Appendix B
SCREENING TOOLS

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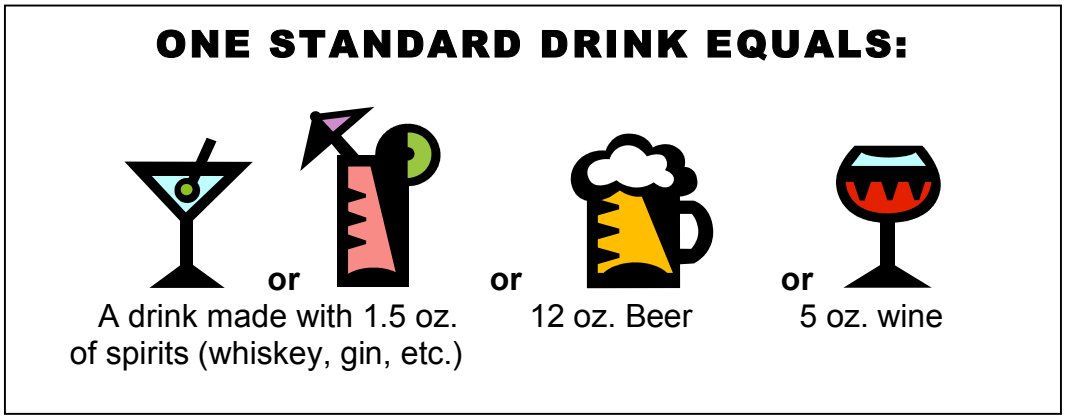
APPENDIX B: ALCOHOL SCREENING TOOLS

The Standard Drink.

Before beginning screening, the health care provider and the patient must both speak the same language regarding alcohol. When referring to "a drink" it is important to clarify what quantity of alcohol one means. In the United States, for the purposes of the screening tools described below, one drink refers to the equivalent of 14 grams of pure alcohol or about 0.6 fluid ounces of pure alcohol. Thus one standard drink is usually one 12 oz beer, one 5 oz glass of table wine, or one mixed drink made with 1.5ozs of spirits.[1]

Figure 1: Standard Drink Sizes, Courtesy Yale Brief Negotiated Interview Manual[2]



The AUDIT-C, the Screening Tool for the IHS-Tribal ASBI Program.

The AUDIT-C is the *highly* preferred instrument for the IHS-Tribal ASBI Program. It is a brief, three question screening tool that has been demonstrated to have high specificity and sensitivity in identifying patients with hazardous or harmful drinking patterns.[3,4] In comparison with longer screening tools or with patient self-report of risky drinking, this method has been shown to effectively recognize most people who misuse alcohol.

The AUDIT-C was derived by taking the first three questions from AUDIT, *The Alcohol Use Disorders Identification Test*[5] that was developed for the World Health Organization. These items query patients regarding their alcohol consumption patterns and are specifically designed to evaluate hazardous alcohol use. As a result, the AUDIT-C is a quick tool for use in an Alcohol Screening and Brief Intervention Program; especially as such programs do not focus on the dependent drinker. The AUDIT-C neither specifically identifies nor excludes the dependent drinker.

Scoring of the AUDIT-C: The AUDIT-C is scored on a scale of zero to twelve; a score of zero reflects abstinence from alcohol.

- In women, a score of four or higher is considered positive.
- In men, a score of five or more is considered positive.

- ∞ Patients with these scores should be offered a brief intervention.
- ∞ Patients with scores below these limits should be offered preventive advice to remain within the low-risk drinking guidelines.
- ∞ For patients who have never been in alcohol treatment, scores of higher than seven are associated with alcohol dependence. These patients should have additional assessment and may need referral to treatment.

It is possible that a person drinking within low-risk limits will screen positive on the AUDIT-C, resulting in a false positive. This most frequently occurs when all of a patient's points come from the first question alone. In this situation, it is advised that the provider review that patient's drinking history over the past several months to review the accuracy of the test. In addition, the screener may wish to proceed to the full AUDIT tool.

