

Candidate Quality Measures to Assess Care for Alcohol Misuse

Technical Specifications

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Preface

The purpose of this tool is to present detailed technical specifications for the set of quality measures used in the AQual study—a study to develop and evaluate quality measures for alcohol misuse. These measures were selected for testing after a literature review, technical expert panel, and iterative process of specification. We expect this tool will be a useful reference for those interested in applying or adapting measures to assess care for alcohol misuse or for those interested in understanding the details of each quality measure evaluated in the AQual study.

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Abbreviations

AA	Alcoholics Anonymous
AOD	alcohol or other drug dependence
ASI	Addiction Severity Index
AUD	alcohol use disorder
AUDIT-C	Alcohol Use Disorders Identification Test–Consumption
BI	brief intervention
CBT	cognitive behavioral therapy
CPT	cognitive processing therapy
ED	emergency department
FDA	U.S. Food and Drug Administration
HCHV/HCFMI	Health Care for Homeless Veterans/Homeless Chronically Mentally Ill
HEDIS	Healthcare Effectiveness Data and Information Set
ICD	International Statistical Classification of Diseases and Related Health Problems
IESD	index episode start date
LFT	liver function test
MDD	major depressive disorder
MET	motivational enhancement therapy
MH	mental health
MRR	medical record review
NCQA	National Committee for Quality Assurance
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NICE	National Institute for Health and Care Excellence
PCPI	Physician Consortium for Performance Improvement
PHQ	Patient Health Questionnaire
RPT	relapse prevention therapy
RRTP	residential rehabilitation treatment program
SCID	Structured Clinical Interview for DSM Disorders
SRE	Suicide Risk Evaluation
SSDS	Short Screen for Depression Symptoms
SUD	substance use disorder
TSF	12-step facilitation

UB	uniform billing
USPSTF	U.S. Preventive Services Task Force
VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration

Candidate Quality Measures for Alcohol Misuse

Alcohol misuse is defined as drinking above the recommended daily or weekly limits. Alcohol misuse includes the range of elevated drinking, from unhealthy or risky drinking to alcohol use disorder (AUD; formerly diagnosed separately as alcohol abuse and alcohol dependence). Alcohol misuse is prevalent in the United States, with an estimated 20 percent of U.S. medical outpatients drinking at unhealthy levels (Saitz, 2005). Recent studies show that between 7 and 14 percent of the adult U.S. population met the diagnostic criteria for AUD in the previous year, and 29 percent had met criteria for AUD at some point during their life (Grant et al., 2015; SAMHSA, 2014). Alcohol misuse and AUD are associated with a variety of poor health outcomes and serious behavioral consequences (Baan et al., 2007; Corrao et al., 2004; Harris, Lembke, et al., 2012; Larson et al., 2012).

Effective care for alcohol misuse is documented thoroughly in clinical practice guidelines (e.g., U.S. Department of Veterans Affairs/U.S. Department of Defense [VA/DoD] 2009 Clinical Practice Guidelines; 2011 National Institute for Health and Care Excellence [NICE] *Clinical Guidelines*). Care delivered can be grouped into three phases of care: screening and assessment, treatment, and follow-up care. Routine screening for alcohol misuse is recommended, and guidelines suggest that a positive screen for potential alcohol misuse should be followed by an assessment for an alcohol use disorder and a brief intervention (BI). BI is a widely accepted evidence-based practice for reduction of alcohol misuse (Kaner et al., 2007; O'Donnell et al., 2014; Jonas et al., 2012) and consists of feedback or advice to reduce alcohol consumption. Treatment is recommended for patients with an AUD diagnosis (VA, 2009; National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2005). Effective treatments include certain forms of psychotherapy and pharmacotherapy. Guidelines also specify levels and timing of follow-up care dependent upon the course of care undertaken (VA, 2009; NICE, 2011).

