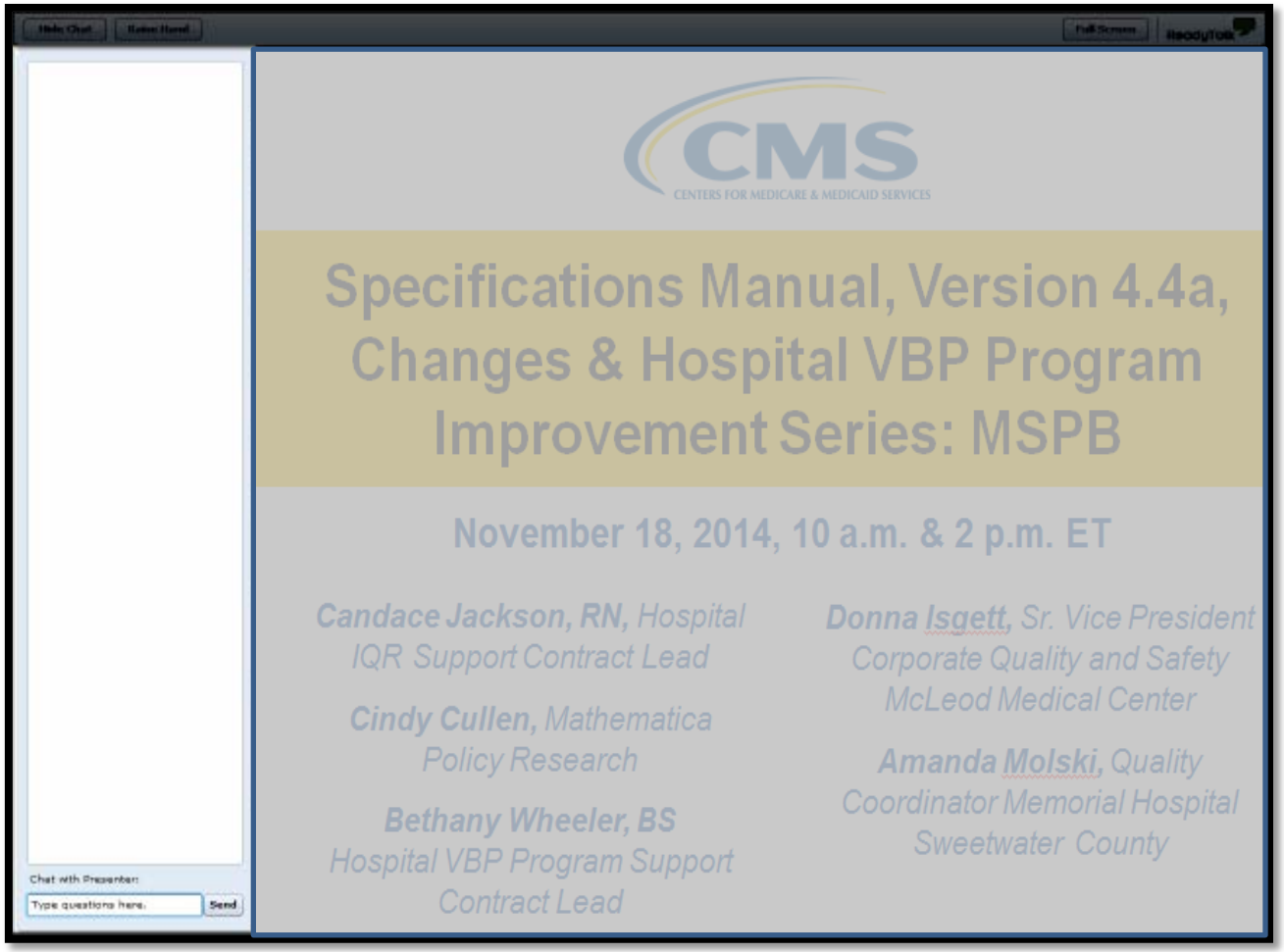
- **Hear a bad echo on the call?**
- **Echo is usually caused by multiple connections to a single event.**
- **Close all but one browser/tab and the echo will clear up.**



Example of Two Connections to Same Event

Submitting Questions

Type questions in the "Chat with Presenter" section, located in the bottom-left corner of your screen.



Keys to Implementing and Abstracting the Substance Use Measure Set

Eric Goplerud, PhD
Vice President and Senior Fellow
NORC at the University of Chicago

Lauren M. Broyles, PhD, RN
Research Health Scientist, VA Pittsburgh Healthcare System
Assistant Professor of Medicine, Clinical and Translational Science and Nursing, University of Pittsburgh

Evette Robinson, MPH
Project Lead, Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Value, Incentives, and Quality Reporting (VIQR) Education and Outreach Support Contractor (SC)

September 1, 2015

Purpose

During this presentation participants will learn about the history and significance of the SUB-1, SUB-2/2a measure, as well as the data reporting requirements and keys to implementing the measure in their own facility.

Learning Objectives

At the conclusion of this presentation on the Substance Use Measure Set SUB-1, SUB-2/2a, attendees will understand the:

- History and significance of the measure set
- Abstraction and data reporting requirements
- Keys to the measures' implementation, including
  - How and why screening is necessary
  - How brief intervention implementation is different in inpatient settings
  - Two screening and brief intervention implementation guides/resources
  - Potential barriers to, as well as facilitators and strategies for implementation of the Substance Use Measure set at their own facilities

Acronyms

AUDIT-C	Alcohol Use Disorders Identification Test-Consumption
BH	Behavioral Health
BI	Brief Intervention
CKF	Chronic Kidney Failure
Dx	Diagnosis
ED	Emergency Department
EMR	Electronic Medical Record
ER	Emergency Room
IPP	Initial Patient Population
IPFQR	Inpatient Psychiatric Facility Quality Reporting
NBHQ	National Behavioral Health Quality
NORC	National Opinion Research Center
PCP	Primary Care Physician
QI	Quality Improvement
RCT	Randomized Control Trials
ROI	Return on Investment
SA	Substance Abuse
SBI	Screening and Brief Intervention
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SC	Support Contractor
SUB	Substance Use Measure
SUD	Substance Use Disorder
Tx	Treatment
VA	Veterans Affairs