The **AUDIT-C** Tool

1. How often do you have a drink containing alcohol?
   - Never (0 pts)
   - Monthly or less (1 pt)
   - Two to four times a month (2 pts)
   - Two to three times a week (3 pts)
   - Four or more times a week (4 pts)

2. How many drinks do you have on a typical day when you are drinking?
   - One or Two (0 pts)
   - Three or Four (1 pt)
   - Five or Six (2 pts)
   - Seven to Nine (3 pts)
   - Ten or More (4 pts)

3. How often do you have five or more drinks on one occasion?
   - Never (0 pts)
   - Less than monthly (1 pt)
   - Monthly (2 pts)
   - Weekly (3 pts)
   - Daily or almost daily (4 pts)

The full AUDIT is a ten question instrument that not only evaluates issues of hazardous alcohol consumption but also symptoms of alcohol dependence and alcohol-related

problems. The tool was developed based on data collected from a large multinational study and focuses on recent symptoms rather than lifetime experiences. The full AUDIT does not take long to administer and can be provided either as a verbal interview or a written questionnaire. It is scored on a scale of zero to forty. If a person scores eight or more, it is an indicator of hazardous or harmful alcohol use and potential alcohol dependence. The World Health Organization has divided AUDIT scores into four risk levels, each with a designated intervention level ranging from alcohol intervention to simple advice to adding a brief intervention to immediate referral to a specialist.[4] Other researchers have decided that all patients with an AUDIT score over eight merits a brief intervention and patients with a score over 16 require referral for treatment.[4]

Screening Adolescents: The CRAFFT Test[6]

Because adolescents have unique social situations and are in different developmental stages, alcohol and drug misuse patterns may not be as easy to identify in this population. The CRAFFT is an alternative tool which screens for alcohol and drug problems by utilizing questions regarding behaviors that are reliable indicators for consumption and risk rather than inquiring directly. It is verbally administered and simple to score. Each yes answer receives one point; a score of two or more indicates a potential problem and the need to proceed to a brief intervention or additional evaluation for treatment.

The CRAFFT Tool

1. Have you ever ridden in a **C**ar driven by someone (including yourself) who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself, **A**lone?
4. Do you ever **F**orget things you did while using alcohol or drugs?
5. Do your **F**amily or **F**riends ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into **T**rouble while you were using alcohol or drugs?

Source: Knight JR, Sherrit L, Shrier LS, Harris SK, Chang G. "Validity of the CRAFFT Substance Abuse Screening Test Among Adolescent Clinic Patients." ***Archives of Pediatrics and Adolescent Medicine.*** **2002; 156(6): 607-614.**

The CAGE: Commonly Used, but Correctly?

The CAGE[7] may be the most commonly used alcohol screening tool. It asks four questions to identify patients with alcohol dependence syndrome and is positive when the answer to two or more questions is "yes." The disadvantage of this tool is that it misses at-risk alcohol and drug use behaviors. In addition, the CAGE questions refer to the patient's lifetime drinking experience and may not capture current behavior.

The **CAGE** Tool

1. Have you ever felt you should **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **G**uilty about your drinking?
4. Have you had an **E**ye opener first thing in the morning to steady nerves or get rid of a hangover?

Source: Ewing JA. "Detecting Alcoholism: The CAGE Questionnaire." *JAMA* 1984; 252(14): 1905 -1907.

To improve identification of patients who are at-risk for hazardous and harmful drinking or drug use, many practitioners add three questions regarding consumption to the CAGE tool. These are similar to the questions asked by the AUDIT-C. If the product of the responses to questions one and two produces a total number of drinks per week exceeding the recommended weekly guidelines (seven for women and 14 for men) or if the response to question 3 is more than zero, the patient is considered positive.

Consumption Questions to Accompany the **CAGE** Tool

1. On average, how many days per week do you have a drink containing alcohol?
2. On a typical day when you drink, how many drinks do you have?
3. How many times in the past year have you had ***X*** or more drinks in a day?

   (X=5 for men; X=4 for women)

Document All Screening

In any program, the purpose of screening is to identify patients with alcohol and drug misuse behaviors so that they may receive additional treatment, whether that is a brief intervention or more intensive care. Consequentially, the results of such screening must be clearly indicated so whoever is to provide the subsequent treatment can locate the patients and offer care. Moreover, scores on tests may then be tracked over time to monitor for changes. For IHS-Tribal ASBI Program, documentation instructions are provided in the Appendix E, which also includes information regarding CPT/HCPCS and GPRA codes.

References

1. National Institute on Alcohol Abuse and Alcoholism. *Helping Patients Who Drink Too Much: A Clinician's Guide*. 2005 Edition. National Institutes of Health Publication No 07-3769. Rockville, Maryland.

2. D'Onofrio G, Pantalon MV, Degutis LC, Fiellin D, and O'Connor PG. *Alcohol Screening and Brief Intervention Project: BNI Training Manual*. New Haven, Connecticut: Yale University School of Medicine, 2002.

3. Bradley KA, DeBenedetti AF, Volk RJ, Williams EC, Frank D, and Divlahan DR. "AUDIT-C as a Brief Screen for Alcohol Misuse in Primary Care." *Alcoholism Clinical and Experimental Research.* 2007; 31(7): 1208-1217.