Despite guidance offered in clinical practice guidelines, significant concerns have been raised over the poor quality of care for alcohol misuse in usual care settings (McCarty, 2007; Institute of Medicine, 2001; Solberg, Maciosek, and Edwards, 2008; McGlynn, Schneider, and Kerr, 2014). Assessing the quality of care through the use of reliable measures is important for identifying gaps in quality of care and essential for monitoring the results of quality improvement efforts (Sollecito and Johnson, 2011; McLaughlin and Kaluzny, 2005). Quality measures are often derived from clinical practice guidelines and assess the degree to which patients receive guideline-concordant care. Unfortunately, there are few validated quality measures to assess treatment for

alcohol misuse; in particular, few measures have demonstrated predictive validity in examining the relationship between process of care and patient outcomes.

Perhaps the most commonly used substance use disorder (SUD) treatment quality measures are from the Healthcare Effectiveness Data and Information Set (HEDIS). The HEDIS SUD measures may be applied to AUD populations, with a subset of SUD conditions, but they are intended for use in SUD conditions more broadly. Measures relevant to AUD assess whether individuals with SUD initiate treatment and engage in treatment, measured by the number of SUD-related visits within specified time periods. While there is some evidence that the HEDIS measures of initiation of treatment and treatment engagement are associated with modest improvements in patient outcomes (Garnick et al., 2007; Harris, Lembke, et al., 2012), HEDIS measures assess only whether SUD care was received, not whether the care associated with the service was adequate (e.g., whether the received treatment reflects evidence-based care). Furthermore, the HEDIS measures do not address the full, recommended range of care for alcohol misuse described above.

This document provides detailed technical specifications for candidate quality measures for alcohol misuse. These measures were developed as part of the AQual study, a multiyear NIAAA-funded study to evaluate the predictive validity (that is, the link between improvements on these processes of care and improvements in outcomes) of potential quality measures for alcohol misuse.

The rest of this document describes the overall study context and goals, the specific institutional context in which these measures were developed and will ultimately be tested, and the steps taken to arrive at the final set of measures. The final set of measures is described in terms of their denominator population as well as their required data sources. Document appendixes include detailed specifications of key definitions (Appendix 1), as well as the full set of quality measure specifications (Appendix 2).

Study Context

The goal of the AQual study was to develop and evaluate quality measures to assess the care for alcohol misuse and AUD. The AQual study team took the following five steps to develop and evaluate quality measures:

1. **Candidate measure identification and development:** This step consisted of a review of existing quality measures through literature review and measure databases. Clinical practice guidelines were also reviewed to develop new candidate measures. This process is reported in Hepner et al. (under review).
2. **Measure selection:** In this step, we convened an expert panel that reviewed, rated, and selected measures from the set of measures identified above. This process is also reported in Hepner et al. (under review).
3. **Measure specification:** After measures were selected, we identified measure

statements, numerators, and denominators, as well as the phase of care with which each measure was involved. We also identified the required data sources and technical specifications required in order for the measures to be applied within the context of this study. The outcomes of the measure specification process are reported in this tool.

4. **Measure validation:** In this final step, we conduct empirical investigations of measure process-outcome links. This step is currently ongoing, and findings will be disseminated in future reports.

As described above, this tool describes the technical specifications and selected candidate quality measures that will be tested for predictive validity in future work. To evaluate the measures, we partnered with, and operationalized measures within, VA Greater Los Angeles Healthcare System. VA conducts population-based alcohol screening annually, and it is in this setting that this study was conducted. For this reason, all measures assume that population-based screening is being conducted, and there is no initial measure in this set related to screening for alcohol misuse.

Each of the measures selected for testing was selected due to its likely association with outcomes in the general population (see the section below on “Measure Identification, Development, and Specification”). It is important to note, however, that each measure operationalized in this manual was developed within the specific context of the VA Greater Los Angeles Healthcare System. In some cases the operational definitions of the measures will need to be modified to suit a context beyond that of the VA.

