Research shows that the emergency department (ED) can be an effective place to screen and refer patients for substance use services: One study found that 26% of patients screened in the ED exceeded the low-risk limits set by the National Institute of Alcohol Abuse and Alcoholism. This measure will help inform the statewide quality improvement focus area of integrating behavioral and physical health.

As such, this measure tracks screening, brief intervention, and referral to treatment (SBIRT) in the ED. It is in two parts: The first tracks ED patients age 12+ who are screened for alcohol or other substance use and the second tracks whether those who screen positive receive a brief intervention.

**Name and date of specifications used:** This is a non-standard measure the Oregon Health Authority (OHA) developed in collaboration with the Oregon Association of Hospitals and Health Systems (OAHHS), based on recommendations from SAMHSA and CMS. The measure specifications draw from the Joint Commission specifications and learnings from the BIG Hospital SBIRT Initiative and the Boston University BNI-ART Institute.

Additional details are available online at:

- [http://www.bu.edu/bniart/](http://www.bu.edu/bniart/)

SBIRT resources include:

- OHSU’s SBIRT page, which includes SBIRT tools, training curriculum, and videos on implementing SBIRT: [http://www.sbirtoregon.org/](http://www.sbirtoregon.org/)

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• OHA’s SBIRT resource page: http://www.oregon.gov/oha/amh/Pages/SBIRT.aspx

Measure Type:
HEDIS □ Joint Commission □ Survey □ Other ■ Specify: OHA-developed

Data Source²: Hospitals will track these data internally (through electronic health records, chart abstractions, or another manual process). OAHHS will collect these data from DRG hospitals via its online reporting tool and report to OHA.

Measurement Period:

Year 4 Benchmarks
Brief Screen: 83.5% (90th percentile HTPP Year 2 brief screens)
Full Screen: 71.3% (90th percentile HTPP Year 2 full screens)

Important Year 4 Benchmark Notes:

1. Screening Rate. Hospitals can submit either patients receiving the brief screen or the full screen; the associated benchmark then applies (though note hospitals will be held to the benchmark for the screening type submitted in Year 2).

2. Brief Intervention. The brief intervention rate is a reporting requirement, but there is no benchmark that must be achieved in HTPP Year 4. However, hospitals should be prepared for the brief intervention to be factored into the benchmark in future years.

3. Following SBIRT Process. Regardless of the screening rate a hospital chooses to report (brief or full screen), all hospitals are expected to follow proper SBIRT processes. This means patients in the ED should first receive a brief screen. A full screen is then only needed if the brief screen is positive⁷. A brief intervention should then be offered to those who screened positive on the full screen, or, if appropriate, the patient should be referred to treatment (see process flow on page 8-9).

   • In Year 3, five of the six hospitals held to the full screening benchmark were not first conducting a brief screen, instead moving directly to the full screen for all

² OHA reserves the right to contact hospitals directly or through OAHHS with additional questions about data submitted as part of the program. Hospitals must be able to provide documentation of data submitted should it be requested.
patients. Given this, the benchmark is artificially inflated for the hospital implementing SBIRT per the full process. To address this issue in Year 3, the full screen benchmark (90th percentile of HTPP full screening reporting rate) was applied to the five hospitals that were conducting the full screen only. The hospital conducting both the brief and full screens was eligible for payment in Year 3 based upon achievement of an improvement target only (no benchmark). The Minnesota method was not used as it factors in the artificially inflated benchmark. In order to qualify for payment in Year 3, this hospital needed to increase its screening rate by 3 percentage points over Year 2 (this is the improvement target floor).

- In Year 4, OHA will continue to calculate the full screen benchmark as the 90th percentile of the hospitals that are conducting full screens only. However, as these five hospitals change their processes to incorporate a brief screen, they will become improvement target only for Year 4. **This does not impact the hospitals held to the brief screening benchmark.** Any hospital submitting data for the full screen should consult the “SBIRT Guidance Document – Hospitals Submitting Data for Full Screen” document on the HTPP webpage, noting that any changes in processes must be made by **March 2, 2017**.

