Inpatient Psychiatric Facility Quality Reporting Program

Support Contractor

Keys to Implementing and Abstracting the Substance Use Measure Set

Questions and Answers

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

Speaker(s):
Eric Goplerud, PhD
Vice President and Senior Fellow
National Opinion Research Center (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, IPFQR Program
VIQR Outreach and Education Support Contractor

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Question 1: Is it correct to say that we are only to screen for alcohol use and no other substance abuse (e.g., narcotics, anxiety medications)?

Answer 1: Yes, SUB-1 and SUB-2 are assessing alcohol use only.

Question 2: In regard to Wanda's question we can screen for other drug use using other tools correct? It is just not required for SUB.

Answer 2: That is correct.

Question 3: Is there a specific tool that can be used to abstract data needed for SUB-1, SUB-2/2a, etc.?

Answer 3: The AUDIT-C tool will be reviewed later in the presentation. This tool is used for alcohol screening. Paper tools to assist with abstraction are available on the

QualityReportingCenter.com website. Select the Inpatient topic and then the IPFQR Program Resources and Tools.

Question 4: When are SUB-3 and SUB-4 being implemented for IPFs?

Answer 4: SUB-3 and SUB-4 are not being implemented for the IPFQR program at this time.

Question 5: Can someone advise if the Final Rule for FY 2016 has expanded the IPFQR measure set to include SUB-2/2a?

Answer 5: Yes, this measure was finalized for the FY 2018 payment determination. The data collection period will be January 1 through December 31, 2016, and the data submission period will be July 1 through August 15, 2017.

Question 6: What does SBIRT stand for?

Answer 6: The acronym stands for **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment.

Question 7: What constitutes a Brief Intervention?

Answer 7: The components of the intervention 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; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to. Brief intervention corresponds directly with the 5 A's (Ask, Advise, Assess, Assist, Arrange) recommended for alcohol dependence.

Question 8: Is the Audit-C Tool Copyrighted? Can we build that into our electronic documentation?

Answer 8: The Audit-C tool is available for use in the public domain. Yes, it can be built into the EHR.

Question 9: What is the plan for submitting and reporting data via *QualityNet* on the Tobacco measures?

Answer 9: The TOB measures will be added to the web-based measures application in *QualityNet*.

Question 10: Will there be a first 3-day requirement [for the SUB-2/2a measures]?

Answer 10: TOB-1 and TOB-2 are to be performed within the first 3 days after admission. TOB-3 is assessed at discharge. SUB-1 is to be performed within the first 3 days

after admission. For SUB-2, the Brief Intervention is to be completed prior to discharge.

Question 11: If the provider used the '3' would that count as non-compliant for the measure?

Answer 11: Please submit this question using the *QualityNet* Q and A tool.

Question 12: Can a licensed counselor or similar therapist provide the brief intervention?

Answer 12: Absolutely, a counselor or therapist can provide brief intervention. There is no evidence that one profession is better than any other. The key thing is to have someone ask and counsel. According to the data element, the brief intervention is conducted by a qualified healthcare professional or trained peer support person, following a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence). 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.

Question 13: If we provide an education form that includes the 5 As, is a copy of what was given to the patient sufficient to comply with counseling provided?

Answer 13: Simply handing patients an education form would not be considered sufficient; however, if patients are counseled and given a form as a guide or reminder, then that would certainly meet the criterion. If a copy of the education form that includes the 5 As is placed in the medical record, it must reflect that interaction with the patient (i.e., counseling) occurred.

Question 14: Does the patient need to receive medication to pass the measure SUB-2a? What if we provide the counseling and set up the referral for the patient on discharge?

Answer 14: The numerator for SUB-2a includes patients who received a brief intervention during the hospital stay.

Inaccurate information was presented during the webinar and an IPFQR POC-Notify ListServe was released on September 2, 2015, addressing the errors; it stated the following:

"The purpose of this email is to correct misinformation that was presented during the IPFQR Program webinar titled *Keys to Implementing and Abstracting the Substance Use Measure Set: SUB-1, SUB-2/2a*, held on Tuesday, September 1, 2015.

Listed below are the definitions of the SUB-1 and SUB-2/2a measures:

- **SUB-1** includes patients over 18 who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use.

- **SUB-2** includes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay.
- **SUB-2a**, a subset of SUB-2, includes patients who received the brief intervention during the hospital stay.