IPFQR Program

HISTORY AND RELEVANCE OF THE SUBSTANCE USE MEASURE SET

Alcohol Use: Diseases and Injuries

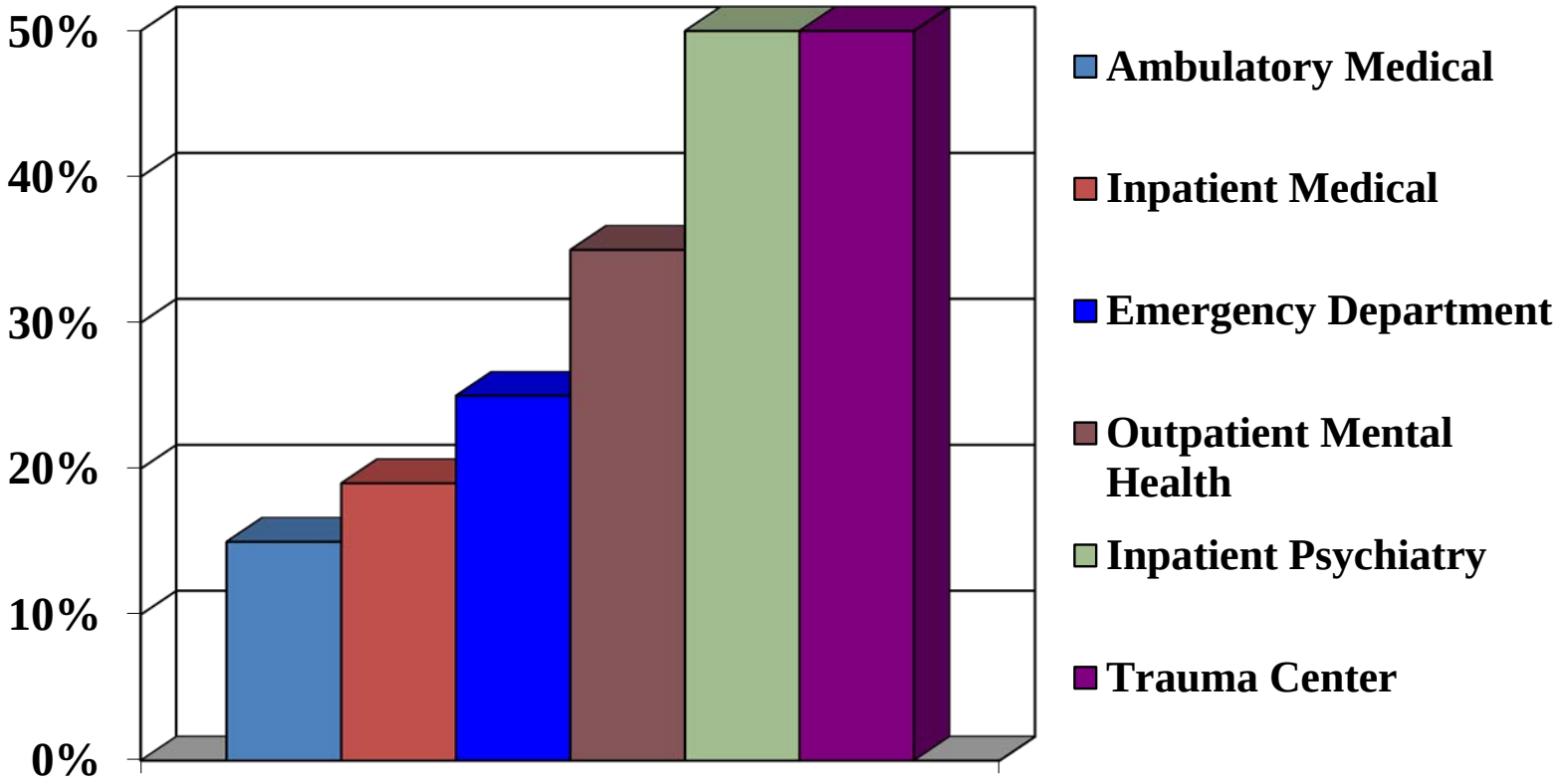
Under 35 yrs

Over 35 yrs

AGES 18 AND UP, MALES AND FEMALES			
Alcoholic psychoses, alcohol dependence, nondependent use of alcohol, ethanol toxicity, accidental poisoning by alcohol (E-code), alcohol use/abuse (E-code)	1.00	Alcoholic liver cirrhosis	1.00
Accidental aspiration	1.00	Chronic pancreatitis	0.84
Assault	0.47	Gastrointestinal hemorrhage unspecified	0.50
Accidents caused by fire	0.44	Chronic hepatitis	0.50
Hypothermia	0.42	Gastro-esophageal hemorrhage	0.47
Accidental drowning	0.34	Malignant gum neoplasm	0.45
Firearm injuries, accidental or undetermined intent	0.25	All liver cirrhosis	0.45
Accidental falls (males, under 65)	0.22	Esophageal varices	0.45
Suicide, self-inflicted injury	0.20	Laryngeal cancer	0.39
Child abuse	0.16	Esophageal cancer	0.33
Accidental falls (females, under 65)	0.14	Hemorrhagic stroke	0.26
Accidental falls (males, 65+)	0.12	Oropharyngeal cancer	0.26
Motor vehicle traffic accidents (road injuries)	0.10	Liver cancer	0.25
Work/machine injuries	0.07	Acute pancreatitis	0.24
Accidental falls (females, 65+)	0.04	Supraventricular cardiac dysrhythmias	0.22
Alcoholic polyneuropathy	1.00	Psoriasis	0.22
Alcoholic cardiomyopathy	1.00	Stomach cancer	0.20
Alcoholic gastritis	1.00	Epilepsy	0.15
Alcoholic hepatitis	1.00	Esophagitis	0.10
		Gastroesophageal reflux disease	0.10
		Gastric diverticulum	0.10
		Duoden or Peptic ulcer	0.10

Where are the Patients?

Settings Where Unhealthy or Dependent Use is Common



Screening and Treating Acutely Ill and Injured Patients with Comorbid Substance Use

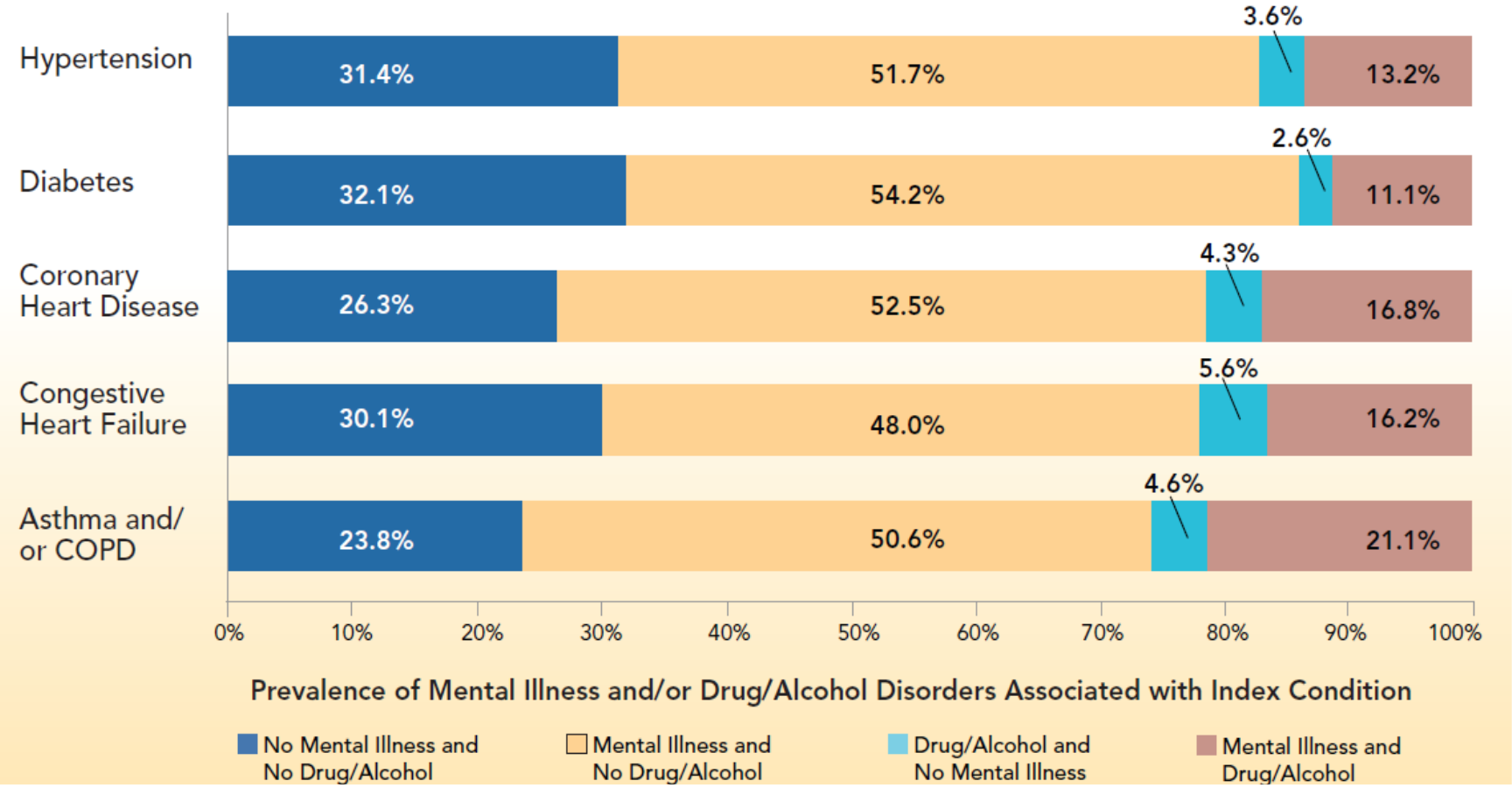
- Cochrane Collaboration review
  - 14 RCTs, adults and adolescents
- Outcomes favor BI over non-treatment controls
  - Significant drop in alcohol consumption at six months
  - Significant drop in alcohol consumption at nine months
  - Self Reporting at one year favors BI
  - Significantly fewer deaths at six months and one year

Screening and Brief Interventions in Hospital Emergency Departments

Systematic review of ED SBI

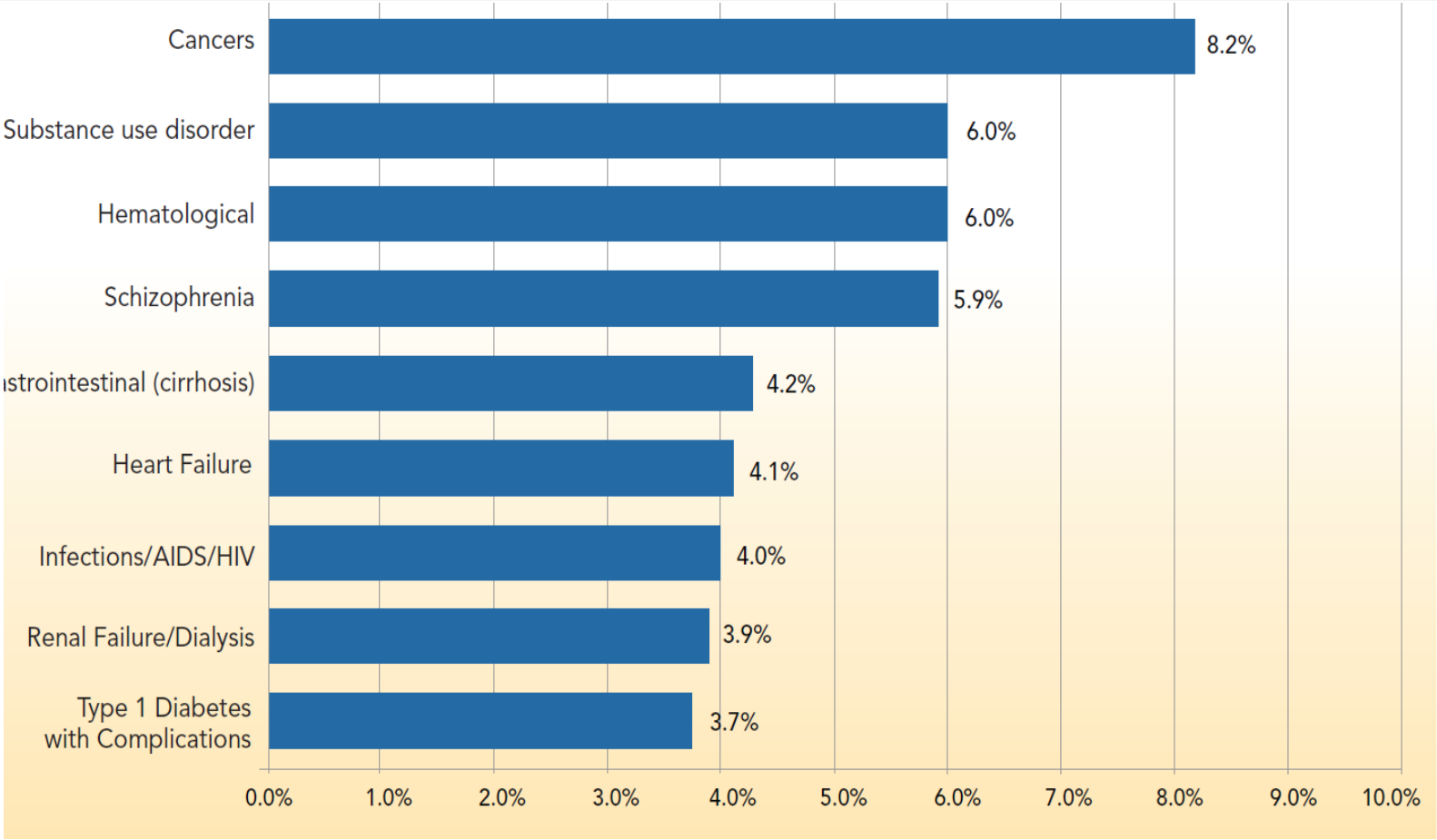
- 12 RCTs with pre- and post-BI results
- 11 or 12 observed significant effects on alcohol intake, risky drinking practices, alcohol-related negative consequences, and injury frequency

