National Consensus Standards for Behavioral Health Conditions

...an unofficial introduction

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Disclosure

• I have no personal financial relationship with the manufacture of any products or services discussed in this presentation.

• I am a health commissioner for San Francisco City and County Department of Public Health.

• I have been a member of the NQF Behavioral Health Standing Committee since 2013. The views presented do not represent those of NQF or its constituent organizations.
Established in 1999, NQF is a non-profit, non-partisan, membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare performance measurement. The goal is to make healthcare in the U.S. better, safer, and more affordable.

**Mission:** To lead national collaboration to improve health and healthcare quality through measurement

- An Essential Forum
- Gold Standard for Quality Measurement
- Leadership in Quality
NQF Activities in Multiple Measurement Areas

- **Performance Measure Endorsement**
  - 600+ NQF-endorsed measures across multiple clinical areas
  - 19 empaneled standing committees

- **Measure Applications Partnership (MAP)**
  - Advises HHS on selecting measures for 20+ federal programs, Medicaid, and health exchanges

- **National Quality Partners**
  - Convenes stakeholders around critical health and healthcare topics
  - Spurs action on patient safety, early elective deliveries, and other issues

- **Measurement Science**
  - Convenes private and public sector leaders to reach consensus on complex issues in healthcare performance measurement such as attribution, alignment, sociodemographic status (SDS) adjustment
NQF endorsement evaluation

MAP feedback on endorsed measures:
- Entered into NQF database
- Shared with Committee during maintenance
- *Ad hoc* review if MAP raises any major issues addressing criteria for endorsement

NQF evaluation summary provided to MAP

MUC given conditional support pending NQF endorsement

MAP pre-rulemaking recommendations

MUC that has never been through NQF

- NQF outreach to MUC developers in February and during Call for Measures
- Funding proposals include MAP topics
- MAP feedback to Committee

- NQF endorsement
- Evaluation
- Pre-rulemaking recommendations
- NQF evaluation summary provided to MAP
- MUC given conditional support pending NQF endorsement
- MAP pre-rulemaking recommendations
- NQF endorsement evaluation
- NQF evaluation summary provided to MAP
- MUC that has never been through NQF

CDP-MAP INTEGRATION – INFORMATION FLOW
Types of Performance Measures

- Quality
- Resource use/cost
- Efficiency (combination of quality and resource use)
- Composite (two or more measures in a single score)

NQF endorsement reflects *rigorous scientific and evidence-based* review for Standardized performance measures are used for comparisons.
Characteristics of Measures

- **Measures are different from concepts or ideas**
  - Quality of care is an abstract construct
  - A quality measure is a numeric quantification of healthcare quality

- **Measures have detailed specifications**
  - What to count (including codes, definitions)
  - Who is included and/or excluded
  - When to count
  - Where to find data
  - How to compute score

\[
\text{Numerators} = X \\
\text{Denominators} = Y
\]
2-D Measurement Framework: AMI Episode

- **Post AMI Trajectory 1 (T1)**
  - **Relatively healthy adult**
  - Focus on:
    - Secondary prevention
    - Quality of Life
    - Functional Status
    - Advanced care planning

- **Post AMI Trajectory 2 (T2)**
  - **Adult with multiple co-morbidities**
  - Focus on:
    - Palliative Care
    - Functional Status
    - Advanced Care Planning

**Population Health**
- **1st Prevention**
- **2nd Prevention** (CAD with prior AMI)
- **Staying Healthy**

**Care Coordination**
- **Acute Phase**
- **Post Acute/Rehabilitation Phase**
- **2nd Prevention**

**Patient & Family Engagement**

**Overuse**
- Episode begins – onset of symptoms
- Episode ends – 1 year post AMI

**Safety**
Person-Centered Measures

Physician Quality Reporting System (PQRS)

NQF# 0018 Blood Pressure Control
(Cardiovascular and Diabetes Families)

NQF# 0326 Advance Care Plan
(Care Coordination, Hospice, and Dual Eligible Beneficiaries Families)

Hospital Inpatient Quality Reporting Program (IQR)

NQF# 0289 Median Time to ECG
(Care Coordination and Cardiovascular Families)

NQF# 0141 Patient Fall Rate
(Safety Family)

Inpatient Rehabilitation Facilities Quality Reporting (IRF)

NQF# 0418 Screening for Clinical Depression
(Dual Eligible Beneficiaries Family)

NQF# 0648 Timely Transmission of Transition Record
(Care Coordination, Hospice, and Dual Eligible Beneficiaries Families)
NQF currently has more than 50 endorsed measures within the area of behavioral health. Endorsed measures undergo periodic evaluation to maintain endorsement – “maintenance”.

### Behavioral Health Portfolio of MUC measures: 4

*Measures for maintenance evaluation*

- 0008: Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) (CMS)*
- 0027: Medical Assistance With Smoking and Tobacco Use Cessation (NCQA)*
- 0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (PCPI Foundation)*
- 3185: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure) (PCPI Foundation)
- 0108: Follow-Up Care for Children Prescribed ADHD Medication (NCQA)*
- 0576: Follow-Up After Hospitalization for Mental Illness (NCQA)*
- 3132: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (eMeasure) (CMS)
- 3148: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (CMS)*
- 3172: Continuity of Pharmacotherapy for Alcohol Use Disorder (RAND Corporation)
- 3175: Continuity of Pharmacotherapy for Opioid Use Disorder (RAND Corporation)
Measure Evaluation Criteria
Overview
NQF Consensus Development Criteria

- Criteria #1: Importance to Measure and Report*
- Criteria #2: Scientific Acceptability of Measure Properties*
- Criteria #3: Feasibility
- Criteria #4: Usability and Use *(must-pass)*
- Criteria #5: Comparison to Related or Competing Measures

Final Recommendation for Endorsement/Harmonization
Criterion #1: Importance to Measure & Report

1. **Importance to measure and report** - Extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality where there is variation in or overall less-than-optimal performance.

