# The Future of Hospital SBIRT

## SBIRT Colorado Annual Conference
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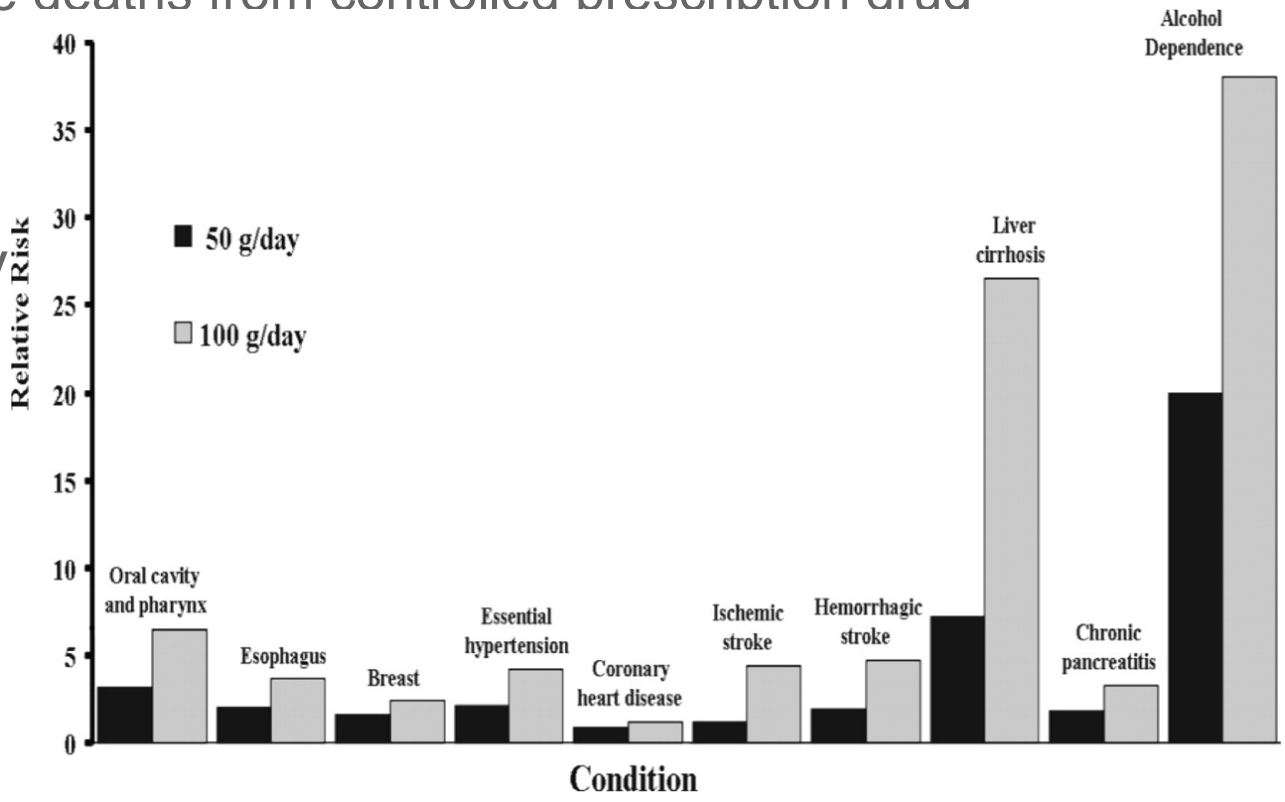
# Substance Use Disorders and Risky Substance Use: Significant Public Health Problem

- Excess mortality:
  - 98,334 deaths annually from alcohol-related causes
  - 16,044 deaths annually from illicit drugs
  - 20,044 overdose deaths from controlled prescription drug
- Excess morbidity





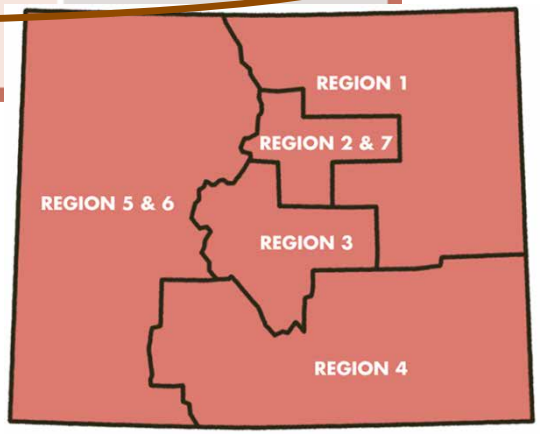

Mokdad, A. H., Marks, J. S., Stroup, D. F., & Gerberding, J. L. (2004). Actual causes of death in the United States, 2000. JAMA, 291(10), 1238-1245.

# Need, certainly. Why Hospitals?

- SUDs are public health issues, but how do SUDs impact hospitals?
  - More prevalent in Colorado than elsewhere
  - Alcohol, drugs, and increasingly, prescription drug use are crowding Colorado EDs
  - Expensive ED visits, especially for uncompensated care and returning ED visits by uninsured
  - Common complicating problem of Colorado hospitalized patients
    - Medical complications (MICU, return to surgery, longer length of stays)
    - Unstable discharges, rehospitalization

# Why Hospital SBIRT: Prevalence of risky substance use among Colorado adults and adolescents

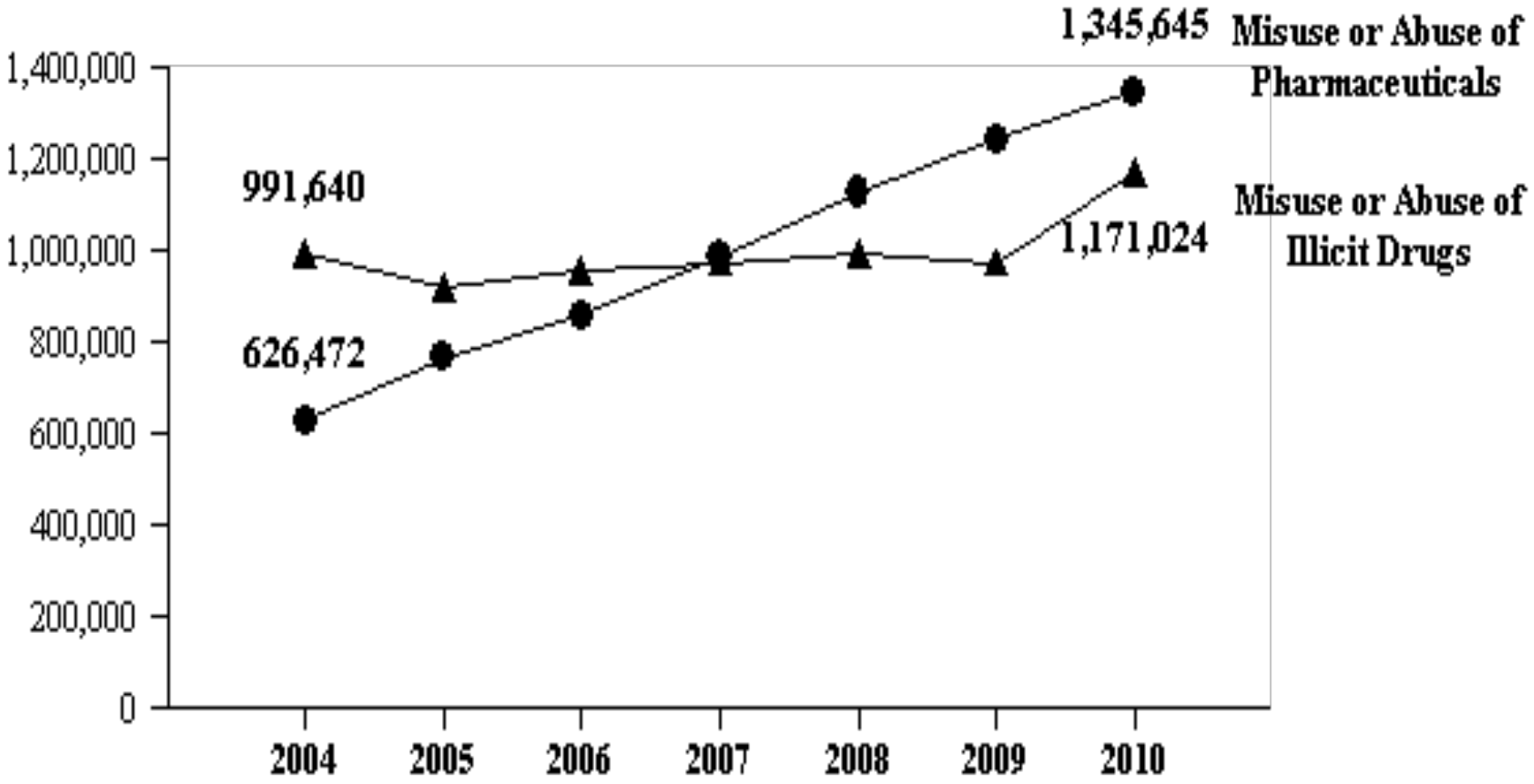
| COLORADO | PAST MONTH BINGE ALCOHOL | ALCOHOL DEPENDENT OR ABUSE | DRUG DEPENDENT OR ABUSE | PAIN MEDICATION MISUSE |
|---|---|---|---|---|
| Region 1 | 27.5 | 10.5 | 3.2 | 5.47 |
| Region 2 & 7 | 27.2 | 10.3 | 3.5 | 5.57 |
| Region 3 | 21.4 | 8.2 | 2.8 | 5.71 |
| Region 4 | 22.2 | 8.5 | 2.7 | 4.84 |
| Region 5 & 6 | 27.6 | 7.9 | 3.0 | 4.92 |
| Colorado | 26.2 | 9.9 | 3.8 | 5.26 |
| National | 23.2 | 7.5 | 2.8 | |