Prevalence of Comorbid Mental and Substance Use Conditions



Boyd, C., Leff, B., Weiss, C., Wolff, J., Hamblin, A., & Martin, L. (2010). Faces of Medicaid: Clarifying multimorbidity patterns to improve targeting and delivery of clinical services for Medicaid populations. *Center for Health Care Strategies.*

Effects of Comorbid Diseases on 30-day Readmissions



Boyd, C., Leff, B., Weiss, C., Wolff, J., Hamblin, A., & Martin, L. (2010). Faces of Medicaid: Clarifying multimorbidity patterns to improve targeting and delivery of clinical services for Medicaid populations. *Center for Health Care Strategies.*

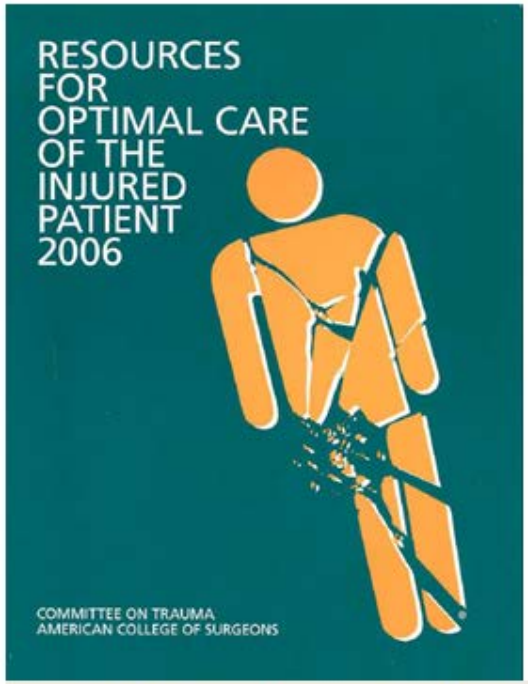
Most Common Diagnoses for 30-day Readmissions, 2012 HCUP

Principal diagnosis at 30-day readmission	Rank	Readmissions for any cause, %
Mood disorders as principal diagnosis at initial admission		
Mood disorders	1	60.1
Schizophrenia	2	9.0
Alcohol-related disorders	3	3.4
Substance-related disorders	4	3.1
Poisoning by psychotropic agents	5	1.4
Schizophrenia as principal diagnosis at initial admission		
Schizophrenia	1	70.3
Mood disorders	2	11.3
Substance-related disorders	3	1.4
Alcohol-related disorders	4	1.1
Fluid and electrolyte disorders	5	0.6

Note: Hospital stays were identified based on the principal diagnosis using Clinical Classifications Software (CCS). The principal diagnosis for readmissions also was identified using CCS categories. Patients under age 1 year were excluded from the analysis because of limited availability of patient linkage numbers.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Readmissions Database (NRD), 2012

Hospital Accreditation and Performance Metrics



CMS Inpatient Psych Incentive
FY 2014 SUB-1
FY 2016 SUB-2/-2a

American College of Surgeons-Committee on Trauma Accreditation Requirements

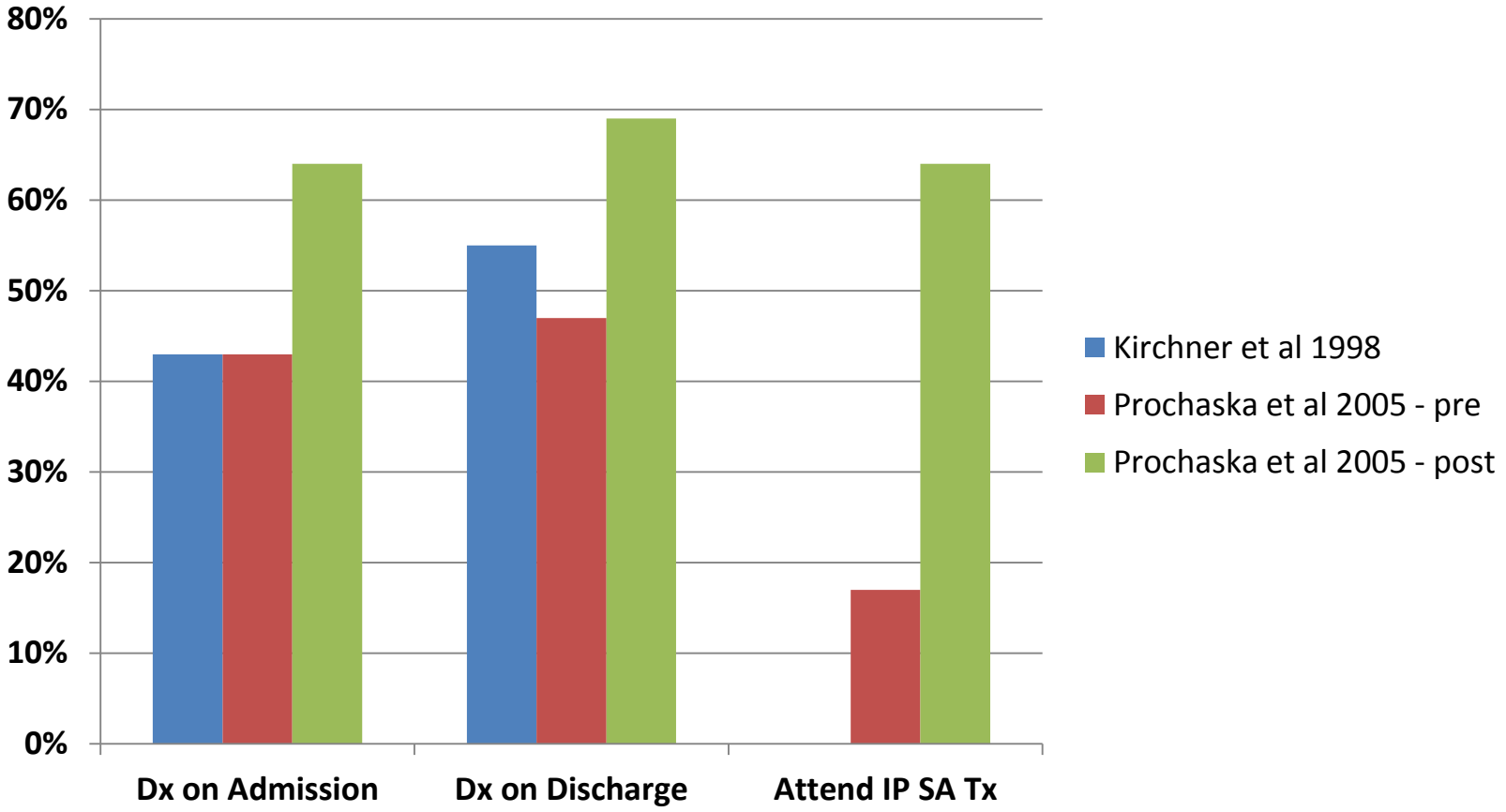
Joint Commission Technical Advisory Panel: Global Measures for Tobacco and Alcohol, June 2009

- Michael Fiore, MD (chair)
- Robert Adsit, MEd
- Nancy Rigotti, MD
- Larry Gentilello, MD
- Linda Sarna, RN, DNSc
- Eric Goplerud, PhD (co-chair)
- Katharine Bradley, MD, MPH
- Steve Bernstein, MD
- Connie Revell
- Constance Weisner, SrPH, MSW

Tobacco and Alcohol, Drug SBIRT Measures

- SUB-1 Screening for risky alcohol use
- SUB-2 Brief intervention
- SUB-3 Treatment initiation or referral on discharge
- SUB-4 Follow-up post discharge

Identification of Substance Use Disorders on Admission and Discharge



Prochaska, J. J., Gill, P., Hall, S. E., & Hall, S. M. (2014). Identification and treatment of substance misuse on an inpatient psychiatry unit. *Psychiatric Services*. Kirchner JE, Owen RR, Nordquist C, et al: Diagnosis and management of substance use disorders among inpatients with schizophrenia. Psychiatric Services 49:82–85, 1998

Practical Examples of Hospital SBIRT

- Falmouth Hospital (Massachusetts)
- Denver General Hospital (Colorado)
- Gunderson Lutheran Hospital (Wisconsin)
- Oregon Health Sciences University (Oregon)
- Christiana Hospital (Delaware)
- Salina Regional Hospital (Kansas)
- Temple University Hospital (Pennsylvania)

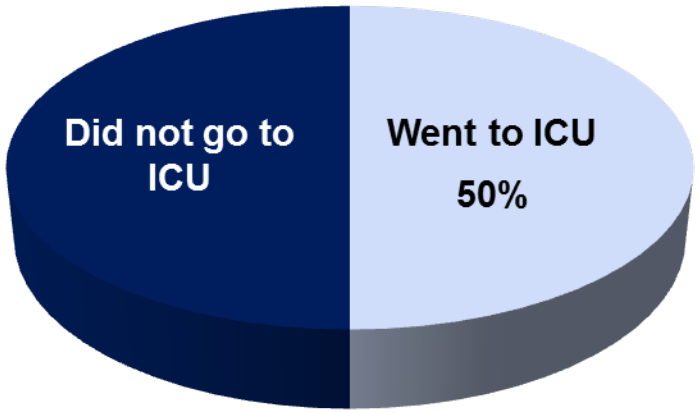
Collaborations Between Substance Use Programs and Hospitals: Gosnold and Falmouth Hospitals

