

## SBIRT Workgroup

May 30, 2014

Notes

### **Attending**

Jim Winkle (OHSU), Helen Kurre (Providence), Lynnea Lindsey (Trillium), Dominique Buele (Providence), Jennifer Murphy (Mosaic), Debbie Dobkins (St Charles), Dan Toma (Moda), David Dorr (OHSU), Sarah Dryfuss (OPCA), Lizzy Randleman (PacificSource), Ariel Singer (OPCA), Graham Bouldin (Health Share).

OHA staff: Sarah Bartelmann, Nicole Corbin, Pam Martin, Stefanie Murray, Crystal Nielson, Michael Oyster.

### **SBIRT in the Emergency Department**

The Oregon Hospital Performance Metrics Advisory Committee is tasked with establishing measures and quality pool methodology for hospitals. One measure currently on the table is SBIRT in Emergency Department settings – does the SBIRT workgroup have any input on a recommended benchmark?

- Will the hospitals be using the full screening rate as the performance measure? Undecided.
- Is anyone in Oregon measuring this that we could use to get a baseline?
  - Boston University: Project Assert is focusing on linking SBIRT and ED.

### **Update on federal measure development work**

Original goal for today was to review a draft human readable form of the electronic clinical quality measure (eCQM) for SBIRT, but learned that there is a federal project (partnership between SAMHSA and the Office of the National Coordinator for Health Information Technology) to develop eCQM for SBIRT. Would be great to align with these efforts to the extent possible, so would like to work with federal partners to access their draft measurement before we develop anything further in-state.

### **Group discussion on e-measure specifications**

Would like to walk through some decision points regarding SBIRT measure specifications, gather feedback and can then use to adapt the federal specifications in development, or further develop our own in-state specifications.

*Expand SBIRT measure to include tobacco and prescription drug use?*

- We have not tried to include misuse of prescription drugs in SBIRT implementation, but have included tobacco. FQHCs already measure this through UDS reporting. Also note the workflow is slightly different: SBIRT calls for brief annual screening with appropriate follow up but tobacco use screening should occur at every visit.
- Do not recommend adding prescription drug use to the SBIRT protocol. We know that it is a significant public health issue in Oregon, so even though there are legitimate reasons to not add it now, we should keep this on the table for future development.
- From a population health perspective, it makes sense to monitor prescription drug misuse, but this will cause implementation problems for SBIRT. What are the ramifications of

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adding to the measure? Overall we didn't perform well this year, so okay to expand direction?

- In support conceptually, but need to think about how a pre or other screening capture prescription drug misuse.
- Support screening for these issues together, makes sense for clinic workflow, but in terms of the measurement, tobacco use is mandatory meaningful use measure and the data will be captured elsewhere in the EHR. We may be able to combine SBIRT with depression screening and prescription drug misuse, but there will be challenges with documentation in the electronic medical record.
- We need to move to comprehensive wellness assessments, but if we are still trying to report data on a FFS billable code basis, the situation is complicated.

#### *Lowering the age from 18 years and up to 12 years and up*

- Age 12 seems low. Could we move it to age 16+?
- Age 12 was most likely chosen because CRAFFT screening begins at age 12.
- For clinics that have already implemented SBIRT, who are they screening, or would the lowered age be new implementation?
  - Not aware of any FQHCs conducting SBIRT <18, but there are talks with NARA about lowering the age for high risk populations. Support lowering to age 12 for high risk population, but 12 may be too young for a lower risk population.
  - Weigh the benefit of early detection.
  - There is interest in Portland area clinics in lowering the age / implementing CRAFFT for 12+. This aligns with adolescent well child visits and helps refine engagement with adolescents.
  - Trillium is using this as an incentive metric for pediatric practices – use CRAFFT and screen adolescents.
  - OHA could run the 2013 data to see how many 12+ are picked up in the data.
  - St Charles started with age 18 because of the CCO measure specifications. Now that providers are aware of the CRAFFT screening, there is interest in implementing for adolescents, but waiting until we have to.
- Performance challenges with the measure as currently written – we haven't figured out how to do this well in the adult population. Will we dilute the ability to make progress on improving the measure if we expand the denominator by adding adolescents?
  - Recommend separate rates: one for adults and one for adolescents.

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- Phase in SBIRT for adolescents. Do not add to the specifications for 2015, 2016 is more reasonable.
- Note the technical expert panel did recommend screening for adolescents but with a different NQF measure: risky behavior screenings (bundled). It would be interesting to know why federal partners selected completely different approach to this measure.