Colorado above national averages

SOURCE: National Survey on Drug Use and Health, 2009.

# Why Hospital SBIRT: Drug-Related Emergency Department Visits: 2004 to 2010




SOURCE: Adapted by CESAR from Substance Abuse and Mental health Services Administration (SAMHSA), "Highlights of the 2010 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits," *The DAWN Report*, July 2, 2012. Available online at http://www.samhsa.gov/data/2k12/DAWN096/SR096EDHighlights2010.pdf.

# Why Hospital SBIRT: Costly Patients in the ED

## Excess ED Costs -- $248 million annually

| TEST OR PROCEDURE | COST | ETOH + | ETOH - |
|---|---|---|---|
| Ambulance transportation | $ 600.00 | 47.7% | 18.5% |
| CBC | $ 8.97 | 32.6% | 11.7% |
| Electrolytes | $ 9.80 | 16.0% | 4.0% |
| Blood Glucose testing | $ 5.48 | 17.2% | 5.2% |
| Urinalysis | $ 4.43 | 18.0% | 7.2% |
| Chest X-Ray | $ 26.88 | 19.2% | 10.0% |
| CAT Scan/MRI | $ 440.21 | 29.4% | 8.7% |
| EKG | $ 17.01 | 16.6% | 6.4% |
| Urinary catheterization | $ 90.38 | 3.8% | 1.3% |
| IV fluid administration | $ 40.23 | 28.8% | 9.9% |



SOURCE: Terence O'Keeffe, Shahid Shafi, Jason L. Sperry, and Larry M. Gentilello The implications of alcohol intoxication and the Uniform Policy Provision Law on trauma centers; a national trauma data bank analysis of minimally injured patients. J Trauma. 2009 February; 66(2): 495–498.

# Why Hospital SBIRT? Colorado ED Visits Likely Positive for Risky Substance Use, Costs & Savings*

| | Likely to Screen Positive | Annual Costs Undetected | Savings if Detected |
|---|---|---|---|
| All Payers ED Visits | 123,398 | $175,101,664 | $35,328,918 |
| Insurance ED Visits | 34,405 | $ 61,030,664 | $12,077,104 |
| Medicaid ED Visits | 18,183 | $ 32,253,864 | $ 6,382,385 |
| Medicare ED Visits | 4,941 | $ 8,763,843 | $ 1,734,240 |
| Uninsured ED Visits | 43,120 | $ 76,848,444 | $15,135,188 |

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* Of 1,045,155 ED visits 2006; Schur, Goplerud (2007) Estimating the costs and benefits of routine emergency department SBI.

# Why Hospital SBIRT?
# Problem Drinking Causes Disease and Injury

**AGES 18 AND UP, MALES AND FEMALES**

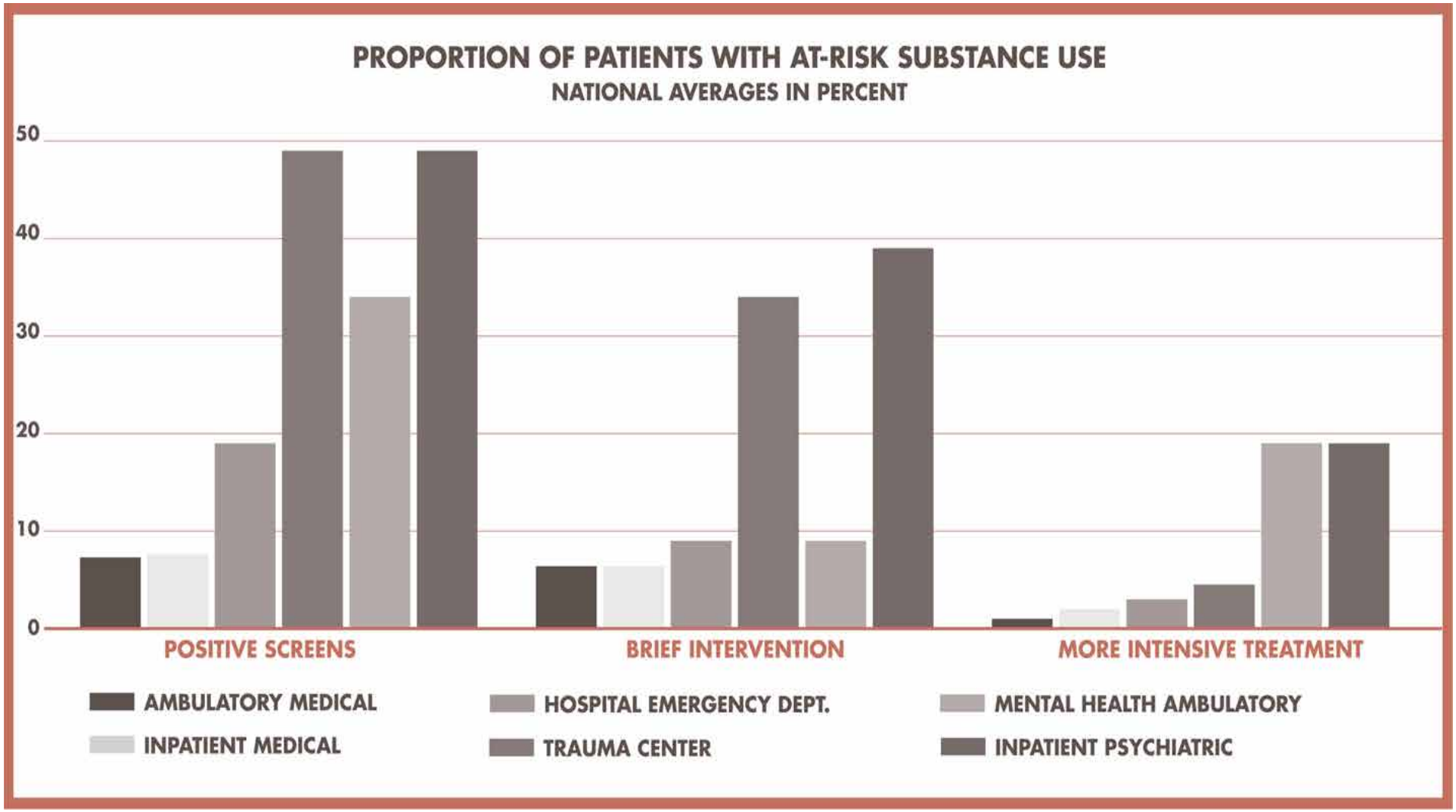
| Under 35 Yrs | | Over 35 yrs | |
|---|---|---|---|
| Alcoholic psychoses, alcohol dependence, nondependent use of alcohol, ethanol toxicity, accidental poisoning by alcohol (E-code), alcohol use/abuse (E-code) | 1.00 | Alcoholic liver cirrhosis | 1.00 |
| Accidental aspiration | 1.00 | Chronic pancreatitis | 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 |