- 100 bed general hospital; 50 bed addiction treatment center
- Courteous but distant neighbors since 1982
- Mutually necessary but not collaborative
- Gosnold “a place to send ‘those’ people”

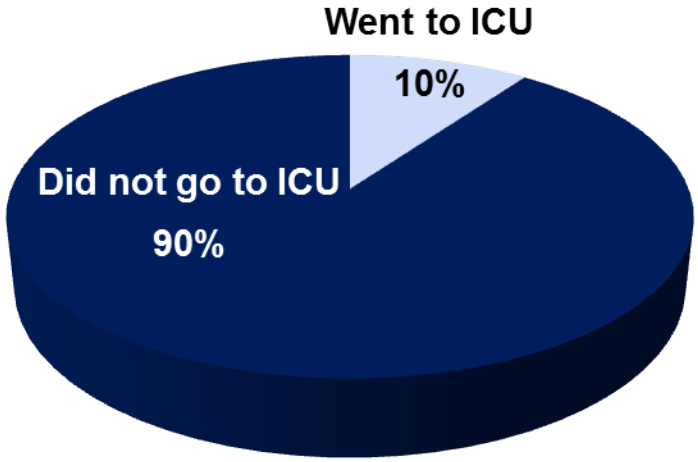
So what changed???

Gosnold: ICU Transfers Pre and Post Project

PRE



POST

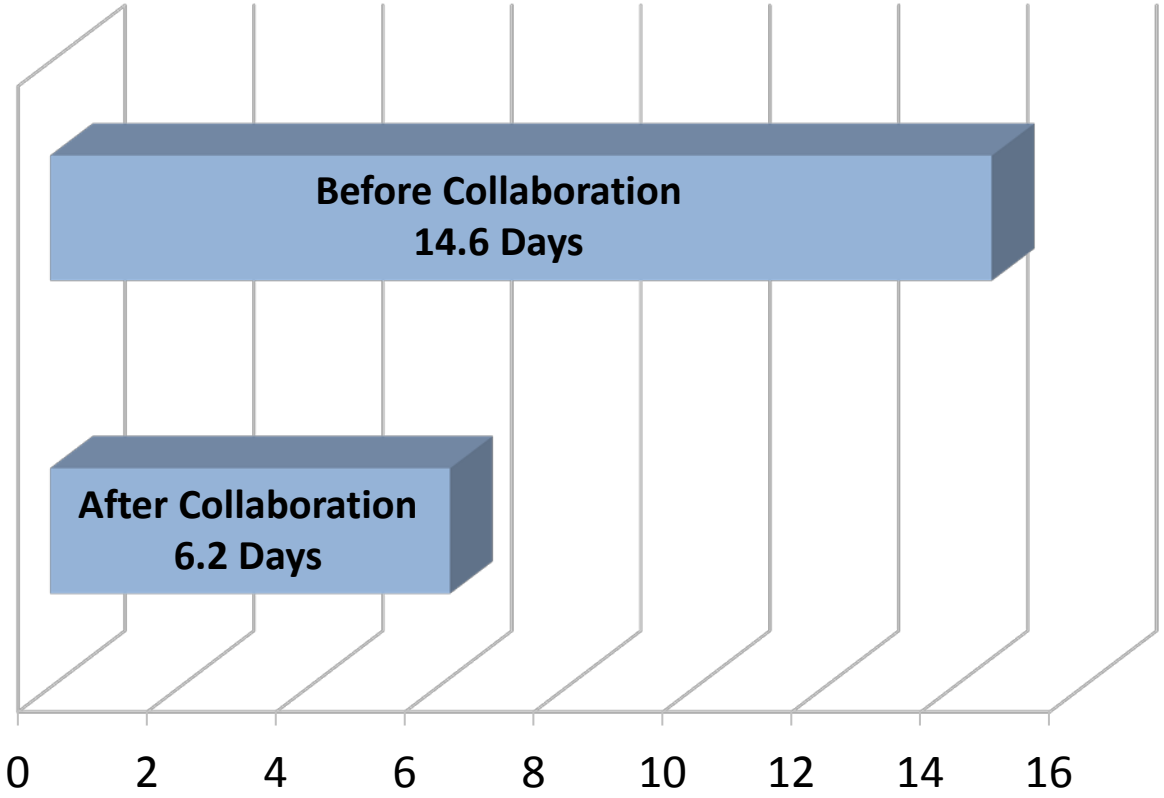


Cost per day

Med-Surg Floor vs. ICU

30%-40% LOWER IN MED-SURG

Gosnold: Average Length of Stay



Project Engage at Christiana Hospital

- Targeting hospitalized substance users at withdrawal risk, significant comorbid addiction
- Bedside peer-to-peer intervention using motivational interviewing
- Addictions community social worker to assist in removing barriers to transition to care and help with integration into the hospital milieu

CHRISTIANA CARE HEALTH SYSTEM

BCCS
Brandywine Counseling & Community Services

Christiana Care Health System: Preliminary Claims Analysis

Claims from June 1–November 30, 2009 Three Months Before and After Claims Review, n = 18			
Metric	**Pre**	**Post**	**Finding**
Medical inpatient admits	12	8	33% decrease $35,938
ER visits	54	33	38% decrease $4,248
BH/SA inpatient admits	7	10	43% increase ($1,579)
BH/SA outpatient visits	12	16	33% increase ($847)
PCP office visits	27	51	88% increase ($1,281)
Modified from Wright, Delaware Physicians Care Inc, 2010			**Total Savings = $36,479**

Christiana Care Health System: Claims From Next Two Cohorts

Claims from January 1–December 30, 2010 Six Months Before and After Claims Review, n = 25			
Metric	**Pre**	**Post**	**Finding**
Medical inpatient admits	17	7	58% decrease : $68,422 saved
ER visits	133	116	12.7% decrease : $3,308 saved
			Total Savings = $71,730

Claims from January 1–December 30, 2011 Six Months Before and After Claims Review, n = 30			
Metric	**Pre**	**Post**	**Finding**
Medical inpatient admits	42	22	48% decrease : $184,236 saved
ER visits	153	151	1% decrease : $8,690 saved
			Total Savings = $192,926

Modified from Wright, Delaware Physicians Care Inc, 2010

Salina Regional Health Center

Overview

- 199 bed Acute Care Regional Health Center-Level III Trauma Center
- 27,000 ED presentations per year
- Alcohol/Drug DRG was second most frequent readmission

Services provided

- 24-7 coverage of ED
- Full time SUD staff on medical and surgical floors
- Warm hand-off provided to all SUD/MH services
- Universal Screening and SBI beginning in 2013

Outcomes

- Readmission DRG moved from second to thirteenth
- 70% of alcohol/drug withdrawal LOS were three days or less
- 83% of SUD patients triaged in ED were not admitted
- 58% of patients recommended for further intervention attended first two appointments (warm hand-off)
- Adverse patient and staff incidents decreased by 60%
- CKF detox admissions increased 450% in first year
- 300% increase in commercial insurance reimbursement

Investing in Substance Abuse Treatment Results in a Positive ROI

- Substance abuse treatment has an ROI of between $1.28 to $7.26 per dollar invested.
- For every treatment dollar cut from substance abuse treatment in the proposed budget, the actual costs to taxpayers will increase between $1.28 and $7.26.
  - Individuals needing substance abuse treatment will seek services from more expensive systems, e.g., emergency rooms and prisons.

Bhatti et al. To Treat or Not To Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders. Washington, DC: Urban Institute. Health Serve Res. 2006 February; 41(1): 192–213.

Susan L Ettner, David Huang, Elizabeth Evans, Danielle Rose Ash, Mary Hardy, Mickel Jourabchi, and Yih-Ing Hser The economic costs of substance abuse treatment: Updated estimates and cost bands for program assessment and reimbursement, Journal of Substance Abuse Treatment (2006)

IPFQR Program

MEASURE ABSTRACTION AND DATA REPORTING REQUIREMENTS

Substance Use Measure Set

- SUB-1: Alcohol Use Screening
- SUB-2/-2a: Alcohol Use Brief Intervention Provided or Offered and the subset SUB-2a Alcohol Use Brief Intervention

SUB-1: Alcohol Use Screening

Chart Abstracted

Description: Hospitalized patients who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use

Numerator: The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first three days of admission

Denominator: The number of hospitalized inpatients 18 years of age and older

SUB-1 Numerator and Denominator Statements

Numerator Statement

- Excluded Populations
  - None
- Data Element
  - Alcohol Use Status

Denominator Statement

- Excluded Populations
  - Patients less than 18 years of age
  - Patients who are cognitively impaired
  - Patients who have a duration of stay less than or equal to three days or greater than 120 days
  - Patients with *Comfort Measures Only* documented

SUB-2 and SUB-2a

- The measure set is chart-abstracted.
- The measure set 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, a subset of the first, which includes only those patients who received a brief intervention. (80 FR 46700)

SUB-2: Alcohol Use Treatment Provided or Offered

Description: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay

Numerator: The number of patients who received or refused a brief intervention

Denominator: The number of hospitalized inpatients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence)

SUB-2a: Alcohol Use Treatment

Description: Patients who received the brief intervention during the hospital stay

Numerator: The number of patients who received a brief intervention

Denominator: The number of hospitalized inpatients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence)

SUB-2/-2a Numerator and Denominator Statements

Numerator Statement

- Excluded Populations
  - None
- Data Element
  - Brief Intervention

Denominator Statement

- Excluded Populations
  - Patients less than 18 years of age
  - Patients who are cognitively impaired
  - Patients who refused or were not screened for alcohol use during the hospital stay
  - Patients who have a duration of stay less than or equal to three days or greater than 120 days
  - Patients with Comfort Measures Only documented

Difference Between SUB-2 and SUB-2a

- **SUB-2** includes all patients who screened positive for unhealthy alcohol use and were offered and received **OR** offered and refused a brief intervention during the hospital stay.

