APPENDIX F
SBIRT DATA COLLECTION GUIDE

This guide is intended to help your team build a sustainable data collection process in an EHR. Each row is a data field accompanied by a recommended answer format and options, a data description and analysis questions to consider in order to get the most out of the information you collect. Following these fields from top to bottom will take a provider through the SBIRT process of data collection and analysis. Here are some general recommendations to guide your EHR development/modification process:

- It is likely that you are already collecting many of these data points; therefore, **we recommend adding 19 SBIRT-specific data points to your EHR** that are critical to understanding your patient population and quality improvement needs. If resources and capabilities allow, an additional seven data points will further enhance your quality improvement capabilities.
- **Use a drop-down menu of options whenever possible and avoid using freeform text boxes**. This will improve data quality by reducing provider variability and making it as easy as possible to enter data. Drop down options below are suggestions, but do not represent an exhaustive list of options.
- Judicious use of EHR hard stops or a programmable process by which a response is required before a user can move forward with a task. Research shows that hard stops are associated with higher performance on both process and outcomes measures (Powers et. al, 2018). Consider potential unintended consequences including avoidance of hard-stopped workflow, increased alert frequency and delay to care.
- Enable best practice alerts that instruct provider to deliver the appropriate intervention based on the screening results (e.g., if patient screens lowest risk, provide anticipatory guidance).

KEY

Critical SBIRT Data Points (19)
Additional Recommended SBIRT Data Points (7)
Data Points Likely to Be Available Already (15)

- Bold analysis questions should be prioritized.
- Analysis questions with benchmarks are measures that relate to outcomes mentioned in this document.

Data Field (EHR Name)	Answer Options	Data Description	Analysis Questions
Client and Clinic Identification			
Patient ID Number (Datatable.PatientID)	Numerical entry	Unique client ID used to track throughout the SBIRT data process.	**Overall, did adolescents with multiple screening results show decreased risk over time?** Did programs more consistently provide completed screening data over time? Did programs more consistently match the intervention with the screening results over time?
Encounter Date (Encounter.Date)	MM/DD/YYYY	The data of the earliest encounter provided.	
Name of Clinic (Clinic.Name)	Drop Down: Populate this field with clinic names if applicable	Name of clinic where patient is seen.	

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Client Demographics			
Date of Birth (DOB)	MM/DD/YYYY	For the purpose of adolescent SBIRT data tracking and analysis, only patients ages 12-18 should be included in data set.	What demographic characteristics predict risk level? Are there differences in patient SBIRT outcomes when stratified by demographic characteristics?
Gender (Gender.Identity)	Drop Down: Male, Female, Transgender, Other, Unreported/ Refused to Report	It is likely that you are already collecting demographic information for general patient tracking purposes. This data should complement SBIRT-specific data to provide an overall picture of the patient population.	
Race (Race)	Drop Down: American Indian or Alaska Native, Asian, Black or African American, Multiracial, Native Hawaiian or Pacific Islander, White, Other, Unreported/Refused to Report		
Ethnicity (Ethnicity)	Drop Down: Hispanic, Not Hispanic, Unreported/Refused to Report		
Patient best served in language other than English (Patient.Language)	Drop Down: Yes, No, Unreported/Refused to Report		
Sexual Orientation (Sexual.Orientation)	Drop Down: Straight, Lesbian or Gay, Bisexual, Other, Unreported/Refused to Report	Research shows that the odds of substance use for LGB youth are, on average, 190% higher than for heterosexual youth and substantially higher within some subpopulations of LGB youth (340% higher for bisexual youth, 400% higher for females) (Marshal, et. al, 2008).	

