



Measure Information - Composite

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 2597

De.2. Measure Title: Substance Use Screening and Intervention Composite

Co.1.1. Measure Steward: American Society of Addiction Medicine

De.3. Brief Description of Measure: Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results

1d.3. Developer Rationale: This measure is intended to assess the extent to which primary care patients receive evidence-based screenings for potential abuse of several categories of substances, including tobacco, alcohol, and drugs. Rather than encourage providers to screen for just one of these categories of abuse, this measure instead encourages a more comprehensive screening and accompanying intervention.

Composite performance measures have a variety of uses.

Data reduction: A large and growing array of individual indicators makes it possible for users to become overloaded with data. A composite measure reduces the information burden by distilling the available indicators into a simple summary.

Scope expansion: The information in a composite measure is highly condensed, making it feasible to track a broader range of metrics than would be possible otherwise. Composite measures have been described as a tool for making provider assessments more comprehensive.

Provider performance valuation: Performance indicators are used for various decisions about providers, including the allocation of pay-for-performance incentives, designation of preferred provider status, and assignment of letter grades and star rating categories. If a decision is to be based on multiple indicators instead of a single indicator, a method of translating several variables into a single decision is needed. Composite measures serve this function by assigning providers to position on a scale of better-to-worse performance.

S.4. Numerator Statement: Patients who received the following substance use screenings at least once within the last 24 months AND who received an intervention for all positive screening results:

Tobacco use component

Patients who were screened for tobacco use at least once within the last 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Unhealthy alcohol use component

Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user

Drug use component (nonmedical prescription drug use and illicit drug use)

Patients who were screened for nonmedical prescription drug use and illicit drug use at least once within the last 24 months using a systematic screening method AND who received brief counseling if identified as a nonmedical prescription drug user or illicit drug user

S.7. Denominator Statement: All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12 month measurement period

<p>S.10. Denominator Exclusions: Denominator exceptions include documentation of medical reason(s) for not screening for tobacco use, unhealthy alcohol use, or nonmedical prescription drug/illicit drug use (eg, limited life expectancy, other medical reasons)</p>
<p>De.1. Measure Type: Composite</p> <p>S.23. Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record</p> <p>S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual</p>
<p>IF Endorsement Maintenance – Original Endorsement Date: Mar 06, 2015 Most Recent Endorsement Date: Mar 06, 2015</p>
<p>1d.1. Composite Measure Construction: two or more individual performance measure scores combined into one score</p> <p>Component Measures (if endorsed or submitted for endorsement):</p> <p>0028 : Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention</p> <p>2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling</p>

<p>1. Evidence, Performance Gap, Priority – Importance to Measure and Report</p>
<p>Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. <i>Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.</i></p>
<p>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form</p>
<p>1b. Performance Gap</p> <p>Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:</p> <ul style="list-style-type: none"> considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or disparities in care across population groups. <p>1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)</p> <p>The composite measure is intended to promote screening and intervention for substance use. Because many patients will not self-identify or have not yet developed detectable problems associated with substance use, screening can identify patients for whom intervention may be indicated. Brief motivational counseling (and pharmacotherapy for tobacco use) for these various substances have been shown to be an effective treatment for reducing problem use, particularly in primary care settings.</p> <p>1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.</p> <p>Tobacco Component:</p> <p>2010 CMS Physician Quality Reporting Initiative:</p> <p>Data Source: This measure was used in the 2010 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 58.36% is the aggregate performance rate in the total patient population and 68.56% is the mean performance rate of TIN/NPI's.</p> <p>10th percentile: 0.00%</p> <p>25th percentile: 32.53%</p> <p>50th percentile: 98.31%</p> <p>75th percentile: 100%</p> <p>90th percentile: 100%</p> <p>Exception Rate: 0.00%</p> <p>Maximum Performance Score: 100%</p> <p>Interquartile Range: 67.47%</p> <p>Confidential CMS PQRI 2010 Performance Information by Measure. Jan-Sept TAP file.</p>

Alcohol Component:

2010 CMS Physician Quality Reporting Initiative:

Data Source: This measure was used in the 2010 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 85.54% is the aggregate performance rate in the total patient population and 82.34% is the mean performance rate of TIN/NPI's.