- **SUB-2a** includes only those patients who were offered and **actually received** the brief intervention during the hospital stay.

SUB-2 Allowable Values

1. The patient received the components of a brief intervention.
2. The patient refused/declined the brief intervention.
3. Brief counseling was not offered to the patient during the hospital stay or unable to determine if a brief intervention was provided from medical record documentation.

SUB-2 and SUB-2a
Brief Intervention: Definition

- A single interaction conducted by a qualified healthcare professional or 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
- Corresponds directly with the 5 A's (Ask, Advise, Assess, Assist, Arrange) recommended for alcohol dependence

SUB-2 and SUB-2a
Brief Intervention: Notes for Abstraction

- A qualified healthcare professional may be defined as a physician, nurse, certified addictions counselor, psychologist, social worker, or health educator with training in brief intervention.
- 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, select Value “3.”
- Select Value “3” if the documentation provided is not explicit enough to determine if the intervention provided contained the specific components or if it is determined that the intervention does not meet the intent of the measure.

SUB-2/-2a Measure Data Reporting

- Adopted in the FY 2016 IPF PPS Final Rule for the FY 2018 payment determination and subsequent years
- Data reporting to begin with patient discharges in CY 2016 (January 1–December 31, 2016)
  - Includes patients discharged in the first quarter of 2016 who were admitted at the end of 2015 and have an LOS of less than 120 days
- Sampling allowed
  - Per the FY 2016 IPF PPS Final Rule, The Joint Commission/CMS Global Initial Patient Population Sampling methodology
- Data collected in CY 2016 will be submitted to CMS during the July 1–August 15, 2017 data submission period and will impact FY 2018

SUB-2/-2a Measure Data Reporting

Yearly Sample Size	
Number of Cases in Initial Patient Population	**Number of Records to be Sampled**
≥ 6,117	1,224
3,057–6,116	20%
609–3,056	609
0–608	All cases

SUB-2/-2a Measure Data Reporting

Monthly Sample Size		Quarterly Sample Size	
Average Monthly Initial Patient Population Size "*N*"	**Minimum Required Sample Size "*n*"**	**Average Quarterly Initial Patient Population Size "*N*"**	**Minimum Required Sample Size "*n*"**
≥ 510	102	≥ 1530	306
255–509	20%	765–1529	20%
51–254	51	153–764	153
< 51	No sampling 100% IPP required	6–152	No sampling 100% IPP required
		0–5	If submission occurs, 1–5 cases of the IPP may be submitted

IPFQR Program

KEYS TO IMPLEMENTATION AND OPERATIONALIZATION OF THE MEASURES

Overview

- How and why SBI implementation is unique in inpatient care settings
- Tips and strategies from the existing implementation guides and literature
- Lessons learned from the Veterans Health Administration

Unique Aspects of Inpatient Setting

- Patient acuity
- Staff volume, diversity, and roles
- Inpatient workflow
- Inpatient culture and paradigm

Practical Planning Worksheets

V. Appendices

Appendix A: Our Alcohol SBI Service

I. The Planning Team (Step 2)

Who is on the Planning Team?	
Name	**Position**

How will the planning team work together?	
How and why was the planning process established?	
Who does each team member represent and how will their input and feedback be elicited?	
What specific tasks should the planning process accomplish?	
What is the timeline?	
What are each person's responsibilities?	
How will decisions be made?	

The Screening Plan (Step 3)	
Who will be screened?	
When will screening take place?	
How often will screening occur?	
Who will perform the screening and where?	
What screening instruments will we use?	

IV. Implementation Plan (Steps 6, 7 and 8)

What training will be provided?		
Training	**Who**	**When/Where**
General orientation to alcohol SBI		
How to conduct screening in our program		
How to conduct brief interventions		
Specialized training: For supervisors For quality improvement For billing Other		

How will we pilot test our program?	
When will the pilot test begin?	
Where will the pilot test be implemented? Which clinic? System wide?	
How will the pilot test be announced?	
What reminders and aids will be used to support staff?	
What data will be collected, how, and by whom?	
How and by whom will collected data be analyzed, summarized, and shared with staff?	
When will the planning team meet to review results and revise program plans?	
When will results of the pilot test be shared with key staff?	

Common Themes

- Early planning for sustainability
- Cultural shift = workforce education + champions
- Multidisciplinary collaboration
- Dedicated role(s) and effort
- Serious attention to record-keeping procedures (EMR)

VA Pittsburgh Healthcare System

VA SUB/TOB ORYX Measures

- Effective January 1, 2014
- For all VA Medical Centers nationwide
- Similar to those in VA primary care
- Apply to all hospitalized patients

SUBSTANCE USE NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

Collected For:
The Joint Commission Only
CMS Informational Only

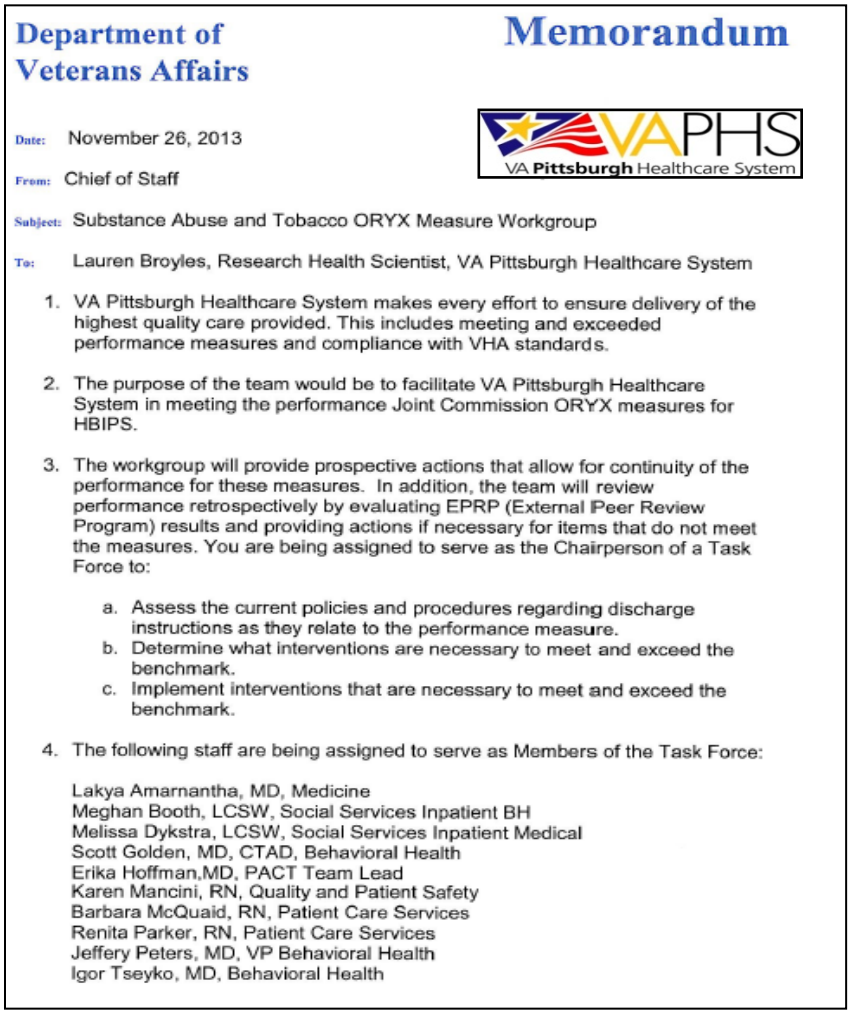
Set Measure ID#	Measure Short Name
SUB-1	Alcohol Use Screening
SUB-2	Alcohol Use Brief Intervention Provided or Offered
SUB-2a	Alcohol Use Brief Intervention
SUB-3	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge
SUB-3a	Alcohol and Other Drug Use Disorder Treatment at Discharge
SUB-4	Alcohol and Drug Use: Assessing Status after Discharge

TOBACCO TREATMENT NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

Collected for: The Joint Commission Only
CMS Informational Only

Set Measure ID #	Measure Short Name
TOB-1	Tobacco Use Screening
TOB-2	Tobacco Use Treatment Provided or Offered
TOB-2a	Tobacco Use Treatment
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge
TOB-3a	Tobacco Use Treatment at Discharge
TOB-4	Tobacco Use: Assessing Status After Discharge

Charter and Workgroup



Department of Veterans Affairs — **Memorandum**

VAPHS VA Pittsburgh Healthcare System

Date: November 26, 2013

From: Chief of Staff

Subject: Substance Abuse and Tobacco ORYX Measure Workgroup

To: Lauren Broyles, Research Health Scientist, VA Pittsburgh Healthcare System

1. VA Pittsburgh Healthcare System makes every effort to ensure delivery of the highest quality care provided. This includes meeting and exceeded performance measures and compliance with VHA standards.

2. The purpose of the team would be to facilitate VA Pittsburgh Healthcare System in meeting the performance Joint Commission ORYX measures for HBIPS.

3. The workgroup will provide prospective actions that allow for continuity of the performance for these measures. In addition, the team will review performance retrospectively by evaluating EPRP (External Peer Review Program) results and providing actions if necessary for items that do not meet the measures. You are being assigned to serve as the Chairperson of a Task Force to:

   a. Assess the current policies and procedures regarding discharge instructions as they relate to the performance measure.
   b. Determine what interventions are necessary to meet and exceed the benchmark.
   c. Implement interventions that are necessary to meet and exceed the benchmark.

