Alcohol and Drug Misuse

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a workgroup including CCOs and clinics and included clinical piloting. The measure calls for use of standardized assessment tools.

URL of Specifications: N/A. Value sets used in this measure may be accessed through the Value Set Authority Center (VSAC): https://vsac.nlm.nih.gov/.

Measure Type:

HEDIS☐ PQI☐ Survey☐ Other■ Specify: OHA-developed

Measure Utility:

CCO Incentive ■ State Quality ☐ CMS Adult Core Set ☐ CMS Child Core Set ☐
Other☐ Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2020 – December 31, 2020

Benchmark:

	2019	**2020**
Benchmark for OHA measurement year	n/a *	n/a*
Source		

* CCOs must report minimum population threshold and other reporting parameters as specified in OHA reporting guidance to qualify for 100% of quality pool (in addition to meeting 75% of remaining measures).

Changes in Specifications from 2019 to 2020:

- SBIRT Rate 1 uses the same qualifying encounters as CMS2 (depression screening and follow-up). For 2020, there are updates to the depression screening encounter value set.

Value Set Name and OID	Status
Value set Depression Screening Encounter Codes (2.16.840.1.113883.3.600.1916)	Added 11 CPT codes (96105, 96110, 96112, 96125, 96136, 96138, 99078, 99401, 99402, 99403, 99404) and deleted 1 CPT code (96118).
Value set Depression Screening Encounter Codes (2.16.840.1.113883.3.600.1916)	Deleted 10 SNOMED CT codes (108250004, 252592009, 274803000, 30346009, 37894004, 277404009, 43362002, 48423005, 67533008, 91573000).

Denied claims: n/a

Measure Details

Measure Components and Scoring

Two rates are reported for this measure:

(1) The percentage of patients who received age-appropriate screening and

(2) The percentage of patients with a positive full screen who received a brief intervention, a referral to treatment, or both

Screening in an ambulatory setting is required once per measurement year. This measure does not require screening to occur at all encounters.

Rate 1

Data elements required denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

The denominator criteria for SBIRT Rate 1 are identical to the denominator criteria for the depression screening and follow-up measure (NQF0418e/ CMS2v9). Eligible encounters are identified through the Depression Screening Encounter Codes Grouping Value Set (2.16.840.1.113883.3.600.1916).[1]

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received an age-appropriate screening, using an SBIRT screening tool approved by OHA, during the measurement period **AND** had either a brief screen with a negative result or a full screen.

> **Note**: This measure leaves flexibility for clinical preferences on whether to do a brief screen before a full screen. Although a negative brief screen is numerator compliant, a positive brief

[1] Grouping Value Sets are lists of specific values (terms and their codes) derived from single or multiple standard vocabularies used to define clinical concepts (e.g. patients with diabetes, clinical visit, reportable diseases) used in clinical quality measures and to support effective health information exchange. Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/

screen, by itself, is **not** numerator compliant. If a patient has a positive brief screen, then a full screen must be completed for numerator compliance on Rate 1. A full screen is numerator compliant, regardless of the result.

Note: Approved SBIRT screening tools are available on the HSD-Approved Evidence-Based Screening Resources/ Tools (SBIRT) page: https://www.oregon.gov/oha/HSD/AMH/Pages/EB-Tools.aspx . The name of the screening tool used must be documented in the medical record, but it does not need to be captured in a queryable field.

The clinician should interpret the age-appropriate screening tool to determine if the result is positive or negative. Where the screening tool includes guidance on interpreting scores, the clinician should consult that guidance. This is the same approach used to identify positive or negative results for depression screening in NQF0418e/ CMS2. There may be instances in which it is appropriate for clinicians to use their discretion in interpreting whether a result is positive or negative, such as for patients reporting use of topical medicinal marijuana.

Note: The screening(s) and result(s) must be captured as queryable structured data in the EHR. The EHR does not need to capture each response to each question in the screening tool as structured data. It is acceptable to capture the interpretation and the follow-up as structured data, without having a field for each question in the screening tool used. For supporting documentation, keeping a scan or other non-structured documentation of the screening tool (including the name of the screening tool used) is acceptable. The intent of this guidance is that the data elements needed to calculate the measure can be reported out of the EHR, without chart review. OHA does not intend to be prescriptive about how supporting documentation is maintained in a patient's medical record.

Required exclusions for numerator: SBIRT services received in an emergency department (Place of Service 23) or hospital setting (POS 21).

Rate 2

Data elements required denominator: All patients in Rate 1 denominator who had a positive full screen during the measurement period.

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received a brief intervention, a referral to treatment, or both that is documented within 48 hours of the date of a positive full screen.

Note – Brief Intervention: Brief interventions are interactions with patients that are intended to induce a change in a health-related behavior. They are short, one-on-one counseling sessions ideally suited for people who use substances or drink in ways that are harmful or abusive. Examples of brief interventions include assessment of the patient's commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources.