Offering cessation medication to patients is not part of the aforementioned measures.

During this presentation:

- **Slide 38** referenced "cessation medication (if indicated) and practical counseling" for the SUB-2/2a measure.
  - The phrase "cessation medication (if indicated) and practical counseling" should have been replaced with "brief intervention."
- **Slide 42** included a list of FDA-approved medications for treatment.
  - Medication treatment **is not** a component of the SUB-1 or the SUB-2/2a measures.

We apologize for any confusion these errors may have caused. The PowerPoint and webinar recording will be revised to reflect the corrected information."

Question 15: When will SUB-2 and -2a [measures] be reported? Secondly, does the alcohol intervention have to be offered in the first 3 days after admission?

Answer 15: SUB-2 and SUB-2a will be collected starting January 1, 2016 with the reporting period of July 1, 2017 through August 15, 2017. SUB-2 includes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention *during the hospital stay*. SUB-2a includes only those who *received* the brief intervention during the hospital stay.

Question 16: Is there a contraindication for patients with alcohol and opioid use/abuse to receive any of the approved medications?

Answer 16: Although not contraindicated, naltrexone (PO and IV) can cause immediate opioid withdrawal, which can be very uncomfortable. This presentation inadvertently included information about SUB-3 which is NOT being collected for the IPFQR Program. Please see answer 14.

Question 17: Dr. Goplerud, is there a reason that youth younger than 18 are not included in the samples? Are there just not enough young people with this critical problem to be studied?

Answer 17: There are insufficient randomized controlled trials (RCTs) with the adolescent populations. The Joint Commission relied on the research review and recommendations made by the US Preventive Service Task Force, which at the time

that the SUB-1 to SUB-4 were developed had not (and still has not) determined sufficient research. The condition is prevalent among adolescents and young adults.

Question 18: How is "unhealthy alcohol use" defined? Is there such a thing as "healthy" alcohol use?

Answer 18: Unhealthy alcohol use is drinking that affects the patient's safety, per the AUDIT-C tool. The definition of "healthy alcohol use" may be subjective.

Question 19: Per the IPF PPS Final Rule, I thought, stated that data would not need to be collected until July 1, 2016 discharges?

Answer 19: Per the FY 2016 IPF PPS Final Rule, data will be collected starting January 1, 2016 for HBIPS-2/-3/-5, SUB-1/-2/2a, TOB-1/-2/2a/-3/3a. The Transition Record measures (NQF #0647 and #0648) and Screening for Metabolic Disorders measure data will be collected starting July 1, 2016. The reporting date of July 1 through August 15, 2017, remains the same.

Question 20: Is this population addressing only for Inpatient Psych patients or all inpatients?

Answer 20: The presenters may be discussing the measures as they relate to all inpatient admissions to their facilities; however, the IPFQR Program for CMS covers only patients admitted to the IPFs.

Question 21: Sounds like counseling alone isn't enough but must have documentation of providing medications or why medications weren't offered. Are both medication and counseling required for [the SUB-]2a [measure]?

Answer 21: This presentation inadvertently included information about SUB-3 which is NOT being collected for the IPFQR Program at this time. Please see answer 14.

Question 22: What constitutes "training" in brief intervention?

Answer 22: A Brief Intervention must be performed by staff specially trained in providing brief interventions to patients for substance (alcohol) use. Information on Screening, Brief Intervention & Referral to Treatment (SBIRT) is available at: http://www.hospitalsbirt.webs.com/. Your facility's Human Resources department should be able to verify this competency, since maintaining personnel records of training and education is a requirement for compliance. A free online SBIRT course is provided through Medscape addressing the basic principles of SBIRT. A free membership to Medscape is required to access the training. Go to Medscape at: https://login.medscape.com/login/sso/getlogin?urlCache=aHR0cDovL3d3dy5tZWRzY2FwZS5vcmcvdmlld2FydGljbGUvODMwMzMx&ac=401.

Question 23: On slide 42: It displays the following: "FDA approved medications appropriate for alcohol use treatment" - does one of these medications have to be offered?

Answer 23: No, medications do not have to be offered. This presentation inadvertently included information about SUB-3, which is NOT being collected for the IPFQR Program at this time. Please see answer 14.

Question 24: Do licensed professionals who are qualified health professionals need to be trained in SBIRT or just health educators and peers?