### Improvement Target

<table>
<thead>
<tr>
<th>Brief Screen: Minnesota method with 3 percentage point floor</th>
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</thead>
<tbody>
<tr>
<td>Full Screen: Minnesota method with 3 percentage point floor</td>
</tr>
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</table>

### Equation

The equation for the screening rate is the number screened / number of patients age 12+ in the ED * 100. **The numerator depends upon the screening type being reported (brief or full screen); the same denominator is used regardless of whether the number of brief or full screens is submitted. See below for details.**

The equation for the brief intervention is the number receiving a brief intervention / number of patients age 12+ screening positive for unhealthy alcohol or drug use on the full screening tool * 100.

### Overview

The Joint Commission measure specifications break down the SBIRT measure into a cascading rate, incorporating a screening rate, followed by brief intervention rate for those who screen

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3 Information on improvement target calculations can be found in the ‘Hospital Improvement Target Brief’, here: [http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx](http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx).
positive, and a treatment provided or offered at discharge rate for those who received a brief intervention.

The Oregon Health Authority (OHA), in partnership with the Oregon Association of Hospital and Health Systems (OAHHS), has developed a measure to address screening and brief interventions provided in EDs, utilizing the cascading rate approach.

Note that while OHA/OAHHS will collect and report data on both the screening and brief intervention rate, only hospital performance on the screening rate is tied to the quality pool payment (“incentivized”) for this measure.

The Joint Commission specifications are focused on alcohol use screening and brief interventions. To align with the CCO SBIRT incentive measure4, the OHA/OAHHS developed measure will address both alcohol and other drug use.

**Data elements required denominator:**

**Screening Rate**

*Unique count* of individuals age 12 years and older with a qualifying ED visit during the measurement period. The individual must be at least age 12 on the date of the ED visit to be included in the denominator. *The same denominator is used regardless of whether a brief or full screening rate is submitted.*

**Brief Intervention Rate**

*Unique count* of individuals age 12 years and older with a qualifying ED visit during the measurement period, who (1) were screened for alcohol and other drug use at their visit, and (2) who screened positive on both the brief and full screening tool7. The individual must be at least age 12 on the date of the ED visit to be included in the denominator.

**Required exclusions for denominator:** Measure set consists of the following:

**Screening Rate:**

Any of the following criteria removes individuals from the denominator:

- Individual refuses to participate
- Situations where the individual’s functional capacity or ability to communicate may impact the accuracy of results of standardized alcohol or drug use screening tools.
- Medical stabilization is the primary function of the ED and treatment must be delivered to obtain that outcome. Therefore, the denominator should exclude individuals where

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4 The CCO incentive measure specifications for SBIRT are available online at:
http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

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time is of the essence and to delay treatment would jeopardize the individual’s health status\(^5\).

To support identification of patients who may need to be excluded from the screening denominator, hospitals may use the Emergency Severity Index (ESI) or similar triage scales\(^6\). Information for ESI inclusion or exclusion in the denominator is provided here as a reference to support hospital reporting; however, as these triage scales require nurse / staff judgment, there is some level of interpretation that will need to be reflected in SBIRT reporting.

ESI acuity level 1 patients should be excluded from the denominator, as they are in an emergent situation where time is of the essence. Patients who are ESI acuity level 2 should be included in the denominator generally (i.e., if the ED is allowing them to wait to be bedded); however, any ESI acuity level 2 patients who are in need of immediate bedding may be excluded from the denominator.

**Brief Intervention Rate:**
No additional exclusions, but note that only individuals who qualified for the screening rate denominator, were screened, and screened positive on both the brief and full screens should be included in the brief intervention denominator.

**Deviations from cited specifications for denominator:**
None.

**Data elements required numerator:** Note the individual’s medical record must provide documentation that these services (screening and brief intervention) were provided. This information must include, at a minimum, the date, the screening tool used, the score, and, as appropriate, the brief intervention provided and any referral to treatment offered.

The measure set consists of the following:

**Screening Rate**
Unique count of individuals age 12 years and older with a qualifying ED visit during the measurement period, with one or more alcohol or drug use screenings using an age-appropriate, validated screening tool approved by OHA (for full list of approved screening tools, see [www.oregon.gov/oha/amh/Pages/eb-tools.aspx](http://www.oregon.gov/oha/amh/Pages/eb-tools.aspx)). The individual must be at least age 12 on the date of the ED visit to be included in the denominator.

