**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** 2152

**Measure Title**: Unhealthy Alcohol Use: Screening & Brief Counseling

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 11/1/2018

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| **Instructions**  *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*  *Complete* ***EITHER 1a.2, 1a.3 or 1a.4*** *as applicable for the type of measure and evidence.*  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Outcome: [**3**](#Note3) Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component. * For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful. * Process measures incorporating Appropriate Use Criteria: See NQF’s guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org) and/or modified GRADE.  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Outcome: Click here to name the health outcome

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors.* (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: The measure focuses on screening adults for unhealthy alcohol use and the provision of brief counseling for those identified as unhealthy alcohol users

Appropriate use measure: Click here to name what is being measured

Structure: Click here to name the structure

Composite: Click here to name what is being measured

**1a.2** **LOGIC MODEL** Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient’s health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

This measure is intended to promote unhealthy alcohol use screening and brief counseling which has been shown to be effective in reducing alcohol consumption, particularly in primary care settings. Unhealthy alcohol use “contributes to hypertension, cirrhosis, gastritis, gastric ulcers, pancreatitis, breast cancer, neuropathy, cardiomyopathy, anemia, osteoporosis, cognitive impairment, depression, insomnia, anxiety, suicide, injury, and violence.”(1)

Reference:

1. Jonas DE, Garbutt JC, Amick HR, et al. Behavioral Counseling After Screening for Alcohol Misuse in Primary Care: A Systematic Review and Meta-analysis for the U.S. Preventive Services Task Force. Ann Intern Med. 2012 Sep 25

**1a.3** **Value and Meaningfulness:**  **IF** this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

Not applicable

**\*RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) \*\***

**1a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.**

Not applicable

**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures, including those that are instrument-based) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.**

**What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)**

☐ Clinical Practice Guideline recommendation (with evidence review)

