



## 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 #: 3488**

**Corresponding Measures:**

**De.2. Measure Title:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

**Co.1.1. Measure Steward:** National Committee for Quality Assurance

**De.3. Brief Description of Measure:** The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

**1b.1. Developer Rationale:** This measure targets individuals with alcohol or other drug abuse or dependence who are discharged to the community from the emergency department. These individuals may be particularly vulnerable to losing contact with the health care system. High use of the emergency department may signal a lack of access to ongoing care or a gap in fulfilling urgent care needs. Therefore, this point of transition presents an opportunity to ensure that the patient is connected to care and receives follow-up. Health plans have access to information and care management processes to ensure that follow-up care occurs. Therefore, health plans can help connect patients into outpatient care after emergency department use.

Individuals discharged from the emergency department face two main risks: (1) disengagement from treatment and (2) readmission to the emergency department. Treatment disengagement is a problem because individuals with the most serious mental health problems or alcohol or drug use disorders may require ongoing support and counseling to live independently in the community. Individuals who lose contact with outpatient care providers begin a vicious cycle of symptom deterioration (Killaspy, 2007) that necessitates further crisis intervention in emergency settings (Fischer, 2008; Jencks, 2009). Preserving individuals' engagement with post-discharge treatment requires high quality handoffs between emergency settings and ambulatory care providers (Hartley, 2007; Wislar, 1998) as readmission is problematic because it involves further disruptions in life and becomes costly for health care systems, especially the emergency department setting.

Fischer, EP, McCarthy JF, Ignacio RV, et al. (2008) Longitudinal Patterns of Health System Retention Among Veterans with Schizophrenia or Bipolar Disorder. *Community Mental Health Journal*. 44:321–330.

Hartley, D, Ziller EC, Loux JA, et al. (2007) Use of Critical Access Hospital Emergency Rooms by Patients with Mental Health Symptoms. *Journal of Rural Health*. 23:108–115.

Jencks, SF, Williams MV, Coleman EA. (2009) Rehospitalizations Among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine*. 360:1418–28.

Killaspy, H. (2007) Why do psychiatrists have difficulty disengaging with the out-patient clinic? Invited commentary on: Why don't patients attend their appointments? *Advances in Psychiatric Treatment*. 13:435–437.

Wislar, JS, Grossman J, Kruesi MP, et al. (1998) Youth Suicide-Related Visits in an Emergency Department Serving Rural Counties: Implications for Means Restriction. *Annals of Suicide Research*. 4:75–87.

**S.4. Numerator Statement:** The numerator consists of two rates:

- 30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total

days). Include visits that occur on the date of the ED visit.

- 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

These rates are stratified by age (13–17, 18 and older, total).

**S.6. Denominator Statement:** Emergency department (ED) visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

**S.8. Denominator Exclusions:** Patients in hospice.

**De.1. Measure Type:** Process

**S.17. Data Source:** Claims

**S.20. Level of Analysis:** Health Plan

**IF Endorsement Maintenance – Original Endorsement Date:** Oct 24, 2019 **Most Recent Endorsement Date:**

**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?** Not applicable.

## 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

[FUA\\_Evidence\\_Form.docx](#)

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

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

Yes

### 1b. Performance Gap

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

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

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

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

This measure targets individuals with alcohol or other drug abuse or dependence who are discharged to the community from the emergency department. These individuals may be particularly vulnerable to losing contact with the health care system. High use of the emergency department may signal a lack of access to ongoing care or a gap in fulfilling urgent care needs. Therefore, this point of transition presents an opportunity to ensure that the patient is connected to care and receives follow-up. Health plans have access to information and care management processes to ensure that follow-up care occurs. Therefore, health plans can help connect patients into outpatient care after emergency department use.

Individuals discharged from the emergency department face two main risks: (1) disengagement from treatment and (2) readmission to the emergency department. Treatment disengagement is a problem because individuals with the most serious mental health problems or alcohol or drug use disorders may require ongoing support and counseling to live independently in the community.

Individuals who lose contact with outpatient care providers begin a vicious cycle of symptom deterioration (Kilaspay, 2007) that necessitates further crisis intervention in emergency settings (Fischer, 2008; Jencks, 2009). Preserving individuals' engagement with post-discharge treatment requires high quality handoffs between emergency settings and ambulatory care providers (Hartley, 2007; Wislar, 1998) as readmission is problematic because it involves further disruptions in life and becomes costly for health care systems, especially the emergency department setting.