   **1a. Evidence:** the measure focus is evidence-based

   **1b. Opportunity for Improvement:** 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

   **1c. Quality construct and rationale** (composite measures only)
Subcriterion 1a: Evidence for Measure Focus

- Hierarchical preference for
  - Outcomes linked to evidence-based processes/structures
  - Outcomes of substantial importance with plausible process/structure relationships
  - Intermediate outcomes
  - Processes/structures

Most closely linked to outcomes
Criterion #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 health care delivery

2a. Reliability (must-pass)
   2a1. Precise specifications including exclusions
   2a2. Reliability testing—data elements or measure score

2b. Validity (must-pass)
   2b1. Specifications consistent with evidence
   2b2. Validity testing—data elements or measure score
   2b3. Justification of exclusions—relates to evidence
   2b4. Risk adjustment—typically for outcome/cost/resource use
   2b5. Identification of differences in performance
   2b6. Comparability of data sources/methods
   2b7. Missing data
Reliability and Validity

Assume the center of the target is the true score…

- **Reliable Not Valid**: Consistent, but wrong
- **Neither Reliable Nor Valid**: Inconsistent & wrong
- **Both Reliable And Valid**: Consistent & correct
Criterion #3: Feasibility

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

3a: Clinical data generated during care process

3b: Electronic sources

3c: Data collection strategy can be implemented
Criterion #4: Usability and Use

Extent to which potential audiences 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

4b: Improvement

4c: Benefits outweigh the harms

4d: Vetting by those being measured and others
Criterion #1: Importance to measure and report
Criteria emphasis is different for new vs. maintenance measures

<table>
<thead>
<tr>
<th>New measures</th>
<th>Maintenance measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Evidence – Quantity, quality, consistency (QQC)</td>
<td>DECREASED EMPHASIS: Require measure developer to attest evidence is unchanged evidence from last evaluation; Standing Committee to affirm no change in evidence</td>
</tr>
<tr>
<td>• Established link for process measures with outcomes</td>
<td>IF changes in evidence, the Committee will evaluate as for new measures</td>
</tr>
<tr>
<td>• Gap – opportunity for improvement, variation, quality of care across providers</td>
<td>INCREASED EMPHASIS: data on current performance, gap in care and variation</td>
</tr>
</tbody>
</table>
## Criterion #2: Scientific Acceptability

<table>
<thead>
<tr>
<th>New measures</th>
<th>Maintenance measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Measure specifications are precise with all information needed to implement the measure</td>
<td>NO DIFFERENCE: Require updated specifications</td>
</tr>
<tr>
<td>• Reliability</td>
<td>DECREASED EMPHASIS: If prior testing adequate, no need for additional testing at maintenance with certain exceptions (e.g., change in data source, level of analysis, or setting) Must address the questions for SDS Trial Period</td>
</tr>
</tbody>
</table>
Criteria #3-4: Feasibility and Usability and Use

<table>
<thead>
<tr>
<th>New measures</th>
<th>Maintenance measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feasibility</strong></td>
<td></td>
</tr>
<tr>
<td>• Measure feasible, including eMeasure feasibility assessment</td>
<td>NO DIFFERENCE: Implementation issues may be more prominent</td>
</tr>
<tr>
<td><strong>Usability and Use</strong></td>
<td></td>
</tr>
<tr>
<td>• Use: used in accountability applications and public reporting</td>
<td>INCREASED EMPHASIS: Much greater focus on measure use and usefulness, including both impact and unintended consequences</td>
</tr>
<tr>
<td>• Usability: impact and unintended consequences</td>
<td></td>
</tr>
</tbody>
</table>
Recommendation for Endorsement or Endorsement +

- The Committee votes on whether to recommend a measure for **NQF Endorsement**
- Or “Endorsement +” designation, indicating that the measure exceeds NQF criteria if
  - **Meets evidence criteria without exception**
  - **Good results on reliability testing of the measure score**
  - **Good results on empirical validity testing of the measure score (not just face validity)**
  - **Well-vetted in real world settings by those being measured and others in key areas.**

- **Harmonization** of related or competing measures
Enroll for an account and set up dashboard to follow this project at [www.qualityforum.org](http://www.qualityforum.org) – Click on DASHBOARD
The Business of Making Measures
Busy Clinic - The App!
Behavioral Health Standing Committee

- Peter Briss, MD, MPH, (Co-Chair)
- Harold Pincus, MD (Co-Chair)
- Robert Atkins, MD, MPH
- Mady Chalk, PhD, MSW
- Shane Coleman, MD, MPH*
- David Einzig, MD
- Julie Goldstein Grumet, PhD
- Charles Gross, PhD*
- Constance Horgan, ScD
- Lisa Jensen, DNP, APRN
- Dolores (Dodi) Kelleher, MS, DMH
- Kraig Knudsen, PhD
- Michael R. Lardieri, LCSW
- Tami Mark, PhD, MBA

- Raquel Mazon Jeffers, MPH, MIA
- Bernadette Melnk, PhD, RN, CPNP/FAANP, FNAP, FAAN
- Laurence Miller, MD
- Brooke Parish, MD*
- David Pating, MD
- Vanita Pindolia, PharmD
- Rhonda Robinson Beale, MD
- Lisa Shea, MD, DFAPA
- Andrew Sperling, JD*
- Jeffery Susman, MD
- Michael Trangle, MD
- Bonnie Zima, MD, MPH
- Leslie S. Zun, MD, MBA

*indicates new committee member
**MEASURE WORKSHEET**

This document summarizes the evaluation of the measure as it progresses through NQF’s Consensus Development Process (CDP). The information submitted by measure developers/stewards is included after the Brief Measure Information, Preliminary Analysis, and Pre-meeting Public and Member Comments sections.

To navigate the links in the worksheet: Ctrl + click link to go to the link; ALT + LEFT ARROW to return

<table>
<thead>
<tr>
<th>Brief Measure Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOF #: 0108</strong></td>
</tr>
<tr>
<td><strong>Corresponding Measures:</strong></td>
</tr>
<tr>
<td><strong>Measure Title:</strong> Follow-Up Care for Children Prescribed ADHD Medication (ADD)</td>
</tr>
<tr>
<td><strong>Measure Steward:</strong> National Committee for Quality Assurance</td>
</tr>
<tr>
<td><strong>Brief Description of Measure:</strong> Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. An initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.</td>
</tr>
<tr>
<td><strong>Developer Rationale:</strong> Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. Medications can improve function, but proper monitoring is recommended. The intent of this measure is to ensure timely and continuous follow-up visits for children who are newly prescribed ADHD medication. The goal is to encourage monitoring of children for medication effectiveness, occurrence of side effects and adherence.</td>
</tr>
<tr>
<td><strong>Numerator Statement:</strong> Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.</td>
</tr>
<tr>
<td><strong>Denominator Statement:</strong> Children 6-12 years of age newly prescribed ADHD medication.</td>
</tr>
<tr>
<td><strong>Denominator Exclusions:</strong> Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date. Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion. Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.</td>
</tr>
<tr>
<td><strong>Measure Type:</strong> Process</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Claims (Only), Pharmacy</td>
</tr>
<tr>
<td><strong>Level of Analysis:</strong> Health Plan, Integrated Delivery System</td>
</tr>
<tr>
<td><strong>IF Endorsement Maintenance — Original Endorsement Date:</strong> Aug 10, 2009 <strong>Most Recent Endorsement Date:</strong> Mar 06, 2015</td>
</tr>
</tbody>
</table>
Evidence: Gap