x US Preventive Services Task Force Recommendation

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐ Other

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * **Title:** Behavioral Counseling After Screening for Alcohol Misuse in Primary Care: A Systematic Review and Meta-analysis for the U.S. Preventive Services Task Force * **Author:** Jonas DE, Garbutt JC, Amick HR, Brown JM, Brownley KA, Council CL, Viera AJ, Wilkins TM, Schwartz CJ, Richmond EM, Yeatts J, Swinson Evans T, Wood SD, and Harris RP. * **Date:** November 6, 2012 * **Citation:** Jonas DE, Garbutt JC, Amick HR, Brown JM, Brownley KA, Council CL, Viera AJ, Wilkins TM, Schwartz CJ, Richmond EM, Yeatts J, Swinson Evans T, Wood SD, and Harris RP. Behavioral counseling after screening for alcohol misuse in primary care: A systematic review and meta-analysis for the U.S. Preventive Services Task Force. Ann Intern Med. 2012;157:645-654. * **URL:** [**https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care**](https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care) |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | The USPSTF recommends that clinicians screen adults aged 18 years and older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | Moderate Strength of Evidence: Moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of the effect and may change the estimate. |
| Provide all other grades and definitions from the evidence grading system | The strength of evidence was graded based on the guidance established for the AHRQ Evidence-based Practice Center Program. Developed to grade the overall strength of a body of evidence, this approach incorporates four key domains: risk of bias (includes study design and aggregate quality), consistency, directness, and precision of the evidence. We considered all evidence from intermediate outcomes to be indirect. It also considers other optional domains that may be relevant for some scenarios, such as a dose-response association, plausible confounding that would decrease the observed effect, strength of association (magnitude of effect), and publication bias.  Definitions of the grades of overall strength of evidence  Grade: Definition  High: High confidence that the evidence reflects the true effect. Further research is very unlikely to change our confidence in the estimate of effect.  Moderate: Moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of the effect and may change the estimate.  Low: Low confidence that the evidence reflects the true effect. Further research is likely to change our confidence in the estimate of the effect and is likely to change the estimate.  Insufficient: Evidence either is unavailable or does not permit estimation of an effect. |
| Grade assigned to the **recommendation** with definition of the grade | B Recommendation  The USPSTF recommends this service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.  Source: <https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions#grade-definitions-after-july-2012> |
| Provide all other grades and definitions from the recommendation grading system | A Recommendation: The USPSTF recommends this service. There is high certainty that the net benefit is substantial.  B Recommendation: The USPSTF recommends this service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.  C Recommendation: The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgement and patient preferences. There is at least moderate certainty that the net benefit is small.  D Recommendation: The USPSTF recommends against this service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.  I Statement: The USPSTF concludes that that current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.  Source: <https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions#grade-definitions-after-july-2012> |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | The USPSTF evidence review included 23 randomized, controlled trials included in 38 articles.  The quality of the body of evidence for adults was summarized according to the grades of evidence rating as “moderate strength of evidence” for each of 3 intermediate outcomes reported [consumption (mean drinks/week), heavy drinking episodes, and achievement of recommended drinking limits]. For specific patient populations, the quality of the body of evidence varied depending on the intermediate outcome studied. Details are as follows:  Adults:  Consumption: Reduction of 3.6 (2.4 to 4.8) from baseline ~23 [Moderate Strength Of Evidence (SOE)]  Heavy Drinking Episodes: 12% fewer subjects reported heavy drinking episodes (7%, 16%) from ~52% at baseline [Moderate SOE]  Recommended Drinking Limits: 11% more subjects achieved (8%, 13%) [Moderate SOE]  Older adults:  Consumption: Reduction of 1.7 (0.6 to 2.8) from baseline ~16 [Moderate SOE]  Heavy Drinking Episodes: [Insufficient SOE]  Recommended Drinking Limits: 9% more subjects achieved (2%, 16%) [Low SOE]  Young adults or college students  Consumption: Reduction of 1.7 (0.7 to 2.6) from baseline ~15 [Moderate SOE]  Heavy Drinking Episodes: 0.9 fewer heavy drinking days (0.3, 1.5) from ~6.2 days per month at baseline [Moderate SOE]  Recommended Drinking Limits: [Insufficient SOE]  Pregnant women  Consumption: Data from 1 study found no difference [Low SOE]  Heavy Drinking Episodes: [Insufficient SOE]  Recommended Drinking Limits: [Insufficient SOE]  Of note, none of the studies were designed to achieve abstinence, and the report indicated it should probably not be a goal of behavioral interventions for most people.  For most [long term] health outcomes, available evidence either demonstrated no difference between interventions and controls (e.g., mortality: low SOE) or was insufficient to draw conclusions (e.g., accidents, injuries, alcohol-related liver problems: insufficient SOE). Some evidence suggests that interventions improve some utilization outcomes for adults (e.g., hospital days and costs: low SOE). [The recent] meta-analyses did not find a reduction in all-cause mortality for adults (four studies; rate ratio 0.64, 95% confidence interval [CI], 0.24 to 1.7) or for all age groups combined (adults, older adults, and young adults/college students) (six studies; rate ratio 0.52, 95% CI, 0.22 to 1.2). |
| Estimates of benefit and consistency across studies | Although the results by population group are summarized in the section above, additional details addressing the consistency of results across studies are provided below:  --Consumption: Behavioral interventions resulted in a greater reduction in quantity of alcohol consumed than controls at 12 months (weighted mean difference [WMD], -3.6 drinks per week, 95% CI, -4.8 to -2.4, moderate SOE). Subgroup analyses for men and women found similar benefits. When stratifying by intensity of the intervention, we found no statistically significant difference between very brief interventions and controls (just one study contributed), but found greater reduction for brief, brief multi-contact, and extended multi-contact interventions than for controls. We found similar results for studies conducted in the United States compared with those conducted in other countries, a trend toward a greater reduction in consumption for interventions delivered primarily by primary care providers (WMD, -4.0 drinks per week, 95% CI, -5.4 to -2.6) than for those delivered primarily by research personnel (WMD, -3.0, 95% CI, -5.0 to -1.0), and that studies enrolling 10 percent or more subjects with alcohol dependence found behavioral interventions to be ineffective or less effective than other studies.  -- Heavy drinking episodes: Behavioral interventions resulted in 12 percent more subjects reporting no heavy drinking episodes by 12 months compared with controls (risk difference 0.12, 95% CI, 0.07 to 0.16, moderate SOE). Subgroup analyses for men and women found similar results. When stratifying by intensity of the intervention, brief multi-contact and extended multi-contact interventions were efficacious at 12 months (with 11 percent and 19 percent absolute difference compared with controls, respectively), but brief interventions did not reach statistical significance compared with controls.  -- Recommended drinking limits achieved: 11 percent more subjects receiving interventions achieved recommended drinking limits by 12 months compared with controls (risk difference 0.11, 95% CI, 0.08 to 0.13, moderate SOE). Subgroup analyses for men and women found similar magnitude of benefit. All of the intervention intensities studied were efficacious. The absolute difference in percentage of subjects achieving recommended drinking limits was numerically greatest for the brief multi-contact interventions (15% compared with 8%for very brief and brief interventions at 12 months), but the confidence intervals overlap. |
| What harms were identified? | The study authors found no evidence of direct harms, aside from opportunity costs associated with interventions, which ranged from 5 minutes to 2 hours dispersed over several in-person or telephone visits [moderate SOE]. The authors searched for evidence of potential adverse effects, such as illegal substance use, increased smoking, anxiety, stigma, labeling, discrimination, or interference with the physician–patient relationship. They found no evidence for most of these potential harms and very limited evidence reporting no difference between groups for smoking rates and anxiety [low SOE]. Other than the results for opportunity costs, the results are limited by the few trials that reported any information; 5 of 23 reported smoking, and 2 reported anxiety. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | We are aware that the current guideline recommendation is under review by the USPSTF. The public comment version of the draft recommendation statement is posted at: <https://www.uspreventiveservicestaskforce.org/Page/Document/final-research-plan/unhealthy-alcohol-use-in-adolescents-and-adults-including-pregnant-women-screening-and-behavioral-counseling-interventions>  The public comment period ended on July 2, 2018. A date for when to expect the final updated guideline recommendation to be published is not yet known. Upon review of the draft recommendation statement, there are no changes that would affect the measure. |

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**1a.4 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

Not applicable.

**1a.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.** A list of references without a summary is not acceptable.

**1a.4.2 What process was used to identify the evidence?**

**1a.4.3.** **Provide the citation(s) for the evidence.**