The AQual Study Population

It is important to note that, while the measures described in this document were developed for use in any health system, the specifications, as explained in the previous paragraph, were developed for testing within a specific study population within the VA Greater Los Angeles Healthcare System. As noted previously, subsequent work will validate the measures described here within this population of patients. The study population consisted of veterans who screened positive for alcohol misuse on a routine screen in primary care. VA requires an annual screen for alcohol misuse using the three-item Alcohol Use Disorders Identification Test–Consumption (AUDIT-C). While AUDIT-C scores greater than or equal to 3 for women and 4 for men have been found to best balance sensitivity and specificity for identifying alcohol misuse (Dawson et al., 2005), VA practice guidelines currently incentivize brief intervention for all patients screening positive with a score of 5 or more (VA, 2009). Therefore, the study population for the AQual study was limited to VA patients who screened positive for alcohol misuse with an AUDIT-C score of 5 or more.

VA currently implements quality measures for both alcohol screening and brief

intervention. The screening quality measure requires annual screening of all outpatients with the 3-item AUDIT-C as described above. The brief intervention performance measure requires documentation of alcohol-related advice and feedback (two core components of brief intervention) for all patients screening positive with scores of 5 or more on the AUDIT-C. Announcement of both performance measures was accompanied by dissemination of national clinical reminders embedded in the electronic medical record and support documentation of both screening and brief intervention (Williams et al., 2014; Lapham et al., 2012; Bradley, Williams, et al., 2006). Within VA Greater Los Angeles Healthcare System, a score of 5 or greater on the AUDIT-C will lead to prompts for the clinician to conduct a brief intervention.

Because of this context for evaluating the quality measures, readers will note that we do not include a quality measure on conducting a screen for alcohol misuse. It is essential that a system have an alcohol misuse screening in place, along with a quality measure to ensure that routine screening is occurring, as a positive screen is the foundation of all subsequent clinician follow-up.

Patients recruited for the AQual study were also subject to additional eligibility criteria for research purposes, although these requirements are not intended to apply to the selected measures when employed in clinical populations beyond this study. These criteria include

- **no recent alcohol-related treatment:** We required that the patients have no formal treatment (inpatient or outpatient encounters) for alcohol misuse in the three months prior to the qualifying AUDIT-C screening. This allowed us to observe the full course of care for alcohol misuse that the patient received to best observe the link between processes of care and outcomes.
- **engaged in care within the regional VA system:** We required that participating patients have at least one outpatient visit at a regional VA facility *for any reason* in the 12 months prior to the visit in which the AUDIT-C screen was conducted. Because the goal of the study was to observe the care participants receive in the six months (183 days) subsequent to screening, we aimed to increase the likelihood that participating patients received their regular care at VA.
- **not cognitively impaired:** We excluded patients with one or more outpatient encounters or inpatient admissions in the past 12 months with a primary or secondary diagnosis of dementia or delirium. Patients with severe cognitive impairment may receive different care for alcohol misuse and may have had difficulty participating in the study's telephone surveys.
- **age:** We required patients to be at least 18 years of age on the date of the visit in which the AUDIT-C screen was conducted.
- **other practical eligibility requirements:** For the purpose of the study, we also required patients to have a telephone number and address on file, and be able to complete a phone interview in English.

This study population is the context in which the measures described in this tool will

ultimately be tested for validity. Measures described in this tool may specify additional “denominator” requirements beyond the requirements described above.

Measure Identification, Development, and Specification

Identification and development of candidate quality measures detailed in this document are described elsewhere (Hepner et al., under review). Briefly, we conducted a systematic review of literature on existing quality measures related to alcohol misuse and AUD, as well as SUD more broadly. We also examined existing clinical practice guidelines and quality measure databases. This process generated 25 candidate measures, many with multiple potential specifications.

