



## Measure Information

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 sub criterion 1b).

### Brief Measure Information

NQF #: 2152

Corresponding Measures:

De.2. Measure Title: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Co.1.1. Measure Steward: PCPI Foundation

De.3. Brief Description of Measure: Percentage of patients aged 18 years and older 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

1b.1. Developer Rationale: This measure is intended to promote unhealthy alcohol use screening and brief counseling which have been shown to be effective in reducing alcohol consumption, particularly in primary care settings.

S.4. Numerator Statement: 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

S.6. Denominator Statement: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

S.8. Denominator Exclusions: Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

De.1. Measure Type: Process

S.17. Data Source: Registry Data

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Mar 04, 2014 Most Recent Endorsement Date: Jun 10, 2019

IF this measure is included in a composite, NQF Composite#/title:

2597:Substance Use Screening and Intervention Composite

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?

### 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

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. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[2152\\_nqf\\_evidence\\_attachment\\_01NOV18\\_Final.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

**1b. Performance Gap**

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

**1b.1. Briefly explain the rationale for this measure** (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

*If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.*

This measure is intended to promote unhealthy alcohol use screening and brief counseling which have been shown to be effective in reducing alcohol consumption, particularly in primary care settings.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** *(This is required for maintenance of endorsement. 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 include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

An abbreviated version of this measure (which focuses only on the screening for unhealthy alcohol use component of the measure and not the brief counseling component) was included in CMS' Physician Quality Reporting System (PQRS) program from 2009-2016. Average performance rates from 2012 through 2015, reflecting the most recent data that have been made publicly available, are as follows:

PQRS #173 Preventive Care and Screening: Unhealthy Alcohol Use – Screening

2012: 74.5%

2013: 75.5%

2014: 66.2%

2015: 74.0%

Additional data analysis provided for 2015 PQRS data are as follows:

Performance 10th Percentile: 19.80

Performance 25th Percentile: 56.60

Performance 50th Percentile: 84.62

Performance 75th Percentile: 100.00

Performance 100th Percentile: 100.00

Performance Interquartile Range: 43.41 (2)

The current version of the measure is included in the Merit-based Incentive Payment System (MIPS), however data are not yet available.

1. Centers for Medicare & Medicaid Services. Physician Quality Reporting System 2015 Reporting Experience Including Trends (2007-2015). 2017. Available at:<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>

2. Additional 2015 PQRS data provided as requested from CMS.

**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.**

A number of studies, including patient and provider surveys, have documented low rates of alcohol misuse screening and counseling in primary care settings.

According to a study analyzing the quality of health care in the United States, on average, 45% of patients (n=6,676) were screened for problem drinking.(1)

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.(2)

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. (3)

A national systematic sample of 2,000 physicians practicing general internal medicine, family medicine, obstetrics-gynecology, and psychiatry were surveyed to determine the frequency of screening and intervention for alcohol problems. Of the 853 respondent physicians, 88% usually or always ask new outpatients about alcohol use. When evaluating patients who drink, 47% regularly inquire about maximum amounts on an occasion, and 13% use formal alcohol screening tools. Only 82% routinely offer intervention to diagnosed problem drinkers. (4)

In 2014, the CDC analyzed data from 17 states and the District of Columbia via the Behavioral Risk Factor Surveillance System to estimate the prevalence of adults who reported receiving elements of alcohol screening and brief intervention. While 77.7% of adults reported being asked about alcohol use by a health professional, only 32.9% were asked about binge-level alcohol consumption and among binge drinkers only 37.2% reported being counseled on the harms of binge drinking. Only 18.1% reported being advised to cut down on alcohol consumption or to quit drinking. (5)

A multi-site, cross-sectional survey of primary care residents from six primary care residency programs administered from March 2010 through December 2012 found that a minority of the residents appropriately screen or provide intervention for at risk alcohol users. While 60% (125/208) stated they screen patients at an initial visit, only 17% (35/208) screened patients at subsequent visits. 54% (108/202) reported they did not feel they had adequate training to provide brief intervention to patients found to be at-risk alcohol users and 21% (43/208) felt they could really help at-risk drinkers. (6)

A study evaluating self-reported prevalence of alcohol screening using information drawn from the ConsumerStyles survey (a random internet panel) found that only 24.7% (n=2,592) of adults reported being asked about their alcohol use. While prevalence among men and women were about the same, there was lower prevalence of screening among Black non-Hispanics than white non-Hispanics (16.2% vs. 26.9%) and college graduates reported a higher prevalence of screening than those with a high school degree or less (38.1% vs. 20.8%). (7)

A cross-sectional analysis using 2016 DocStyles data that evaluated with use of different screening tools used to screen for alcohol misuse by 1,506 primary care providers found that while most providers screen for alcohol misuse (96%) only 38% reported using a USPSTF recommended screening tool. (8)

1. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348:2635-2645.
2. 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.
3. 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.
4. Friedmann PD, McCullough D, Chin MH, Saitz R. Screening and intervention for alcohol problems. A national survey of primary care physicians and psychiatrists. *J Gen Intern Med*. 2000 Feb;15(2):84-91.
5. McKnight-Eily LR, Okoro CA, Mejia R, Denny CH, Higgins-Biddle J, Hungerford D, et al. Screening for excessive alcohol use and brief counseling of adults—17 states and the District of Columbia, 2014. *MMWR Morb Mortal Wkly Rep* 2017;66:313-319.
6. Barnes Le K, Johnson A, Seale P, Woodall H, Clark DC, Parish DC, et al. Primary care residents lack comfort and experience

with alcohol screening and brief intervention: A multi-site survey. J Gen Intern Med. 2015. 30(6):790-6.

7. Denny CH, Hungerford DW, McKnight-Eily LR, Green PP, Dang Ep, Cannon MJ, et al. Self-reported prevalence of alcohol screening among U. S. adults. Am J Prev Med. 2016. March;50(3):380-383.

8. Tan CH, Hungerford DW, Denny C, McKnight-Eily LR. Screening for alcohol misuse: Practices among U.S. primary care providers, DocStyles 2016. Am J Prev Med. 2018;54(2):173-180.

**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 maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

While this measure is included in a federal reporting program, disparities data have not yet been made available to us to analyze and report.

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4**

Historically, 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.”(1)

More recent literature shows that there are differences in patient populations that receive screening for unhealthy alcohol use. A study evaluating self-reported prevalence of alcohol screening using information drawn from the ConsumerStyles survey (a random internet panel) found that only 24.7% (n=2,592) of adults reported being asked about their alcohol use. While prevalence among men and women were about the same, there was lower prevalence of screening among Black non-Hispanics than white non-Hispanics (16.2% vs. 26.9%) and college graduates reported a higher prevalence of screening than those with a high school degree or less (38.1% vs. 20.8%). (2)

In 2014, the CDC analyzed data from 17 states and the District of Columbia via the Behavioral Risk Factor Surveillance System to estimate the prevalence of adults who reported receiving elements of alcohol screening and brief intervention. The prevalence of being asked about binge drinking was higher among males (35%) and in people with less than a high school diploma (40.1%). Additionally, non-Hispanic whites and Asian/Pacific Islanders were asked about binge drinking less frequently than non-Hispanic blacks and American Indian/Alaskan Natives. (3)

1. Chartier K, Caetano R. Ethnicity and Health Disparities in Alcohol Research. Alcohol Res Health. 2010;33(1-2):152-160.

2. Denny CH, Hungerford DW, McKnight-Eily LR, Green PP, Dang Ep, Cannon MJ, et al. Self-reported prevalence of alcohol screening among U. S. adults. Am J Prev Med. 2016. March;50(3):380-383.

3. McKnight-Eily LR, Okoro CA, Mejia R, Denny CH, Higgins-Biddle J, Hungerford D, et al. Screening for excessive alcohol use and brief counseling of adults—17 states and the District of Columbia, 2014. MMWR Morb Mortal Wkly Rep 2017;66:313-319.

## 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 sub criteria 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

**De.6. Non-Condition Specific**(check all the areas that apply):

Primary Prevention, Screening

**De.7. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Elderly

**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 measure specifications are included as an attachment with this submission. Additional measure details may be found at the PCPI website: <http://www.thepcpi.org/?page=PCPI Measures>

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped 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)

This is not an eMeasure Attachment:

**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.2c. Is this an instrument-based measure** (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

**S.2d. Is this an instrument-based measure** (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

**S.3.1. For maintenance of endorsement:** Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

No

**S.3.2. For maintenance of endorsement**, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Supporting guidelines and coding included in the measure are reviewed on an annual basis. However, this annual review has not resulted in any changes for this measure.

**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) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

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

**S.5. 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, time period for data collection, 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 (S.14).*

Time Period for Data Collection: At least once during the 24 month period.

**Definitions:**

Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:

- AUDIT Screening Instrument (score  $\geq 8$ )
- AUDIT-C Screening Instrument (score  $\geq 4$  for men; score  $\geq 3$  for women)
- Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response  $\geq 2$ )

Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive brief alcohol cessation counseling submit G9624.

**For Registry:**

Report Quality Data Code:

G9621 - Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling

OR

G9622 - Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method

**S.6. Denominator Statement** (Brief, narrative description of the target population being measured)

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

**S.7. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, 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 target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

Time Period for Data Collection: 12 consecutive months

**For Registry:**

Patients aged  $\geq 18$  years

AND

At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 2

OR

At Least One Preventive Visit during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

**S.8. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

**S.9. Denominator Exclusion Details** *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, 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.)*

Time Period for Data Collection: Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter.