Answer 24: All healthcare professionals who will perform brief interventions MUST receive special training on how to perform a brief intervention.

Question 25: Who does the initial screen[ing], the physician/nurse?

Answer 25: The alcohol use screening can be done by a physician or nurse.

Question 26: If [a] patient [is in the] inpatient [unit] less than 3 days, are they excluded from numerator?

Answer 26: Patients with a length of stay less than or equal to 3 days are excluded from the SUB-1 and SUB-2/2a measures.

Question 27: For SUB-2 and SUB-2a [measures] is there a time frame that this needs to be done, i.e., within the first 3 days?

Answer 27: SUB-2 includes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention *during the hospital stay*. SUB-2a includes only those who *received* the brief intervention during the hospital stay.

Question 28: Is there a specific tool that can be used to abstract data needed for SUB-1, SUB-2/2a, etc.?

Answer 28: The AUDIT-C tool will be reviewed later in the presentation. This tool is used for alcohol screening. Paper tools to assist with abstraction are available on the QualityReportingCenter.com website Select the Inpatient topic, then the IPFQR Program Resources and Tools. Currently, a paper tool is available for SUB-1. Additional tools for other measures will be available before measure data abstraction begins.

Question 29: The AUDIT-C is a short version of what tool?

Answer 29: The AUDIT-C is a short version of the AUDIT tool.

Question 30: With the AUDIT-C tool, I have noticed there are different scoring methodologies for women. Some sources are indicating a risk for unhealthy drinking if greater

than 2, some sources are stating unhealthy alcohol use if greater than 3, and some are stating greater than 4. Please clarify the scoring methodology for women when using the AUDIT-C?

Answer 30: According to the AUDIT-C, a score of 3 or more is considered positive for women, categorizing them as hazardous drinkers or ones with active alcohol use disorder.

Question 31: For the Salina Regional Health Center slide. What DRG was used to identify "alcohol or substance use"?

Answer 31: It is unknown what DRGs were used at Salina Regional Health Center.

Question 32: Are any of these studies specific for psych patients?

Answer 32: All three of the studies cited by Dr. Goplerud were for psychiatric inpatients. They were relatively small, uncontrolled studies, and must be reviewed with caution.

Question 33: We do a lot of detox on your inpatient unit, so we know they have substance use disorders (SUD) when they arrive for admission. Also, what about substances other than alcohol, since half [of the patients] seeking detox are opiate users?

Answer 33: At this time, the IPFQR Program is collecting information on tobacco and alcohol use only.

Question 34: When does this become mandatory?

Answer 34: Per the FY 2016 IPF PPS Final Rule, data for SUB-1-2/2a and TOB-1-2/2a-3/3a will be collected starting January 1, 2016. To meet the IPFQR program requirement, Inpatient Psychiatric Facilities (IPFs) are required to submit all quality measures in the form, manner, and time, as specified by the Secretary, to the Centers for Medicare & Medicaid Services (CMS), beginning with Fiscal Year (FY) 2014 payment determination year and subsequent fiscal years. Because this is a pay-for-reporting program, eligible facilities will be subject to payment reduction for non-participation. Eligible IPFs that do not participate in the IPFQR program in a fiscal year, or do not meet all of the reporting requirements, will receive a 2.0 percentage point reduction of their annual update to their standard federal rate for that year. The reduction is non-cumulative across payment years.

Question 35: Why does slide 38 refer to cessation medication/practical counseling? This is not discussed at all in the Brief Intervention data element.

Answer 35: This presentation inadvertently included information about SUB-3 which is NOT being collected for the IPFQR Program. Please see answer 14.

Question 36: Dr. Goplerud, what is a "warm hand-off" as noted in slide 28?

Answer 36: A warm hand off is the direct physical transfer of a patient from a trusted psychiatric inpatient staff member to a care manager or clinician from the community program. Warm hand off also sometimes refers to a telephonic referral in which the referring inpatient staff member gets the referring organization on the phone with the patient present, discusses with the referring organization and the patient the planned transfer, and has the patient talk directly by phone at that time with the community agency's staff person. There are some instances where the warm hand-off is also facilitated by the community staff member coming on site for counseling sessions, the community agency's staff person accompanying the patient to an ambulatory clinic or partial program from the inpatient unit, or for one or the other staff members physically accompanying the patient during the physical transition from one facility to another (e.g., sharing a taxi).