As explained by SAMHSA:

> "Brief interventions are evidence-based practices designed to motivate individuals at risk of substance abuse and related health problems to change their behavior by helping them understand how their substance use puts them at risk and to reduce or give up their substance use. Healthcare providers can also use brief interventions to encourage those with more serious dependence to accept more intensive treatment within the primary care setting or a referral to a specialized alcohol and drug treatment agency.
>
> "In primary care settings, brief interventions last from 5 minutes of brief advice to 15-30 minutes of brief counseling. Brief interventions are not intended to treat people with serious substance dependence, but rather to treat problematic or risky substance use. Skillfully conducted, brief interventions are essential to successful SBIRT implementation. The two most common behavioral therapies used in SBIRT programs are brief versions of cognitive behavioral therapy and motivational interviewing, or some combination of the two."

https://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions

A brief intervention of less than 15 minutes can count for Rate 2 numerator compliance. Because reimbursement codes for brief intervention services may require services of at least 15 minutes, such codes would undercount services that qualify for the Rate 2 numerator. Although clinics may bill for SBIRT services when appropriate, this measure (unlike the earlier claims-based CCO SBIRT measure) does not require use of billing codes to determine whether screening or a brief intervention or referral occurred. Documentation in the medical record (e.g., through checkboxes, flowsheets, or other structured data) that a brief intervention was completed is sufficient.

Note – Referral to Treatment: A referral is counted for Rate 2 numerator compliance when the referral is made. Given the challenges of documenting whether a referral was completed (that is, whether the patient actually saw the provider to whom the patient was referred), numerator compliance is not dependent on referral completion.

Required exclusions for numerator: SBIRT services received in an emergency department or hospital setting.

Denominator Exclusions and Exceptions – Rate 1 and Rate 2

Required exclusions for denominator: Patients with:

Exclusions	Value Set Name	Value Set OID
Active diagnosis of alcohol or drug dependency	Alcohol and Drug Dependence	2.16.840.1.113883.3.464.1003.106.12.1001
Engagement in treatment	Alcohol and Drug Dependence Treatment	2.16.840.1.113883.3.464.1003.106.12.1005
Dementia or mental degeneration	Dementia & Mental Degenerations	2.16.840.1.113883.3.526.3.1005
Limited life expectancy	Limited Life Expectancy	2.16.840.1.113883.3.526.3.1259

Palliative care (includes comfort care and hospice)	Palliative Care	2.16.840.1.113883.3.600.1.1579

Note: As with the earlier, claims-based version of this measure, SBIRT screening and intervention services are designed to prevent Oregon Health Plan members from developing a substance abuse disorder or for early detection. These services are not intended to treat members already diagnosed with a substance abuse disorder or those members already receiving substance abuse treatment services.

The exclusions for active diagnosis of alcohol or drug dependency, dementia or mental degeneration, limited life expectancy, and palliative care apply if they occur before the qualifying encounter (that is, before a visit that puts the patient in the denominator for Rate 1).

The exclusion for engagement in treatment applies if the patient was engaged in treatment before the qualifying visit and up to one year before the start of the measurement year.

Denominator Exceptions: Any of the following criteria also remove patients from the denominator.

Exception	Grouping Value Set
Patient Reason(s) Patient refuses to participate	Patient Reason refused 2.16.840.1.113883.3.600.791
Medical Reason(s) Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. OR Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium	Medical or Other reason not done 2.16.840.1.113883.3.600.1.1502

Note: For this SBIRT measure, these exclusion criteria may be captured using the SNOMED-CT codes in the value sets listed below *or* otherwise captured in a queryable field, such as a checkbox for noting patient refusal of screening. In other words, as the measure steward for this CCO SBIRT measure, OHA uses the same concepts but is less stringent than the measure steward for the depression screening and follow-up measure (NQF0418e/ CMS2) about how data is captured for these denominator exceptions.

Note: These exceptions could be applied at different points in the SBIRT process. For example, if the patient refuses screening at any point before the needed screening is completed, the patient would be excepted from Rate 1. Because a positive full screen is required for a patient to be counted in Rate 2, a patient who is an exception for Rate 1 would not be counted in Rate 2.

- Patient refuses brief screen. = Exception. Patient is not counted in rate 1.

- Patient completes brief screen, which is negative. = Process complete, and patient is numerator compliant for Rate 1.
- Patient completes brief screen, which is positive. Patient then completes full screen. = Process complete for rate 1, and patient is numerator compliant. (If full screen is positive, proceed to evaluate brief intervention or referral for rate 2.)
- Patient completes brief screen, which is positive. Patient then refuses full screen, either before starting or partway through. = Exception. Patient is not counted in rate 1.
- Patient completes full screen, which is positive. Patient then refuses brief intervention or referral to treatment. = Patient is numerator compliant for rate 1 but is not counted for rate 2.

Deviations from cited specifications for denominator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: For now, OHA does not use continuous enrollment criteria for EHR-based measures; the "eligible as of the last date of the reporting period" rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/
- CMS/ ONC eCQI Resource Center: https://ecqi.healthit.gov/
- Year Eight (2020) guidance will be available online at: http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Version Control

1/28/2020: Added clarifying text on p3 after "Note: The screening(s) and result(s) must be captured as queryable structured data in the EHR." Corrected references to NQF endorsement to NQF0418e and corrected "For more information" section on p6 to refer to Year Eight (2020) guidance.