Evidence-based alcohol or drug use screening tools include the SBIRT “brief” annual screen, the CRAFFT\(^7\) tool for adolescents, the AUDIT, and the DAST (the CRAFFT, AUDIT, and DAST are “full” screening tools\(^7\)). Experts recommend using the “brief” screening tool to eliminate abstainers

\(^5\) Note that these individuals may be candidates for screening and brief intervention once they are stabilized, but that contact would occur outside the boundaries of this incentive measure (i.e., these individuals should not be counted in the numerator or denominator).


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who rarely or never consume alcohol or use drugs; individuals who screen positive on the “brief” screening tool should then receive the “full” screen to determine those who are at-risk and may require further intervention.

Hospitals can submit either patients receiving the brief screen or the full screen; the associated benchmark then applies (though note hospitals will be held to the benchmark for the screening type submitted in Year 2). However, as part of best clinical practice, hospitals are encouraged to conduct the full screen on anyone screening positive on the brief screen, even if it is reporting the brief screen for the HTPP measure (and as part of the SBIRT process, a full screen should be conducted before offering a brief intervention).

**Note on the CRAFFT adolescent screening tool:** The CRAFFT is a full, rather than “brief” screening tool. While it is a “full” screening tool, there is not an analogous “brief” screening tool for adolescents. Therefore, the CRAFFT can be used as the first line of screening for an adolescent, and a follow-up screening is not needed as part of the SBIRT process; practitioners would proceed directly to the brief intervention for those screening positive for substance abuse. However, as hospitals can report either brief or full screening rates, the CRAFFT can be counted as either a brief or a full screen for numerator credit.

The full list of OHA-approved, evidence-based SBIRT screening tools is available online at [www.oregon.gov/oha/amh/Pages/eb-tools.aspx](http://www.oregon.gov/oha/amh/Pages/eb-tools.aspx).

**Brief Intervention Rate**
Unique count of individuals age 12 years and older with a qualifying ED visit during the measurement period, who (1) were screened for alcohol and other drug use at their visit, (2) who screened positive on both a brief and full screen, and (3) who received a brief intervention. The individual must be at least age 12 on the date of the ED visit to be included in the denominator.

The goal of a brief intervention is to educate patients and increase their motivation to reduce risky behavior. A brief intervention as defined by the SAMHSA SBIRT program involves 1-5 sessions lasting a few minutes to an hour. Examples of brief interventions include assessment of the patients’ commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources.

**Required exclusions for numerator:** None.

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7 Note the CRAFFT for adolescents is an exception here. While it is a ‘full’ screening tool, there is not an analogous ‘brief’ screening tool for adolescents. Therefore, the CRAFFT can be used as the first line of screening for an adolescent, and a follow-up screening is not needed as part of the SBIRT process; practitioners would proceed directly to the brief intervention for those screening positive for substance abuse. However, as hospitals can report either brief or full screening rates, the CRAFFT can be counted as either a brief or a full screen.

8 See SAMHSA’s SBIRT white paper, ‘Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Health’, here: [http://beta.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf](http://beta.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf).
Deviations from cited specifications for numerator: N/A

**Explanation of Exclusions and Deviations**

List other required exclusions and or deviations from cited specifications not already indicated:
N/A

**Additional Notes**

**Additional Notes to Ensure Distinct Counts:** Note that the measure is a **unique** count of individuals seen in a hospital’s ED over the measurement period, and that a patient need only be screened once in the measurement **year** (January 1 – December 31) in order for the hospital to get credit.

Since it is an unduplicated count, patients visiting the ED more than once in the measurement year will only be counted once in the data submitted. Hospitals will receive credit if the patient is screened (and offered a brief intervention, if appropriate) at any visit made to the ED during the measurement year. For example:

- A patient visits Hospital A’s ED twice in HTPP Year 4, but is only screened during the second visit. When data for the measurement year are formally submitted to the OHA, the data must be unduplicated by patient. So, this patient is only counted once in the denominator, and the hospital receives numerator credit since the patient was screened at least once during the measurement year (i.e., this patient is counted once in the denominator and once in the numerator).

