



## 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 #:** 2597

**Corresponding Measures:**

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

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

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

**1b.1. Developer Rationale:** The composite measure is intended to promote screening and intervention for substance use. Because many patients will not self-identify or have not yet developed detectable problems associated with substance use, screening can identify patients for whom intervention may be indicated. Brief motivational counseling (and pharmacotherapy for tobacco use) for these various substances have been shown to be an effective treatment for reducing problem use, particularly in primary care settings.

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

Tobacco use component

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

Unhealthy alcohol use component

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

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

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

**S.6. Denominator Statement:** All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12 month measurement period

**S.8. Denominator Exclusions:** Denominator exceptions include documentation of medical reason(s) for not screening for tobacco use, unhealthy alcohol use, or nonmedical prescription drug/illicit drug use (eg, limited life expectancy, other medical reasons)

**De.1. Measure Type:** Composite

**S.17. Data Source:** Electronic Health Records, Other

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

**IF Endorsement Maintenance – Original Endorsement Date:** Mar 06, 2015 **Most Recent Endorsement Date:** Mar 06, 2015

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

**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

#### 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.

### 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.*

The composite measure is intended to promote screening and intervention for substance use. Because many patients will not self-identify or have not yet developed detectable problems associated with substance use, screening can identify patients for whom intervention may be indicated. Brief motivational counseling (and pharmacotherapy for tobacco use) for these various substances have been shown to be an effective treatment for reducing problem use, particularly in primary care settings.

**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.*

Tobacco Component:

2010 CMS Physician Quality Reporting Initiative:

Data Source: This measure was used in the 2010 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 58.36% is the aggregate performance rate in the total patient population and 68.56% is the mean performance rate of TIN/NPI's.

10th percentile: 0.00%

25th percentile: 32.53%

50th percentile: 98.31%

75th percentile: 100%

90th percentile: 100%

Exception Rate: 0.00%

Maximum Performance Score: 100%

Interquartile Range: 67.47%

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

Alcohol Component:

2010 CMS Physician Quality Reporting Initiative:

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

10th percentile: 12.50%

25th percentile: 83.64%

50th percentile: 100%

75th percentile: 100%

90th percentile: 100%

Exception Rate: 1.00%

Maximum Performance Score: 100%

Interquartile Range: 16.36%

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

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

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

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

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

Finally, the tobacco component of the composite measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke. Tobacco use remains the single largest preventable cause of death and disease in the United States.(6) In 2010, an estimated 19.3% (45.3 million) of U.S. adults were current cigarette smokers; of these, 78.2% smoked every day, and 21.8% smoked some days.(6) An recent analysis of National Health and Nutrition Examination Survey (NHANES) data found that approximately 76% of current smokers have at least one outpatient office visit each year, representing a significant opportunity to screen for tobacco use and deliver effective cessation interventions.(7) A 2006 study

analyzed data from the National Ambulatory Medical Care Survey (NAMCS) and found suboptimal rates of "asking" about tobacco use, providing "assistance" with tobacco cessation, and prescribing pharmacotherapy for cessation. Overall, 32% of patient charts did not include information about tobacco use, 81% of smokers did not receive assistance and less than 2% received a prescription for pharmacotherapy.(8) A recent CDC analysis of 2010 National Health Interview Surveys (NHIS) data found that less than half of smokers (48.3%) who saw a health professional in the past year reported receiving advice to quit. (9)

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

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** (*This is required for 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.

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

**1b.5. If no or limited data on disparities from the measure as specified is reported in 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**

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

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

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

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

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

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

#### Citations

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

#### 1c. Composite Quality Construct and Rationale

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

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

- Measures with two or more individual performance measure scores combined into one score for an accountable entity.

- Measures with two or more individual component measures assessed separately for each patient and then aggregated into one score for an accountable entity:
  - all-or-none measures (e.g., all essential care processes received, or outcomes experienced, by each patient);

**1c.1.** Please identify the composite measure construction: **two or more individual performance measure scores combined into one score**

**1c.2. Describe the quality construct, including:**

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

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

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

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

Composite performance measures have a variety of uses.

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

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

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

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

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

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

$$\frac{(N1+N2+N3)}{[(D1+D2+D3) - (DE1+DE2+DE3)]}$$

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when

implemented. **Measures must be judged to meet the 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):

Screening

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

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

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

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the 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 an eMeasure Attachment: Substance\_Use\_Composite\_ASAM\_07072014.zip

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

No data dictionary Attachment:

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

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.

**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.

**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.

n/a

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) 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 received the following substance use screenings at least once within the last 24 months AND who received an intervention for all positive screening results:

Tobacco use component



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

Unhealthy alcohol use component

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

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

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

**S.5. 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).*

For Tobacco

HQMF eMeasure specification attached to this form.

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

For Alcohol

HQMF eMeasure specification attached to this form.

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

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

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

Drug

HQMF eMeasure specification attached to this form.

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

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

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

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

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

**S.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).*

For Tobacco

HQMF eMeasure specification attached to this form.

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

For Alcohol

HQMF eMeasure specification attached to this form.

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

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

**S.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.)*

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

For Tobacco  
HQMF eMeasure specification attached to this form.  
All measure specific value sets for the Tobacco component are available at <https://vsac.nlm.nih.gov/>.

For Alcohol  
HQMF eMeasure specification attached to this form.  
35/43 measure specific value sets are published by the VSAC and are currently in use.  
8/43 measure specific value sets are currently in a draft authoring status in the VSAC.  
Of the 43 value sets included in this measure, 2/43 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].

Drug  
HQMF eMeasure specification attached to this form.  
33/41 measure specific value sets are published by the VSAC and are currently in use.  
8/41 measure specific value sets are currently in a draft authoring status in the VSAC.  
Of the 41 value sets included in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].

**S.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.)*

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

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

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

$$\frac{(N1+N2+N3)}{[(D1+D2+D3) - (DE1+DE2+DE3)]}$$

**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-- this measure is not based on a sample.

**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 is not based on a survey.

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

If other, please describe in S.18.

Electronic Health Records, Other

**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)

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.)

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

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

[Composite\\_Measure\\_Testing\\_Attachment\\_6\\_20\\_14.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.*

**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.*

**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.*

**3. Feasibility**

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

**3a. Byproduct of Care Processes**

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

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

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

If other:

**3b. Electronic Sources**

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

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

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

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. 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: [NQF\\_Feasibility-\\_NIDA\\_Composite\\_Overall-635405924006233882.docx](#)

### 3c. Data Collection Strategy

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

**3c.1. 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 testing and operational use of the measure in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, and other feasibility issues unless otherwise noted.

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

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

## 4. Usability and Use

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

### 4a. Accountability and Transparency

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

#### 4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
<a href="#">Public Reporting</a>	

**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

**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?)

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

**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.)

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

**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.

**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.**

**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.

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

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

**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.**

#### **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 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 unintended consequences at this time, but we continuously monitor for them.

#### 4b2.2. Please explain 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.  
No

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

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

#### 5a. Harmonization 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?

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

n/a

#### 5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

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

## Appendix

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

**Attachment** Attachment: [NIDA-EMMES\\_Substance\\_Use\\_Composite\\_Measure\\_Updates.doc](#)

## Contact Information

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

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

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## Additional Information

**Ad.1 Workgroup/Expert Panel involved in measure development**

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

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

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

**Ad.2 Year the measure was first released:** 2014

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

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

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

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

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

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