10th percentile: 12.50%

25th percentile: 83.64%

50th percentile: 100%

75th percentile: 100%

90th percentile: 100%

Exception Rate: 1.00%

Maximum Performance Score: 100%

Interquartile Range: 16.36%

Confidential CMS PQRI 2010 Performance Information by Measure. Jan-Sept TAP file

No performance scores on the drug component are available at this time.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

The drug measure component is intended to promote the implementation of SBIRT, or the practice of screening, brief intervention, and referral to treatment, for the purpose of identifying and addressing the health of illicit drug users. According to the SAMHSA 2014 National Survey on Drug Use and Health (NSDUH), in 2013, 22.7 million individuals aged 12 or older required treatment for an illicit drug or alcohol use problem. Of these, only 2.5 million (roughly 10%) received treatment at a specialty facility, similar to numbers from 2002 through 2012. Therefore, the vast majority of persons with substance use disorders (SUD), approximately 20.2 million persons in 2013, are not seen by specialty treatment programs and rarely screened, assessed, or treated for medically-harmful substance use in general medical settings. Furthermore, efforts to integrate SUD care with primary care in general medical settings have largely fallen short. Since evidence-based treatments for SUD are accumulating and substance abuse and related problems are among the leading preventable causes of emergency department visits and mortality in the U.S. according to the CDC, under-screening and under-treatment of SUD is a major public health concern. (1)

The alcohol component of the composite measure is intended to promote unhealthy alcohol use screening and brief counseling which have been shown to be effective in reducing alcohol consumption. About 30% of the U.S. population misuse alcohol, with most engaging in what is considered risky drinking. (2) A recent analysis of data from the National Alcohol Survey shows that approximately one-third of at-risk drinkers (32.4%) and persons with a current alcohol use disorder (31.5%) in the United States had at least 1 primary care visit during the prior year, demonstrating the potential reach of screening and brief counseling for unhealthy alcohol use in the primary care setting.(3) A number of studies, including patient and provider surveys, have documented low rates of alcohol misuse screening and counseling in primary care settings. In the national Healthcare for Communities Survey, only 8.7% of problem drinkers reported having been asked and counseled about their alcohol use in the last 12 months.(4) A nationally representative sample of 648 primary care physicians were surveyed to determine how such physicians identify--or fail to identify--substance abuse in their patients, what efforts they make to help these patients and what are the barriers to effective diagnosis and treatment. Of physicians who conducted annual health histories, less than half ask about the quantity and frequency of alcohol use (45.3 percent). Only 31.8 percent say they ever administer standard alcohol or drug use screening instruments to patients. (5)

Finally, the tobacco component of the composite measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke. Tobacco use remains the single largest preventable cause of death and disease in the United States.(6) In 2010, an estimated 19.3% (45.3 million) of U.S. adults were current cigarette smokers;

of these, 78.2% smoked every day, and 21.8% smoked some days.(6) An recent analysis of National Health and Nutrition Examination Survey (NHANES) data found that approximately 76% of current smokers have at least one outpatient office visit each year, representing a significant opportunity to screen for tobacco use and deliver effective cessation interventions.(7) A 2006 study analyzed data from the National Ambulatory Medical Care Survey (NAMCS) and found suboptimal rates of "asking" about tobacco use, providing "assistance" with tobacco cessation, and prescribing pharmacotherapy for cessation. Overall, 32% of patient charts did not include information about tobacco use, 81% of smokers did not receive assistance and less than 2% received a prescription for pharmacotherapy.(8) A recent CDC analysis of 2010 National Health Interview Surveys (NHIS) data found that less than half of smokers (48.3%) who saw a health professional in the past year reported receiving advice to quit. (9)

1. Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
2. Substance Abuse and Mental Health Services Administration. Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.
3. Mulia N, Schmidt LA, Ye Y, Greenfield TK. Preventing disparities in alcohol screening and brief intervention: the need to move beyond primary care. *Alcohol Clin Exp Res*. 2011 Sep;35(9):1557-60.
4. D'Amico EJ, Paddock SM, Burnam A, Kung FY. Identification of and guidance for problem drinking by general medical providers: results from a national survey. *Med Care*. 2005 Mar;43(3):229-36.
5. Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse. New York: The National Center on Addiction and Substance Abuse at Columbia University; 2000.
6. Centers for Disease Control and Prevention (CDC). Vital signs: current cigarette smoking among adults aged ≥18 years--United States, 2005-2010. *MMWR Morb Mortal Wkly Rep*. 2011 Sep 9;60(35):1207-12.
7. Kahende JW, Adhikari B, Maurice E, Rock V, Malarcher A. Disparities in Health Care Utilization by Smoking Status – NHANES 1999-2004. *Int. J. Environ. Res. Public Health*. 2009, 6(3), 1095-1106.
8. Ferketich AK, Khan Y, Wewers ME. Are physicians asking about tobacco use and assisting with cessation? Results from the 2001-2004 national ambulatory medical care survey (NAMCS). *Prev Med*. 2006 Dec;43(6):472-6.
9. Centers for Disease Control and Prevention (CDC). Quitting Smoking Among Adults --- United States, 2001—2010. *MMWR Morb Mortal Wkly Rep*. 2011 Nov 11; 60(44):1513-1519.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