4. The following staff are being assigned to serve as Members of the Task Force:

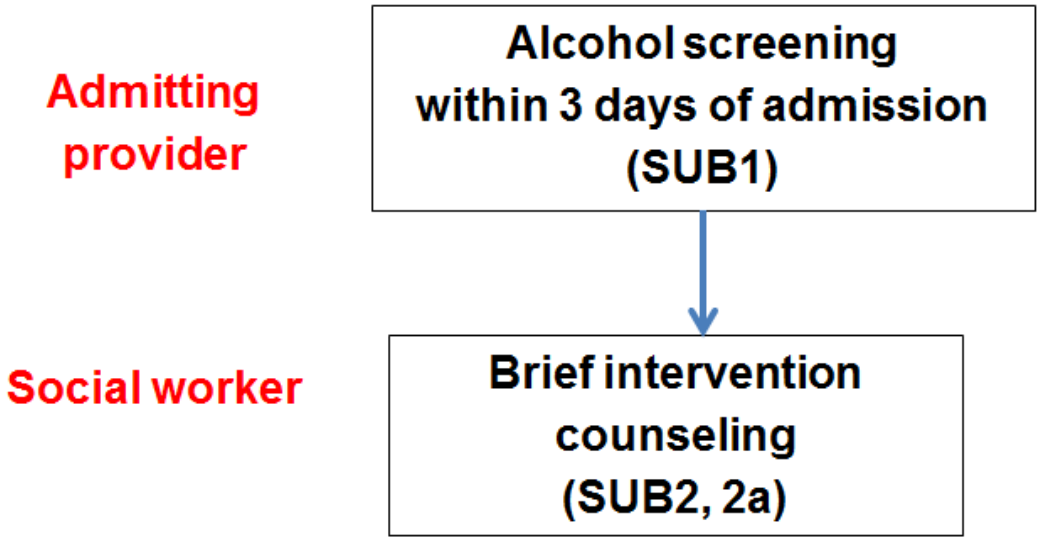
   Lakya Amarnantha, MD, Medicine
   Meghan Booth, LCSW, Social Services Inpatient BH
   Melissa Dykstra, LCSW, Social Services Inpatient Medical
   Scott Golden, MD, CTAD, Behavioral Health
   Erika Hoffman,MD, PACT Team Lead
   Karen Mancini, RN, Quality and Patient Safety
   Barbara McQuaid, RN, Patient Care Services
   Renita Parker, RN, Patient Care Services
   Jeffery Peters, MD, VP Behavioral Health
   Igor Tseyko, MD, Behavioral Health

- Nursing
  - Inpatient Medicine, Psychiatry, and Primary Care
- Social Work
  - Inpatient Medicine and Psychiatry
- Medicine
  - Inpatient Medicine and Psychiatry
- Psychiatry
- Substance Use Specialists
  - Outpatient
- Quality and Performance
- Clinical Informatics
- Research

Guiding Principles

- “Meaningful metrics”
- Patient-centered
- Efficient for staff/congruent with practice
- Interdisciplinary
- Participatory

Operationalizing the Substance Use Measures



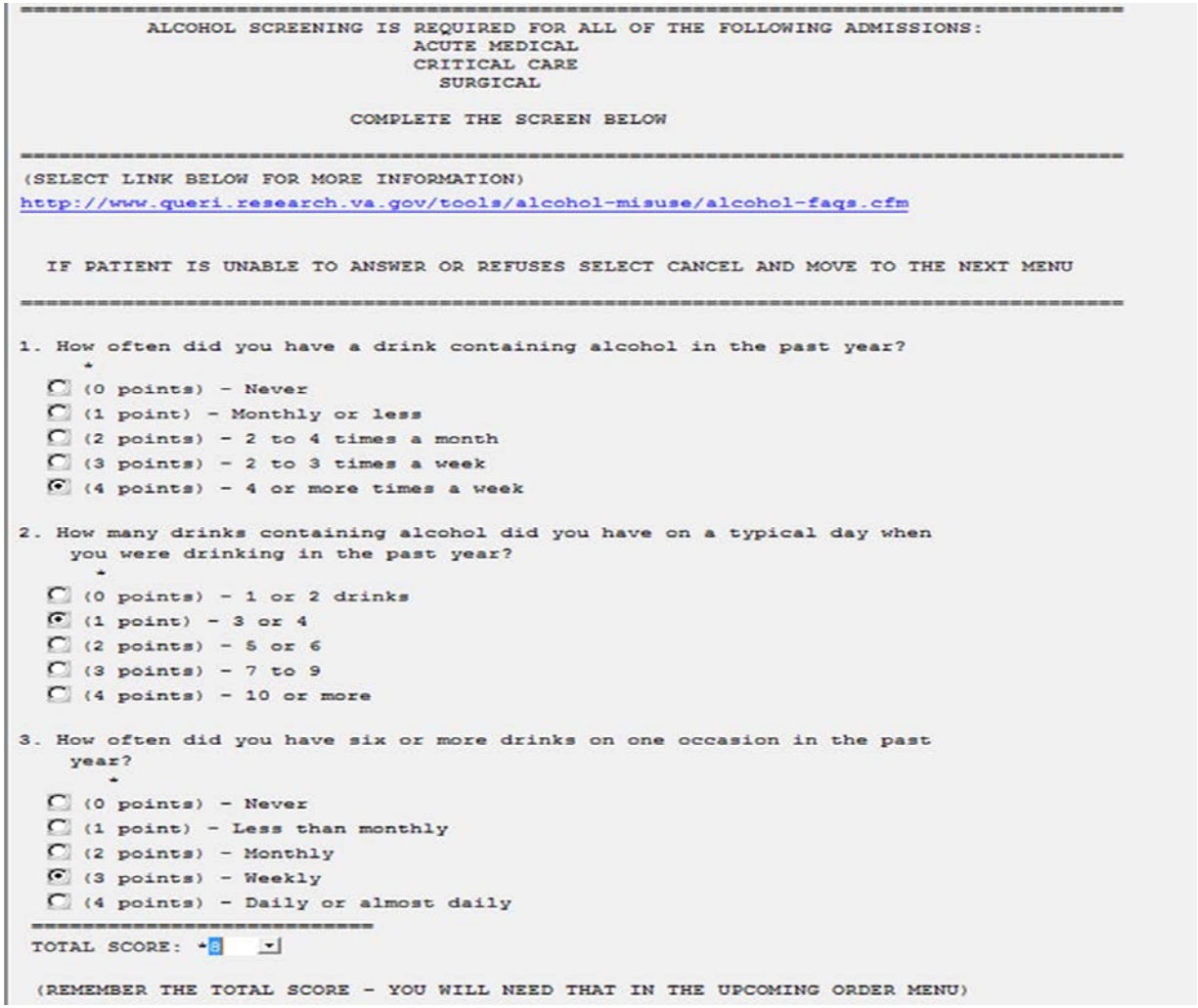
IF ALCOHOL OR SUBSTANCE USE DISORDER, ALSO:

Referral to outpatient treatment OR offer addiction pharmacotherapy

Follow-up contact 15-30 days after discharge

(SUB3, 3a, 4)

AUDIT-C



ALCOHOL SCREENING IS REQUIRED FOR ALL OF THE FOLLOWING ADMISSIONS:
ACUTE MEDICAL
CRITICAL CARE
SURGICAL

COMPLETE THE SCREEN BELOW

(SELECT LINK BELOW FOR MORE INFORMATION)
http://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-faqs.cfm

IF PATIENT IS UNABLE TO ANSWER OR REFUSES SELECT CANCEL AND MOVE TO THE NEXT MENU

1. How often did you have a drink containing alcohol in the past year?
*
( ) (0 points) - Never
( ) (1 point) - Monthly or less
( ) (2 points) - 2 to 4 times a month
( ) (3 points) - 2 to 3 times a week
(•) (4 points) - 4 or more times a week

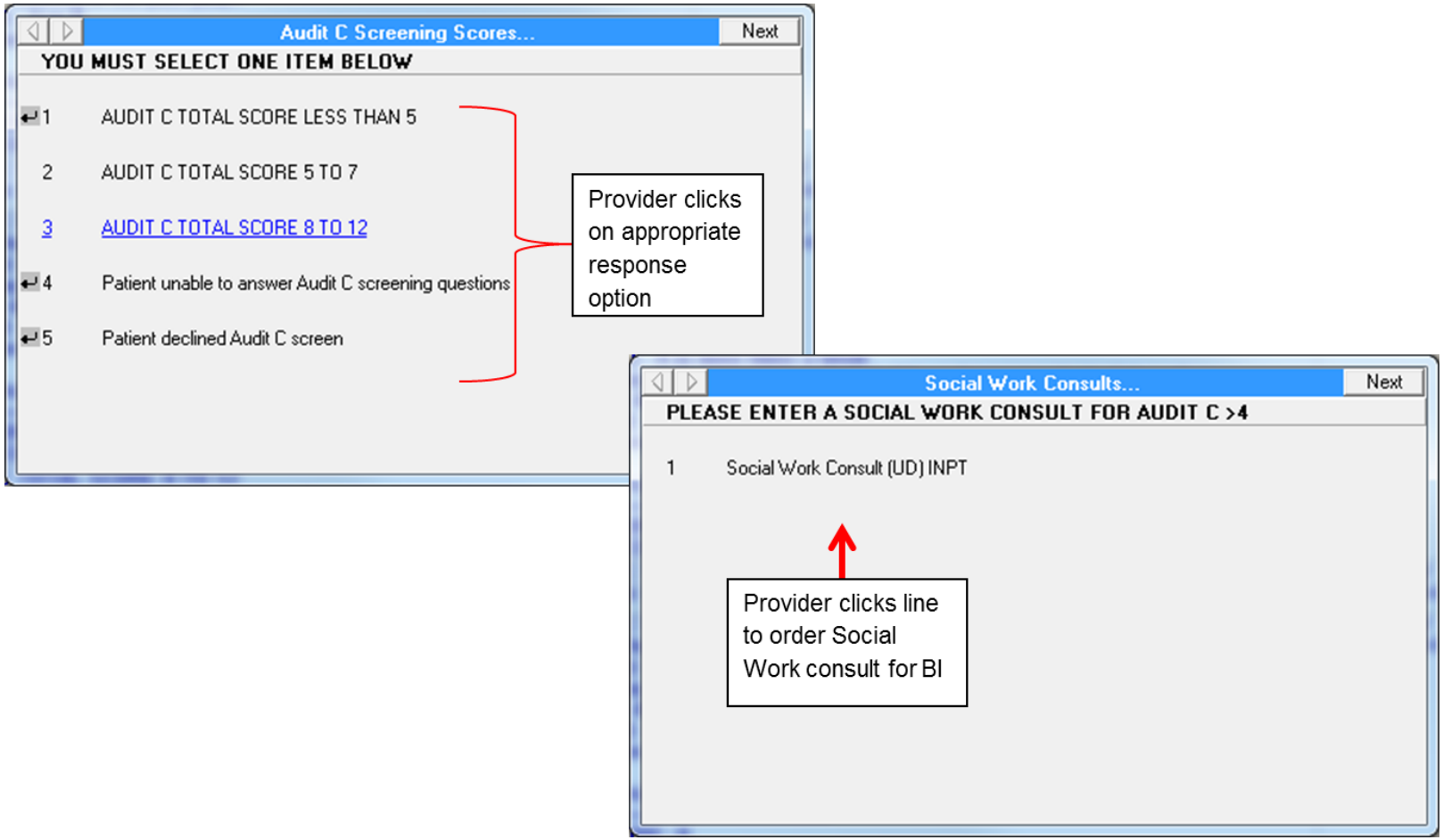
2. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?
*
( ) (0 points) - 1 or 2 drinks
(•) (1 point) - 3 or 4
( ) (2 points) - 5 or 6
( ) (3 points) - 7 to 9
( ) (4 points) - 10 or more