We used a modified RAND/UCLA Appropriateness Methodology (Shekelle et al., 2001), a two-phase expert panel review process, to review and select measures for further testing. We gathered nine experts in alcohol misuse treatment with a variety of professional roles (practitioner, researcher, and/or administrator), degrees (M.D., Ph.D.), training backgrounds (internal/family medicine, psychiatry, psychology), institution types (academic medical center, VA, public sector, private sector), and treatment settings (primary care, mental health specialty care, and substance abuse specialty care). The first phase involved independent ratings of measures along the following dimensions: validity, feasibility of national implementation, and importance. This was followed by a face-to-face discussion between panel members and a second round of ratings subsequent to the panel discussion. This process resulted in the 27 measures that we include in this document. The final measure set is longer than the initial set presented to the panel because alternative specifications were chosen for several measures.

Measures included a range from nationally endorsed quality measures to newly developed measures not yet tested in any environment. In subsequent phases of this study, we will test measures to determine their predictive validity. In turn, this will inform which of these measures should be considered descriptive measures of processes of care for alcohol misuse versus measures that could be used for accountability purposes.

Subsequent to measure selection, the AQual team developed technical specifications with the intention of operationalizing the selected measures within the VA context described earlier. This process involved ongoing discussions with a team of VA and non-VA mental health clinicians, as well as behavioral and public health researchers from both within and outside of VA. The team worked to identify the data sources and variables necessary to populate the measures, as well as precisely specifying the codes and/or medical record documentation that would qualify a patient for a particular denominator, as well as those codes and/or medical record documentation that would qualify as a “pass” on a particular measure.

Here we rely on two broad sources of data to identify eligible patients and describe their course of care as required by the quality measures. Administrative data document information about an inpatient stay or outpatient visit, including information about the provider who treated the patient, the diagnoses assigned, the procedures performed, and any prescriptions filled. Administrative data do not include detailed clinical information, such as notes entered into the patient’s medical record by providers. These more detailed data were obtained from medical record review (MRR) data. The following section, “Overview of Quality Measures,” includes a more detailed look at data sources associated with each quality measure.

While the generalizability of the quality measures across health care systems was considered throughout the process, the measures were operationalized and applied within the Veterans Health Administration (VHA). Due to differences in available data, these measures will likely need some adaptation to be implemented in other health care systems.

It should be noted that many quality measures for alcohol misuse care, like the ones we examined, are defined with a denominator consisting of numbers of patients who have screened positive for alcohol misuse or have been diagnosed with an AUD. As recent articles have pointed out, validity problems can arise when screening or diagnostic accuracy varies across facilities being monitored (Harris, Rubinsky, and Hoggatt, 2015; Bradley et al., 2013). Interpretation of these measures, both in the current study and in future adaptations, should take these issues into account.

Finally, please note that these specifications were developed, specified, and tested in the years 2011 through 2015. Since that time, the International Statistical Classification of Diseases and Related Health Problems (ICD) has been updated (ICD-9 was updated to ICD-10). For a crosswalk between these two diagnostic classification groups, please see Table 10.01 in the Joint Commission’s ICD-9 to ICD-10 crosswalk tables (Joint Commission, 2014). Similarly, the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), has been updated to a 5th edition (DSM-V) since these specifications were developed. See the DSM-V for updated definitions for alcohol use disorders where relevant (American Psychiatric Association, 2013). Due to these changes, and other definitional changes that might occur, applying these measures in the future may require additional modifications to reflect changes in coding practices.

Overview of Quality Measures

Of the 27 measures included in this document, seven are related to screening and assessment for other conditions, 16 are related to treatment, and four are related to follow-up care (Table 1). Ten measures use administrative data only, while 17 are hybrid measures that use both administrative data and medical record review data.

Table 1: Number of Measures, by Data Source and Type of Care Assessed

Type of Data Utilized	Type of Care Assessed		
	Screening and Assessment	Treatment	Follow-up
Administrative data	1 measure	8 measures	1 measure
Administrative data and medical record review data	6 measures	8 measures	3 measures

Table 2 provides an overview of the care process assessed by each measure, along with the phase of care (screening/assessment, treatment, and follow-up) and data source for each measure (administrative data or both administrative data and medical record review data). Treatment measures include initial actions and interventions delivered by the provider after a positive screen for potential alcohol misuse. Follow-up measures include subsequent actions beyond the initial actions taken by the provider.