The PQRS program periodically provides us with confidential performance data for the individual component measures (tobacco and alcohol), however this data does not include race/ ethnicity/ gender/ age or any other population groups that would be required to evaluate disparities.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

Illicit drug use affects many populations, though some are at higher risk than others. Those at highest risk for illegal drug use include young adults (18 to 25 years old)(1), males, and those who did not graduate from high school(2), where youth, older adults, and women are at particular risk for prescription drug abuse.(3)

Among individuals affected by illicit drug use, there is a disparity among populations with regards to access to treatment for the drug use. As reported by Wells et al, "a total of 31.9% of whites, 28.1% of African Americans, and 30.1% of Hispanics had some alcoholism, drug abuse, and mental health care, mostly in primary care. Among those with perceived need, compared to whites, African Americans were more likely to have no access to alcoholism, drug abuse, or mental health care (25.4% versus 12.5%), and Hispanics were more likely to have less care than needed or delayed care (22.7% versus 10.7%). Among those with need, whites were more likely than Hispanics or African Americans to be receiving active alcoholism, drug abuse, or mental health treatment (37.6% versus 22.4%–25.0%)."(4)

In addition to racial disparities in illicit drug use, screening, and treatment, disparities also exist based on geographical setting. Data collected through the National Survey on Drug Use and Health indicate that misuse of prescription drugs is less common in rural than metropolitan counties nationally; a report on these findings by SAMHSA recommend public health information-sharing to raise

awareness of the extent of prescription drug misuse to bolster prevention and treatment efforts in these more affected geographies.(5)

We are not aware of any publications/evidence outlining disparities specific to the provision of screening and brief counseling for unhealthy alcohol use. However, existing literature has shown variations across race and “ethnicities in drinking, alcohol use disorders, alcohol problems, and treatment use. Higher rates of high-risk drinking among ethnic minorities are reported for Native Americans and Hispanics, although within ethnic group differences (e.g., gender, age group, and other subpopulations) also are evident for ethnicities. Whites and Native Americans have a greater risk for alcohol use disorders relative to other ethnic groups. However, once alcohol dependence occurs, Blacks and Hispanics experience higher rates than Whites of recurrent or persistent dependence. Furthermore, the consequences of drinking appear to be more profound for Native Americans, Hispanics, and Blacks.”(6)

Finally, variations in smoking prevalence persist, particularly by race/ethnicity, education, income, and region. Specifically, among racial/ethnic populations, non-Hispanic American Indians/Alaska Natives had the highest prevalence (31.4%), followed by non-Hispanic whites (21.0%) and non-Hispanic blacks (20.6%). Smoking prevalence generally decreased with increasing education and was higher among adults living below the poverty level (28.9%) than among those at or above the poverty level (18.3%). (7) A recent CDC analysis of 2010 National Health Interview Surveys (NHIS) data found that among those who had visited a health-care provider, women (51.7%) and persons aged ≥ 65 years (57.1%) were more likely to have received cessation advice. Hispanic smokers were less likely (34.7%) to have received advice to quit than other racial/ethnic populations. Those without a health plan (35.3%) were least likely to have received cessation advice, whereas Medicare enrollees (59.0%) were the most likely to receive advice.(8) This is in slight contrast to the data reported by AHRQ’s 2010 National Healthcare Disparities report which found no statistically significant differences by race and ethnicity in the percentage of current adult smokers who received advice to quit smoking. From 2002 to 2007, female current adult smokers continued to be more likely than males to receive advice to quit smoking. Additionally, in 2007, near-poor current adult smokers were significantly less likely than high-income current adult smokers to receive advice to quit smoking (58.8% compared with 67.8%). (9)