3. How often did you have six or more drinks on one occasion in the past year?
*
( ) (0 points) - Never
( ) (1 point) - Less than monthly
( ) (2 points) - Monthly
(•) (3 points) - Weekly
( ) (4 points) - Daily or almost daily

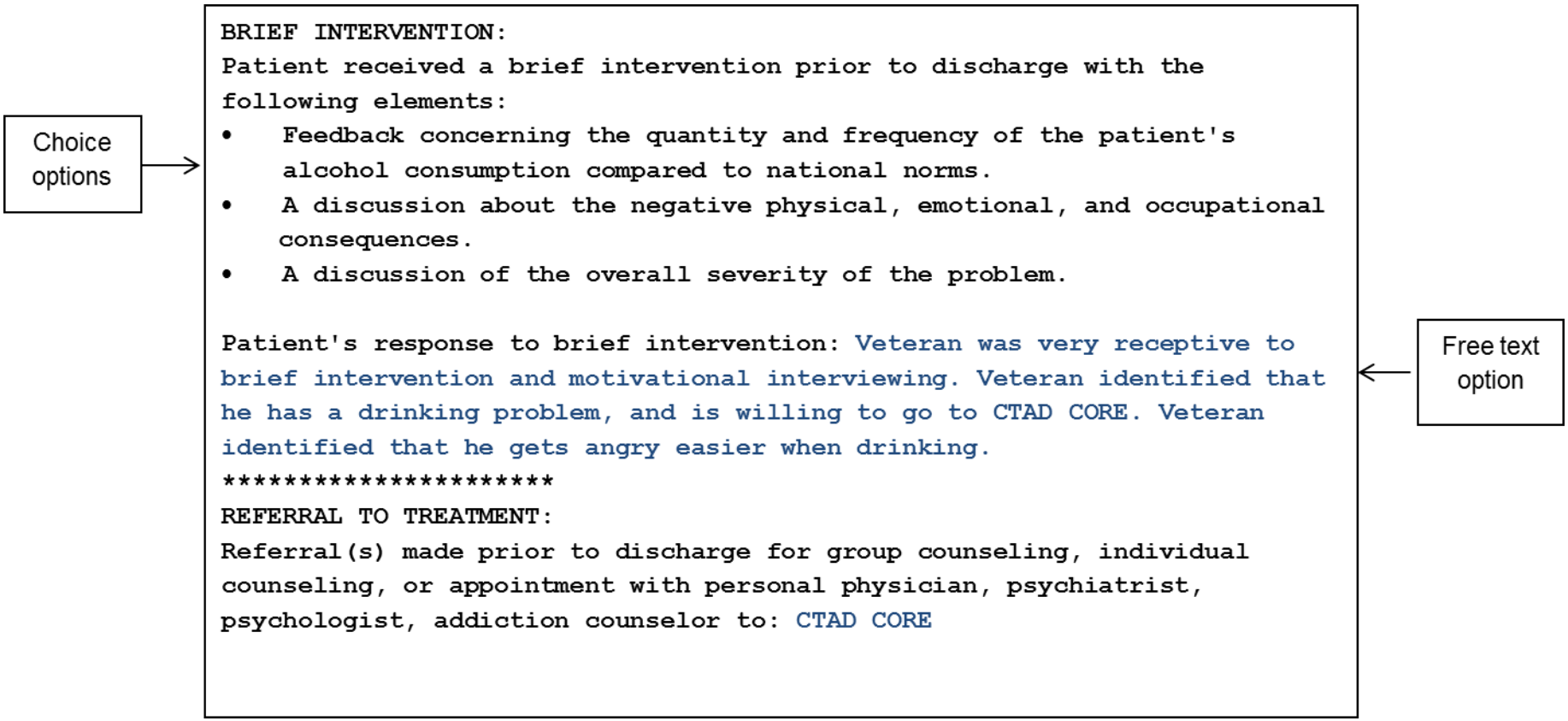
TOTAL SCORE: *8

(REMEMBER THE TOTAL SCORE - YOU WILL NEED THAT IN THE UPCOMING ORDER MENU)

EMR Screen Shots



Social Work Plan of Care Note



Facilitators

- Administrative support and buy-in
- Team and clinical champions with skills/roles
- Performance Measurement and Informatics partners
- Prior research and relationships
- “Outsider status”
- Momentum from dual roll-out of alcohol and tobacco measures

Barriers and Hurdles

- Unfunded mandate
  - Limited guidance and resources
- Complex measures
  - Measure burnout
- Sheer number of services, stakeholders, disciplines
- Layers of required approvals
- Busy clinicians, researchers, and staff
- Personalities and politics
- “Taboo” topic
- Electronic medical record

Practical Suggestions

- Read existing SBI implementation resources
- Establish a charter
- Cultivate leadership buy-in
- Establish an interdisciplinary team with all potential stakeholders
- Identify additional champions
- Consider EMR capabilities WHILE designing processes of care
- Conduct test runs, demos, pilots

HELPFUL LINKS AND REFERENCES

Guest Speakers' Contact Information

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www.sbirteducation.com

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Lauren.Broyles@va.gov

Helpful Links

Substance Use Measures Information

- **FY 2016 IPF PPS Final Rule:** http://www.gpo.gov/fdsys/pkg/FR-2015-08-05/pdf/2015-18903.pdf
- **The Joint Commission Specifications Manual, Version 5.0a:** https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228774725171
- **Hospital SBIRT Initiative:** http://hospitalsbirt.webs.com/
- **Monthly conference calls** on integrating SBIRT into routine hospital practice: http://hospitalsbirt.webs.com/progress.htm
- **Substance Abuse and Mental Health Services Administration**. *Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment*. Technical Assistance Publication (TAP) Series 33. HHS Publication No. (SMA) 13-4741. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. http://store.samhsa.gov/shin/content//SMA13-4741/TAP33.pdf

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Upcoming IPFQR Program Educational Webinar Dates

- **September 17, 2015:** *FY 2016 Final Rule, APU, and Reporting Period Review*
- **October 15, 2015:** *New Measures and Non-Measure Reporting – Part 1*
- **November 19, 2015:** *New Measures and Non-Measure Reporting – Part 2*
- **December 17, 2015:** *Public Reporting and FUH Measure Review*