Fischer, EP, McCarthy JF, Ignacio RV, et al. (2008) Longitudinal Patterns of Health System Retention Among Veterans with Schizophrenia or Bipolar Disorder. *Community Mental Health Journal*. 44:321–330.

Hartley, D, Ziller EC, Loux JA, et al. (2007) Use of Critical Access Hospital Emergency Rooms by Patients with Mental Health Symptoms. *Journal of Rural Health*. 23:108–115.

Jencks, SF, Williams MV, Coleman EA. (2009) Rehospitalizations Among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine*. 360:1418–28.

Kilaspay, H. (2007) Why do psychiatrists have difficulty disengaging with the out-patient clinic? Invited commentary on: Why don't patients attend their appointments? *Advances in Psychiatric Treatment*. 13:435–437.

Wislar, JS, Grossman J, Kruesi MP, et al. (1998) Youth Suicide-Related Visits in an Emergency Department Serving Rural Counties: Implications for Means Restriction. *Annals of Suicide Research*. 4:75–87.

**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.*

The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data is summarized at the health plan level and summarized by mean, standard deviation, and performance at 10th, 25th, 50th, 75th, and 90th percentile. Data is stratified by year and product line (i.e. commercial, Medicare, Medicaid).

Commercial health plans, 30-day follow-up (Age 13-17)

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	Interquartile Range
2017	9.5%	10.3%	2.6%	5.2%	7.5%	10.7%	16.7%	5.6%
2016	11.7%	6.7%	3.9%	6.5%	10.6%	15.7%	20.0%	9.3%

Commercial health plans, 30-day follow-up (Age 18+)

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	Interquartile Range
2017	14.8%	7.2%	7.4%	10.5%	13.8%	18.0%	22.6%	7.5%
2016	18.7%	8.5%	9.1%	12.9%	17.5%	23.4%	29.2%	10.4%

Commercial health plans, 30-day follow-up (Total)

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	Interquartile Range
2017	14.3%	7.1%	6.8%	10.0%	13.3%	17.6%	22.0%	7.7%
2016	18.2%	8.3%	8.8%	12.5%	16.9%	22.7%	28.3%	10.1%

Commercial health plans, 7-day follow-up (Age 13-17)

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	Interquartile Range
2017	7.0%	9.5%	1.3%	3.2%	5.4%	8.4%	13.2%	5.2%
2016	9.0%	5.5%	3.4%	5.4%	7.5%	11.6%	16.1%	6.2%

Commercial health plans, 7-day follow-up (Age 18+)

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	Interquartile Range
2017	10.8%	6.5%	4.8%	7.2%	10.0%	13.3%	17.3%	6.1%
2016	14.4%	7.6%	6.3%	9.1%	13.0%	18.0%	22.6%	8.9%

Commercial health plans, 7-day follow up (Total)

#3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, Last Updated:  
Oct 24, 2019

YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range  
 2017 | 10.4% | 6.4% | 4.6% | 6.8% | 9.7% | 12.9% | 16.7% | 6.1%  
 2016 | 14.0% | 7.4% | 6.2% | 8.8% | 12.6% | 17.7% | 21.7% | 8.9%

Medicaid health plans, 30-day follow-up (Age 13-17)

YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range  
 2017 | 11.9% | 10.3% | 2.9% | 5.1% | 8.9% | 16.7% | 22.2% | 11.6%  
 2016 | 12.9% | 10.2% | 3.4% | 6.4% | 9.2% | 18.2% | 26.0% | 11.8%

Medicaid health plans, 30-day follow-up (Age 18+)

YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range  
 2017 | 18.5% | 10.0% | 6.7% | 10.4% | 16.6% | 25.6% | 32.3% | 15.2%  
 2016 | 20.1% | 13.4% | 7.3% | 10.4% | 15.8% | 27.1% | 39.1% | 16.7%

Medicaid health plans, 30-day follow-up (Total)

YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range  
 2017 | 18.1% | 9.9% | 6.7% | 10.1% | 16.3% | 24.5% | 32.2% | 14.4%  
 2016 | 19.7% | 13.3% | 6.9% | 9.8% | 15.3% | 26.9% | 37.0% | 17.1%