Citations

1. National Institute on Drug Abuse. General Questions on Drug Abuse. Available at http://drugfactsweek.drugabuse.gov/chat/chatfaqs_topics/general_questions.php. Accessed August 22, 2013.
 2. Substance Abuse and Mental Health Services Administration. Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings. NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: 2011. Available at <http://www.samhsa.gov/data/nsduh/2k11results/nsduhresults2011.htm#2.5>. Accessed August 26, 2013.
- Quoted verbatim from:
3. National Institute on Drug Abuse. Prescription Drugs: Abuse and Prevention. Available at <http://www.drugabuse.gov/publications/research-reports/prescription-drugs/preventing-recognizing-prescription-drug-abuse>. Updated October 2011. Accessed August 26, 2013.
 4. Wells K, Klap R, Koike A, Sherbourne C. Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry* 2001;158(12): 2027-2032.
 5. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. The NSDUH Report: Nonmedical Use of Prescription-Type Drugs, by County Type. April 11, 2013. Rockville, MD.
 6. Chartier K, Caetano R. Ethnicity and Health Disparities in Alcohol Research. *Alcohol Res Health*. 2010;33(1-2):152-160.
 7. Centers for Disease Control and Prevention (CDC). Vital signs: current cigarette smoking among adults aged ≥ 18 years--United States, 2005-2010. *MMWR Morb Mortal Wkly Rep*. 2011 Sep 9;60(35):1207-12.
 8. Centers for Disease Control and Prevention (CDC). Quitting Smoking Among Adults --- United States, 2001—2010. *MMWR Morb Mortal Wkly Rep*. 2011 Nov 11; 60(44):1513-1519.
 9. Agency for Healthcare Research and Quality. 2010 National Healthcare Disparities Report. Rockville, MD. Available at: <http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf>.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

The 2011 National Prevention Strategy (NPS) identified the Prevention of Drug Abuse and Excessive Alcohol Use as one of seven prevention priorities. Drug use can be described by nine categories of illicit drug use: use of marijuana, cocaine, heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives.

Included in this categorization of drug use is the abuse of prescription drugs, which is defined by the National Institute on Drug Abuse (NIDA) as “the use of a medication without a prescription, in a way other than as prescribed, or for the experience or feelings elicited.” According to the Centers for Disease Control and Prevention (CDC), prescription drug abuse is the fastest growing problem in the United States.

Among Americans above the age of 12 years old, individuals that engage in illicit drug use number 26.2 million. Additionally, data from the 2011 National Survey on Drug Use and Health (NSDUH) reveals that an annual average of 15.7 million people aged 12 years old and older misuse prescription drugs between 2005 and 2011.

Illicit drug use, including the use of illegal drugs and the misuse of prescription drugs, can yield a myriad acute and long-term negative health effects. Though these effects can vary by drug, short-term effects can include short-term memory loss, erratic and violent behavior, irregular heartbeat, dangerously high body temperatures, seizures, systemic vasodilation, and overdose. Long term effects of illicit drug use can include addiction, lung and upper airway cancers, nasal damage, psychosis, cardiac and neurological damage, liver and kidney damage, myelin breakdown, seizures, and collapsed veins.

The mortality rate associated with illicit drug use varies by drug; however, the overall rate for drug-induced deaths is 12.9 per 100,000 individuals. Annually, approximately 20,000 individuals die due to illegal drug use, and 20,000 die from non-medical prescription drug use.

A 2011 report from the National Institute on Drug Abuse (NIDA) advises that “more than 80 percent of Americans had contact with a healthcare professional in the past year, placing doctors in a unique position, not only to prescribe medications, but also to identify abuse (or nonmedical use) of prescription drugs and prevent the escalation to addiction. By asking about all drugs, physicians can help their patients recognize that a problem exists, set recovery goals, and seek appropriate treatment. Screening for prescription drug abuse can be incorporated into routine medical visits. Doctors should also take note of rapid increases in the amount of medication needed or frequent, unscheduled refill requests. Doctors should be alert to the fact that those addicted to prescription drugs may engage in “doctor shopping”—moving from provider to provider—in an effort to obtain multiple prescriptions for the drug(s) they abuse.”

Alcohol misuse, which includes the full spectrum from risky or hazardous drinking to alcohol dependence, is associated with numerous health and social problems and more than 80,000 deaths per year in the United States. Alcohol misuse is the third leading cause of preventable death in the United States, after tobacco use and being overweight. Excessive alcohol use is responsible for 2.3 million years of potential life lost (YPLL) annually, or an average of about 30 years of potential life lost for each death.