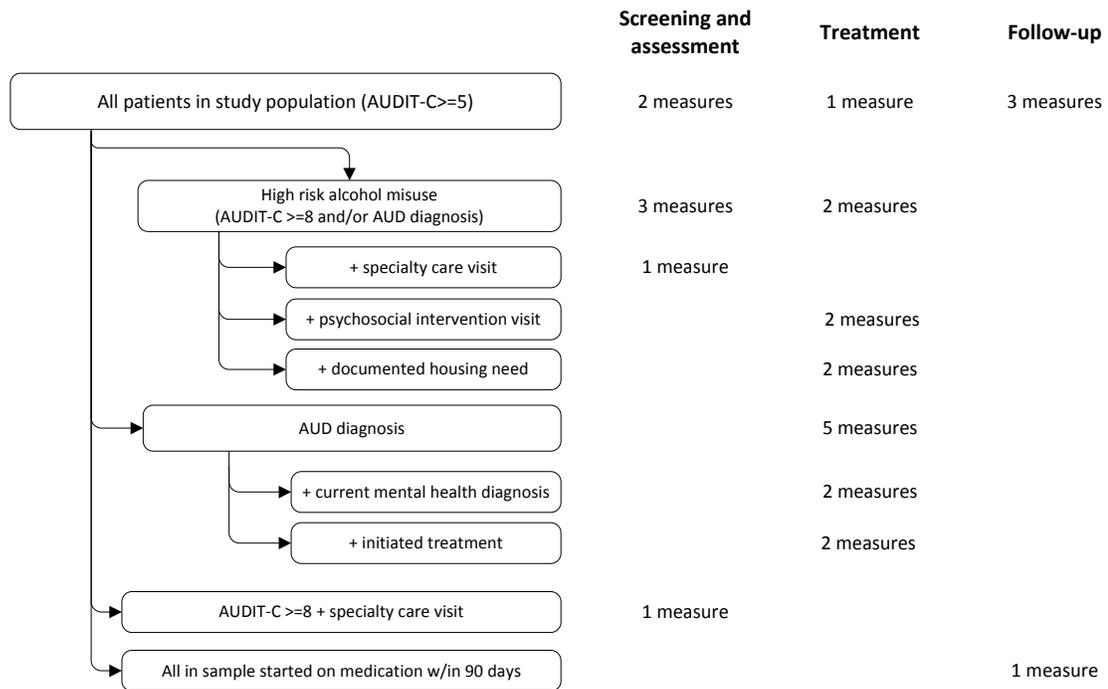
Table 2: Candidate Quality Measures for Alcohol Misuse and Associated Data Sources

Measure Name	Data Source
Screening and Assessment	
Assess for alcohol use disorders	Administrative and medical record review data
Screen for depression	Administrative and medical record review data
Assess for depression	Administrative and medical record review data
Evaluate for suicide risk	Administrative and medical record review data
Screen for other substance use	Administrative and medical record review data
Assess for other substance use	Administrative and medical record review data
Test liver function	Administrative data
Treatment	
Conduct brief intervention	Administrative and medical record review data
Discuss treatment options	Administrative and medical record review data
Offer psychosocial intervention	Administrative and medical record review data
Offer pharmacotherapy	Administrative and medical record review data
Psychosocial intervention dose	Administrative data
Psychosocial intervention quality	Administrative and medical record review data
Receipt of pharmacotherapy for alcohol dependence	Administrative data
Refer to recovery support in the community	Administrative and medical record review