Medicaid health plans, 7-day follow-up (Age 13-17)

YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range  
 2017 | 8.1% | 8.9% | 1.3% | 2.6% | 6.0% | 10.0% | 15.9% | 7.4%  
 2016 | 9.0% | 9.1% | 1.6% | 3.2% | 6.3% | 11.1% | 17.2% | 7.9%

Medicaid health plans, 7-day follow-up (Age 18+)

YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range  
 2017 | 12.6% | 7.8% | 4.4% | 7.1% | 10.6% | 16.8% | 22.6% | 9.7%  
 2016 | 15.0% | 11.5% | 5.4% | 7.3% | 10.7% | 17.5% | 32.5% | 10.3%

Medicaid health plans, 7-day follow up (Total)

YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range  
 2017 | 12.2% | 7.7% | 4.3% | 6.9% | 10.4% | 16.7% | 21.9% | 9.8%  
 2016 | 14.6% | 11.4% | 4.7% | 6.6% | 10.9% | 17.4% | 31.4% | 10.8%

Medicare health plans, 30-day follow-up

YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range  
 2017 | 12.2% | 7.9% | 4.8% | 7.1% | 10.8% | 15.3% | 21.9% | 8.2%  
 2016 | 13.9% | 7.8% | 5.2% | 7.7% | 12.8% | 17.7% | 25.0% | 10.0%

Medicare health plans, 7-day follow up

YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range  
 2017 | 8.4% | 6.1% | 2.8% | 4.8% | 7.0% | 10.6% | 15.6% | 5.8%  
 2016 | 10.0% | 6.2% | 3.0% | 5.7% | 9.0% | 13.5% | 18.9% | 7.7%

The data references are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2016, HEDIS measures covered 114.2 million commercial health plan beneficiaries and 47.0 million Medicaid beneficiaries. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the median eligible number of encounters for the measure across health plans.

Commercial health plans, 30-day follow-up (Age 13-17)

YEAR | N Plans | Median Denominator Size per plan  
 2017 | 96 | 60  
 2016 | 87 | 66

Commercial health plans, 30-day follow-up (Age 18+)

YEAR | N Plans | Median Denominator Size per plan

2017 | 321 | 167

2016 | 300 | 169

Commercial health plans, 30-day follow-up (Total)

YEAR | N Plans | Median Denominator Size per plan

2017 | 327 | 176

2016 | 303 | 177

Commercial health plans, 7-day follow-up (Age 13-17)

YEAR | N Plans | Median Denominator Size per plan

2017 | 96 | 60

2016 | 87 | 66

Commercial health plans, 7-day follow-up (Age 18+)

YEAR | N Plans | Median Denominator Size per plan

2017 | 321 | 167

2016 | 300 | 169

Commercial health plans, 7-day follow up (Total)

YEAR | N Plans | Median Denominator Size per plan

2017 | 327 | 176

2016 | 303 | 177

Medicaid health plans, 30-day follow-up (Age 13-17)

YEAR | N Plans | Median Denominator Size per plan

2017 | 83 | 64

2016 | 66 | 77

Medicaid health plans, 30-day follow-up (Age 18+)

YEAR | N Plans | Median Denominator Size per plan

2017 | 157 | 561

2016 | 120 | 566

Medicaid health plans, 30-day follow-up (Total)

YEAR | N Plans | Median Denominator Size per plan

2017 | 158 | 616

2016 | 121 | 633

Medicaid health plans, 7-day follow-up (Age 13-17)

YEAR | N Plans | Median Denominator Size per plan

2017 | 83 | 64

2016 | 66 | 77

Medicaid health plans, 7-day follow-up (Age 18+)

YEAR | N Plans | Median Denominator Size per plan

2017 | 157 | 561

2016 | 120 | 566

Medicaid health plans, 7-day follow up (Total)

YEAR | N Plans | Median Denominator Size per plan

2017 | 158 | 616

2016 | 121 | 633

Medicare health plans, 30-day follow-up

YEAR | N Plans | Median Denominator Size per plan

2017 | 250 | 90

2016 | 218 | 96

Medicare health plans, 7-day follow up

YEAR | N Plans | Median Denominator Size per plan

2017 | 250 | 90

2016 | 218 | 96

**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.**

There is room for improvement in measure performance. Average performance rates for both 7-day and 30-day follow up are low for commercial, Medicare, and Medicaid health plans. Average 30-day follow-up performance across all ages is 12 percent for Medicare plans, 18 percent for Medicaid plans, and 14 percent for commercial plans. Average 7-day follow-up performance across all ages is 8 percent for Medicare plans, 12 percent for Medicaid plans, and 10 percent for commercial plans.