Excessive alcohol use has immediate effects that increase the risk of many harmful health conditions. These immediate effects are most often the result of binge drinking and include the following—

- Unintentional injuries, including traffic injuries, falls, drownings, burns, and unintentional firearm injuries.
- Violence, including intimate partner violence and child maltreatment. About 35% of victims report that offenders are under the influence of alcohol. (5.2) Alcohol use is also associated with 2 out of 3 incidents of intimate partner violence. (5.2) Studies have also shown that alcohol is a leading factor in child maltreatment and neglect cases, and is the most frequent substance abused among these parents.
- Risky sexual behaviors, including unprotected sex, sex with multiple partners, and increased risk of sexual assault. These behaviors can result in unintended pregnancy or sexually transmitted diseases.

- Miscarriage and stillbirth among pregnant women, and a combination of physical and mental birth defects among children that last throughout life.
- Alcohol poisoning, a medical emergency that results from high blood alcohol levels that suppress the central nervous system and can cause loss of consciousness, low blood pressure and body temperature, coma, respiratory depression, or death.

Over time, excessive alcohol use can [also] lead to the development of chronic diseases, neurological impairments and social problems. These include but are not limited to—

- Neurological problems, including dementia, stroke and neuropathy.
- Cardiovascular problems, including myocardial infarction, cardiomyopathy, atrial fibrillation and hypertension.
- Psychiatric problems, including depression, anxiety, and suicide.
- Social problems, including unemployment, lost productivity, and family problems.
- Cancer of the mouth, throat, esophagus, liver, colon, and breast. In general, the risk of cancer increases with increasing amounts of alcohol.
- Liver diseases, including—alcoholic hepatitis, cirrhosis, worsening of liver function and interference with medications used to treat this condition, among persons with Hepatitis C virus.
- Other gastrointestinal problems, including pancreatitis and gastritis.

In the 2012 National Survey on Drug Use and Health, slightly more than half (52.1 percent) of Americans aged 12 or older reported being current drinkers of alcohol. 23.0% of those surveyed participated in binge drinking at least once in the 30 days prior to the survey in 2012 and heavy drinking was reported by 6.5 %. Recent U.S.-based data (1.5) revealed that 21.3% of primary care patients reported risky drinking. In 2006, there were more than 1.2 million emergency room visits and 2.7 million physician office visits due to excessive drinking. The economic costs of excessive alcohol consumption in 2006 were estimated at \$223.5 billion.

The 2011 National Prevention Strategy (NPS) identified the Prevention of Drug Abuse and Excessive Alcohol Use as one of seven prevention priorities, particularly recommending the Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in primary care and trauma centers to reduce excessive alcohol consumption and alcohol-related deaths among adults. Brief alcohol misuse screening and counseling intervention was considered the third highest prevention priority for U.S. adults.

A recent analysis of data from the National Alcohol Survey shows that approximately one-third of at-risk drinkers (32.4%) and persons with a current Alcohol Use Disorder (AUD) (31.5%) in the United States had at least 1 primary care visit during the prior year and demonstrate the potential reach of screening and brief counseling for unhealthy alcohol use in the primary care setting. Among at-risk and AUD drinkers who had at least 1 primary care visit, large majorities (93.4 and 76.0%, respectively) had never considered seeking help for their drinking, largely because they did not perceive themselves to have a drinking problem (95.8 and 92.6%).

Please note: As described in the recent meta-analysis from the USPSTF, the definitions of the spectrum of alcohol misuse continue to evolve. The terms alcohol misuse, unhealthy alcohol use and excessive alcohol use tend to be used synonymously.

Tobacco use remains the single largest preventable cause of death and disease in the United States. The health consequences of tobacco use include heart disease, multiple types of cancer, pulmonary disease, adverse reproductive effects, and the exacerbation of chronic health conditions. Each year, approximately 443,000 persons in the United States die from smoking-related illnesses. In addition, smoking has been estimated to cost the United States \$96 billion in direct medical expenses and \$97 billion in lost productivity each year. In 2010, an estimated 19.3% (45.3 million) of U.S. adults were current cigarette smokers; of these, 78.2% smoked every day, and 21.8% smoked some days. Prevalence was higher among men (21.5%) than women (17.3%). Adults aged 25--44 years (22.0%) and 45--64 years (21.1%) had the highest prevalences among age groups. Current cigarette smoking prevalence among all adults aged ≥18 years has decreased 42.4% since 1965, but declines in current smoking prevalence have slowed during the past 5 years. During 2005--2010, the overall proportion of U.S. adults who were current smokers declined from 20.9% to 19.3%. A recent analysis of National Health and Nutrition Examination Survey (NHANES) data found that approximately 76% of current smokers have at least one outpatient office visit each year, representing a significant opportunity to screen for tobacco use and deliver effective cessation interventions.