4. Bush K, Kivlahan DR, McDonell MB, Fihn SD, and Bradley KA. "The AUDIT Alcohol Consumption Questions (Audit-C): An Effective Brief Screening Test for Problem Drinking." *Archives of Internal Medicine*. 1998; 158; 1789-1795.

5. Babor TF, Higgins-Biddle JC, Saunders JB and Monteiro MG. *AUDIT The Alcohol Use Disorder Identification Test: Guidelines for Use in Primary Care*. Second edition. World Health Organization, Geneva, 2001.

6. Knight JR, Sherrit L, Shier LA, Harris Sk, Chang G. "Validity of the CRAFFT Substance Abuse Screening Test Among Adolescent Clinic Patients." *Archives of Pediatrics & Adolescent Medicine.* 2002; 156: 607-614.

7. Ewing JA. "Detecting Alcoholism: The CAGE Questionnaire." *JAMA* 1984; 252(14): 1905-1907.

Appendix C
CUE CARDS AND PATIENT HANDOUTS

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The **AUDIT-C** Tool

4. How often do you have a drink containing alcohol?
   - Never (0 pts)
   - Monthly or less (1 pt)
   - Two to four times a month (2 pts)
   - Two to three times a week (3 pts)
   - Four or more times a week (4 pts)

5. How many drinks do you have on a typical day when you are drinking?
   - One or Two (0 pts)
   - Three or Four (1 pt)
   - Five or Six (2 pts)
   - Seven to Nine (3 pts)
   - Ten or More (4 pts)

6. How often do you have five or more drinks on one occasion?
   - Never (0 pts)
   - Less than monthly (1 pt)
   - Monthly (2 pts)
   - Weekly (3 pts)
   - Daily or almost daily (4 pts)

Score: Women ≥ **3** or Men ≥ **4** is positive

NIAAA AT-RISK DRINKING

	PER WEEK	PER OCCASION
MEN	> 14 DRINKS	> 4 DRINKS
WOMEN	> 7 DRINKS	> 3 DRINKS
AGE > 65	> 7 DRINKS	> 3 DRINKS

Standard Drink = 14g of pure alcohol

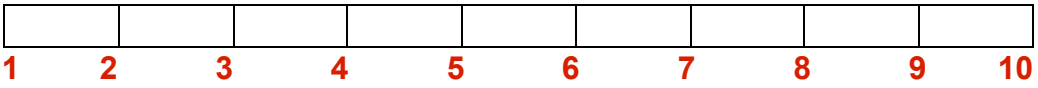
or ONE

1.5 oz of liquor

5 oz glass of wine

12 oz of beer

READINESS TO CHANGE RULER



BRIEF NEGOTIATED INTERVIEW (BNI) STEPS

1. Raise subject	➢ Hello, I am _____. Would you mind taking a few minutes to talk with me about your alcohol use? **<<PAUSE>>**
2. Provide feedback	
Review screen	➢ From what I understand you are drinking [insert screening data]… We know that drinking above certain levels can cause problems, such as [insert facts]…I am concerned about your drinking.
Make connection	➢ What connection (if any) do you see between your drinking and this ED visit? **If patient sees connection:** reiterate what patient has said **If patient does not see connection:** make one using facts
Show NIAAA guidelines & norms	➢ These are what we consider the upper limits of low risk drinking for your age and sex. By low risk we mean that you would be less likely to experience illness or injury if you stayed within these guidelines.
3. Enhance motivation	
Readiness to change	➢ **[Show readiness ruler]** On a scale from 1-10, how ready are you to change any aspect of your drinking?
Develop discrepancy	➢ **If patient says:** **≥2 ask** Why did you choose that number and not a lower one?; **≤1 or unwilling, ask** What would make this a problem for you?…How important would it be for you to prevent that from happening?... Have you ever done anything you wish you hadn't while drinking? Discuss pros & cons.
4. Negotiate & advise	
Negotiate goal	➢ Reiterate what patient says in Step 3 and say, What's the next step?
Give advice	➢ If you can stay within these limits you will be less likely to experience [further] illness or injury related to alcohol use.
Summarize	➢ This is what I've heard you say…Here is a drinking agreement I would like you to fill out, reinforcing your new drinking goals. This is really an agreement between you and yourself.
Provide handouts	➢ **Provide:** - Drinking agreement [patient keeps 1 copy] - Patient general health information handout
Suggest f/u	➢ **Suggest f/u to discuss drinking level/pattern**
Thank patient	➢ **Thank patient for his/her time**

Project ED Health, D'Onofrio, Pantalon, et al. (NIAAA)

Drinking Agreement:

Date _____

I, _____, agree to the following drinking limit:

Number of drinks per week: _____
Number of drinks per occasion:_____

Patient
Signature:_____

Remember: It is never a good idea to drink and drive
It is illegal to drink alcohol if you are under the age of 21.