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Co-occurring Conditions			
Smoking Status (Smoking.Status)	Drop Down: Currently Smokes, Formerly Smoked, Never Smoked	Evidence suggests that 50-80% of people with mental illness are at significantly higher risk for cardiovascular morbidity and mortality than the general population. Cessation is associated with a roughly 50% decrease in risk of coronary heart disease.	Does the presence of a co-occurring condition predict risk level?
Diagnosis (ICD-10.Code)	Check all that apply: Anxiety (F41), Depression (F32), Bipolar (F31), Schizophrenia (F20), Stress (F43.9), Substance Use Disorder (F19.10), Nicotine Dependence (F17), Asthma (J45), Primary Hypo/ Hypertension (I10-I16), Obesity (E65-E68), Anemia (D50), Diabetes (E08-E13), Migraine (G43), Fluid Electrolyte Acid/ Base (E87.5-6), Other	This is not an exhaustive list. Identify those diagnoses that are most relevant to SBIRT for your organization or include all ICD 10 codes. Diagnosis can be used in analysis of the data to better understand the patient population need.	
Diabetes (A1c)	Numerical entry	Evidence suggests that diabetes in people with mental illness is 2-3 times higher than that of the general population. Monitoring A1c level can help prevent and address diabetes.	
Asthma Diagnosis (Asthma)	Drop Down: Yes, No	Relapse rates for patients with substance use disorders are like those with asthma. Monitoring asthma diagnosis can help prevent relapse in substance use treatment.	
Obesity (BMI)	Numerical entry	People with serious mental illness have higher rates of obesity and some psychotropic drugs have been documented to cause weight gain. Monitoring weight can help prevent and address obesity and associated health issues.	
Depression Screening using PHQ-9 (PHQ)	Drop Down: 1, 2, 3, 4, 5, 6, 7, 8, 9	PHQ-9 rates an individual's level of depression and measures whether the patient's symptoms are responding to treatment.	

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Screening Procedures			
Screening? (Patient.Screen)	Drop Down: Yes, Screening Refused, Provider Unable to Screen	The goal is universal screening at every health maintenance visit. *Consider hard stop*	**What percentage of adolescents have been screened? (Benchmark 90%)** How are screenings being delivered? Does the parent being present at the screening relate to reported risk level?
How was screening administered? (Screen.Admin)	Drop Down: Self-Administered Provider Administered	Did the provider ask the screening questions and record the answers or did the patient read the questions and record the answers?	
Was parent present for screening? (Parent.Present)	Drop Down: Yes, No	If the parent was in the room at the time of the screening, select Yes/No.	
Screening Results			
Screening for tobacco use (Screening.Tobacco)	Drop Down: No Use, Couple of Times, Monthly Use, Weekly Use, Missing Screen	A response of weekly use to any substance equals High Risk for SUD. A response of monthly use to any substance equals Moderate Risk for SUD. A response of "once or twice" to any substance equals Low Risk for SUD. No endorsement of drug use equals Prevention Opportunity. If no screening information is provided value is coded as Missing Screen. *Consider hard stops* *Enable best practice alerts*	**What percentage of adolescents have complete screening data?** What percentage of adolescents are also being given the CRAFFT?
Screening for alcohol use (Screening.Alcohol)	Drop Down: No Use, Couple of Times, Monthly Use, Weekly Use, Missing Screen		
Screening for marijuana use (Screening.Marijuana)	Drop Down: No Use, Couple of Times, Monthly Use, Weekly Use, Missing Screen		
Screening for prescription drugs (Screening. Prescription.Drugs)	Drop Down: No Use, Couple of Times, Monthly Use, Weekly Use, Missing Screen		
Screening for Brief Intervention Result (S2BI.Result)	Drop Down: High Risk, Moderate Risk, Low Risk, Lowest Risk, Missing Screen		
CRAFFT Result (CRAFFT)	Drop Down:1, 2, 3, 4, 5, 6	CRAFFT is a substance use screening tool for adolescents aged 12-21.	

Using the CRAFFT in tandem with the S2BI can enhance the adolescent health assessment processes. Ensure your EHR fields for the two tools are integrated so that the documentation is complimentary rather than duplicative.

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Brief Intervention			
What type of intervention was delivered? (Int.Delivered)	Drop Down: Anticipatory Guidance, Cessation Advice, Discussed Reducing Use and Risky Behaviors, Declined Intervention, Provider Unable to Conduct Intervention	If risk level is "Prevention Opportunity" indicate Anticipatory Guidance If risk level for any substance is "Moderate Risk for SUD" to "High Risk for SUD" indicate one or both of the following BI components: Provided cessation advice. Discussed reducing use and risky behaviors. All adolescents should receive some form of intervention, since even if they score "No Use," it is still a prevention opportunity and anticipatory guidance should be given. *Consider hard stop*	**If any intervention is indicated, how often was the intervention commensurate with the level of risk?** **What is the proportion of patients who were eligible for BI for whom change plan is documented? (Benchmark 80%)** What percentage of records indicate that any intervention was delivered?
Date of brief intervention (Int.Date)	MM/DD/YYYY	The goal is to deliver the brief intervention on the same day as the screening.	
BI Change Plan (BI.Change.Plan)	Check all that apply: Patient will reduce use, patient will make quit attempt, patient will abstain from risky behavior, patient will remove triggers to use, patient will employ coping mechanisms, patient refused change plan, provider unable to address change plan	Indicated when patient agrees to make a behavioral change.	
BI Contingency Plan (BI.Cont.Plan)	Check all that apply: Provider offered to discuss change plan, Agreed to revisit change plan during future visit, Received education on SU, Accepted educational resources	Indicated when a patient declines intervention.	
BI Plan/ Contingency Details (BI.Detail)	Text Box	Use this field to document plan details such as agreed upon timelines, goals, action items, and who is accountable.	