Additionally, a number of studies have documented the cost effectiveness of Screening, Brief Intervention, And Referral To Treatment (SBIRT) for people with substance use disorders and those at risk of developing these disorders.

1c.4. Citations for data demonstrating high priority provided in 1a.3

See citations within the individual component submission forms.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

n/a

1d. Composite Quality Construct and Rationale

1d.1. A composite performance measure is a combination of two or more component measures, each of which individually reflects quality of care, into a single performance measure with a single score.

For purposes of NQF measure submission, evaluation, and endorsement, the following will be considered composites:

- Measures with two or more individual performance measure scores combined into one score for an accountable entity.
- Measures with two or more individual component measures assessed separately for each patient and then aggregated into one score for an accountable entity:
 - all-or-none measures (e.g., all essential care processes received, or outcomes experienced, by each patient); or
 - any-or-none measures (e.g., any or none of a list of adverse outcomes experienced, or inappropriate or unnecessary care processes received, by each patient).

1d.1. Please identify the composite measure construction: [two or more individual performance measure scores combined into one score](#)

1d.2. Describe the quality construct, including:

- the overall area of quality
- included component measures and
- the relationship of the component measures to the overall composite and to each other.

[The composite measure focuses on screening and brief intervention for primary care patients in order to detect substance abuse and reduce the risk of adverse outcomes through brief intervention. Each component of the composite includes a screening and brief intervention for a distinct substance \(ie, alcohol, tobacco, prescription or illicit drug\) which together are recommended as the optimal and complete set of screenings appropriate for primary care patients. These screenings have individually been shown to improve patient outcomes.](#)

1d.3. Describe the rationale for constructing a composite measure, including how the composite provides a distinctive or additive value over the component measures individually.

[This measure is intended to assess the extent to which primary care patients receive evidence-based screenings for potential abuse of several categories of substances, including tobacco, alcohol, and drugs. Rather than encourage providers to screen for just one of these categories of abuse, this measure instead encourages a more comprehensive screening and accompanying intervention.](#)

[Composite performance measures have a variety of uses.](#)

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[Scope expansion: The information in a composite measure is highly condensed, making it feasible to track a broader range of metrics than would be possible otherwise. Composite measures have been described as a tool for making provider assessments more comprehensive.](#)

[Provider performance valuation: Performance indicators are used for various decisions about providers, including the allocation of pay-for-performance incentives, designation of preferred provider status, and assignment of letter grades and star rating categories. If a decision is to be based on multiple indicators instead of a single indicator, a method of translating several variables into a single decision is needed. Composite measures serve this function by assigning providers to position on a scale of better-to-worse performance.](#)

1d.4. Describe how the aggregation and weighting of the component measures are consistent with the stated quality construct

and rationale.

The measure follows a combined scoring approach in which the composite measure is scored as a proportion or rate, where higher score equals better quality. The numerators for each component are added together, and evaluated over the combined denominators of the components, less the combined denominator exceptions for each of the components. This evaluates the share of primary care patients who received a comprehensive screening for all potentially abused substances, and who then received a brief intervention for any abuse the screening uncovered.

The underlying calculation used for our opportunity-based provider-level composite score is as follows:

$$(N1+N2+N3)$$

$$[(D1+D2+D3) - (DE1+DE2+DE3)]$$

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Behavioral Health : Alcohol, Substance Use/Abuse, Behavioral Health : Screening, Behavioral Health : Tobacco Use, Prevention : Screening, Prevention : Tobacco Use

De.6. Cross Cutting Areas (check all the areas that apply):

Prevention : Screening

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

The HQMF eMeasure specifications that make up this composite measure are attached with this form. Value sets are available in the VSAC at <https://vsac.nlm.nih.gov/>. See S.6 or S.9 for additional information about value sets.