What to do with Patients whose Screening Test Results are Negative

Provide Feedback about the Results of the Screening Test

Example

"I have looked over the results of the questionnaire you completed a few minutes ago. If you remember, the questions asked about how much alcohol you consume, and whether you have experienced any problems in connection with your drinking. From your answers it appears that you are at low risk of experiencing alcohol-related problems if you continue to drink moderately (abstain)."

Educate Patients about Low-Risk Levels and the Hazards of Exceeding them

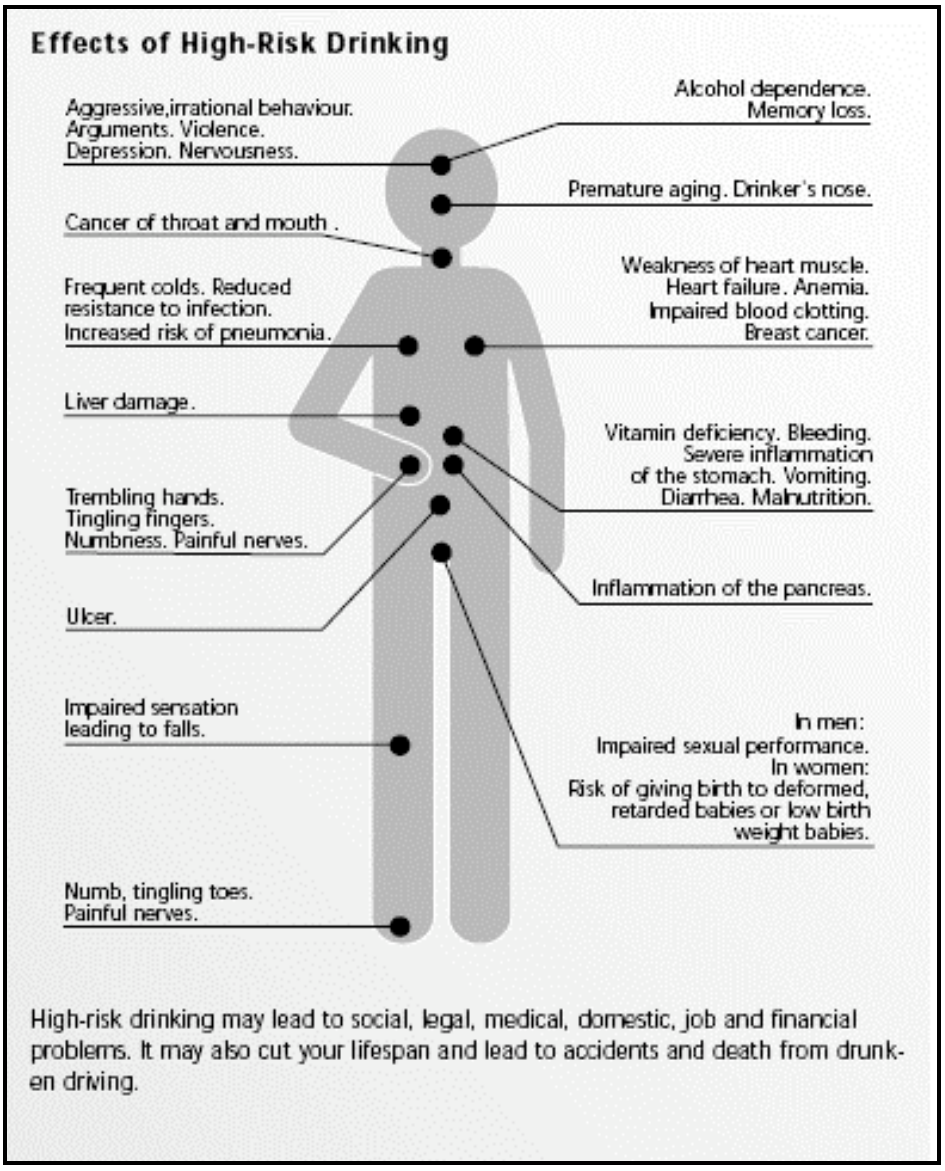
Example

"If you do drink, please do not consume more than two drinks per day and always make sure that you avoid drinking at least two days of the week, even in small amounts. It is often useful to pay attention to the number of 'standard drinks' you consume, keeping in mind that one bottle of beer, one glass of wine, and one drink of spirits generally contain about the same amounts of alcohol. People who exceed these levels increase their chances of alcohol-related health problems like accidents, injuries, high blood pressure, liver disease, cancer, and heart disease."