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Referral to Treatment			
What type of referral was made? (RT.Type)	Select all that apply: Internal BH/PCP, OT, OST, EPP, ResT, SBS, PSS, OCS Declined Referral, Provider Unable to Make Referral, N/A Based on Screening Results	If risk level for any substance is High Risk, indicate one of the following referral types: • Internal Behavioral Health/ Primary Care Provider (Internal BH/PCP) • Outpatient Treatment (OT) • Outpatient SUD Treatment (OST) • External Private Practice (EPP) • Residential Treatment (ResT) • School-based Services (SBS) • Peer Support Services (PSS) • Other Community Services (OCS) *Consider hard stop*	**What is the proportion of adolescents referred who attend initial referral visit within 60 days? (Benchmark 50%)** **What is the proportion of adolescents eligible for referral for whom referral plan is documented? (Benchmark 80%)**
Referral Provider Name (RT.Provider)	Drop Down: Can be populated with typical referral providers or left as a text box	It is important to record this for follow-up purposes.	
Referral Appointment Status (RT.Status)	Drop Down: Appointment Scheduled, Appointment Request Sent to Referral Provider, Patient Provided with Referral Contact Information	Filling out this field will help to track access to care and progress towards scheduling an appointment.	
What is the appointment date? (Appoint.Date)	MM/DD/YYYY	If applicable, record the appointment date for follow-up.	
Did patient attend the referral appointment? (RT.Attend)	Drop Down: Yes, No, Information Unavailable	Whenever possible, record the patient's attendance at the referral appointment.	
Reason patient did not attend referral (RT.Missed.Reason)	Select all that apply: Does not believe it is necessary, Wants to continue use, Scheduling Conflict, Cost, Transportation, Does Not Want Parent to Find out, General Confidentiality Concerns, Other (with text box), Information Unavailable	Record reason/s for missed appointment so barriers to treatment can be addressed.	

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Referral to Treatment (continued)			
Referral Plan (RT.Plan)	Check all that apply: Patient Agreed to Schedule Appointment with Referral Provider, Patient Agreed to Identify a Provider of Their Choosing, Patient Agreed to Attend Appointment Within One Week, Patient Agreed to Attend Appointment Within One Month, Patient Agreed to Attend Appointment Within Three Months, Provider Will Submit Required Information to Referral Provider	Indicated when a referral is accepted.	**What is the proportion of adolescents referred who attend initial referral visit within 60 days? (Benchmark 50%)** **What is the proportion of adolescents eligible for referral for whom referral plan is documented? (Benchmark 80%)**
Referral Contingency Plan	Check all that apply: Provider Offered to Provide Referral, Agreed to Revisit Referral During Future Visit, Accepted Referral Provider Contact Information	Indicated when a patient declines intervention.	
Referral Plan/ Contingency Details (RT.Plan.Detail)	Text Box	Use this field to document plan details such as referral provider contact information, agreed upon timelines, goals, action items, resource needs and who is accountable.	
Follow-Up			
Follow-up Plan (Followup.Plan)	Choose all that apply: Screen patient at next visit, Discuss progress on Change Plan/ Contingency Plan during next visit, Provider will follow up with referral provider to track progress, Provider will follow up with patient to track progress, Provider is unable to follow-up on referral	Indicated if screening results are Moderate Risk for SUD or higher, i.e. if patient received a BI or referral. Follow-up plan: Narrative documentation of agreed-upon strategies and timeline for revisiting goals outlined in the change, contingency or referral plans. Be sure to record who is accountable for each component of the plan.	Are clinics and providers able to follow-up on referrals? Are providers choosing the appropriate follow-up plan based on screening results and patient decisions?
Follow-up Plan Details (Followup.Detail)	Text Box	Use this field to document plan details such as agreed-upon timelines, action items, provider contact information and who is accountable and care updates from the referral provider.	

APPENDIX G
SAMPLE DATA DASHBOARD