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

Attachment Attachment: [Substance_Use_Composite_ASAM_07072014.zip](#)

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

n/a

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Patients who received the following substance use screenings at least once within the last 24 months AND who received an intervention for all positive screening results:

Tobacco use component

Patients who were screened for tobacco use at least once within the last 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Unhealthy alcohol use component

Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user

Drug use component (nonmedical prescription drug use and illicit drug use)

Patients who were screened for nonmedical prescription drug use and illicit drug use at least once within the last 24 months using a systematic screening method AND who received brief counseling if identified as a nonmedical prescription drug user or illicit drug user

S.5. Time Period for Data *(What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)*

Each of the components look for performance at least once within 24 months prior to the end of the measurement period (measurement period or year prior)

S.6. Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b) IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.*

For Tobacco

HQMF eMeasure specification attached to this form.

All measure specific value sets for the Tobacco component are available at <https://vsac.nlm.nih.gov/>.

For Alcohol

HQMF eMeasure specification attached to this form.

35/43 measure specific value sets are published by the VSAC and are currently in use.

8/43 measure specific value sets are currently in a draft authoring status in the VSAC.

Of the 43 value sets included in this measure, 2/43 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].

Drug

HQMF eMeasure specification attached to this form.

33/41 measure specific value sets are published by the VSAC and are currently in use.

8/41 measure specific value sets are currently in a draft authoring status in the VSAC.

Of the 41 value sets included in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*

All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12 month measurement period

S.8. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

S.9. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

For Tobacco

HQMF eMeasure specification attached to this form.

All measure specific value sets for the Tobacco component are available at <https://vsac.nlm.nih.gov/>.

For Alcohol

HQMF eMeasure specification attached to this form.

35/43 measure specific value sets are published by the VSAC and are currently in use.

8/43 measure specific value sets are currently in a draft authoring status in the VSAC.

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Drug

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33/41 measure specific value sets are published by the VSAC and are currently in use.

8/41 measure specific value sets are currently in a draft authoring status in the VSAC.

Of the 41 value sets included in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Denominator exceptions include documentation of medical reason(s) for not screening for tobacco use, unhealthy alcohol use, or nonmedical prescription drug/illicit drug use (eg, limited life expectancy, other medical reasons)

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

The components of this measure were created using the PCPI methodology. The PCPI exception methodology states that exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this composite measure, exceptions may include medical reason(s) (eg, limited life expectancy). Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

For Tobacco

HQMF eMeasure specification attached to this form.

All measure specific value sets for the Tobacco component are available at <https://vsac.nlm.nih.gov/>.

For Alcohol

HQMF eMeasure specification attached to this form.

35/43 measure specific value sets are published by the VSAC and are currently in use.

8/43 measure specific value sets are currently in a draft authoring status in the VSAC.

Of the 43 value sets included in this measure, 2/43 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].

Drug

HQMF eMeasure specification attached to this form.

33/41 measure specific value sets are published by the VSAC and are currently in use.

8/41 measure specific value sets are currently in a draft authoring status in the VSAC.

Of the 41 value sets included in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

We encourage the results of this measure to be stratified by race, ethnicity, payer, and administrative sex, and have included these variables as supplemental data elements to be collected in the HQMF eMeasure.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

No risk adjustment or risk stratification.

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

n/a

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

To calculate performance rate for the overall composite measure: Our approach to the composite measure algorithm for the NIDA Substance Use Screen and Brief Counseling electronic clinical quality measure is to employ a simple scoring methodology which identifies the number of eligible patients who received recommended care for each component measure divided by the number of eligible patients (or “opportunities”). This scoring method, known as opportunity- based scoring, is identical to that used by the Centers for Medicare and Medicaid Services (CMS) in its pay-for-performance programs.

The underlying calculation used for our opportunity-based provider-level composite score is as follows:

$(N1+N2+N3)$

$[(D1+D2+D3) - (DE1+DE2+DE3)]$

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available in attached appendix at A.1

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Not applicable-- this measure is not based on a sample.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

Not applicable-- this measure is not based on a survey.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

If data required to determine if an individual patient should be included in a specific performance measure based on defined criteria is missing, those cases would ineligible for inclusion in the denominator and therefore the case would be deleted.

If data required to determine if a denominator eligible patient qualifies for the numerator (or has a valid exclusion/exception) is missing, this case would represent a quality failure.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Not applicable.