Disparities

- HEDIS measures are stratified by type of insurance. The developer cites literature that suggests that children from minority families experience decreased access to and utilization of health services for ADHD, as well as decreased rates of diagnosis of and treatment for ADHD.
# MEASURE WORKSHEET

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<tr>
<td><strong>NQF #: 3172</strong></td>
</tr>
<tr>
<td><strong>Corresponding Measures:</strong></td>
</tr>
<tr>
<td><strong>Measure Title:</strong> Continuity of Pharmacotherapy for Alcohol Use Disorder</td>
</tr>
<tr>
<td><strong>Measure Steward:</strong> RAND Corporation</td>
</tr>
<tr>
<td><strong>Brief Description of Measure:</strong> Percentage of adults 18-64 years of age with pharmacotherapy for alcohol use disorder (AUD) who have at least 180 days of treatment and a Proportion of Days Covered (PDC) of at least 0.8</td>
</tr>
<tr>
<td><strong>Developer Rationale:</strong> In spite of its high prevalence and its substantial burden on patients, their families and society, alcohol use disorder (AUD) remains a severely undertreated condition. According to the 2014 National Survey on Drug Use and Health (NSDUH), 16.3 million Americans ages 18 years and older suffered from AUD (SAMHSA, 2014a), representing almost 7 percent of the adult population (SAMHSA, 2014b). But only 15.2 percent of patients, who reported that they needed alcohol treatment, actually received it (SAMHSA, 2014c).</td>
</tr>
<tr>
<td><strong>Numerator Statement:</strong> Individuals in the denominator who have at least 180 days of treatment and a PDC of at least 0.8 for AUD medications</td>
</tr>
<tr>
<td><strong>Denominator Statement:</strong> Individuals 18-64 years of age who had a diagnosis of AUD and at least one claim for an AUD medication</td>
</tr>
<tr>
<td><strong>Denominator Exclusions:</strong> There are no denominator exclusions.</td>
</tr>
</tbody>
</table>

| **Measure Type:** Process |
| **Data Source:** Claims (Other), Pharmacy |
| **Level of Analysis:** Health Plan, Population : Regional and State |
1a. Evidence. The evidence requirements for a process or intermediate outcome measure is that it is based on a systematic review (SR) and grading of the body of empirical evidence where the specific focus of the evidence matches what is being measured.

The developer provides the following evidence for this measure:
- Systematic Review of the evidence specific to this measure? □ Yes □ No
- Quality, Quantity and Consistency of evidence provided? □ Yes □ No
- Evidence graded? □ Yes □ No

Evidence Summary:
- The developer provides a diagram of the relationship of this process of care (pharmacotherapy for Alcohol Use Disorder (AUD) proportion of days covered (PDC) > 0.8 for at least 180 days) to lower AUD relapse rates, which in turn leads to fewer adverse outcomes and decreased costs.
- Evidence provided by the developers to support the measure includes two recommendations from the VA/DOD 2015 Guidance on Management of Substance Use Disorders.
  - Recommendation 5: For patients with moderate-severe alcohol use disorder, we recommend offering one of the following medications (recommendation grade: “strong for…”):
    - Acamprosate (evidence grade—moderate)
    - Disulfiram (not graded; based on randomized, double-blind, placebo-controlled trials)
  - Recommendation 6: For patients with moderate-severe alcohol use disorder for whom first-line pharmacotherapy is contraindicated or ineffective, we suggest offering gabapentin. (recommendation grade: “weak for…”; evidence not graded)
    - Naltrexone—oral or extended release (evidence grade—low to moderate)
    - Topiramate (not graded, but relied on randomized, double-blind, placebo-controlled trials)

Evidence provided several citations to support their use of the 180-day minimum treatment period and the use of an 80% threshold for PDC.

2b2. Validity testing

2b7. Validity Testing. Should demonstrate the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality.

SUMMARY OF TESTING

Validity testing level □ Measure score □ Data element testing against a gold standard □ Both

Method of validity testing of the measure score:
- □ Face validity only
- □ Empirical validity testing of the measure score

Validity testing method:
- Face validity was assessed by a 10 clinicians with expertise in treating AUD. These individuals were asked to rate their agreement, on a 5-point scale, with the following statement: “Performance scores resulting from the measure as defined can be used to distinguish good from poor quality.”
- According to NQF guidance, the face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process, by identified experts, and explicitly addresses how performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The testing conducted by the developer conforms to NQF’s requirements for face validity.

Validity testing results:
- Of the 10 clinicians surveyed, 2 strongly agreed and 4 agreed, that results from the measure can be used to distinguish good from poor quality. The remaining 4 clinicians neither agreed nor disagreed.

Questions for the Committee:
- Did the clinicians included in the face validity assessment have the appropriate expertise to judge the face validity of the measure?
- Do the results demonstrate sufficient validity so that conclusions about quality can be made?
- Do you agree that the score from this measure as specified is an indicator of quality?
## MEASURE WORKSHEET

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### Brief Measure Information

<table>
<thead>
<tr>
<th>NQF #: 3205</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Title: Medication Continuation Following Inpatient Psychiatric Discharge</td>
</tr>
<tr>
<td>Measure Steward: Centers for Medicare &amp; Medicaid Services, Contracting Officer’s Representative (COR)</td>
</tr>
<tr>
<td>Brief Description of Measure: This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. The performance period for the measure is two years.</td>
</tr>
<tr>
<td>Developer Rationale: The aim of the proposed measure is to address gaps in continuity of pharmaceutical treatment during the transition from inpatient care to outpatient care. Pharmacotherapy is the primary form of treatment for most patients discharged from an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder. The measure focuses on medication continuation because it is an essential step in medication adherence.</td>
</tr>
</tbody>
</table>

### Numerator Statement: The numerator for this measure includes:

1. Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge
2. Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge
3. Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

### Denominator Statement: The target population for this measure is Medicare fee-for-service (FFS) beneficiaries with Part D coverage aged 18 years and older discharged from an inpatient psychiatric facility with a principal diagnosis of MDD, schizophrenia, or bipolar disorder.

### Denominator Exclusions: The denominator for this measure excludes discharged patients who:

1. Received Electroconvulsive Therapy (ECT) during the inpatient stay or follow-up period.
2. Received Transcranial Magnetic Stimulation (TMS) during the inpatient stay or follow-up period.
3. Were pregnant during the inpatient stay.
5. Had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia.