There is also a wide range in performance for both the 7-day and 30-day follow-up rates. For example, in 2017, Medicare plan performance (across all ages) for 7-day follow-up ranged from 3 percent (plans in the 10th percentile) to 16 percent (plans in the 90th percentile). 30-day follow-up rates (across all ages) similarly showed a wide range in performance; for example, Medicaid health plan performance ranged from 7 percent (in the 10th percentile) to 32 percent (in the 90th percentile).

**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.**

HEDIS data are stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities, if the data are available to a plan. The HEDIS Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA’s Multicultural Health Care Distinction Program outlines standards for collecting, storing, and using race/ethnicity and language data to assess health care 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**

Data show noticeable differences in rates of access to substance abuse treatment programs with regards to race/ethnicity and age. African Americans are less likely than Whites to access treatment for substance use disorders (Satre et al, 2010). SAMSHA reported in 2008 that approximately 60 percent of whites with substance abuse problems were admitted to substance abuse treatment programs, which is significantly higher than 21 percent of African Americans, 14 percent of Hispanics, 2 percent of American Indians or Alaska Natives, 1 percent of Asian/Pacific Islanders, and 2 percent of other racial/ethnic groups. Furthermore, individuals between the ages of 25-29 had the highest rate of admissions to substance abuse treatment programs compared to all other ages (NIDA, 2011).

For patients with both depression and a substance use disorder, women are more likely than men to receive treatment (Satre et al, 2010). A recent study in Canada also found that mental health patients with higher numbers of ED visits for substance use disorders were “...less likely to receive follow-up care and more likely to die within 2 years” (Urbanoski et al., 2018).

National Institute on Drug Abuse (NIDA). 2015. "Trends & Statistics." Available from URL: <http://www.drugabuse.gov/related-topics/trends-statistics>.

Satre, D., C.I. Campbell, N.P. Gordon, C. Weisner. "Ethnic disparities in accessing treatment for depression and substance use disorders in an integrated health plan." *Int J Psychiatry Med*. 2010 ; 40(1): 57–76.

Urbanoski K., J. Cheng, J. Rehm, P. Kurdyak. "Frequent use of emergency departments for mental and substance use disorders." *Emerg Med J* 35:220–225. doi:10.1136/emered-2015-205554

## 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](#), [Behavioral Health : Alcohol](#), [Substance Use/Abuse](#)

**De.6. Non-Condition Specific**(check all the areas that apply):  
[Access to Care](#), [Care Coordination](#), [Disparities Sensitive](#)

**De.7. Target Population Category** (Check all the populations for which the measure is specified and tested if any):  
[Populations at Risk](#)

**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.)  
[Not applicable.](#)

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

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)  
[Attachment Attachment: 3488\\_FUA\\_Value\\_Sets\\_Spring\\_2019.xlsx](#)

**S.2c.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.  
[No, this is not an instrument-based measure](#) **Attachment:**

**S.2d.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.  
[Not an instrument-based measure](#)

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

Yes

**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.

Measure #2605, Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence, has been split into two separate measures:

- Follow-Up After Emergency Department Visit for Mental Illness (#3489)
- Follow-Up After Emergency Department Visit for Alcohol and other Drug Dependence (#3488)

Added telehealth to the numerators.

**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).*

The numerator consists of two rates:

- 30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.
- 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

These rates are stratified by age (13–17, 18 and older, total).

**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).*

30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

Value Set).

- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

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

Emergency department (ED) visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

**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).*

Age: 13 years and older as of the date of the ED visit

Benefit: Medical and chemical dependency.

Note: Members with detoxification-only chemical dependency benefits do not meet these criteria.

Continuous Enrollment: Date of emergency department visit through 30 days after the ED visit

Event/diagnosis criteria: An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

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

Patients in hospice.