Measure Name	Data Source
	data
Offer of housing services	Administrative and medical record review data
Receipt of housing services	Administrative data
Treatment for co-occurring mental health and substance use	Administrative data
Receipt of integrated co-occurring disorder treatment	Administrative and medical record review data
Treatment initiation (primary)	Administrative data
Treatment initiation (secondary)	Administrative data
Treatment engagement (primary)	Administrative data
Treatment engagement (secondary)	Administrative data
Follow-up	
Reassess alcohol use	Administrative and medical record review data
Repeat brief intervention	Administrative and medical record review data
Medication evaluation and management	Administrative data
Conduct any alcohol-related follow-up	Administrative and medical record review data

Each measure’s denominator reflects the population for which a given process of care may be indicated, and the denominators therefore vary across measures. Six of the 27 measures have as their denominator the entire study population (i.e., those that screen positive for alcohol misuse with a score of 5 or greater on the AUDIT-C). The other 21 measures are relevant only for certain higher-risk subgroups, such as those with “high-risk alcohol misuse” (e.g., patients with an AUDIT-C score of 8 or greater at the index visit or with an AUD diagnosis within 30 days after the index visit date). Figure 1 shows the number of measures applicable to different subgroups, by phase of care assessed.

Figure 1: Number and Type of Measure, by Denominator Population



Guide to Measure Appendixes

The two appendixes provide detailed information about the selected measures. Appendix 1 includes “Key Definitions” used as key components of several of the measures. In Appendix 2, detailed specifications are provided for each measure. Each measure is defined using a measure statement, numerator, and denominator. We then describe the full technical specifications for each of the candidate measures, including detailed definitions of the measure numerator, denominator, and any secondary specifications. We also include a brief rationale for selecting the measure, including reference to clinical practice guidelines and supporting literature; we include benchmarking information where that is available. Finally, we include a summary of our technical expert panel discussion, described in more detail in Hepner et al. (under review).

Summary

This tool presents detailed technical specifications for the set of quality measures that were identified and specified, and that will ultimately be tested, in the AQual study—a study to develop and evaluate quality measures for alcohol misuse. These measures were selected for testing after a literature review, technical expert panel, and iterative process of specification. Future reports will describe findings related to their predictive validity. We are currently testing measures described in this document in a VA setting, and these later data will provide information on which of the measures may be most important in improving outcomes for patients identified with alcohol misuse. We expect that this document will be useful to those interested in potential measures to assess the quality of care for alcohol use, and to those who are interested in the AQual study specifically.

Appendix 1: Key Definitions

In this appendix we describe a set of key definitions used throughout the subsequent quality measure specifications. Decisions about specific codes used in these definitions, and throughout the appendixes more broadly, were made in consultation with our internal team of experts as well as experts from within and outside of VA.

KD1. Index visit

The index visit is the outpatient visit on which the initial qualifying AUDIT-C screen was conducted. The index visit is considered the initiation of the six-month observation period over which the care will be observed for the purposes of the AQual study.

KD2. Alcohol misuse

Participants are identified with possible alcohol misuse (hereafter referred to as alcohol misuse) when they receive an AUDIT-C score of 5 or higher at the index visit. A score of 5 or higher corresponds to the cut-point identified by VA as indicative of possible alcohol misuse and at which brief intervention is incentivized. A score of 5 or higher on the AUDIT-C is an eligibility requirement for this study.

KD3. Diagnosis of alcohol use disorder

An AUD diagnosis is defined using ICD-9 diagnostic codes consistent with alcohol abuse or dependence (please see note in “Guide to Measure Appendices” regarding the update from ICD-9 to ICD-10), including

- Alcohol Abuse: 305.0, 305.00, 305.01, 305.02
- Alcohol Dependence: 303.93, 303.90, 303.91, 303.92.

KD4. High-risk alcohol misuse

Patients are characterized as having high-risk alcohol misuse if they had an AUDIT-C score of 8 or greater at the index visit or received an AUD diagnosis within 30 days after the index visit date, inclusive of the date of the index visit. AUD diagnosis is defined above in KD3.