SOURCE: Centers for Disease Control and Prevention. (2008a). *Alcohol and public health: Alcohol-Related Disease Impact (ARDI).*

# Colorado Inpatients with SUDs or Unhealthy Use by Payer

| | Total hospital discharges | Medicare 32% | Medicaid 12% | Self pay 8% | Insurance 42% | Other, charity 6% |
|---|---|---|---|---|---|---|
| Colorado Inpatient Discharges 2009 | 349,613 | 111,876 | 41,954 | 27,969 | 146,837 | 20,977 |
| Colorado Inpatients with likely substance use disorders | 22,725 | 2,363 | 2,550 | 3,054 | 8,552 | 2,291 |
| Colorado Inpatients with likely SUDs or unhealthy substance use | 48,946 | 5,090 | 5,492 | 6,578 | 18,419 | 4,934 |

# Concentrated substance use risk in specific hospital services



# Consequences that matter to hospitals
## Unstable discharges, rehospitalization risk

**Crude Rates and Risks of Recurrent Acute Care Hospital Utilization Within 30 Days After Index Hospitalization**

| | No SUDs (n = 615) | SUDs(n = 123) | *P* |
|---|---|---|---|
| **Rates of reutilization** | | | |
| Acute care reutilizations*: visits/patient/30 days | 0.32 | 0.63 | <0.01 |
| ED visits: no. visits/patient/30 days | 0.16 | 0.37 | 0.02 |
| Rehospitalization: visits/patient/30 days | 0.16 | 0.26 | 0.09 |
| **Risks of reutilization** | | | |
| Subjects with any acute care reutilization* in 30 days | 38% | 52% | <0.01 |
| Subjects with any ED visit in 30 days | 23% | 34% | <0.01 |
| Subjects with any rehospitalization in 30 days | 23% | 33% | 0.02 |



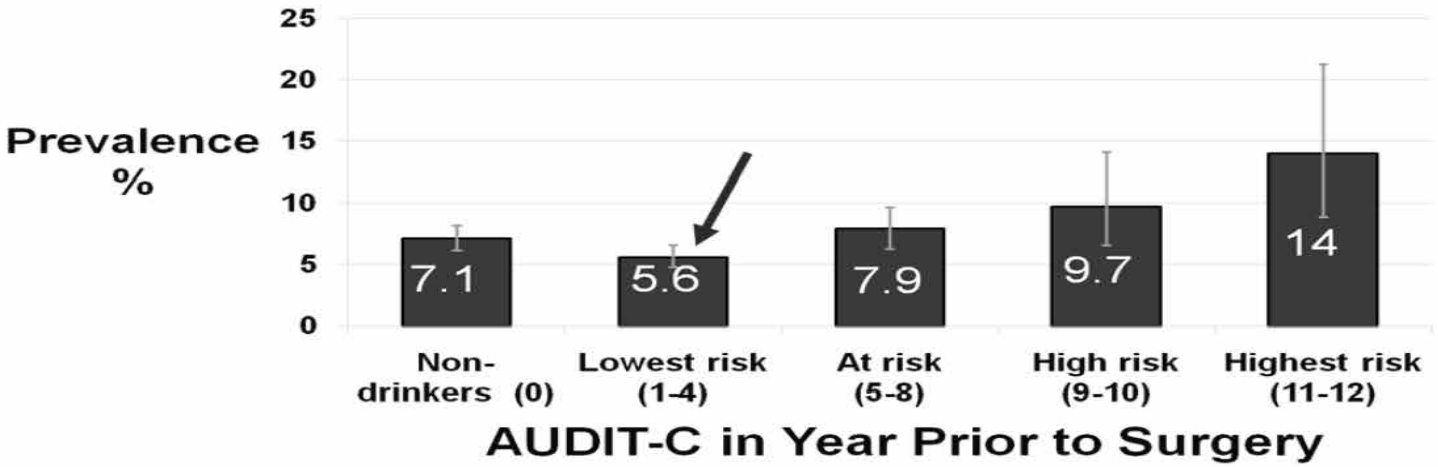
Forsythe S, Chetty VK, Mitchell S, Jack BW. Acute care hospital utilization among medical inpatients discharged with a substance use disorder diagnosis. J Addict Med 2012;6:50-56. Rubinsky AD, Sun H, Blough D et al. AUDIT-C alcohol screening results and postoperative inpatient health care use. J Am Coll Surg 2012;213:296-305.

# Consequences that matter to hospitals

## Surgical complications, infection risk, longer hospital stays, return to MICU and surgery

| | Low AUDIT | High AUDIT P |
|---|---|---|
| Post operative hospital length of stay | 5.0 | 5.8 |
| ICU days | 2.8 | 4.5 |
| Probability of return to OR w/in 30 days | 5% | 10% |

## AUDIT-C and Post-operative Complications*



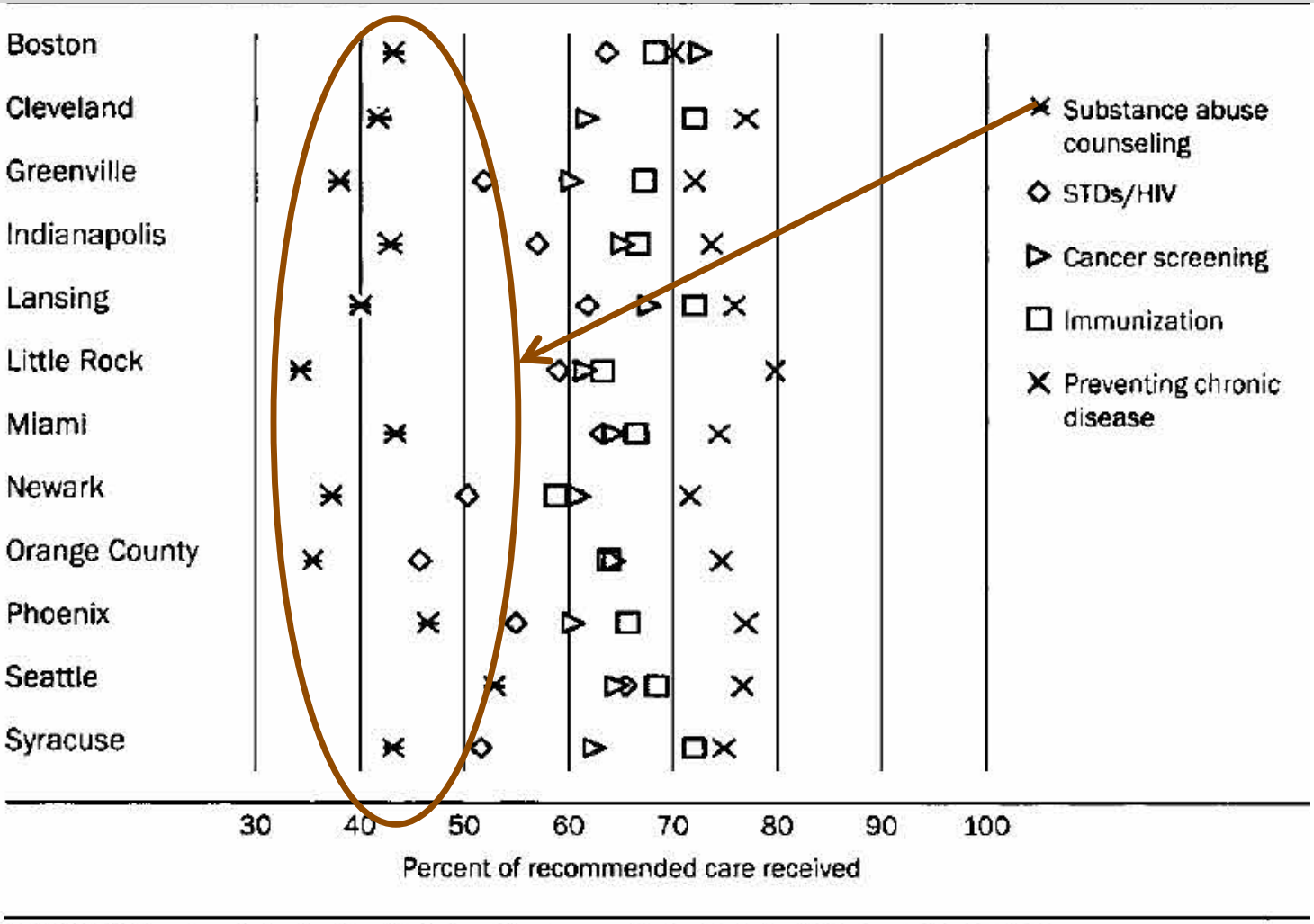

*Adjusted for age, smoking, & time from screen to surgery

Bradley JGIM 2010



Forsythe S, Chetty VK, Mitchell S, Jack BW. Acute care hospital utilization among medical inpatients discharged with a substance use disorder diagnosis. J Addict Med 2012;6:50-56. Rubinsky AD, Sun H, Blough D et al. AUDIT-C alcohol screening results and postoperative inpatient health care use. J Am Coll Surg 2012;213:296-305.