### Measure Type: Process

### Data Source: Claims (Only)

### Level of Analysis: Facility
Feasibility

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 a PRO-PM, consider implications for both individuals providing PRO data (patients, service recipients, respondents) and those whose performance is being measured.
Data used in the calculation of this measure are obtained from administrative claims, which are routinely, reliably, and securely collected for billing purposes. We do not anticipate any feasibility or implementation issues related to data collection for this measure.

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).
There are no fees, licensing, or other requirements associated with the use of this measure.

Useability

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 the Measures Under Consideration (MUC) list to be reviewed by the Measure Applications Partnership (MAP) for use in the IPFQR Program.
Review of HEDIS: AOD_IET Measure

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence* (first visit in calendar year) who received the following:

- Index Episode Start Date (IESD)
- 14 days inclusive
- Initiation Visit
- 30 days
- Two Engagement Visits

Primary Focus:
- Inpatient
- Intensive Outpatient
- Partial Hospitalization
- Outpatient
- Detoxification
- ED Encounter

HEDIS “dependence” definition is very broad and contains almost all alcohol and substance related codes (see appendix)
Unhealthy Drinking In KPNC Primary Care

- **Abstainers**
- **Low-Risk Drinkers**
- **Unhealthy Drinkers** w/out dependence 6.8%
- **Alcohol Dependent** 0.8%

Institute of Medicine, 1990, and World Health Organization, 2001
## 20 Most Frequent Dx in Med-FMS 2013

<table>
<thead>
<tr>
<th>Diagnoses 2013</th>
<th># Index Visits</th>
<th>% Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ALCOHOL ABUSE</td>
<td>2527</td>
<td>12%</td>
</tr>
<tr>
<td>2 ALCOHOL DEPENDENCE</td>
<td>2484</td>
<td>9%</td>
</tr>
<tr>
<td>3 ALCOHOL USE, EXCESSIVE, NON-DEPENDENT</td>
<td>1454</td>
<td>6%</td>
</tr>
<tr>
<td>4 OPIOID DEPENDENCE</td>
<td>905</td>
<td>12%</td>
</tr>
<tr>
<td>5 CANNABIS DEPENDENCE</td>
<td>455</td>
<td>6%</td>
</tr>
<tr>
<td>6 CANNABIS ABUSE</td>
<td>428</td>
<td>7%</td>
</tr>
<tr>
<td>7 SUBSTANCE ABUSE</td>
<td>344</td>
<td>20%</td>
</tr>
<tr>
<td>8 ALCOHOL DEPENDENCE, CONTINUOUS</td>
<td>184</td>
<td>9%</td>
</tr>
<tr>
<td>9 DRUG DEPENDENCE</td>
<td>165</td>
<td>16%</td>
</tr>
<tr>
<td>10 DRUG ABUSE</td>
<td>140</td>
<td>26%</td>
</tr>
<tr>
<td>11 ALCOHOLISM</td>
<td>133</td>
<td>19%</td>
</tr>
<tr>
<td>12 OPIOID WITHDRAWAL</td>
<td>131</td>
<td>27%</td>
</tr>
<tr>
<td>13 DRUG SEEKING BEHAVIOR</td>
<td>125</td>
<td>12%</td>
</tr>
<tr>
<td>14 CAFFEINE USE</td>
<td>119</td>
<td>2%</td>
</tr>
<tr>
<td>15 ALCOHOL ABUSE, EPISODIC</td>
<td>96</td>
<td>16%</td>
</tr>
<tr>
<td>16 OPIOID DEPENDENCE, CONTINUOUS</td>
<td>94</td>
<td>12%</td>
</tr>
<tr>
<td>17 CAFFEINE DEPENDENCE</td>
<td>81</td>
<td>5%</td>
</tr>
<tr>
<td>18 METHAMPHETAMINE DEPENDENCE</td>
<td>81</td>
<td>11%</td>
</tr>
<tr>
<td>19 SEDATIVE, HYPNOTIC OR ANXIOLYTIC DEPENDENCE</td>
<td>79</td>
<td>11%</td>
</tr>
<tr>
<td>20 POLYSUBSTANCE ABUSE</td>
<td>71</td>
<td>11%</td>
</tr>
</tbody>
</table>
HEDIS IET AOD

Measures Endorsed

Alcohol Measures

### 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

#### Maintenance Measure

**Description:** The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:

a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

**Numerator Statement:**

a) Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

- If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant.
- If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with an AOD diagnosis (Table IET-A) within 14 days of the IESD (inclusive).
- If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive).
- Do not count Index Episodes that include detoxification codes (including Inpatient detoxification) as being initiation of treatment.

b) Engagement of AOD Treatment:

- Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period.

- If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the initiation encounter (inclusive).
- Do not count engagement encounters that include detoxification codes (including Inpatient detoxification).

**Denominator Statement:** Members age 13 years of age and older with a medical and chemical dependency benefit who were diagnosed with a new episode of alcohol and drug dependency (AOD) during the intake period of January 1 - November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.

**Exclusions:**

- Include members who had a claim/encounter with a Diagnosis of AOD (Table IET-A) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the Negative Diagnosis History.

For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.

Exclude from the denominator members whose Initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

**Adjustment/Stratification:** No risk adjustment or risk stratification N/A

**Level of Analysis:** Health Plan, Integrated Delivery System, Population: County or City, Population: National, Population: Regional

**Type of Measure:** Process

**Data Source:**

- Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

**Measure Steward:** National Committee for Quality Assurance

**Steering Committee:** In-Person April 17-18, 2012
Substance Use National Hospital Inpatient Quality Measures

<table>
<thead>
<tr>
<th>Set Measure ID #</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUB-1</td>
<td>Alcohol Use Screening</td>
</tr>
<tr>
<td>SUB-2</td>
<td>Alcohol Use Brief Intervention Provided or Offered</td>
</tr>
<tr>
<td>SUB-2a</td>
<td>Alcohol Use Brief Intervention Treatment</td>
</tr>
<tr>
<td>SUB-3</td>
<td>Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge</td>
</tr>
<tr>
<td>SUB-3a</td>
<td>Alcohol and Other Drug Use Disorder Treatment at Discharge</td>
</tr>
<tr>
<td>SUB-4</td>
<td>Alcohol and Drug Use: Assessing Status After Discharge</td>
</tr>
</tbody>
</table>
AUDIT Screening Tool

### Alcohol Use Disorders Identification Test

#### Domain
- Hazardous Alcohol Use (1-3)
- Dependence Syndromes (4-6)
- Harmful Alcohol Use (7-10)

#### AUDIT Score
- **WHO**
  - <8: (Alc Education) No Action
  - 8-15: (Simple Advice) RN Advice
  - >16: (Brief Counsel) LCSW&MD inbasket
- **Kaiser**
  - >20: (Specialist Tx) ___

### Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have a drink containing alcohol?</td>
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<td>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
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<td>3. How often do you have six or more drinks on one occasion?</td>
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<td>4. How often during the last year have you found that you were not able to stop drinking once you had started?</td>
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<td>5. How often during the last year have you failed to do what was normally expected of you because of drinking?</td>
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<td>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</td>
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<td>7. How often during the last year have you had a feeling of guilt daily after drinking?</td>
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<td>8. How often during the last year have you been unable to remember what happened the night before because of your drinking?</td>
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<tr>
<td>9. Have you or someone else been injured because of your drinking?</td>
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<td>10. Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down?</td>
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### Total
Rx: Medication Recommendation

1. **Naltrexone** – Injectable Extended Release (Vivitrol) 380mg IM  
   a. Hold if LFT > 3x normal or recent opioid use.  
   b. If decides against IM, consider oral Naltrexone 50mg daily. (#30)

2. **Topiramate** – (second choice)  
   a. Start 50mg hs x 1 week, then increase 100mg hs. (#50)  
“Compared with other medications for alcohol use disorders, XR-NTX is associated with increased days on medication and lower utilization and cost of inpatient and emergency care.”

Aetna, 2011: XR-NTX (n=211) Disulfiram (1043), Oral NTX (1408), Acamprosate (2479)

### 1661 SUB-1 Alcohol Use Screening

**Status: New Submission**

**Description:** Hospitalized patients 18 years of age and older who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening; SUB-2 Alcohol Use Brief Intervention; Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).

**Numerator Statement:** The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking

**Denominator Statement:** The number of hospitalized inpatients 18 years of age and older

**Exclusions:** The denominator has three exclusions:
- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who have a duration of stay less than or equal to one day or greater than 120 days

**Adjustment/Stratification:** No risk adjustment or risk stratification Not Applicable Not Applicable, the measure is not stratified

**Level of Analysis:** Facility, Population: National

**Type of Measure:** Process

**Data Source:** Electronic Clinical Data, Paper Medical Records

**Measure Goal:** The Joint Commission

### STEERING COMMITTEE MEETING [9/5/13]

**1. Importance to Measure and Report:** The measure meets the importance criteria

1a. High impact: 1b. Performance Gap, 1c. Evidence

1a. Impact: H-16; M-4; I-0; G-0; L-0; 1b. Performance Gap: H-12; M-7; I-0; L-0; 1c. Evidence: Y-17; N-0; I-2

**Rationale:**
- The Steering Committee initially reviewed and rated the importance criteria for this measure on April 18, 2012, during the first phase of this project; accordingly, Importance to Measure and Report was not discussed during the phase two meeting. Instead, the votes from Phase 1 were carried over, and appear above.

**2. Scientific Acceptability of Measure Properties:** The measure meets the scientific acceptability criteria

2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: H-2; M-16; I-0; L-0; 2b. Validity: H-2; M-17; I-2; L-0

**Rationale:**
- The Steering Committee agreed the measure met the criteria. Reliability testing of the measure involved the re-abstraction of 96 medical records at five hospitals and the overall agreement rate was 75 percent. Following the re-abstraction, focus groups were conducted at each hospital and differences in abstraction were further discussed and highlighted as an opportunity for improvement on the measure.
- On a previous review of the measure the Steering Committee had indicated concern regarding the reliability of the data element focused on screening patients for alcohol use; however, the developer noted that alterations to the measure had substantially improved the measure’s reliability.
- The face validity of the measure was initially assessed through a public comment period and issues identified were addressed through measure revisions. An alpha test was then incorporated into the pilot test of the measure to revalidate its validity. Finally, an eleven member Technical Advisory Panel was asked to review the measure specifications on a five scale. The measure score varied from 4.12 - 5 based on clarity of specifications, usefulness, interpretability, data accessibility and ease of collection and national use.
## Submission Specifications

**Status:** New Submission

**Description:** The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included.

These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use SUB-1 Alcohol Use Brief Intervention Provided or Offered: SUB-1 Alcohol Use Brief Intervention Provided or Offered: SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use Assessment Status after Discharge.

**Numerator Statement:** SUB-2 The number of patients who received or refused a brief intervention.

**Denominator Statement:** The number of hospitalized patients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence).

**Exclusions:** The denominator has 4 exclusions as follows:
- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who refused or were not screened for alcohol use during the hospital stay
- Patients who have a length of stay less than or equal to one day and greater than 120 days

**Adjustment/Stratification:** No risk adjustment or risk stratification. Not applicable. Not applicable, the measure is not stratified. However, there is a subset measure SUB-2a which removes patients from the numerator who refused the brief intervention. The subject measure has overlapping populations and is different from a stratum where the measure population is mutually exclusive.

This measure was added as a result of the pilot experience and a sub-analysis performed on the pilot data. Because those who refuse a brief intervention are put in the numerator, it was felt that this could open the door to possible gaming. We looked at the denominator to determine how many patients actually received the brief intervention. Only 6% of those were in the numerator did not receive the brief intervention due to refusal. For measures that are to be publically reported, it was felt transparency was important so this measure was added as a subset.

**Level of Analysis:** Facility, Population: National

### STEERING COMMITTEE MEETING [06/5/013]

1. Importance to Measure and Report: The measure meets the importance criteria
   - 1a. Impact: H-18; M-1; 1-0; 1-0; 1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-14; N-0; I-3

**Rationale:**
- The Steering Committee initially reviewed and rated the importance criteria for this measure on April 18, 2012, during the first phase of this project; accordingly, importance to Measure and Report was not discussed during the phase two meeting. Instead, the votes from Phase 1 were carried over, and appear above.

2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria
   - 2a. Reliability - precise specifications, testing.
   - 2b. Validity - testing, threats to validity

**Rationale:**
- The Steering Committee agreed that the measure meets the criteria. Reliability involved the re-abstraction of 96 medical records at five hospitals. Initial reliability testing indicated an agreement rate of 71.4% percent; however, improvements to the measure focusing on skip logic, refinement of data definitions and notes for abstraction increased the agreement rate to 80.2 percent. Following the re-abstraction, focus groups were conducted at each hospital and changes in abstraction were further discussed and highlighted as an opportunity for improvement on the measure.

- The face validity of the measure was initially assessed through a public comment period and issues identified were addressed through measurement revisions. An alpha test was then incorporated into the pilot test of the measure to reevaluate its validity. Finally, an eleven member Technical Advisory Panel was asked to review the measure specifications on a five-point scale. The measure score varied from 3.87 to 4.9 based on clarity of specifications, usefulness, interpretability, data accessibility and ease of collection and national use.