- Another patient visits Hospital B’s ED three times in the measurement year, but is never screened. When data for the measurement year are formally submitted to the OHA, the data must be unduplicated by patient. So, this patient is only counted once, but the hospital will not receive credit since the patient was never screened (i.e., the patient is counted once in the denominator, but does not appear in the numerator since she was never screened).

**Patients Screened When Admitted:** Many hospitals also conduct SBIRT screenings for patients who are admitted to the hospital. Such screenings will be treated as follows:

- If a patient who was previously admitted and screened while an inpatient is later seen in the ED, the hospital may **not** count the screening that occurred while the patient was admitted towards the HTPP SBIRT measure. The patient must be screened again as part of the ED visit. For example: Patient A is admitted to the hospital for surgery and stays for five days. During that five-day stay, Patient A is screened as part of the hospital’s inpatient SBIRT process. Patient A is then discharged. Four months later, Patient A
breaks her arm and is seen in the ED. In order for the hospital to receive credit for the HTPP SBIRT measure, Patient A must again be screened as part of her ED visit.

- OHA has also consulted with the Joint Commission regarding how screening in the ED will impact the Joint Commission inpatient metric. Though the HTPP SBIRT in the ED measure only requires one screen during the entire measurement year, the Joint Commission inpatient measure requires a screen for each admission. However, as long as any SBIRT screening that takes place in the ED becomes a permanent part of the inpatient medical record for an admission, the ED screen can be counted for the Joint Commission inpatient screening for that admission.

  o For example: Patient B goes to the ED with respiratory issues and is screened. At that time, Patient B is found to have pneumonia and is admitted. In this instance, the hospital would receive credit for the HTPP SBIRT measure since the patient was seen in the ED and was screened. In addition, the hospital would not need to rescreen Patient B for the Joint Commission inpatient measure so long as the SBIRT screening that took place in the ED is a permanent part of the inpatient medical record for that admission.

  o If Patient B is seen in the ED a month later and is admitted as part of the ED visit, Patient B would not need to be rescreened to receive credit for the HTPP SBIRT measure; however, the Joint Commission inpatient measure would require a separate screening.

  o In addition, if Patient B is later admitted to the hospital (without going through the ED), the Joint Commission inpatient measure requires a separate screening.

SBIRT Process Flow:

Regardless of the screening rate a hospital chooses to report (brief or full screen), all hospitals are expected to follow proper SBIRT processes. This means patients in the ED should first receive a brief screen. A full screen is then only needed if the brief screen is positive for risky drug or alcohol use. A brief intervention should then be offered to those who screened positive on the full screen, and, if appropriate, the patient should be referred to treatment. See process flow overleaf (though note exception regarding CRAFFT adolescent screening tool outlined below process flow):

**SBIRT Process Flow: (continued overleaf)**
The diagram below shows the accepted process for implementing SBIRT, regardless of setting:

1. **Conduct Brief Screen Using Approved Screening Tool**
   - **Does patient screen positive for drug/alcohol misuse on brief screening tool?**
     - **Yes**
       - **Conduct Full Screen Using Approved Screening Tool**
       - **Does patient screen positive for drug/alcohol misuse on full screening tool?**
         - **Yes**
           - **Offer brief intervention or, if appropriate, refer to treatment**
         - **No**
           - **End. No need for additional screening or interventions (though positive reinforcement should be provided)**
     - **No**
       - **End.**

**Note on the CRAFFT adolescent screening tool:** The exception to the above is the CRAFFT adolescent screening tool. CRAFFT is a full, rather than “brief” screening tool. While it is a “full” screening tool, there is not an analogous “brief” screening tool for adolescents. Therefore, the CRAFFT can be used as the first line of screening for an adolescent, and a follow-up screening is not needed as part of the SBIRT process; practitioners would proceed directly to the brief intervention for those screening positive for substance abuse. However, as hospitals can report either brief or full screening rates, the CRAFFT can be counted as either a brief or a full screen.