KD5. Date of identification of high-risk alcohol misuse

The date of identification of high-risk alcohol misuse is considered the date of the qualifying AUDIT-C score or the date of the visit on which the AUD diagnosis was coded, whichever appears first in the administrative data.

KD6. Behavioral health specialty care

Behavioral health specialty care visits include psychiatry and/or substance use disorder care in the inpatient or outpatient setting, where care occurs within the 500-series (that is, mental health and substance use disorder treatment) VA clinic stop codes or in any of the following VA inpatient or residential bed section codes for behavioral health specialty care:

- 39: Compensated Work Therapy/Transitional Residence
- 33: Geriatric Evaluation and Management (GEM) Psychiatry
- 74: Substance Abuse—High Intensity
- 79: Special Inpatient Posttraumatic Stress Disorder (PTSD) Unit
- 88: Domiciliary PTSD (Dom PTSD)
- 89: Sustained Treatment and Rehabilitation (STAR) I, II, & III Programs
- 91: Evaluation / Brief Treatment PTSD
- 92: Psychiatry—General Intervention
- 93: High Intensity Mental Health Care—Inpatient
- 94: Mental Health Observation
- 109/1K: Psychosocial Residential Rehabilitation Treatment Program
- 110/1L: Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program
- 111/1M: Substance Abuse Residential Rehabilitation Treatment Program

KD7. Substance use disorder specialty care

SUD specialty care includes SUD diagnosis-related (either primary or nonprimary) outpatient or inpatient visits, where care occurs within a SUD clinic or bed section code 86 (domiciliary substance use).

SUD diagnoses are defined according to the following ICD-9 codes (please see note in “Guide to Measure Appendices” regarding the update from ICD-9 to ICD-10):

- 303.90–303.92: Other and unspecified alcohol dependence
- 304.00–304.02: Opioid type dependence
- 304.10–304.12: Barbiturate and similarly acting sedative or hypnotic dependence
- 304.20–304.22: Cocaine dependence
- 304.30–304.32: Cannabis dependence
- 304.40–304.42: Amphetamine and other psychostimulant dependence
- 304.50–304.52: Hallucinogen dependence
- 304.60–304.62: Other and unspecified drug dependence
- 304.70–304.72: Combinations of opioid type with any other
- 304.80–304.82: Combinations of drug dependence excluding opioid type
- 304.90–304.92: Unspecified drug dependence
- 305.00–305.02: Alcohol abuse
- 305.20–305.22: Cannabis abuse
- 305.30–305.32: Hallucinogen abuse

- 305.40–305.42: Barbiturate and similarly acting sedative or hypnotic abuse
- 305.50–305.52: Opioid abuse
- 305.60–305.62: Cocaine abuse
- 305.70–305.72: Amphetamine or related acting sympathomimetic abuse
- 305.90–305.92: Other, mixed, or unspecified drug abuse

SUD clinic stop codes include

- 513: Substance Use Disorder Ind
- 514: Substance Use Disorder Home Visit
- 519: Substance Use Disorder/PTSD teams
- 523: Opioid substitution
- 545: Phone Substance Use Disorder
- 547: Intense Substance Use Disorder Group
- 548: Intense Substance Use Disorder Individual
- 560: Substance Use Disorder Group

KD8. Psychosocial intervention

Defined as AUD diagnosis-related (primary or nonprimary diagnosis; see KD 3 above for definition of AUD diagnoses) outpatient visits, where care occurs within the 500-series (that is, mental health and substance use treatment) VA clinic stop codes, excluding clinic stop codes 523, 533, 538, and 565, and having one of the following psychotherapy current procedural terminology (CPT) codes (note that two or more “15 MINUTES” codes are required in the same visit/day to count toward one qualifying psychosocial intervention visit; CPT codes were updated January 2013, and those updated codes are reflected below):