**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.)*

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

**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.)*

This measure is stratified by age:

- Age 13 to 17 years
- Age 18 and older
- Total (sum of the age stratifications)

**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.)

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug abuse or dependence. Do not include ED visits that result in an inpatient stay, or are followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of ED visits with qualifying follow-up visit within 7 days (Step 2A) by the denominator (Step 1A).

Step 3B: Calculate the 30-day rate by dividing the number of ED visits with qualifying follow-up visit within 30 days (Step 2B) by the denominator (Step 1A).

**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.

**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.

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

If other, please describe in S.18.

Claims

**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.

This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

**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)

Health Plan

**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.)

Not applicable.

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

FUA\_Measure\_Testing\_Form\_April\_2019.docx

### 2.1 For maintenance of endorsement

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

Yes

### 2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

### 2.3 For maintenance of endorsement

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

No - This measure is not risk-adjusted

## 3. Feasibility

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

### 3a. Byproduct of Care Processes

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

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

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

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 claims

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.** For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.**

Attachment:

### **3c. Data Collection Strategy**

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

**3c.1. Required for maintenance of endorsement.** Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

**IF instrument-based,** consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) Information practices and control procedures
- 2) Sampling methods and procedures
- 3) Data integrity
- 4) Compliance with HEDIS specifications
- 5) Analytic file production
- 6) Reporting and documentation

In addition to the HEDIS audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system, NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system informs both annual updates to the measures as well as routine re-evaluation of measures. These processes include updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence.

**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*).

Broad public use and dissemination of these measures are encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers

to any sale, license, or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed, or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

## 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)
Regulatory and Accreditation Programs	<p>Public Reporting</p> <p><a href="https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html">https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html</a> CMS Medicaid Adult Core Set NCQA Health Plan Ratings / Report Cards <a href="https://www.ncqa.org/hedis/reports-and-research/ratings-methodology-and-guidelines/">https://www.ncqa.org/hedis/reports-and-research/ratings-methodology-and-guidelines/</a></p> <p>Quality Improvement (external benchmarking to organizations) NCQA Quality Compass <a href="http://www.ncqa.org/hedis-quality-measurement/quality-measurement-products/quality-compass">http://www.ncqa.org/hedis-quality-measurement/quality-measurement-products/quality-compass</a> SAMHSA Demonstration Program for Certified Community Behavioral Health Clinics (CCBHCs) <a href="https://www.samhsa.gov/section-223">https://www.samhsa.gov/section-223</a></p>

#### 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

**SAMHSA CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS:** This is a demonstration program for states to certify community behavioral health clinics. Certified clinics must meet specific criteria emphasizing high-quality care including reporting quality measures.

**HEALTH PLAN ACCREDITATION:** This measure will be used in scoring for accreditation of Medicare Advantage Health Plans. As of Fall 2017, a total of 184 Medicare Advantage health plans were scored for accreditation, covering 9.2 million Medicare beneficiaries; 451 commercial health plans covering 113 million lives; and 125 Medicaid health plans covering 35 million lives. Health plans are scored based on performance compared to national benchmarks.

**HEALTH PLAN RATINGS/REPORT CARDS:** This measure is used in the calculation of health plan ratings, which are reported on the NCQA website annually. These ratings are based on a plan's performance on their HEDIS, CAHPS and accreditation standards scores. In 2017, a total of 521 Medicare Advantage health plans, 614 commercial health plans and 294 Medicaid health plans across 50

states, D.C., Guam, Puerto Rico, and the Virgin Islands were included in the Ratings.

**CMS MEDICAID ADULT CORE SET:** There are a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers of Medicare & Medicaid (CMS) in partnership with the Agency for Healthcare Research and Quality (AHRQ). The data collected from these measures will help CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, beginning in September 2014, state data on the adult quality measures will become part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid.

**NCQA QUALITY COMPASS:** This measure is used in Quality Compass which is an indispensable tool used for selecting health plans, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

**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?)**

N/A

**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.)**

N/A

**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.**

Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

**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.**

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System, as described in Section 3c.1.

**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.**

NCQA measures are evaluated regularly using a consensus-based process to consider input from multiple stakeholders, including but not limited to entities being measured. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

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

Measure users have sought clarification on the types of encounters, as well as timing of encounters, that satisfy the measure. Measure users have also sought clarification on qualifying chemical dependency benefits for health plan members. This feedback

has helped us refine and clarify criteria in the measure specification.