Congratulate Patients for their Adherence to the Guidelines

Example

"So keep up the good work and always try to keep your alcohol consumption below or within the low-risk guidelines."



Good handout for effects of drinking.

Box 5

The Stages of Change and Associated Brief Intervention Elements[20]

Stage	Definition	Brief Intervention Elements to be Emphasized
Precontemplation	The hazardous or harmful drinker is not considering change in the near future, and may not be aware of the actual or potential health consequences of continued drinking at this level	**Feedback** about the results of the screening, and **Information** about the hazards of drinking
Contemplation	The drinker may be aware of alcohol-related consequences but is ambivalent about changing	Emphasize the benefits of changing, give **Information** about alcohol problems, the risks of delaying, and discuss how to choose a **Goal**
Preparation	The drinker has already decided to change and plans to take action	Discuss how to choose a **Goal**, and give **Advice** and **Encouragement**
Action	The drinker has begun to cut down or stop drinking, but change has not become a permanent feature	Review **Advice**, give **Encouragement**
Maintenance	The drinker has achieved moderate drinking or abstinence on a relatively permanent basis	Give **Encouragement**

Creating Your Habit-Breaking Plan

Reasons for cutting down or stopping drinking

1. _____
2. _____
3. _____

Dangerous Situation 1

_____

Ways of coping:

1. _____
2. _____

Dangerous Situation 2

_____

Ways of coping:

1. _____
2. _____

Dangerous Situation 3

_____

Ways of coping:

1. _____
2. _____

Dangerous Situation 4

_____

Ways of coping:

1. _____
2. _____

Ways of meeting others who don t drink or do so within low-risk limits

1. _____
2. _____

Ways of avoiding boredom to try

1. _____
2. _____

How to remember your plan

1. _____
2. _____

Appendix D
RESOURCES AND LINKS

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APPENDIX D: RESOURCES AND LINKS

Below is an annotated list of websites for additional information regarding Trauma Treatment of Alcohol-Related Injuries, Alcohol Screening, and Brief Motivational Interviewing.

1. Http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf
The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (Second Edition) by Thomas F. Babor, John C. Higgins-Biddle, John B. Saunders and Maristela G. Monteira, published by the Department of Mental Health and Substance Dependence of the World Health Organization in 2001. This is the original manual produced by the World Health Organization that introduces the AUDIT, the Alcohol Use Disorders Identification Test, to identify persons with hazardous and harmful patterns of alcohol consumption. In an easy to read format it provides information ranging from why to screen for alcohol use to how to administer and score the full AUDIT to how to help patients. Their tool is available to download. There is NOT a discussion regarding the usage of just the first three questions as the AUDIT-C.

2. Http://libdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf
Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care by Thomas F. Babor and John C. Higgins-Biddle, published by the Department of Mental Health and Substance Dependence of the World Health Organization in 2001. To be used in conjunction with the AUDIT manual (see #1 above), this manual was developed by the World Health Organization to instruct primary care workers how to conduct brief interventions. Although the IHS-Tribal ASBI Program uses the AUDIT-C for alcohol screening, many other program similarities will be evident. In addition, several patient handouts from this manual are highly recommended.

3. Http://www.niaaa.nih.gov/guide
Helping Patients Who Drink Too Much: A Clinicians Guide, Updated 2005 Edition and an associated instructive power point with slides that can be downloaded and edited are available at this website. In addition, on-line training with free CME/CE credits is available. These basic guides are the foundations for the screening and brief intervention programs that have been developed. Also consider checking out the NIAAA's April 2005, Alcohol Alert #65 for a discussion of various alcohol screening tools, available at:
Http://pubs.niaaa.nih.gov/publications/aa65/AA65.htm

4. Http://www.cdc.gov/ncipc/Spotlight/2003_Alcohol_Conference_Proceedings.htm
The CDC sponsored conference, Alcohol and Other Drug Problems Among Hospitalized Trauma Patients: Controlling Complications, Mortality, and Trauma Recidivism" earned a special issue of the *Journal of Trauma—Injury, Infection & Critical* Care in September 2005 and has been the essential knowledge base for many injury prevention programs. The proceedings of this conference, as published in the Journal, are summarized at this website and available by link.