#### *One rate (grouped) versus multiple rates (cascading)*

- In favor of cascading rates – if nothing else, it feels better to get 80% or 90% rather than 13%. Cascading rates would also provide a richer data set. If you compare the percent of people that received an initial screen with those receiving the full screening, in theory that gives you information about the number of people who qualify based on risky behavior. This can provide better comparisons across populations.
- From a population health impact perspective, cascading rates is a better measurement. If you are only incenting the full screen and the goal is 13%, you might have providers only conducting screening with people who seem like they are substance users. Clinics conducting full screenings with everyone to get credit for the measure is neither patient centered nor clinically appropriate.

If you are looking only at universal brief screening, than you will catch those people with risky behavior. Cascade rates also gives you more granular performance data.

- Often when new eQMs are developed, allow people to still submit the older code-based version of the measure. Cascading rates would be stepping away from any claims based measurement / discarding the previous approach. This could cause more friction for those who are eager to improve but are focused on CPT codes for documentation.
- Cascading rates is more complicated to measure, more mapping in the EHR. Will also to difficult to set appropriate benchmarks.
- If selecting cascading rates, how will the measure be incentivized? Select one of the multiple options, require some level of performance on all rates, or some kind of aggregate score?

#### *Documenting brief interventions*

- If including brief interventions in the measure, need to have some measure of accountability. OHSU has a flow sheet that says “brief intervention was done” but mostly in the chart notes. For the measure, we need to determine what counts as brief intervention – level of the CPT code, audited billing, etc. Does a certain amount of time need to be spend on the intervention? The goal is to have the intervention completed regardless of the time spent. Would advocate for any kind of indication that can be pulled out of the EMR in a structured form. Can look at SNOMED concepts for brief intervention.
- Look at depression screening and follow up plan measure for parallels – if the follow up / brief intervention is recorded in the EHR in some kind of structured narrative note (e.g., talked to patient about x). This can work, but criticism of the measure due to challenges in capturing the details.

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#### *Other potential modifications?*

- If expanding SBIRT to include tobacco and prescription drug use, combined with the question about cascading rates, what is the intersection? If tobacco screening is conducted at every visit and SBIRT is annual, how would that roll up?
  - Diabetes measure example: record the A1c rate / process on the last screening.
  - Would we want to say that “all of these things should happen” to get credit, or would we want each rate measured separately?
    - We are still trying to get the plane off the ground – be careful when we think about adding to the measure.
    - Agree. Wait to add tobacco and prescription drug use. Not aware of the literature supporting adding these components to SBIRT. This is a new program and there is danger of dilution.
    - Agree. Wait to add. Encourage practices to do more of an overall wellness screening and then to use standardized screenings such as SBIRT, CRAFFT, or PHQs. Then incorporate into work flow and develop systematic follow up.

But when you start combining rates (have to have done x, y, and z) that’s very overwhelming. Most EMRs are not set up this way. Even if providers try to do this and collect all the information, if the EMR doesn’t have a sophisticated template, would have to be going to multiple places for all meaningful use documentation.

We can encourage people to not do different screenings for everything. It can be useful to report the sections of the measure separately to know what is going on, but when you start combining rates or incentivizing the combination, that’s a problem. Look at ADHD measure – children who receive follow up at 31-days drop out of the continuation & maintenance rate.

- RE: Smoking and SBIRT. We are talking about moving away from claims data, which is great, but interesting that you can bill a CPT code if you do a brief intervention for smoking that is only 3-10 minutes long, but for alcohol have to spend 15 minutes to use the CPT codes.
- NQF 1507 combines all services: alcohol, drug, tobacco, sexual activity and other substance use (illegal street and prescription misuse). Will run into a problem for tobacco – EMRs have built in codes because tobacco screening is a core meaningful use measure and it will be hard to make changes to incorporate into a combined screening measure.
- As we talk about moving SBIRT to an eQIM, what provisions are we looking at for clinics that are not on an EHR? We would have to have a phased in process, similar to what we did with the existing clinical measures with the proof of concept data? Or would we recommend a hybrid measure? Something for the workgroup to consider in the future.

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- If you collect all data points (cascading rate) you can create a comparable data set to the administrative data and report on the whole population.
- Bring this back for a future workgroup discussion.

**Next meeting**

End of June / early July. Sarah will send Doodle poll to schedule.

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