# Huge Gap between Current and Evidence-based Practices




**SOURCE:** Authors' analysis of original data from the Community Quality Index (CQI) study, 1998–2000.
**NOTES:** STD is sexually transmitted disease. HIV is human immunodeficiency virus.



SOURCE: Kerr EA, McGlynn EA et al. Profiling the quality of care in 12 communities: Results from the CQI study. Health Affairs. 2004; 23(3): 247-56.

# Current and Near Future Developments in Hospital SBIRT

- EBPs growing from research and practice experience
- Reimbursement base improving
- Training and practice support networks strengthening
- Accreditation requirements
- Performance Metrics and Incentives to Report
- Electronic Health Records (EHRs) and Health Information Exchanges (HIEs)

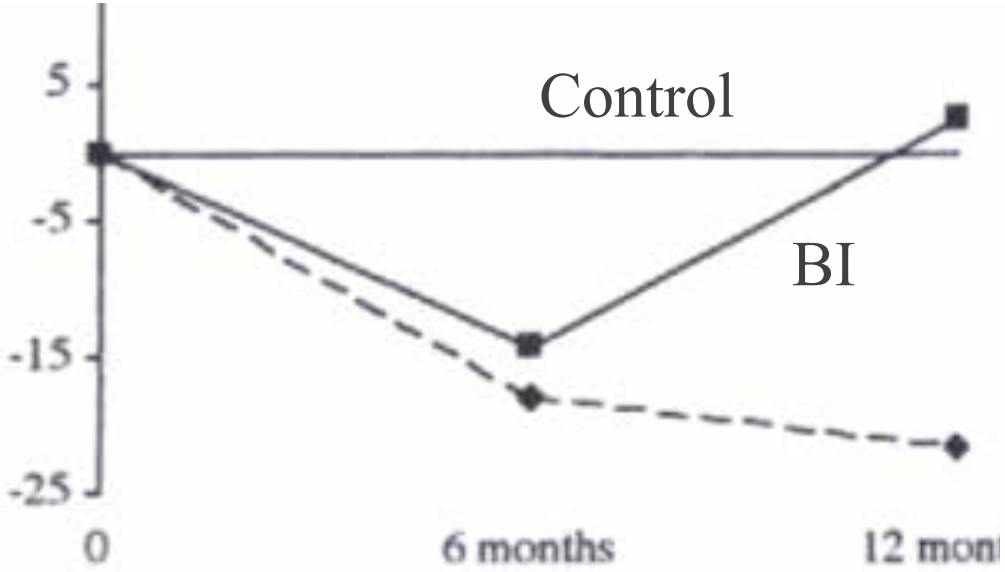
# Screening, Brief Interventions for Alcohol: Major Impact of SBI on Morbidity and Mortality

| Study | Results - conclusions | Reference |
|---|---|---|
| Trauma patients | **48% fewer re-injury (18 months)**<br>**50% less likely to re-hospitalize** | Gentilello et al, 1999 |
| Hospital ER screening | **Reduced DUI arrests**<br>**1 DUI arrest prevented for 9 screens** | Schermer et al, 2006 |
| Physician offices | **20% fewer motor vehicle crashes over 48 month follow-up** | Fleming et al, 2002 |
| Meta-analysis | **Interventions reduced mortality** | Cuijpers et al, 2004 |
| Meta-analysis | **Treatment reduced alcohol, drug use**<br>**Positive social outcomes: substance-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems (e.g., driving under the influence)** | Burke et al, 2003 |
| Meta-analysis | **Interventions can provide effective public health approach to reducing risky use.** | Whitlock et al, 2004 |

# Screening, Brief Interventions for Alcohol: Saves Healthcare Costs

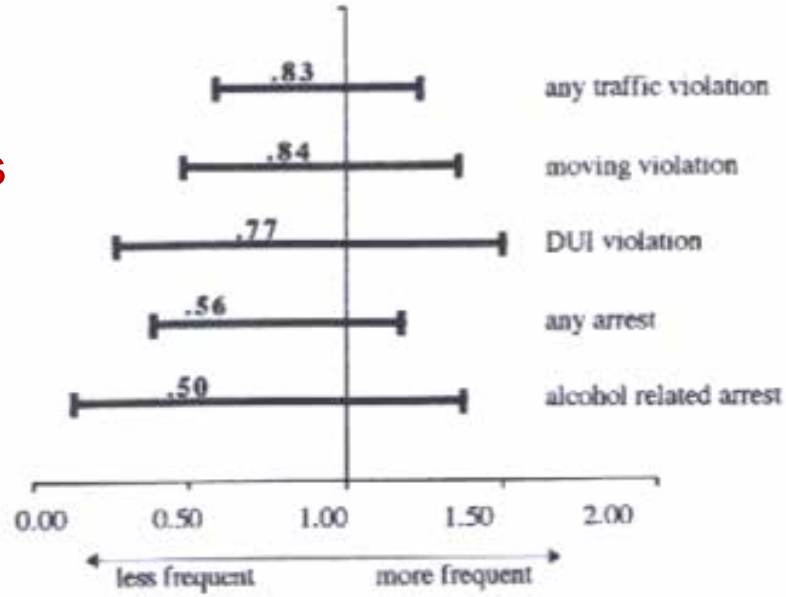
| Study | Cost Savings | Reference |
|---|---|---|
| Randomized trial of brief treatment in the UK | **Reductions in one-year healthcare costs** ***$2.30 cost savings for each $1.00 spent in intervention*** | (UKATT, 2005) |
| Project TREAT (Trial for Early Alcohol Treatment) randomized clinical trial: Screening, brief counseling in 64 primary care clinics of *nondependent alcohol misuse* | **Reductions in future healthcare costs** ***$4.30 cost savings for each $1.00 spent in intervention (48-month follow-up)*** | (Fleming et al, 2003) |
| Randomized control trial of SBI in a Level I trauma center Alcohol screening and counseling for trauma patients (>700 patients). | **Reductions in medical costs** ***$3.81 cost savings for each $1.00 spent in intervention.*** | Gentilello et al, 2005) |

# Research Base Expanding: SBIRT Effectiveness in Hospitals




**Standard drinks per week**

**Adverse Outcomes Controls *vs.* BI at 1 year**




**47% reductions in injuries requiring ED or trauma admission**

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Gentilello LM, Rivara FP, Donovan DM, Jurkovich GJ, et al: Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. Ann Surg, 1999;230: 473-483.

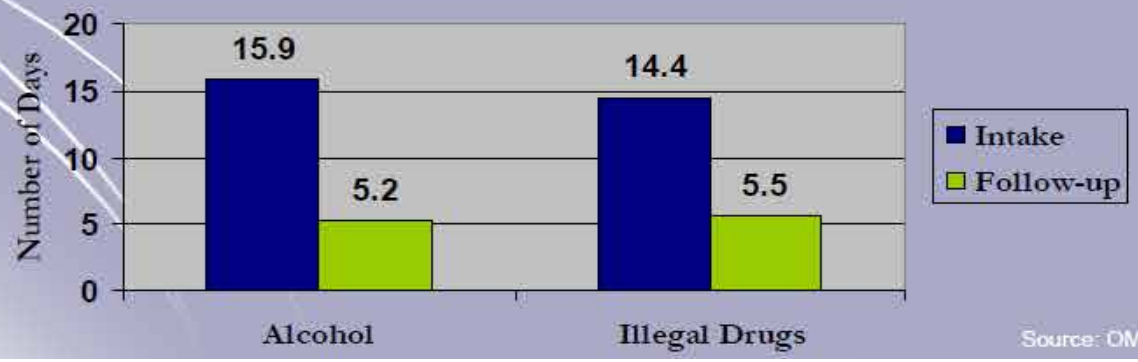
# Practice-based SBIRT Outcomes: Denver Health

Between April 2007 and April 2011 Denver Health hospital staff and health educators have provided SBIRT services to **52,805** patients.