5. Http://www.mayatech.com/cti/sbitrain07
This is the information page for the American College of Surgeons, Committee on Trauma's Screening and Brief Intervention Trainings. The schedule for their workshops is available on this site. Towards the bottom of the page is the link to the *Committee on Trauma's Quick Guide to Alcohol Screening and Brief Intervention (SBI) for Trauma Patients*. It is also sponsored by NHTSA and SAMHSA.

6. Http://sbirt.samhsa.gov
The Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT) website offers a detailed discussion regarding their version of screening and brief intervention which they call SBIRT: Screening, Brief Intervention, Referral, and Treatment. This webpage has links to a number of other research references. In addition, in the near future they plan to have a link to the CDC's online guide, *Implementing Screening and Brief Interventions (SBI) for Unhealthy Alcohol Use: A Step by Step Guide for Trauma Centers*, which is not yet available.

7. Http://www.nhtsa.dot.gov/people/injury/alcohol/EmergCare/toc.htm
In June 2000, the National Highway Traffic Safety Administration, the American College of Emergency Physicians, and the Emergency Nurses Association sponsored a national conference in Washington, D.C. on *Developing Best Practices of Emergency Care for the Alcohol-Impaired Patient.* This website compiles the detailed recommendations, background research, and goals for future directions. Appendix D also offers sample alcohol screening tools.

8. Http://www.projectmainstream.net/projectmainstream.asp?cid=23
Project Mainstream is administered by the Association for Medical Education and Research in Substance Abuse (AMERSA). The area of interest on this website is the 2005 Syllabus. It was developed by the HRSA-AMERSA-SAMHSA/CSAT Interdisciplinary Faculty Development Program in Substance Abuse Education to provide training materials for health professional faculty to train others to assist in achieving Healthy People 2010 goals regarding substance use and related disorders. From the home page, go to the "Resources Section," then click "Project Syllabus" and select from the Modules. Review both the power point presentation and the accompanying word document. The modules of relevance are Module 3: Screening and Assessment; Module 4: Intervention and Referral, and Module 5: Motivational Interviewing, all written by Richard L Brown, MD MPH. These are user-friendly, easy to digest presentations that walk through each topic and hit all the key points without becoming too dense to read. They include references should more information be desired. Overall they are nicely arranged and taught.

9. Http://www.motivationalinterviewing.org
This website was developed by two of the key founders of the theory, William R Miller Ph.D. and Stephen Rollnick, Ph.D., in cooperation with Motivational Interviewing Network of Trainers and Motivational Interviewing Resources LLC. Under section, "Background," the website provides a nice discussion of what is "Motivational Interviewing," how it began and the philosophy behind it. Also gives instruction on key

techniques and how to avoid traps in performing the technique. In the "Library" section, there are a number of references and detailed how-to manuals. Of greater interest in the library section may be the links to brief transcripts of examples of motivational interviews that have been performed illustrating various common events. These transcripts give insight into the actual experience without having to actually purchase the videos. The "Training" section of the website offers both lists of upcoming training events as well as several worthwhile, detailed, downloadable exercises.

10. Http://www1.alcoholcme.com/PageReq?id=1794:12875
Alcohol CME is funded by the National Institute on Alcohol Abuse and Alcoholism to offer educational programs for physicians and other health professionals about alcohol use disorders and treatment. Registration is free but is required to view the courses and obtain CMEs/CEUs. This particular course, *Motivational Interviewing for Primary Care* introduces the background and technique of motivational interviewing and how it applies not only to alcohol use but also tobacco and other substances. At the end of the course there is an optional section on more advanced techniques. It is approved for one hour of credit.

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Appendix E
DOCUMENTATION & CLINICAL QUALITY PERFORMANCE

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APPENDIX E: DOCUMENTATION & CLINICAL QUALITY PERFORMANCE

Documentation that Alcohol Screening and Brief Intervention have been received by a patient is of great importance not only to ensuring the provision of quality coordinated care and improved health outcomes, but also to the monitoring and evaluation of the ASBI model of care. Initial evaluation activities will focus on the early stages of implementation – primarily the delivery of ASBI services in the Emergency Room setting. Future activities may include the development of clinical performance indicators that measure the reduction in injuries and illnesses achieved as a result of wide deployment of the ASBI model of care. Accurate and consistent documentation of ASBI activities in the patient's medical record is essential to ongoing performance monitoring and program evaluation.

The Resource and Patient Management System (RPMS) is the health information system for the Indian Health Service. It is in wide use at many tribal, urban and federal healthcare facilities. The RPMS Electronic Health System is a Windows-based graphical user interface to RPMS that assists the clinician in managing all aspects of the patient's care. The Clinical Reporting System (CRS) is an RPMS application that is used for reporting of clinical quality measures. The next version of CRS, Version 8.0, will include a new set of measures in a topic entitled *Alcohol Screening and Brief Intervention in the ER*.