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 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 measure Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, exceptions may include medical reason(s) (eg, limited life expectancy, other medical reasons). 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 Registry:

Report Quality Data Code:

G9623 - Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons)

**S.10. Stratification Information** *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – 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.)*

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF, the PCPI encourages the collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Rate/proportion

If other:

**S.13. 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.14. Calculation Algorithm/Measure Logic** *(Diagram or 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; time period for data, aggregating data; risk adjustment; etc.)*

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the



denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

**S.15. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

If an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.  
Not applicable. The measure does not require sampling.

**S.16. Survey/Patient-reported data** (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.  
Not applicable. This measure does not use a survey or an instrument.

**S.17. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Registry Data

**S.18. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

If instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.  
Not applicable.

**S.19. 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.20. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

**S.21. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Home Care, Outpatient Services

If other:

**S.22. 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.)

Not applicable.

## 2. Validity – See attached Measure Testing Submission Form

[2152\\_nqf\\_testing\\_attachment\\_7.1.docx](#)

### 2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

### 2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing



attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

### 2.3 For maintenance of endorsement

*Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.*

No - This measure is not risk-adjusted

## 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.

Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

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)** Update this field for maintenance of endorsement.

ALL data elements are in defined fields in a combination of electronic sources

**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.** For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

**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. Please also complete and attach the NQF Feasibility Score Card.**

Attachment:

### 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. Required for maintenance of endorsement.** Describe difficulties (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 instrument-based, consider implications for both individuals providing 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 feasibility 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).**

Not applicable.

## 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.*

Specific Plan for Use	Current Use (for current use provide URL)

#### 4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

Merit-based Incentive Payment System (MIPS)-Sponsored by the Centers for Medicare and Medicaid Services (CMS)

Prior to 2016, this measure was used for Eligible Providers (EPs) in the Physician Quality Reporting System (PQRS). As of 2017, PQRS has been replaced by the Merit-based Incentive Payment System (MIPS). MIPS is a national performance-based payment program that uses performance scores across several categories to determine payment rates for EPs. MIPS takes a comprehensive approach to payment by basing consideration of quality on a set of evidence-based measures that were primarily developed by clinicians, thus encouraging improvement in clinical practice and supporting advances in technology that allow for easy exchange of information.

According to the CY 2018 Quality Payment Program final rule, CMS intends to “make all measures under MIPS quality performance category available for public reporting on Physician Compare in the transition year of the Quality Payment Program, as technically feasible.” These measures include those reported via all available submission methods for MIPS-eligible clinicians and groups. Because this measure has been in use for at least one year and meets the minimum sample size requirement for reliability, this measure meets criteria for public reporting. 2018 data will be available for public reporting on Physician Compare in late 2019.

**4a1.2. 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?)**

Not applicable.

**4a1.3. 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.)**

Not applicable.

**4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

**How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.**

The PCPI measure development process is a rigorous, evidence-based process that has been refined and standardized over the past fifteen years, since the PCPI's inception. Throughout its tenure, several key principles have guided the development of performance measures by the PCPI, including the following which underscore the role those being measured have played in the development process and later through implementation feedback:

**Collaborative Approach to Measure Development**

PCPI measures have been developed through cross-specialty, multi-disciplinary expert work groups. Representatives of all relevant disciplines of medicine and other health care professionals are invited to participate as equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. Liaisons from key measure development organizations, including The Joint Commission and NCQA participate in the PCPI's measure development process to ensure harmonization of measures; measure methodologists, coding and informatics experts also are considered important members of the work group. This broad-based approach to measure development maximizes measure buy-in from stakeholders and minimizes bias toward any individual specialty or stakeholder group. As noted in Ad.1 below, 22 individuals from a diverse group of specialties including psychiatry, family medicine, nursing, occupational therapy, social work, internal medicine, and psychology contributed to the development of this measure.

**Conduct Public Comment Period**

Input from multiple stakeholders is integral to the measure development process. In particular, feedback is critical from those clinicians who will implement these measures. To that end, all measures are released for a 30-day public and PCPI member comment period. All comments are reviewed by the work group to determine whether measure modifications are needed based on comments received.

**Feedback Mechanism**

The PCPI has a dedicated process set up to receive comments and questions from implementers. As comments and questions are received, they are shared with appropriate staff for follow up. If comments or questions require expert input, these are shared with the PCPI's expert works groups to determine if measure modifications may be warranted. Additionally, for PCPI measures included in federal reporting programs, there is a system that has been set up to elicit timely feedback and responses from PCPI staff in consultation with work group members, as appropriate.

**4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

See description in 4a2.1.1 above.