Services Provided at Denver Health:

| | | |
|---|---|---|
| Tobacco Intervention | 13,448 | - 28% |
| **Brief Intervention (at-risk)** | 7,625 | - 16% |
| Brief Therapy | 1,965 | - 4% |
| Referral to Treatment | 1,643 | - 3% |
| Screening & Feedback | 24,091 | - 49% |

Average Number of Days of Use in the Past 30 Days at Intake and at Follow-up (6 Months Later)




Source: OMNI Institute, 2011

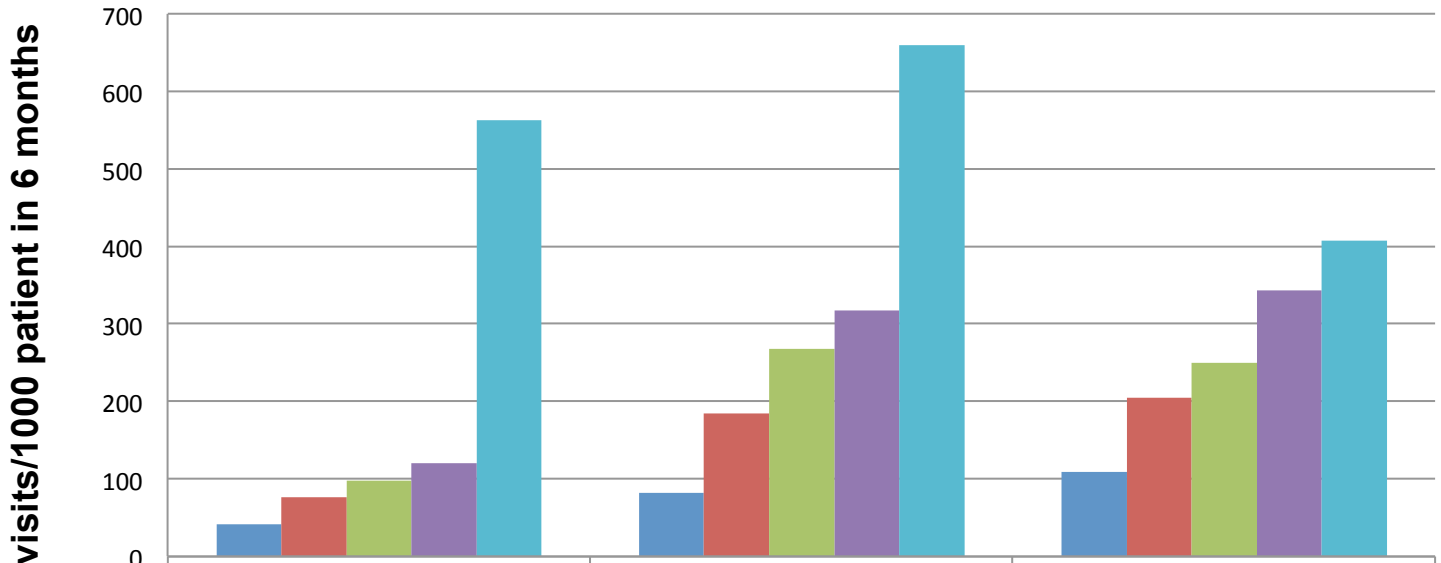
# Effectiveness of medical treatment of substance use that convinces payers: Data from a major health insurer's claims

| | Vivitrol | Acamprosate | Disulfram | Naltrexone |
|---|---|---|---|---|
| BH IP Days/1000 | -30% | -33% | -38% | -31% |
| Medical IP Days/1000 | -76% | -57% | -49% | -67% |
| BH IOP Days/1000 | 29% | 97% | 42% | 48% |
| Psychiatrist Visits/1000 | 41% | 130% | 36% | 133% |
| Psychotherapy Visits/1000 | 93% | 56% | 49% | 85% |
| ER Visits/1000 | -13% | 12% | 0% | 12% |

know®

**16 to 35% Net Medical Cost Savings**

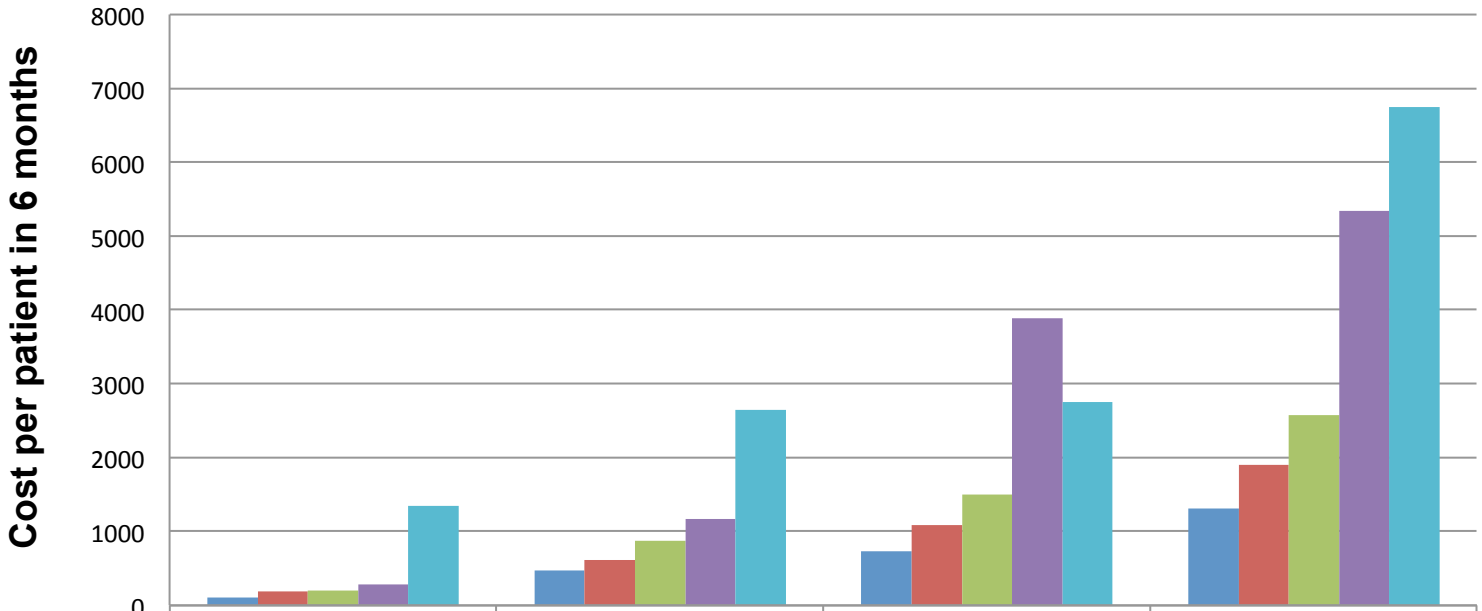
# Inpatient Utilization per 1,000 Alcohol-Dependent Patients in 6 months following diagnosis




| | Detox/Rehab | Alcohol-related Inpatient | Non-alcohol-related Inpatient |
|---|---|---|---|
| Depot NTX | 42 | 82 | 109 |
| Oral NTX | 76 | 184 | 205 |
| Disulfiram | 98 | 268 | 250 |
| Acamprosate | 120 | 317 | 343 |
| Drug-free | 563 | 660 | 407 |

Baser O, Chalk M, Fiellin DA, Gastfriend DR. Alcohol dependence treatments: comprehensive healthcare costs, utilization outcomes, and pharmacotherapy persistence. Am J Manag Care. 2011:17(8);S222-234.