- A Steering Committee member requested clarification regarding the type of individual and training required for those delivering brief interventions to patients.
  - The developer explained that they have created educational standards and core competencies, which are required for individuals who will be performing the interventions. They also stated that in general hospitals develop a cadre of trained people to provide the brief intervention. It was also noted that brief interventions are different from brief counseling.

- Steering Committee members discussed that the measure could be improved by conducting a brief intervention for patients with unhealthy alcohol use and referring patients with an alcohol disorder rate to additional services rather than using a brief intervention for all patients with unhealthy alcohol use. This approach may be less burdensome for providers and administer brief interventions to patients.

- However, the Steering Committee concluded that conducting a brief intervention could help guide the referral and create a greater willingness in the patient to follow through with cessation.

3. Usability: H-2; M-4; L-1; 1-0
   - (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality improvement)

**Rationale:**
- The Steering Committee agreed the measure is usable. CMS has indicated that this measure will be required for reporting in inpatient psychiatric hospitals and psych units in general hospitals starting in 2016.

- A Steering Committee member noted that the measure appropriately follows 1663 SUB-1 alcohol use screening and would be useful for promoting brief interventions.

4. Feasibility: H-2; M-4; L-1; 1-0
   - (4a. Clinical data generated during core delivery; 4b. Electronic source; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)

**Rationale:**
- The Steering Committee agreed the measure is feasible and some data elements are available in electronic sources. In the future, the developer plans to further develop electronic specifications for the measure.

- A Steering Committee member questioned whether the measure may be more feasible in sites dedicated to screening for alcohol misuse, and more difficult to implement in the general population.
JC SUB 3
1664 SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge

STEERING COMMITTEE MEETING [06/15/2013]

1. Importance to Measure and Report: The measure meets the importance criteria
   (1a. High Impact: 1b. Performance Gap, 1c. Evidence)
   1a. Impact: H-10; M-2; L-0; I-0; 1b. Performance Gap: H-12; M-4; L-1; I-0; 1c. Evidence: Y-10; N-4; L-1; I-1
   Rationale:
   • The Steering Committee initially reviewed and rated the importance criteria for this measure on April 18, 2012, during the first phase of this project; accordingly, importance to Measure and Report was not discussed during the phase two meeting. Instead, the votes from Phase 1 were carried over, and appear above.

2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria
   (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
   2a. Reliability: H-4; M-3; L-0; I-0; 2b. Validity: H-0; M-1; L-1; I-0
   Rationale:
   • The Steering Committee agreed the measure meets the criteria. Reliability involved the re-abstraction of 96 medical records at five hospitals and resulted in an overall agreement rate to 96.2 percent for SUB-3 and 93.8 percent for SUB-3a.
   • The face validity of the measure was initially assessed through a public comment period and issues identified were addressed through measure revisions. An alpha test was then incorporated into the pilot test of the measure to re-evaluate its validity. Finally, an eleven-member Technical Advisory Panel was asked to review the measure specifications on a five-point scale. The measure score varied from 3.85 to 5.0 based on criteria of specifications, usefulness, interpretability, data accessibility and ease of collection and national use.
   • A Steering Committee member expressed concern that the measure includes alcohol as well as other drug use disorders, which creates a broad measure and potentially an additional burden for providers. Members also noted that incorporating a prescription discharge may be problematic since use of medications for substance abuse may not be as efficacious as medications to treat other addictions, such as tobacco.
     o The developer referenced a table, linked to the measure, which indicates medications approved by the FDA that could be prescribed to patients. They also clarified that the measure only focuses on the patient’s receipt of a prescription, and does not address patient compliance.
     o The Steering Committee expressed concern that medications for substance abuse may be expensive, which could deter patients from actually filling a prescription but ultimately agreed with the measure, noting the measure is constructed to allow patients to receive a prescription or referral for treatment.
   • The Steering Committee reviewed the measure testing results regarding the identification of meaningful differences in performance and noted that the measure had an overall rate of 3.5 percent, a significant decrease from the baseline of 9.2 percent. This indicates that there was a reduction of differences in performance of the measure among hospitals implementing the measure.

3. Usability: H-3; M-11; L-0; I-0
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality improvement)
   Rationale:
   • The Steering Committee agreed the measure is usable. CMS has indicated that this measure will be required for reporting for inpatient psychiatric hospitals and psych units in general hospitals starting in 2016.

4. Feasibility: H-0; M-11; L-0; I-0
   (a. Clinical data generated during core delivery; b. Electronic source; c. Susceptibility to inaccuracies/unintended consequences identified; d. Data collection strategy can be implemented)
   Rationale:
   • The Steering Committee agreed the measure is feasible and some data elements are available in electronic sources. In the future the developer plans to further develop electronic specifications for the measure.
   • A Steering Committee member expressed concern that the measure includes alcohol as well as other drug use disorders, which could create an additional burden for providers, and that generating the data elements requires chart review.
     o The developer clarified that providers would also need to conduct chart reviews in measures 1651 SUB-1 Alcohol use screening and 1663 SUB-2 Alcohol use brief intervention provided or offered and SUB-3a Alcohol use brief intervention. The developer also noted that hospitals currently implementing the substance abuse suite of measures rely on electronic health records to reduce the burden.

5. Related and Competing Measures
   • This measure is related to the other measures in the SUB suite of measures in addition to the AMA-PCP measure #1512 - Preventive Care and Screening: Unhealthy Diagnoses.

Steering Committee Recommendation for Endorsement: Y-11; N-0
   • The Steering Committee recommended that the developer expand the measurement population to include adolescents (aged 13 and older) to make the measure more consistent with Meaningful Use and to incorporate an age group that also struggles with substance use disorders. The developer noted that they would review the evidence for extending the age range of the measure in the future.

6. Public and Member Comment
   Please refer to the TOB-1 measure review on page 37 for discussion of comments related to the suite of tobacco measures.

7. Consensus Standards Approval Committee (CSAC) Review [January 24, 2014] Y-12; N-0; A-1
   Decision: Approved for endorsement

8. Board of Directors [February 18, 2014]
   Decision: Ratified for endorsement
1a.12 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.

Adults (18-64) Using Pharmacotherapy for Opioid Use Disorder (OUD)

Continuous Use for at least 180 Days without a Gap of More than 7 Days?