IPFQR Program General Resources

Q & A Tool
https://cms-ip.custhelp.com

Email Support
IPFQualityReporting@area-m.hcqis.org

Phone Support
866.800.8765

Inpatient Live Chat
www.qualityreportingcenter.com/inpatient

Monthly Web Conferences
www.QualityReportingCenter.com

Secure Fax
877.789.4443

ListServes
Sign up on
www.QualityNet.org

Website
www.QualityReportingCenter.com

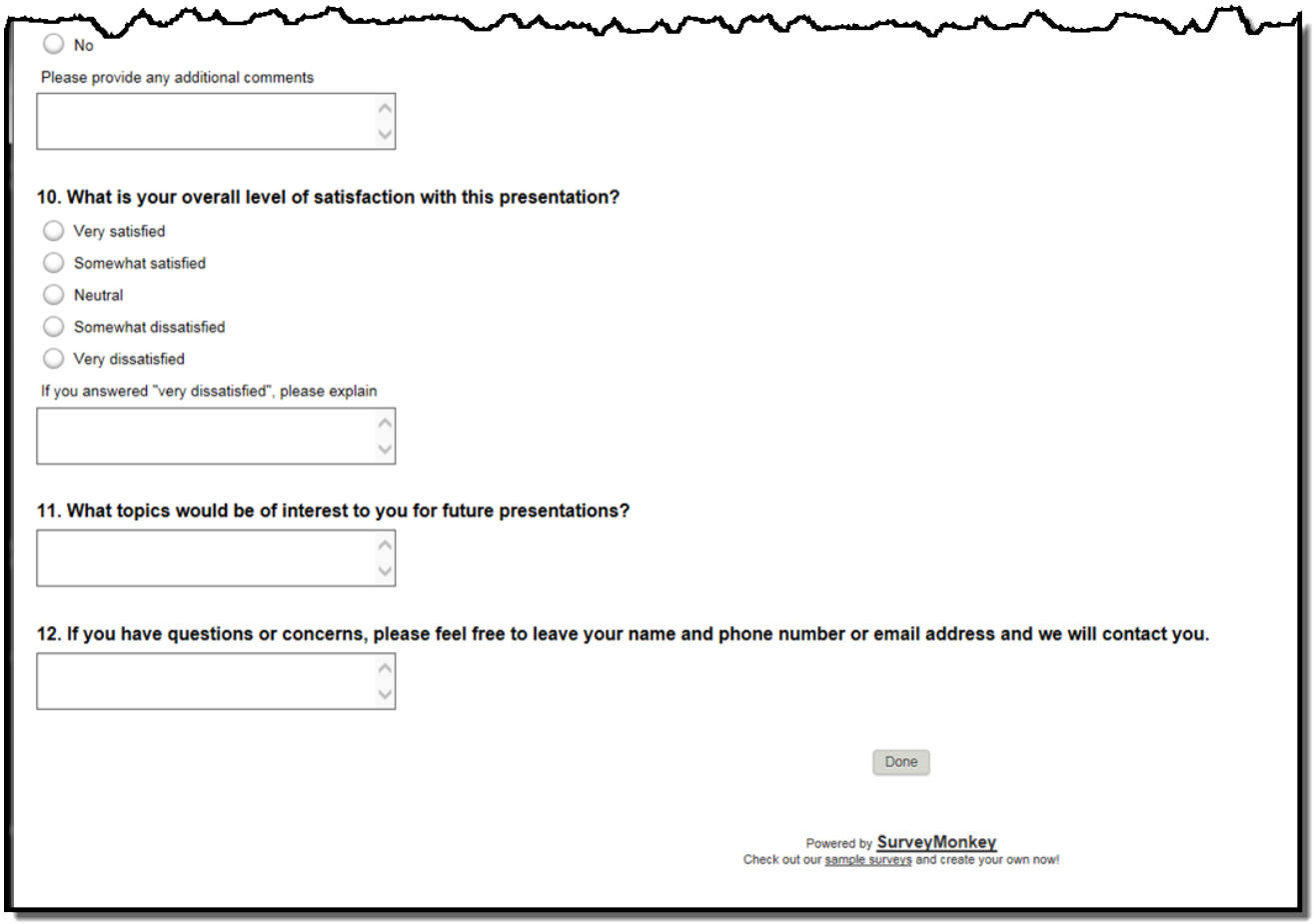
Continuing Education Approval

- This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:
  - Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
  - Florida Board of Nursing Home Administrators
  - Florida Council of Dietetics
  - Florida Board of Pharmacy
  - Board of Registered Nursing (Provider #16578)
    - It is your responsibility to submit this form to your accrediting body for credit.

CE Credit Process

- Complete the ReadyTalk® survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.
- After completion of the survey, click “done” at the bottom of the screen.
- Another page will open that asks you to register in HSAG’s Learning Management Center.
  - This is a separate registration from ReadyTalk
  - Please use your PERSONAL email so you can receive your certificate
  - Healthcare facilities have firewalls up that block our certificates

CE Credit Process: Survey



No

Please provide any additional comments

10. What is your overall level of satisfaction with this presentation?

- Very satisfied
- Somewhat satisfied
- Neutral
- Somewhat dissatisfied
- Very dissatisfied

If you answered "very dissatisfied", please explain

11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

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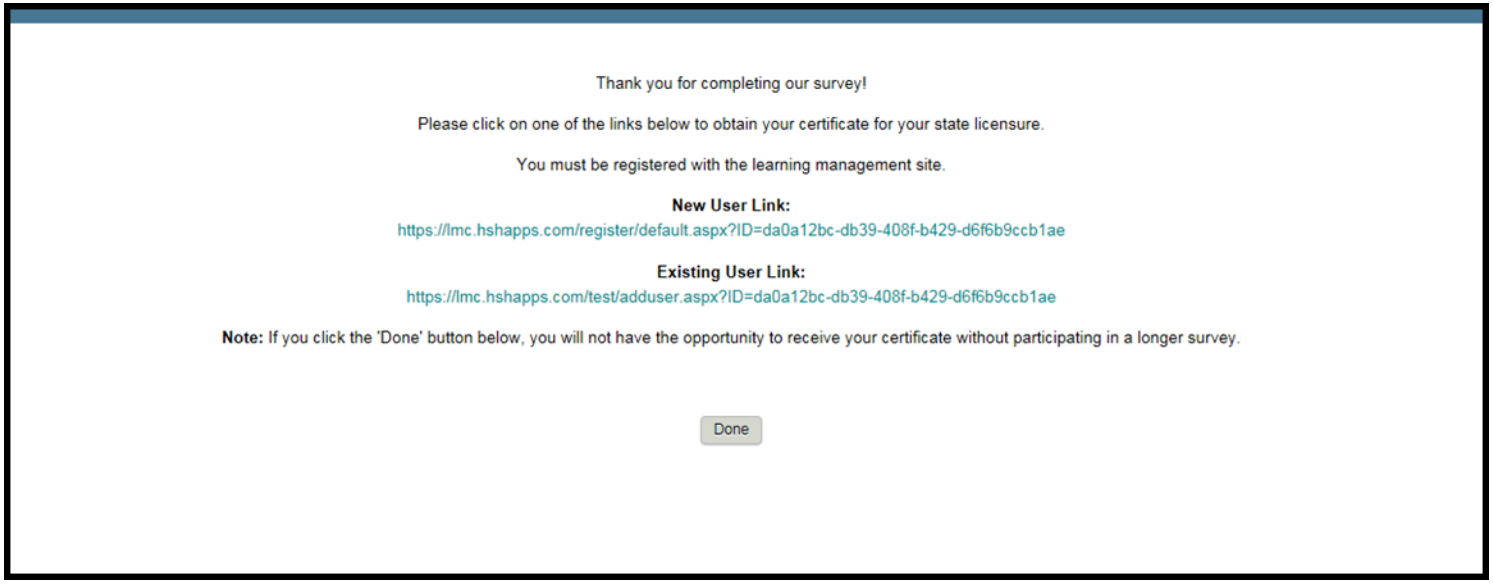
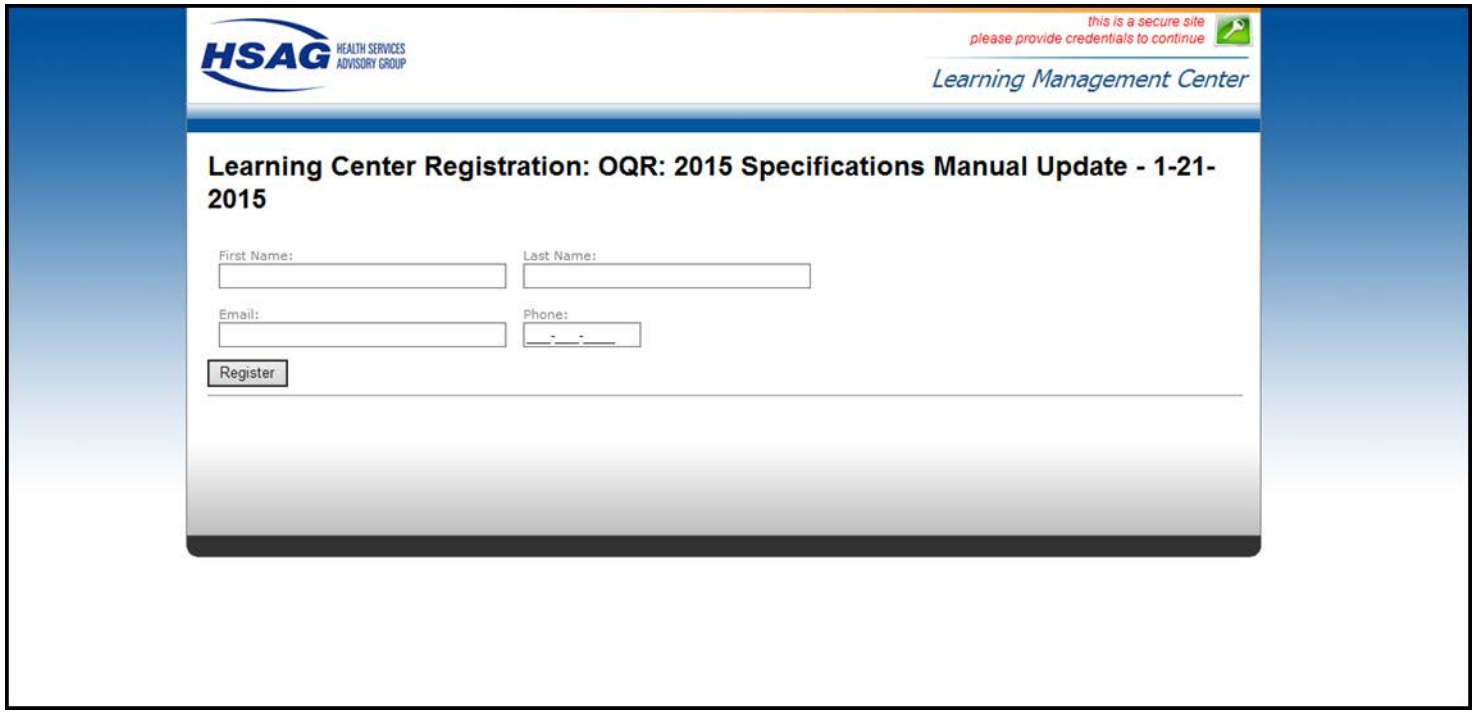


CE Credit Process: New User



CE Credit Process: Existing User