**4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

**Describe how feedback was obtained.**

In addition to the feedback obtained from cross-specialty, multi-disciplinary work groups during the measure development process, the PCPI obtains feedback via a public comment period and an email-based process set up to receive measure inquiries from implementers. The public comment period feedback is provided via an online survey tool and, as mentioned, implementer feedback is provided via email.

**4a2.2.2. Summarize the feedback obtained from those being measured.**

The majority of comments received during public comment were supportive and approving of the broad nature of the measure, its potential for public health impact and patient outcomes. There were some specific comments requesting consideration of a lower age range for the measure and adding a medical reason exception for patients with limited life expectancy.

The majority of feedback from implementers seeks to have the PCPI clarify what qualifies and does not qualify as meeting the measure.

**4a2.2.3. Summarize the feedback obtained from other users**

See summary in 4a2.2 above.

**4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

At the time of original development, the expert work group decided not to adjust the age range as it was developed to align with the USPSTF's recommendation for adults. The latter comment regarding the medical reason exception was incorporated into the final version of the measure.

**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.

**4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (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.)**

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 average performance rates from the PQRS program seemed relatively stable, they remain low. It is important to note that PQRS, now the Merit-based Incentive Payment System (MIPS), has been and remains a voluntary reporting program. In the early years of the PQRS program, participants received an incentive for satisfactorily reporting. As a result, performance rates may not be nationally representative. Beginning in 2015, the program imposed payment penalties for non-participants based on 2013 performance.

Additionally, 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.

**4b2. 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).

**4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.**

We are not aware of any positive or negative unexpected findings for this measure.

**4b2.2. Please explain any unexpected benefits from implementation of this measure.**

We are not aware of any unexpected benefits from implementation of this measure.

## 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.

Yes

**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.**

#2599: Alcohol Screening and Follow-Up for People with Serious Mental Illness (NCQA)

#1661: SUB-1 Alcohol Use Screening (TJC)

#1663: SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB 2a Alcohol Use Brief Intervention (TJC)

**5a. Harmonization of Related Measures**

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 harmonized to the extent possible?**

Yes

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

The related measures listed in 5.1b were developed after our measure. The NCQA measure focuses on a specific sub-population (people with serious mental illness) and is intended for use at the health plan level. In the TJC measures, screening and intervention are separate measures. Additionally, the TJC measures are intended for use at the hospital level. PCPI was contacted by these measure stewards respectively while the measures were developed, and they are currently harmonized to the extent feasible.

**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.)**

No competing NQF-endorsed measure.

**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.

No appendix Attachment:

**Contact Information**

**Co.1 Measure Steward (Intellectual Property Owner):** PCPI Foundation

**Co.2 Point of Contact:** Samantha, Tierney, Samantha.Tierney@ama-assn.org, 312-224-6071-

**Co.3 Measure Developer if different from Measure Steward:** PCPI Foundation

**Co.4 Point of Contact:** Samantha, Tierney, samantha.tierney@ama-assn.org, 312-224-6071-

**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.**

PCPI measures are developed through cross-specialty, multi-disciplinary technical expert panels (TEPs). Representatives of all relevant disciplines of medicine and other health care professionals are invited to participate. In addition, the PCPI strives to include on its TEPs individuals representing the perspectives of patients, consumers, private health plans, and employers. Measure methodologists, and coding and informatics experts also are considered important members of the TEP. All TEP members participate as equal contributors to the measure development process. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. TEPs were convened in 2001 and 2008 to develop, refine and maintain a set of measures addressing preventive care and screening including measure #2152. More recently, in 2016, the PCPI reconvened the Preventive Care TEP which included the following individuals:

Deanna Willis MD, MBA (co-chair)  
John Wong MD (co-chair)  
Susan Blank MD  
Joel Brill MD  
Peter Briss MD  
Sandra Dunbar PhD, RN  
Yngve Falck-Ytter MD  
Susan Friedman MD, MPH  
Marc Ghany MD, MHSc  
Ellen Giarelli EdD, RN, MS, CRNP  
Ashley Halle OTD, OTR/L  
Selena Hariharan MD  
Lori Karan MD  
Martin Mahoney MD, PhD  
Stephen Persell MD, MPH  
Brian Svazas MD, MPH  
Tim Petito OD  
Barbara Resnick PhD, RN, CRNP  
Paola Ricci MD  
Andrew Saxon MD

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 2001

**Ad.3 Month and Year of most recent revision:** 03, 2018

**Ad.4 What is your frequency for review/update of this measure?** Coding/Specifications updates occur annually. See additional information below.

**Ad.5 When is the next scheduled review/update for this measure?** 2019

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These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

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**Ad.7 Disclaimers:** See copyright statement above.

**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 issues are noted that materially affect the integrity of the measure.