Question 37: Page 38 title is for SUB-2/2a but yet the bullets seem to describe SUB3/3a?

Answer 38: This presentation inadvertently included information about SUB-3 which is NOT being collected for the IPFQR Program at this time. Please see answer 14.

Question 39: Page 42 is regarding SUB-2/2a but we are under the impression that medication is needed for SUB-3/3a?

Answer 39: This presentation inadvertently included information about SUB-3 which is NOT being collected for the IPFQR Program at this time. Please see answer 14.

Question 40: The definition of brief intervention on slide 40 doesn't include medication treatment; is medication treatment on slide 42 optional?

Answer 40: This presentation inadvertently included information about SUB-3 which is NOT being collected for the IPFQR Program at this time. Please see answer 14.

Question 41: Does the patient need to receive medication to pass the measure Sub 2a? What if we provide the counseling and set up the referral for the patient? Will we need to have provided both Brief Intervention and discharge meds to meet the new requirements?

Answer 41: This presentation inadvertently included information about SUB-3 which is NOT being collected for the IPFQR Program at this time. Please see answer 14.

Question 42: Does the patient have to be in at 3 days before eligibility for sample?

Answer 42: Patients with a length of stay less than or equal to 3 days are excluded from the SUB-1 and SUB-2/2a measures.

Question 43: The slide referencing SUB-2 description and SUB-2a describes cessation medication and practical counseling. Are these descriptions relation to the SUB-3

measure? We are only required to complete SUB-1 and SUB-2/SUB2-a correct? USE and brief intervention correct?

Answer 43: This presentation inadvertently included information about SUB-3 which is NOT being collected for the IPFQR Program. Please see answer 14.

Question 44: AUDIT-C is a validated tool to screen for unhealthy alcohol use. Articles in literature suggested that some in VHA may be using a gender-neutral AUDIT-C scoring, using 5 or above for 'unhealthy' alcohol' use. Is this being used at VHA and if so, can it be adopted as a validated tool in lieu of the standard AUDIT C scoring where females with score of 3 or males with score of 4 or above are considered unhealthy?

Answer 44: Yes, VA primary care and inpatient care uses an AUDIT-C cut point of 5 for both sexes, and it is a validated tool which provides adequate (though not ideal) sensitivity and specificity for men and less so, for women. Each facility will have to decide whether the compromised sensitivity and specificity of a lower cut point is acceptable in the context of implementation. To help think through these trade-offs, Dr. Broyles recommends checking out "Choice of Screening Cut Points," (pp. 14-15) *VA/DoD Clinical Practice Guidelines for Substance Use Disorder*, which can be found at the following link: http://www.healthquality.va.gov/guidelines/MH/sud/sud_full_601f.pdf.

Question 45: Unhealthy is 8 points or more on the Alcohol Screening

Answer 45: The AUDIT- C is scored on a scale of 0- 12. Each AUDIT-C question has 5 answer choices to which points are allotted. For men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. For women, a score of 3 or more is considered positive.

Question 46: So unhealthy would be #2 selected under SUB-1?

Answer 46: For the data element Alcohol Use Status, allowable value 2 states: The patient was screened with a validated tool within the first three days of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.

Question 47: Previous literature regarding classifying a patient's ETOH use as unhealthy was unclear. Is a score of 5 or greater now considered the standard?

Answer 47: The AUDIT- C is scored on a scale of 0-12. Each AUDIT-C question has 5 answer choices to which points are allotted. For men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. For women, a score of 3 or more is considered positive.

Question 48: Is there an available brief intervention tool that can become part of the chart or will it suffice for [a] social worker to document "5-10 minute brief intervention completed"?

Answer 48: According to the data element *Brief Intervention*, the specified components must be listed for the abstractor to determine that they were addressed. The components of the intervention 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; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to. Brief intervention corresponds directly with the 5 A's (Ask, Advise, Assess, Assist, Arrange) recommended for alcohol dependence.

Question 49: When you use the term, "social worker," does that imply a Master's Prepared LIP, such as an LCSW or LMSW, or can it include a Master's-prepared Licensed Professional Counselor?

Answer 49: According to the data element, the brief intervention is conducted by a qualified healthcare professional or trained peer support person, following a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence). 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 Master's-prepared Licensed Professional Counselor trained in brief interventions would be acceptable.