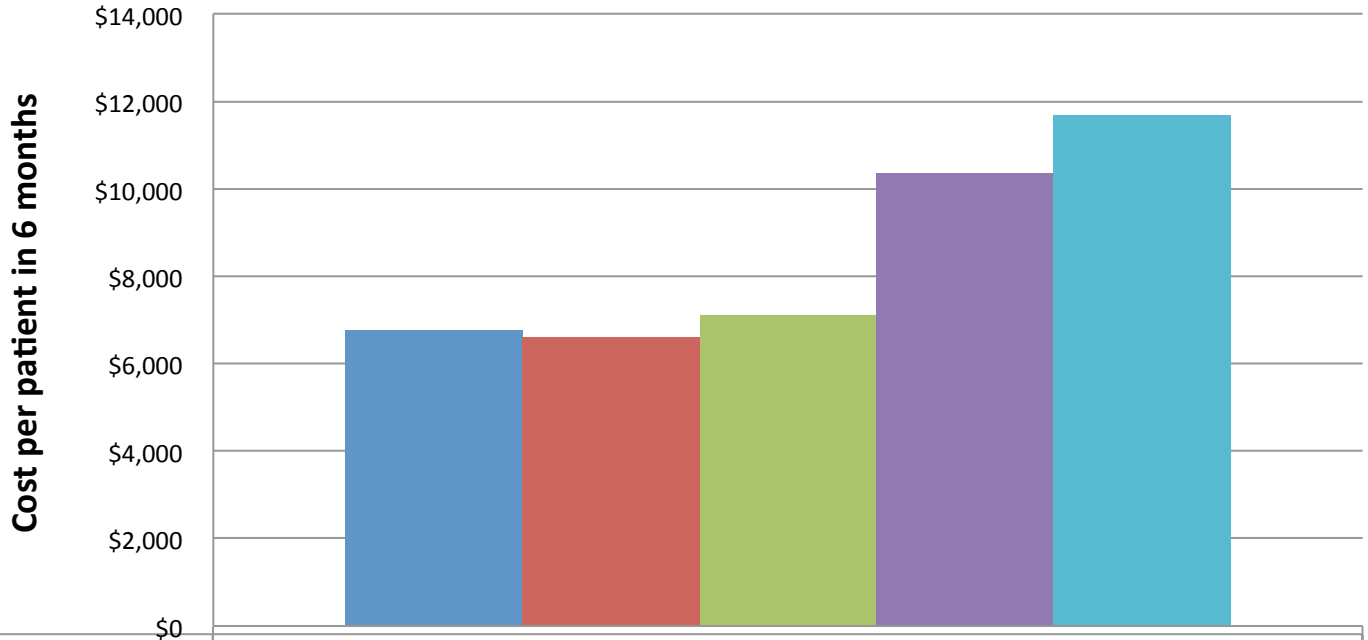
# Inpatient Cost/Alcohol-Dependent Patient in 6 months following diagnosis




| | Detox/Rehab | Alcohol-related Inpatient | Non-alcohol-related Inpatient | Total Inpatient |
|---|---|---|---|---|
| Depot NTX | 105 | 474 | 730 | 1309 |
| Oral NTX | 192 | 618 | 1092 | 1902 |
| Disulfiram | 203 | 874 | 1498 | 2575 |
| Acamprosate | 288 | 1168 | 3885 | 5341 |
| Drug-free | 1350 | 2646 | 2751 | 6747 |

Baser O, Chalk M, Fiellin DA, Gastfriend DR. Alcohol dependence treatments: comprehensive healthcare costs, utilization outcomes, and pharmacotherapy persistence. Am J Manag Care. 2011:17(8);S222-234.

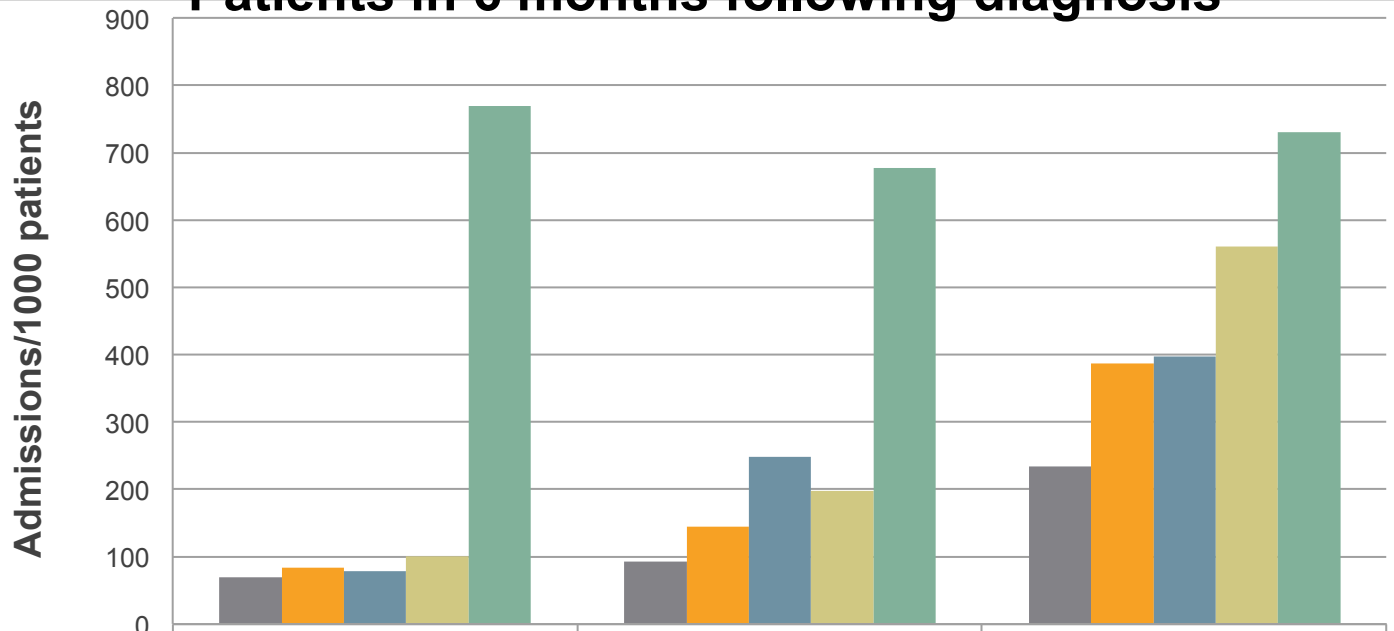
# Total Cost/Alcohol Dependent Patient in 6 months following diagnosis




| | |
|---|---|
| Depot NTX | $6,757 |
| Oral NTX | $6,595 |
| Disulfiram | $7,107 |
| Acamprosate | $10,345 |
| Drug-free | $11,677 |

Baser O, Chalk M, Fiellin DA, Gastfriend DR. Alcohol dependence treatments: comprehensive healthcare costs, utilization outcomes, and pharmacotherapy persistence. Am J Manag Care. 2011:17(8);S222-234.

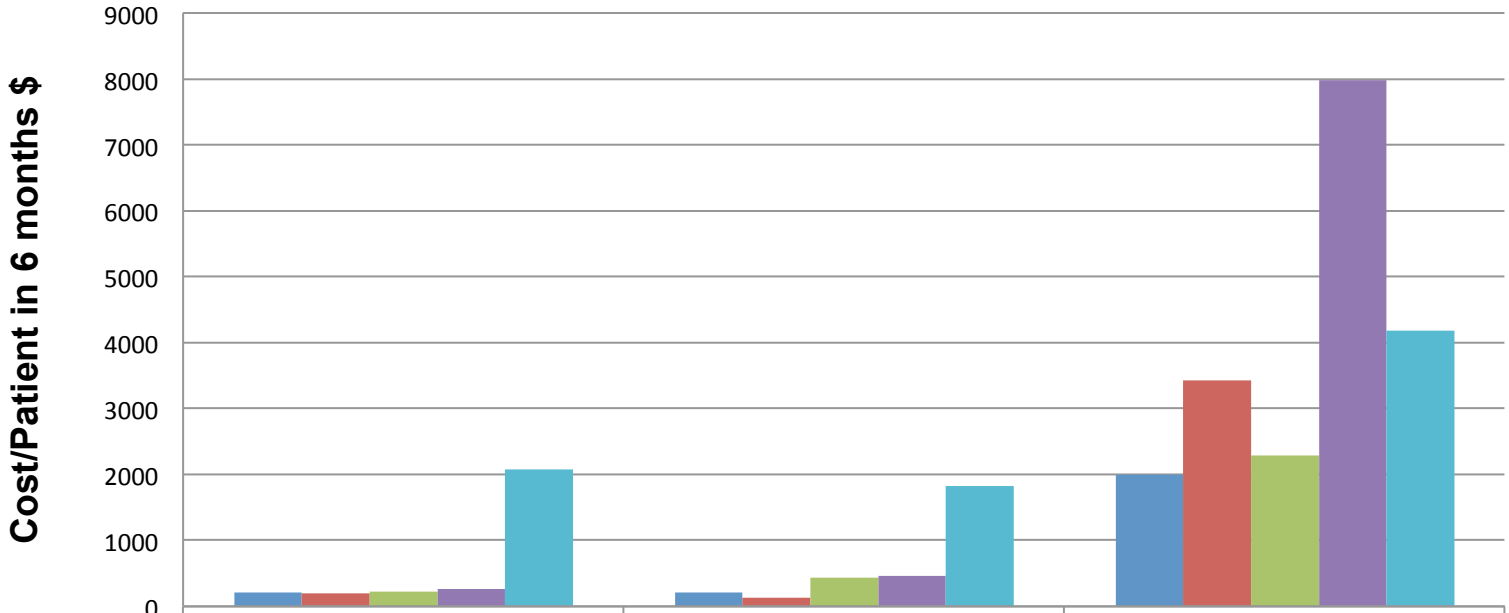
# Hospital Admissions/1000 Opiate Dependent Patients in 6 months following diagnosis