Yes

Better Continuity of Pharmacotherapy

Lower OUD Relapse Rate

Decreased Cost

Lower Rate of Adverse Outcomes

No

Worse Continuity of Pharmacotherapy

Higher OUD Relapse Rate

Increased Cost

Higher Rate of Adverse Outcomes
MEASURE WORKSHEET

This document summarizes the evaluation of the measure as it progresses through NQF’s Consensus Development Process (CDP). The information submitted by measure developers/stewards is included after the Brief Measure Information, Preliminary Analysis, and Pre-meeting Public and Member Comments sections.

To navigate the links in the worksheet: Ctrl + click link to go to the link; ALT + LEFT ARROW to return

Brief Measure Information

NOF #: 5175

Corresponding Measures:
- Measure Title: Continuity of Pharmacotherapy for Opioid Use Disorder
- Measure Steward: RAND Corporation

Brief Description of Measure: Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment

Developer Rationale: The rapidly rising number of deaths and near-deaths from opioid overdoses over the past several years has brought the issue of treating opioid use disorder (OUD) to the forefront of the policy agenda. The Surgeon General, who mailed a call to action to 2.3 million doctors, nurses, dentists, and other clinicians asking them to help address this escalating epidemic (Murthy, 2016), and the governors of many states have prioritized improving access to prevention and treatment of OUD.

The high prevalence of OUD has increased the sense of urgency. According to the 2014 National Survey on Drug Use and Health (NSDUH), 1.7 million adults 18 years and older were classified as having a pain reliever use disorder and 886,000 adults had used heroin in the past year (SAMHSA, 2015). In 2014, there were 489,532 episodes for OUD treatment, including outpatient treatment, detoxification, and residential treatment, in the Treatment Episode Data Set (TEDS) (SAMHSA, 2016).

Medication-assisted treatment (i.e., pharmacotherapy combined with counseling) is an evidence-based and effective treatment option for patients with OUD. Individuals with OUD receiving pharmacotherapy have significantly lower rates of mortality while they continue to receive medication, compared to individuals who were not receiving medication (Brugel et al., 2005; Corrish et al., 2010; Cousins et al., 2016; Davoli et al., 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016). But OUD medications remain markedly underutilized (Volkow et al., 2014). Of the almost half million aforementioned episodes, medication-assisted treatment was planned for only 25.4 percent (20.7 percent in outpatient treatment, 3.6 percent in detoxification, and 1.1 percent in residential treatment) (SAMHSA, 2016).

Additionally, ensuring treatment continuity is critical to the success of medication-assisted treatment. Longer treatment duration for individuals with OUD is associated with better outcomes and the best outcomes have been observed in patients in long-term methadone maintenance programs (“Effective medical treatment of opiate addiction”, 1998; Moos et al., 1999; NIDA 1999; Ouimette et al., 1998; Peles et al., 2013).

In addition, there is strong evidence for increased mortality when individuals with OUD transition off pharmacotherapy, both in the short term (within the first 0-4 weeks after discontinuing pharmacotherapy) and over the long term (Cornsill et al., 2010; Cousins et al., 2016; Davoli et al., 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016).
Curative Factors in Addiction Treatment

Cognitive Skills Training

Identity & Self-Efficacy

Anti-Craving Medications

A Behavioral Program of Recovery

Mind/Body Stress Mgt

Sober Social Networks

4/27/2017
Resilience-based Addiction Treatment

Values (Life of Meaning & Purpose)

Alcoholism
- Motivational Interviewing
- Anti-Craving Medications
- Emotional Regulation

Generalized Resilience Resources
- Cognitive skills (Mastery)
- Self-Concept (Acceptance)
- Social Support (Belonging)
- A Behavioral Program of Recovery

AA/Spirituality
- Relationships
- Hobby/Passion

4/27/2017

Broaden & Build Recovery Behaviors!
## Treatment Effectiveness Assessment (TEA)

The TEA asks you to express the extent of changes for the better from your involvement in the program to this point (or how things are if it's your first TEA or baseline) in four areas: substance use, health, lifestyle, and community. For each area, think about how things have become better and circle the results on the scale below: the more you have improved, the higher the number — from 1 (not better at all) to 10 (very much better). In each area write down the one or two changes most important to you in the Remarks section. Feel free to use the back of this page to add details, explain remarks, and make comments.

### Substance use
How much better are you with drug and alcohol use? Consider the frequency and amount of use, money spent on drugs, amount of drug craving, time spent being loaded, being sick, in trouble and in other drug-using activities, etc.

<table>
<thead>
<tr>
<th>None or not much</th>
<th>Better</th>
<th>Much better</th>
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<td>1</td>
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**Remarks:**

### Health
Has your health improved? In what way and how much? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc.

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<tr>
<th>None or not much</th>
<th>Better</th>
<th>Much better</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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**Remarks:**

### Lifestyle
How much better are you in taking care of personal responsibilities? Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments?

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<th>None or not much</th>
<th>Better</th>
<th>Much better</th>
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<td>10</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Remarks:**

### Community
Are you a better member of the community? Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people?

<table>
<thead>
<tr>
<th>No or not much</th>
<th>Better</th>
<th>Much better</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Remarks:**

**Name:** __________________  **Date:** ______  **First TEA:** [ ]

---

Figure 51 Sample Treatment Effectiveness Assessment (TEA).
Brief Addiction Monitor (BAM) Scoring Guide

1. In the past 30 days, would you say your physical health has been?
   - Excellent 0
   - Very good 1
   - Good 2
   - Fair 3
   - Poor 4

2. In the past 30 days, how many nights did you have trouble falling asleep, or staying asleep?
   - 0 0
   - 1-3 1
   - 4-6 2
   - 7-15 3
   - 16-30 4

3. In the past 30 days, how many days have you felt depressed, anxious, or very upset throughout most of the day?
   - 0 0
   - 1-3 1
   - 4-6 2
   - 7-15 3
   - 16-30 4

4. In the past 30 days, how many days did you drink ANY alcohol?
   - 0 0
   - 1-3 1
   - 4-6 2
   - 7-15 3
   - 16-30 4

5. In the past 30 days, how many days did you have at least 2 drinks (if you are a man) or at least 1 drink (if you are a woman)? One drink is considered one shot of hard liquor (1.5 ounces) or 1 ounce of wine or beer.
   - 0 0
   - 1-3 1
   - 4-6 2
   - 7-15 3
   - 16-30 4

6. In the past 30 days, how many days did you use any illegal street drugs, or abuse any prescription medications?
   - 0 (No) 0
   - 1-3 1
   - 4-6 2
   - 7-15 3
   - 16-30 4