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

The approach to the composite measure algorithm is to employ a scoring methodology which identifies the number of eligible patients who received recommended care for each component measure divided by the number of eligible patients (or "opportunities"). This scoring method, known as opportunity- based scoring, is identical to that used by the Centers for Medicare and Medicaid Services (CMS) in its pay-for-performance programs.

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

Composite_Measure_Testing_Attachment_6_20_14.docx

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

ALL data elements are in defined fields in electronic health records (EHRs)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment Attachment: NQF_Feasibility-_NIDA_Composite_Overall-635405924006233882.docx

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

We have not identified any areas of concern or made any modifications as a result of testing and operational use of the measure in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, and other feasibility issues unless otherwise noted.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (*e.g., value/code set, risk model, programming code, algorithm*).

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned

Current Use (for current use provide URL)

Public Reporting

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

The PCPI, as contracted measure developer, strongly encourages the use of its measures in quality improvement and accountability initiatives and promotes their use in public reporting programs. As a measure developer, we work with measure implementers as opportunities arise to encourage and facilitate the integration of PCPI measures in their programs.

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

This measure has been submitted to CMS for consideration for inclusion in Stage III of the Meaningful Use Program.

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

n/a

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

While the PCPI creates measures with an ultimate goal of improving the quality of care, measurement is a mechanism to drive improvement but does not equate with improvement. Measurement can help identify opportunities for improvement with actual improvement requiring making changes to health care processes and structure. In order to promote improvement, quality measurement systems need to provide feedback to front-line clinical staff in as close to real time as possible and at the point of care whenever possible. (1)

1. Conway PH, Mostashari F, Clancy C. The future of quality measurement for improvement and accountability. JAMA. 2013 Jun 5;309(21):2215-6.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

We are not aware of any unintended consequences at this time, but we continuously monitor for them.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

n/a

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

While there are individual measures addressing screening and brief intervention for alcohol and tobacco use, there is no measure that looks at screening and brief intervention for more than one substance.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment **Attachment:** [NIDA-EMMES_Substance_Use_Composite_Measure_Updates.doc](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [American Society of Addiction Medicine](#)

Co.2 Point of Contact: [Alexis, Geier Horan, \[ageier@asam.org\]\(mailto:ageier@asam.org\), 301-547-4103-](#)

Co.3 Measure Developer if different from Measure Steward: [PCPI](#)

Co.4 Point of Contact: Samantha, Tierney, samantha.tierney@ama-assn.org, 312-464-5524-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The composite measure for substance use screening and counseling was developed based on the findings and recommendation of a Technical Expert Panel (TEP) convened by the MITRE corporation with funding support from the Office of the National Coordinator for Health Information Technology (ONC) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The TEP was composed of public and private sector BH experts (listed below), representing the clinical domains of Alcohol Use, Autism, Depression, Drug Use, Suicide, and Trauma. They were recruited, assembled, and facilitated over a 3-month period named "TEP Phase 2" from July through September 2012. Their purpose was to identify and prioritize recommendations for potential new measures for future development, focusing on the topics of Depression Trended Outcome measurement and Drug Use/Prescription Drug Misuse measures. The TEP found that the initial clinical evidence and technical feasibility review supported the further development of a Composite Substance Abuse Screening and Counseling measure instrument for tobacco, alcohol, and drug use/prescription drug misuse.

COMMUNITY MEMBERS

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Linda Weglicki, NIH/NINR
Rebecca Wolf, CDC/ONDIEH/NCBDDD
Elise Young, HRSA

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2014

Ad.3 Month and Year of most recent revision: 07, 2014

Ad.4 What is your frequency for review/update of this measure? Coding/Specifications updates occur annually. For more information, see Ad.8.

Ad.5 When is the next scheduled review/update for this measure? 07, 2015

Ad.6 Copyright statement: Physician Performance Measures (Measures) and related data specifications are developed by the American Medical

Association (AMA)-convened Physician Consortium for Performance Improvement® (PCPI®).

These Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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agreement between the user and the AMA (on behalf of the PCPI). Neither the AMA, the PCPI nor its members shall be responsible for any use of the Measures.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

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Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA the PCPI and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measure specifications is copyright 2004-2013 American Medical Association.

Ad.7 Disclaimers: Please see the copyright statement above in AD.6 for disclaimer information

Ad.8 Additional Information/Comments: The PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other implementation issues are noted that materially affect the integrity of the measure.