| | Detox/Rehab | Inpatient -Opiate | Inpatient -Other |
|---|---|---|---|
| Depot NTX | 69 | 93 | 234 |
| Oral NTX | 84 | 145 | 387 |
| Bupe | 79 | 249 | 397 |
| Meth | 101 | 198 | 561 |
| Drug-free | 770 | 677 | 731 |

Baser O, Chalk M, Fielin DA, Gastfriend DR. Cost and utilization outcomes of opioid-dependence treatments. Am J Managed Care, 2011:17(6);S235-248.

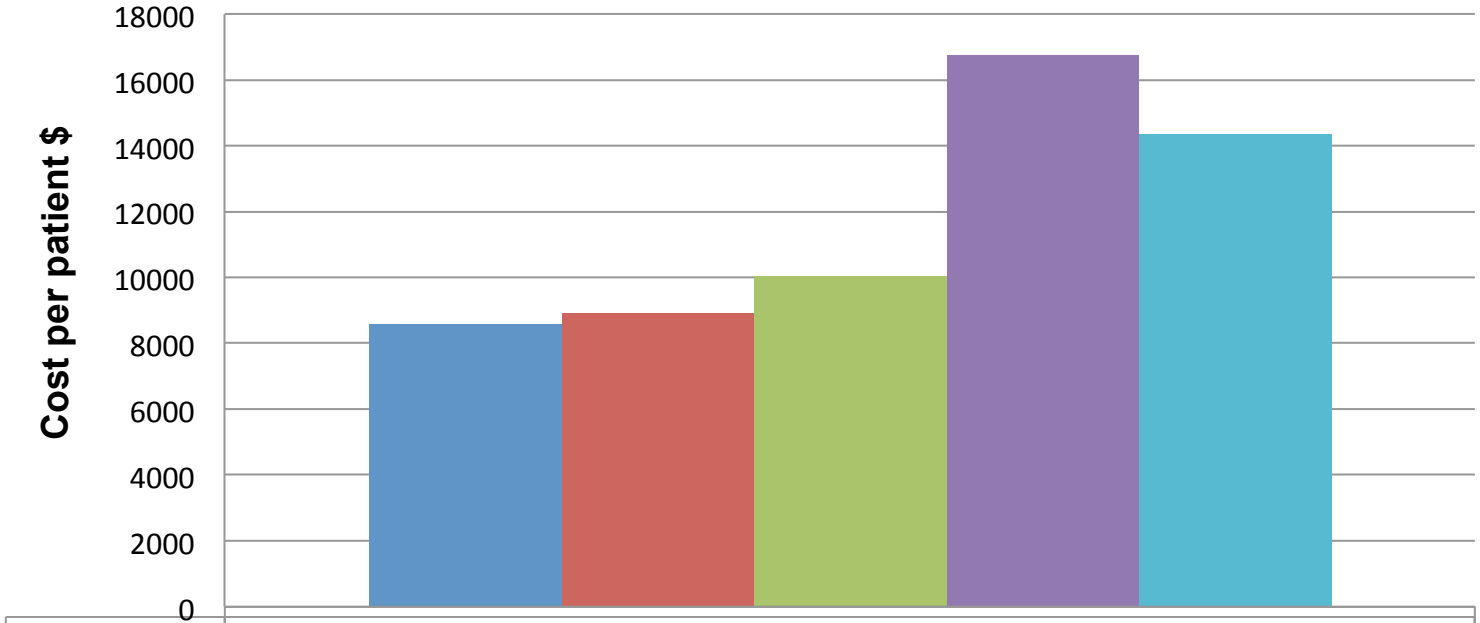
# Inpatient Costs/Opiate-Dependent Patient in 6 months following diagnosis




| | Detox/Rehab | Inpatient -Opiate | Inpatient -Other |
|---|---|---|---|
| Depot NTX | 216 | 213 | 2003 |
| Oral NTX | 193 | 137 | 3428 |
| Bupe | 219 | 440 | 2290 |
| Meth | 264 | 457 | 7976 |
| Drug-free | 2082 | 1823 | 4184 |

Baser O, Chalk M, Fielin DA, Gastfriend DR. Cost and utilization outcomes of opioid-dependence treatments. Am J Managed Care, 2011:17(6);S235-248.

# Total Cost/Opiate Dependent Patient in 6 months following diagnosis




| | |
|---|---|
| Depot NTX | 8582 |
| Oral NTX | 8903 |
| Bupe | 10049 |
| Meth | 16752 |
| Drug-free | 14353 |

Baser O, Chalk M, Fielin DA, Gastfriend DR. Cost and utilization outcomes of opioid-dependence treatments. Am J Managed Care, 2011:17(6);S235-248.

# SBIRT Reimbursement: Improving

http://www.sbirtoregon.org/

**Medicaid (Oregon Health Plan)** | Medicare | Commercial | Clinician notes

| Service | Code | Reimbursement amount | Description |
|---|---|---|---|
| Full screen only | 99420 | $7.23 | • Administration and interpretation of the AUDIT or DAST screening tool, or other approved screening tools (see notes below). |
| Full screen + brief intervention | 99408 | $26.43 | • 15 - 30 minutes of aggregate personnel time administrating and interpreting the full screen, plus performing a brief intervention. |
| | 99409 | $51.75 | • Same as above, only greater than 30 minutes |

**Who can bill?**

- DO; MD; PA; NP; RN; LPN
- And other individuals, if the billing provider is a MD or DO
  This follows "Incident to" rules and must be signed by the billing provider:
  - For example, a LCSW or CADC would be the service provider, while the MD or DO would be the billing provider.
  - "Incident to" rules loosely defines that a PCP has already seen and established care with the patient.
  - Supervised means there is a physician present at the facility who can be readily present. The physician does not have to be in the exam room.
  - Usually the claims will leave a primary care office with the person who provided the service (rendering) and a primary care doctors name as the billing provider.

**Notes**

- Other screening tools eligible for 99420 include the AUDIT-C, ASSIST, CAGE- 4, TWEAK and T-ACE, CRAFT, DUDIT, and GAIN.
- Oregon Health Plan members enrolled with state Managed Care Organizations, e.g., CareOregon, may see reimbursement rates that vary.

# Reimbursement: Improving

http://www.sbirtoregon.org/

Medicaid (Oregon Health Plan) | Medicare | **Commercial** | Clinician notes

| Service | Code | Reimbursement amount * | Description |
|---|---|---|---|
| Full screen only | 99420 | $18 | • Administration and interpretation of the AUDIT or DAST screening tool, or other approved screening tools (see notes below). |
| Full screen + brief intervention | CPT 99408 | $33.41 | • 15 - 30 minutes of aggregate personnel time administrating and interpreting the full screen, plus performing a brief intervention. |
| | CPT 99409 | $65.51 | • Same as above, only greater than 30 minutes |

**Who can bill?**

- Provider coverage depends on patients' commercial coverage; however, most plans allow coverage by a DO; MD; PA; NP; and Licensed Psychologists.
- Non-physicians are reimbursed for 85% of the amounts shown above.
- These codes may be reported to commercial payers that are reimbursing for SBIRT services when provided and billed by a credentialed provider.
- Ancillary staff, including health educators, behavioral health councilors, licensed clinical social workers, physician assistants may perform SBIRT services under the supervision of a credentialed provider.
- The services should relate to a plan of care and will require billing under the supervising physician.