7. In the past 30 days, how many days did you use any of the following drugs?
   - Marijuana (cannabis, pot, weed)?
   - 0 0
   - 1-3 1
   - 4-6 2
   - 7-15 3
   - 16-30 4
   - Sedatives/sleeping pills (e.g., Xanax, Valium, Xerzal, Ambien, Restoril, Serzone, etc.)
   - 0 0
   - 1-3 1
   - 4-6 2
   - 7-15 3
   - 16-30 4
   - Cocaine/Crack?
   - 0 0
   - 1-3 1
   - 4-6 2
   - 7-15 3
   - 16-30 4
   - Other stimulants (amphetamine, methamphetamine, Dexedrine, Ritalin, Adderall, "speed", "crystal meth", "ice", etc.)
   - 0 0
   - 1-3 1
   - 4-6 2
   - 7-15 3
   - 16-30 4

8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?
   - Not at all 0
   - Slightly 1
   - Moderately 2
   - Extremely 3
   - Not applicable

BAM

NATIONAL QUALITY FORUM
### Brief Addiction Monitor (BAM) Scoring Guide continued

9. How confident are you in your ability to be completely abstinent (clean)? From alcohol and drugs in the next 30 days

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>Slightly</td>
<td>1</td>
</tr>
<tr>
<td>Moderately</td>
<td>2</td>
</tr>
<tr>
<td>Considerably</td>
<td>3</td>
</tr>
<tr>
<td>Extremely</td>
<td>4</td>
</tr>
</tbody>
</table>

10. In the past 30 days, how many days did you attend self-help meetings like AA or NA to support your recovery?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1–3</td>
<td>1</td>
</tr>
<tr>
<td>4–8</td>
<td>2</td>
</tr>
<tr>
<td>9–15</td>
<td>3</td>
</tr>
<tr>
<td>16–30</td>
<td>4</td>
</tr>
</tbody>
</table>

11. In the past 30 days, how many days were you in any situations or with anyone that might put you at, an increased risk for alcohol or drugs (i.e., “people around risky, places or things”)?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1–3</td>
<td>1</td>
</tr>
<tr>
<td>4–8</td>
<td>2</td>
</tr>
<tr>
<td>9–15</td>
<td>3</td>
</tr>
<tr>
<td>16–30</td>
<td>4</td>
</tr>
</tbody>
</table>

12. Does your religion or spirituality help support your recovery?

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>Slightly</td>
<td>1</td>
</tr>
<tr>
<td>Moderately</td>
<td>2</td>
</tr>
<tr>
<td>Considerably</td>
<td>3</td>
</tr>
<tr>
<td>Extremely</td>
<td>4</td>
</tr>
</tbody>
</table>

13. In the past 30 days, how many days did you spend much of the time at work, school, or doing volunteer work?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1–3</td>
<td>1</td>
</tr>
<tr>
<td>4–8</td>
<td>2</td>
</tr>
<tr>
<td>9–15</td>
<td>3</td>
</tr>
<tr>
<td>16–30</td>
<td>4</td>
</tr>
</tbody>
</table>

### Brief Addiction Monitor (BAM) Scoring Guide continued

14. Do you have enough income (from legal sources) to pay for necessities such as housing, transportation, food and clothing for yourself and your dependants?

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

15. In the past 30 days, how much have you been bothered by arguments or problems getting along with any family members or friends?

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>Slightly</td>
<td>1</td>
</tr>
<tr>
<td>Moderately</td>
<td>2</td>
</tr>
<tr>
<td>Considerably</td>
<td>3</td>
</tr>
<tr>
<td>Extremely</td>
<td>4</td>
</tr>
</tbody>
</table>

16. In the past 30 days, how many days were you in contact or spend time with any family members or friends who are supportive of your recovery?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1–3</td>
<td>1</td>
</tr>
<tr>
<td>4–8</td>
<td>2</td>
</tr>
<tr>
<td>9–15</td>
<td>3</td>
</tr>
<tr>
<td>16–30</td>
<td>4</td>
</tr>
</tbody>
</table>

17. How satisfied are you with your progress toward achieving your recovery goals?

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>Slightly</td>
<td>1</td>
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<tr>
<td>Considerably</td>
<td>3</td>
</tr>
<tr>
<td>Extremely</td>
<td>4</td>
</tr>
</tbody>
</table>

### Preliminary subscale scoring Information

- **USE**: Sum of items 4, 5, and 6. Scores range from 0-12 with higher scores meaning more use.
- **RISK**: Sum of items 1, 2, 3, 6, 11, 15. Scores range from 0-24 with higher scores meaning more risk.
- **PROTECTION**: Sum of items 9, 10, 12, 13, 14, and 16. Scores range from 0-24 with higher scores meaning more protection.

The number adjacent to each BAM response is the point value (score) for each response.

- Items 7A–7G are not scored as part of the subscales but provide elaboration for Item 6.
- Item 17 can be used as an overall assessment of treatment progress but is not scored on any of the specific subscales.
Measuring Progress: TEMT-KP

I. Rate Your Cravings

<table>
<thead>
<tr>
<th>Activity</th>
<th>Mild difficulty</th>
<th>Moderate difficulty</th>
<th>Strong difficulty</th>
<th>Very strong difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

II. Measure Your Feelings

<table>
<thead>
<tr>
<th>Activity</th>
<th>All the time</th>
<th>Most of the time</th>
<th>More than half of the time</th>
<th>Less than half of the time</th>
<th>At no time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

III. Access Your Recovery Relationships

<table>
<thead>
<tr>
<th>Activity</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

IV. Effectiveness of Your Treatment

For each area, think about how things may have currently improved as a result of your treatment.

1. Are you SATISFIED with...

   - Strongly disagree
   - Disagree
   - Slightly disagree
   - Mixed/Neither
   - Slightly agree
   - Agree
   - Strongly agree

2. Your family relationships?

   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7

3. Your sexual or marital relationship?

   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7

4. Your school and work situation?

   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7

5. How you spend your free time?

   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7

6. The extent to which you are coping or getting help with your problems?

   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7

V. Valuing Your Kaiser Permanente Health Partnership

1. Since entering treatment, have you received adequate care for your medical or mental health conditions?

   - Yes
   - No

2. How confident are you in your ability to make the most of your visits with your primary care medical doctor?

   - Low confidence
   - Moderate confidence
   - High confidence
   - Very high confidence

3. How do you feel about your most recent visit to this department?

   - Only a little or not at all
   - Sometimes
   - Quite a bit
   - Totally

   a. In the session, we discussed the things that are most important to me.
   - 0
   - 1
   - 2
   - 3

   b. I felt understood and respected by my clinician.
   - 0
   - 1
   - 2
   - 3

   c. I understand and agree with my treatment plan.
   - 0
   - 1
   - 2
   - 3

4/27/2017
Questions?