Question 50: We have a patient who stop[ped] drinking three years ago, and screened negative for alcohol use during current hospitalization; however, the diagnosis trigger[ed] the referral and to prescribe FDA approved medication. How do we answer this question?

Answer 50: For SUB-2, if the answer to the data element *Alcohol Use Status* indicates "no or low risk of alcohol related problems," the case is excluded from the denominator. Your system may be set up to trigger the referral, but the measure algorithm will not require it.

Question 51: Am I correct in the understanding that if the patient is screened using the SBIRT, [that] this is in compliance with these new measures?

Answer 51: The first component of the SBIRT process is screening, which provides a quick and simple method of identifying patients who are at risk or who already experience substance-use related issues. A screening tool such as the AUDIT-C can be used to satisfy the first component.

Question 52: Is this approved CE for all nursing boards from all states or just Florida?

Answer 52: As a nationally accredited Nursing provider, the approved CE is for nursing boards nationwide. It is the responsibility of all nurses to report their own credits to their boards as outlined on slide 73 of the presentation.

Question 53: I meant at Pittsburg VA with the reflex sw consult order?

Answer 53: Please submit this question to *QualityNet* via the Q and A link.

Question 54: If there is documentation that counseling/education was provided and we give the patient a form, will this suffice to pass the SUB-2a?

Answer 54: Simply handing patients an education form would not be considered sufficient, however, if patients are counseled and given a form as a guide or reminder that would certainly meet the criterion. If a copy of the education form that includes the 5 A's (Ask, Advise, Assess, Assist, Arrange) is placed in the medical record, it must reflect that interaction with the patient (i.e., counseling) occurred. Brief intervention corresponds directly with the 5 A's recommended for alcohol dependence. The components of the intervention 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; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to.

Question 55: Does a licensed professional counselor (masters in counseling) need more training before being qualified to screen versus a social worker (masters in social work)?

Answer 55: According to the data element, the brief intervention is conducted by a qualified healthcare professional or trained peer support person, following a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence). 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 Master's-prepared Licensed Professional Counselor trained in brief interventions would be acceptable.

Question 56: What do you think is a realistic timeframe for implementing these measures?

Answer 56: Facilities participating in the IPFQR program should already be in the process of collecting data for the SUB-1 measure. Data collection for the SUB-2/2a measure starts January 1, 2016.

Question 57: Are referrals to AA inclusions for counseling provided?

Answer 57: If you are referencing SUB-2/2a, the brief intervention is to be performed during the hospital stay. SUB-3, the measure on treatment at discharge, is not being collected for the IPFQR Program at this time.

Question 58: The screening can be conducted by Social Workers or no?

Answer 58: The alcohol use screening can be done by a physician or by a nurse. However, the brief intervention is to be conducted by a qualified healthcare professional or trained peer support person, following a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence). 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.

Question 59: So, what exactly constitutes [a] brief intervention? Is it just the counseling aspect, or is it a combination of counseling and pharmacological intervention?

Answer 59: It is just the counseling regarding alcohol use. Brief intervention corresponds directly with the 5 A's (Ask, Advise, Assess, Assist, Arrange) recommended for alcohol dependence. The components of the intervention 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; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to.

Question 60: In the measures slides - there was a statement that if you do not assess to use the code "3" if a 3 is used will this be considered not complete or non-complaint for SUB-2.

Answer 60: If allowable, value 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) is selected for the data element *Brief Intervention*, and the case will fail SUB-2 and SUB-2a.

Question 61: Must all the components for brief intervention be met before it can be accepted?

Answer 61: Yes. According to the data element *Brief Intervention*, the abstractor should select allowable value "3," if the documentation provided is not explicit enough to determine whether the intervention provided contained the specific components, or if it is determined that the intervention does not meet the intent of the measure.

Question 62: Asking about what kind of "social worker" can do intervention

Answer 62: According to the data element, the brief intervention is conducted by a qualified healthcare professional or trained peer support person, following a positive

screening result for unhealthy alcohol use or alcohol use disorder (i.e., abuse or dependence). 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.

Question 63: A screening should be completed on ALL admissions, and not strictly those with alcohol/drug dx correct?

Answer 63: Submission of data for SUB-1, the alcohol use screening measure, is required for participation in the IPFQR Program. All patients admitted to the IPF should be screened for alcohol use.