# Reimbursement: Improving

http://www.sbirtoregon.org/

Medicaid (Oregon Health Plan) | **Medicare** | Commercial | Clinician notes

| Service | Code | Reimbursement amount | Description |
|---|---|---|---|
| Full screen only | None | | |
| Full screen + brief intervention | G0396 | $29.42 | • 15 - 30 minutes of aggregate personnel time administrating and interpreting the full screen, plus performing a brief intervention. |
| | G0397 | $57.69 | • Same as above, only greater than 30 minutes |

**Who can bill?**

- DO; MD; PA; NP;
- And other individuals, as long as the billing provider is a MD or DO. Non-physicians are reimbursed for 85% of the amounts shown above.
  This follows "Incident to" rules and must be signed by the billing provider:
  - For example, an RN, LPN, LCSW or CADC would be the service provider, while the MD or DO would be the billing provider.
  - "Incident to" rules loosely defines that a PCP has already seen and established care with the patient.
  - Supervised means there is a physician present at the facility who can be readily present. The physician does not have to be in the exam room.
  - Usually the claims will leave a primary care office with the person who provided the service (rendering) and a primary care doctors name as the billing provider.

# Integrating reimbursement into electronic health records
Oregon Health Sciences University EPIC

http://www.sbirtoregon.org/

**Medicaid (Oregon Health Plan)** | **Medicare** | **Commercial** | **Clinician notes**

Mr. Davis was given a _____ screen today.

a) AUDIT b) DAST

His score placed him into the _____ zone.

a) Low risk b) Risky c) Harmful d) Dependent

We did not discuss this further because _____

a) the patient's low risk did not warrant further discussion
b) the patient expressed an unwillingness to do so
c) we ran out of time and scheduled a follow-up visit for further assessment

In discussing this issue, my medical advice was that he _____

a) abstain
b) cut back to no more than 4 drinks in one day and no more than 14 per week (men)
c) cut back to no more than 3 drinks in one day and no more than 7 per week (women or >65)

His readiness to change was X on a scale of 0 - 10. We explored why it was not a lower number and discussed the patient's own motivation for change.

He agreed that he should _____

a) cut back to the advised daily and weekly limits
b) abstain from use
c) _____

AND/OR

We agreed that he would benefit from _____

a) participation in a 12-step program
b) referral to X
c) calling the Oregon helpline to explore further assessment and treatment options (1-800-923-4357)

He will return in X to discuss how he is doing with this plan. In total, _____ minutes of aggregate clinic personnel time was spent administrating and interpreting the screen, plus performing a brief intervention.

a) 15 - 30 b) >30


**Watch how an SBIRT dotphrase automatically populates a progress note in the EPIC system.**

# Other Hospital SBIRT Reimbursement Supports

| Payer | Code | Description | ED Fee Schedule |
|---|---|---|---|
| Commercial Insurance, Medicaid | 99408 | Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min | $85 |
| Commercial Insurance, Medicaid | 99409 | Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min | $185 |
| Medicare | G0396 | Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min | $32 |
| Medicare | G0397 | Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min | $65 |
| Medicare | G0442 | Prevention: Screening for alcohol misuse in adults including pregnant women once per year. (outpatient) No coinsurance; no deductible for patient www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx | $17 |
| Medicare | G0443 | Prevention: Up to four, 15 minute, brief face-to-face behavioral counseling interventions per year for individuals, including pregnant women, who screen positive for alcohol misuse; No coinsurance; no deductible for patient (outpatient) http://www.cms.hhs.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249 | $25 |
| Medicaid | H0049 | Alcohol and/or drug screening (code not widely used) | $24.00 |
| Medicaid | H0050 | Alcohol and/or drug service, brief intervention, per 15 min (code not widely used) | $48.00 |

# Training and implementation support networks

- BIG (Brief Intervention Group) Hospital Network
  - Collaborative
  - More than 200 hospitals participating
  - TA & Training & Mutual Support


  - Monthly calls 218-339-4600  426443#
    - August 20, 2012 from 2pm - 3pm EST
    - September 17, 2012 from 2pm - 3pm EST
  - Eric Goplerud – 301-634-9525 goplerud-eric@norc.org
  - http//hospitalsbirt.webs.com

# Training and implementation support networks

- SAMHSA SBIRT grantees

  Substance Abuse and Mental Health Services Administration SAMHSA

  - 21 states, 17 medical residency training, 15 college campus
  - SBIRT Colorado – Brie Reimann 303.369.0039 x245

- Emergency Nurses Assn SBIRT Mentors
  - 167 ED Sites, 70 Facility Leaders, 265 Nurse Mentees
  - Cydne Perhats 800/900-9659, x 4108


# Accreditation and Performance Metrics

- American College of Surgeons-Committee on Trauma
  - Level I and Level II Trauma Center accreditation includes SBI
  - 203 Level I and 271 Level II Trauma Centers in US Hospitals
- Veterans Health Administration (VA)
  - Mandatory screening for risky alcohol use with AUDIT-C
- Joint Commission for Accreditation of Health Care Orgs
  - Hospital-based inpatient psychiatric services (HBIPS)
    - Mandatory reporting for 320 psychiatric hospitals since 2011
    - Optional for general hospitals with psychiatric units
    - HBIPS 1 – includes alcohol and drug screening

# Joint Commission: Substance Use Measures (SUB 1-4) Expectations for CMS IPPS 2014

- 4 hospital tobacco and 4 substance use SBIRT measures

  Adopted by TJC 2011 as reportable measure sets for accreditation NQF review 2012, additional data submitted fall 2012

- CMS Inpatient Prospective Payment System Rule (IPPS)

  "Once the e-specifications and the EHR-based collection mechanism are available for the smoking and alcohol cessations measures developed by TJC, we intend to propose two TJC smoking and alcohol cessation measure sets for inclusion in the Hospital IQR Program." (p. 715)


Federal Register, 42 CFR Parts 412, 413, 424, et.al. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates, May 11, 2012:77(92) Part II. http://www.gpo.gov/fdsys/pkg/FR-2012-05-11/pdf/2012-9985.pdf

# SUB-1 Alcohol Use Screening

- Numerator: The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking

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

- Key Point: Validated Questionnaire
  - Instrument that has been psychometrically tested for reliability, validity, sensitivity, and specificity. AUDIT, AUDIT-C, ASSIST. CAGE not recommended

# SUB 2: Alcohol Use Brief Intervention Provided or Offered

- 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.
- Key Point: Components
  - Feedback on use compared with national norms
  - Discussion of consequences of use
  - Joint decision making re: plans for follow-up

# SUB 3 Substance Use Disorder Treatment Provided or Offered at Discharge

- Numerator: The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder **OR** received or refused a referral for addictions treatment.

- Denominator: The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder

- Key Point: TJC now testing SUB-3 in hospital selected services rather than whole hospital.

# SUB-4 Alcohol & Drug Use: Assessing Status After Discharge

- Numerator: The number of discharged patients that are contacted within 30 days after hospital discharge and follow-up information regarding alcohol or drug use status is collected.

- Denominator: The number of discharged patients 18 years of age and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug use disorder during their hospital stay

- Key Point: TJC now testing SUB-4 only for patients identified in SUB-3 – patients with a substance use disorder

# Developments: Looking into the near future

- Standardization of SBIRT
  - Screening, prescreening measures
  - Link with standard protocols for other routinely performed
  - Competencies and processes generalizable
  - Professional standards – nursing, social work, medicine
- Training availability
  - Remote - MedRespond
  - Discipline specific – SBIRT Colorado leading
  - Competency standards
- Financial and clinical accountability
  - ACO and PCMH
  - Incentives through IPPS, bundled payment

# Developments

- EHRs and HIEs
  - Prescreening and management to avoid surgical complications
  - Avoid drug drug interactions
  - Avoid risk potentials with opioids, other psychotropics
- Research
  - Hospital SBIRT, Hospital SBIRT with community linkages
  - Drug SBIRT
  - Nurse-led hospital SBIRT
  - High risk, high cost inpatients with SUDs
- Community SA treatment infrastructure development
  - Primary care
  - Medical treatment
  - Community BH and FQHCs

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# Thank You!

NORC at the UNIVERSITY of CHICAGO

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