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

This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in public reporting and quality improvement programs.

**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.**

During the measure's last major update, feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure to parse it out into two separate measures focused on follow up after an ED visit for mental health and alcohol use disorder, respectively.

**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.

There was a lack of improvement in the measure rates over the two years. The rates seemed to decline over the two years for all product lines. This suggests the challenge in connecting members with AOD to treatment after an ED visit. Literature showed that the most common reasons for members with AOD who did not seek or engage in treatment were that they were not ready to stop using alcohol or illicit drugs, could not afford treatment because they did not have enough health care coverage or feared shame and discrimination. The plans reported the measure offered a chemical dependency benefit, but there may be variations in coverage adequacy or in requirements for prior authorization for treatment for AOD—both perceived and actual—across product lines and health plans. The measure performance demonstrated the need for healthcare organizations to engage in comprehensive efforts to increase follow-up care for members with AOD after ED visits.

**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.**

There were no identified unintended findings for this measure during testing or since implementation.

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

There were no identified unexpected benefits for this measure during testing or since implementation.

**5. Comparison to Related or Competing Measures**

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

**5. Relation to Other NQF-endorsed Measures**

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

Yes

<p><b>5.1a. List of related or competing measures (selected from NQF-endorsed measures)</b>  0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment  3312 : Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs</p> <p><b>5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.</b>  #3453 - Continuity of care after inpatient or residential treatment for substance use disorder (SUD) (CMS)</p>
<p><b>5a. Harmonization of Related Measures</b>  The measure specifications are harmonized with related measures;  <b>OR</b>  The differences in specifications are justified</p> <p><b>5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):</b>  Are the measure specifications harmonized to the extent possible?  Yes</p> <p><b>5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.</b>  The measure is harmonized with the existing NQF-endorsed measure. The following highlights the differences between the measures: Population focus (denominator): The measure targets patients discharged from the emergency department (not detoxification). Numerator: The measure captures follow-up with a primary alcohol or other drug dependence diagnosis.</p>
<p><b>5b. Competing Measures</b>  The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);  <b>OR</b>  Multiple measures are justified.</p> <p><b>5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):</b>  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.)  Not applicable.</p>

<p><b>Appendix</b></p> <p><b>A.1 Supplemental materials may be provided in an appendix.</b> All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.  No appendix Attachment:</p>
<p><b>Contact Information</b></p> <p><b>Co.1 Measure Steward (Intellectual Property Owner):</b> National Committee for Quality Assurance  <b>Co.2 Point of Contact:</b> Bob, Rehm, <a href="mailto:nqf@ncqa.org">nqf@ncqa.org</a>, 202-955-3500-  <b>Co.3 Measure Developer if different from Measure Steward:</b> National Committee for Quality Assurance  <b>Co.4 Point of Contact:</b> Kristen, Swift, <a href="mailto:Swift@ncqa.org">Swift@ncqa.org</a>, 202-955-5174-</p>
<p><b>Additional Information</b></p> <p><b>Ad.1 Workgroup/Expert Panel involved in measure development</b>  Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.  Behavioral Health Measurement Advisory Panel</p>

Katharine Bradley, MD, MPH, Kaiser Permanente Washington Health Research Institute  
 Christopher Dennis, MD, MBA, FAPA, Landmark Health  
 Ben Druss MD, MPH, Emory University  
 Frank A. Ghinassi, PhD, ABPP, Rutgers University Behavioral Health Care  
 Constance M. Horgan, Sc.D., Brandeis University  
 Laura Jacobus-Kantor, PhD, SAMHSA, HHS  
 Jeffrey D. Meyerhoff, MD, Optum Behavioral Health  
 Harold Alan Pincus, MD, Irving Institute for Clinical and Translational Research --Columbia University  
 Michael Schoenbaum, PhD, National Institute of Mental Health  
 John H. Straus, MD, Beacon Health Options

**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, 2016

**Ad.4 What is your frequency for review/update of this measure?** Approximately every 3 years, sooner if the clinical guidelines change significantly.

**Ad.5 When is the next scheduled review/update for this measure?** 12, 2020

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