The following section provides an overview of the ASBI clinical quality performance measure logic and guidance for documenting ASBI activities in the RPMS EHR. A list of available codes to support billing for ASBI activities is also included.

1. **There will be two main denominators (i.e. the set of visits being reviewed) for this set of measures:**

   - Number of visits for Active Clinical patients age 15-34 seen in the emergency room (ER) for an injury.
   - Number of visits for User Population patients age 15-34 seen in the emergency room (ER) for an injury.

In meeting the denominator definition, the patient must: A) meet the Active Clinical definition or User Population definition and B) must have a visit to the ER for an injury during the report period. The key difference between the two denominators is the Active Clinical definition requires the patient to have two visits to defined medical clinics (i.e. primary care clinics, which does not include the ER) during the past three years, whereas User Population requires only one visit to any clinic in the past three years (which includes ER visits).

2. **The numerators (i.e. the criteria the visits in the denominator must meet) that will be included for each of these denominators are:**

- Number of visits for patients who were screened in the ER for hazardous alcohol use.
  - Number of visits where the patients screened positive.
- Number of visits for patients with a positive screen who were provided a brief negotiated interview (BNI) at or within 7 days of the ER visit.
  - Number of visits for patients who received a BNI at the ER.
  - Number of visits for patients who received a BNI within 7 days of the ER visit.

3. The definitions used in this set of measures are:

- Age of the patient will be calculated as of the beginning of the report period. The report period is any one year period defined by the user.

- Emergency room visit defined with clinic code of 30.

- Injury diagnosis defined with any of the following ICD-9 codes during the report period: primary or secondary purpose of visit (POV) 800.0–999.9 or E800.0-E989.

- Hazardous alcohol screening may be conducted by any provider using a standardized brief alcohol screening instrument, including but not limited to the AUDIT, AUDIT-C (first three questions of the 10-item AUDIT), CAGE, CRAFFT or SASQ (Single Alcohol Screening Question). The ASBI Program recommends the AUDIT, the AUDIT-C or the SASQ for adults and the CRAFFT for adolescents.

  - Screening with a standardized instrument other than CAGE: After the screening is conducted, the screening result is documented in RPMS by selecting the equivalent allowable result available with the generic RPMS Alcohol Screening Exam Code #35. Essentially this means mapping the screening score to positive/abnormal or negative/normal.

For example, a score of 8 or greater on the AUDIT is an indication of alcohol use in excess of low-risk guidelines and the equivalent RPMS screening exam code result would be positive/abnormal.

  - PCC Data Entry: Providers should document the results of screening, the name of the screening instrument used, and a brief comment as needed on the PCC encounter form. Data entry staff can enter this information into RPMS using the “EX” mnemonic for exam code #35. The name of the instrument can be documented in the exam code comment field along with any other comment that the provider documented.

- Electronic Health Record: Providers can enter the results of screening directly into RPMS by selecting the Alcohol Screening Exam Code. Exam codes are often found on the Wellness Tab in the EHR. The name of the screening instrument and any other relevant brief comment can be captured in the comment field.

The AUDIT, AUDIT-C and CRAFFT will be included in the VMEASUREMENTS file with the next release of the RPMS Standard Table updates (anticipated April 2008). VMEASURMENTS are measurements associated with a visit (V) such as height, weight, blood pressure, etc. This will preclude the need to map the results of screening using these tools to the allowable results in the generic alcohol screening exam code.

It is important to remember that the EHR can look different at each facility because of the ability to customize the user visual templates. However, each EHR will have all of the components needed for ASBI – exam codes, measurements, billing codes, etc. EHR Clinical Application Coordinators (CAC) are readily available to assist providers in finding things in the EHR, set up short cuts for documentation, etc.

- PCC Data Entry: Providers should enter this information in the Health Factors section of the PCC encounter form. Data entry staff can then enter this information into RPMS with the "HF" mnemonic and select the appropriate CAGE Health Factor.

- Electronic Health Record: Providers can enter CAGE results directly into RPMS by selecting the appropriate CAGE result. Health Factors are often found on the Wellness Tab in the EHR.

∞ Other Alcohol Screening Codes: The preferred method of documenting screening is with the use of the Alcohol Screening Exam Code or the CAGE Health Factor. These codes capture the fact that a screening was conducted as well as the result of the screening. However, the CRS logic for *patients who have been screened* also includes the following codes if they are present during the report period:

- ICD-9 code: V79.1 Screening for Alcoholism
- CPT code: H0049 Alcohol and/or drug Screening

It is important to note that since the result of screening is not captured with these codes they are *not counted for the positive screen numerator*.

4. Patients with a positive screen are required to have a brief intervention, which is defined as a:

∞ Brief negotiated interview (BNI) conducted either at the ER injury visit or within seven (7) days of the ER visit. The BNI may be conducted by any provider at any face-to-face visit (excludes chart reviews and

telecommunication visits). However, the provider must be trained to provide appropriate alcohol intervention.

A brief negotiated interview at a minimum includes the following activities:

- Raise Subject – Establish rapport and directly, but non-judgmentally, raise the issue of the patient's alcohol use.

- Provide Feedback – Review the results of alcohol screening, comparing quantity and frequency to non-hazardous drinking. Discuss the connection between the use of alcohol and the injury or adverse health consequence(s) that resulted in the hospital or clinic visit.

- Enhance Motivation – Assess the patient's readiness to change using the Readiness to Change scale of 1 – 10 (1 = Ready; 10 = Not Ready). Explore pros and cons if the patient is not ready or is resisting change.

- Negotiate and Advise – Summarize the patient's readiness to change and identify next steps. Explore options and negotiate a feasible plan for treatment when indicated.

- Schedule a follow-up appointment with the patient's primary care or behavioral health provider.

∞ It is very important to clearly document the occurrence of a Brief Negotiated Interview in RPMS using either PCC Data Entry or the Electronic Health Record. This can be done by entering one, or both, of the following codes:

- CPT code H0050 (Alcohol and/or Drug Services, Brief Intervention, Per 15 Minutes) or

- Patient Education code AOD-INJ (Alcohol and Other Drugs – Injury)*

  *This is a new RPMS Patient Education code that will be available in RPMS in April 2008.

∞ If a patient has multiple ER visits for injury during the Report Period, each visit will be counted in the denominator. For the screening numerator, each ER visit with injury at which the patient was screened for hazardous alcohol use will be counted. For the positive alcohol use screen numerator, each ER visit with injury at which the patient screened positive for hazardous alcohol use will be counted. For the BNI numerators, each visit where the patient was either provided a BNI at the ER or within 7 days of the ER visit will be counted. An example of this logic is shown in the table below.

Patient: John Doe Report Period: 01/01/08 – 12/31/08			
ER Visit with Injury	Screen Done	Positive Screen	BNI within 7 Days
07/17/08	Yes	Yes	Yes
09/01/08	Yes	Yes	No BNI
11/15/08	No	No Screen	No BNI
CRS Measure Results			
Denominator Count	Screening Number Count	Positive Screening Number Count	BNI Number Count
3	2	2	1

5. Inclusion in RPMS Clinical Reporting System (CRS) Reports

All of the measures for this new topic will be available in the CRS Selected Measures (Local) Report, and a subset of the measures will be included in the new CRS Other National Measures Report. CRS Version 8.0 is anticipated to be released in April 2008.

It is important to remember that the EHR can look different at each facility because of the ability to customize the user visual templates. However, each EHR will have all of the components needed for ASBI – exam codes, measurements, billing codes, etc. EHR Clinical Application Coordinators (CAC) are readily available to assist providers in finding things in the EHR, set up short cuts for documentation, etc.

Health care practitioners can bill for ASBI activities effective January 1, 2008. The CPT and HCPC codes needed to support documentation and billing for ASBI services are available in RPMS. The newest of these codes, two “G” Medicare codes, are expected to be available in RPMS in April 2008.

The information included in the table below is from The George Washington University Medical Center, Ensuring Solutions to Alcohol Problems website. Practical information for implementation of ASBI, including the “SBI Toolkit for Reimbursement” can be found on the Ensuring Solutions Screening and Brief Intervention webpage: http://www.ensuringsolutions.org/resources/resources_list.htm?cat_id=964

Payer	Code	Description
Commercial Insurance	CPT 99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT, DAST), and brief intervention (SBI) services, 15 - 30 minutes
	CPT 99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT, DAST), and brief intervention (SBI) services, greater than 30 minutes
Medicare	G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and brief intervention, 15-30 minutes
	G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and intervention, greater than 30 minutes
Medicaid	H0049	Alcohol and/or Drug Screening
	H0050	Alcohol and/or Drug Services, Brief Intervention, Per 15 Minutes

Note: It is important to remember that the EHR can look different at each facility because of the ability to customize the user visual templates. However, each EHR will have all of the components needed for ASBI – exam codes, measurements, billing codes, etc. EHR Clinical Application Coordinators (CAC) are readily available to assist providers in finding things in the EHR, set up short cuts for documentation, etc.