- 90832 PSYTX PT&/FAMILY 30 MINUTES
- 90833 PSYTX PT&/FAM W/E&M 30 MIN
- 90834 PSYTX PT&/FAMILY 45 MINUTES
- 90836 PSYTX PT&/FAM W/E&M 45 MIN
- 90837 PSYTX PT&/FAMILY 60 MINUTES
- 90838 PSYTX PT&/FAM W/E&M 60 MIN
- 90839 PSYTX CRISIS INITIAL 60 MIN
- 90840 PSYTX CRISIS EA ADDL 30 MIN
- 90845 PSYCHOANALYSIS
- 90847 FAMILY PSYTX W/PATIENT
- 90849 MULTIPLE FAMILY GROUP PSYTX
- 90853 GROUP PSYCHOTHERAPY
- 90875 PSYCHOPHYSIOLOGICAL THERAPY
- 90876 PSYCHOPHYSIOLOGICAL THERAPY
- 90880 HYPNOTHERAPY
- 90899 PSYCHIATRIC SERVICE/THERAPY
- 90901 BIOFEEDBACK TRAIN ANY METH

- 96150 ASSESS HLTH/BEHAVE INIT (15 MINUTES)
- 96151 ASSESS HLTH/BEHAVE SUBSEQ (15 MINUTES)
- 96152 INTERVENE HLTH/BEHAVE INDIV (15 MINUTES)
- 96153 INTERVENE HLTH/BEHAVE GROUP (15 MINUTES)
- 96154 INTERV HLTH/BEHAV FAM W/PT (15 MINUTES)
- H0004 ALCOHOL AND/OR DRUG SERVICES (15 MINUTES)
- H0005 ALCOHOL AND/OR DRUG SERVICES
- H0006 ALCOHOL AND/OR DRUG SERVICES
- H0007 ALCOHOL AND/OR DRUG SERVICES
- H0015 ALCOHOL AND/OR DRUG SERVICES
- H0017 ALCOHOL AND/OR DRUG SERVICES
- H0018 ALCOHOL AND/OR DRUG SERVICES
- H0019 ALCOHOL AND/OR DRUG SERVICES
- H0022 ALCOHOL AND/OR DRUG INTERVEN
- H0023 ALCOHOL AND/OR DRUG OUTREACH
- H0025 ALCOHOL AND/OR DRUG PREVENTI
- H0035 MH PARTIAL HOSP TX UNDER 24H
- H0036 COMM PSY FACE-FACE PER 15MIN (15 MINUTES)
- H0037 COMM PSY SUP TX PGM PER DIEM
- H0039 ASSER COM TX FACE-FACE/15MIN (15 MINUTES)
- H0040 ASSERT COMM TX PGM PER DIEM
- H0046 MENTAL HEALTH SERVICE, NOS
- H0047 ALCOHOL/DRUG ABUSE SVC NOS
- H0050 ALCOHOL/DRUG SERVICE 15 MIN (15 MINUTES)
- H2001 REHABILITATION PROGRAM 1/2 D
- H2011 CRISIS INTERVEN SVC, 15 MIN (15 MINUTES)
- H2012 BEHAV HLTH DAY TREAT, PER HR
- H2013 PSYCH HLTH FAC SVC, PER DIEM
- H2014 SKILLS TRAIN AND DEV, 15 MIN (15 MINUTES)
- H2015 COMP COMM SUPP SVC, 15 MIN (15 MINUTES)
- H2016 COMP COMM SUPP SVC, PER DIEM
- H2017 PSYSOC REHAB SVC, PER 15 MIN (15 MINUTES)
- H2018 PSYSOC REHAB SVC, PER DIEM
- H2019 THER BEHAV SVC, PER 15 MIN (15 MINUTES)
- H2020 THER BEHAV SVC, PER DIEM
- H2021 COM WRAP-AROUND SV, 15 MIN (15 MINUTES)
- H2022 COM WRAP-AROUND SV, PER DIEM
- H2023 SUPPORTED EMPLOY, PER 15 MIN (15 MINUTES)
- H2024 SUPPORTED EMPLOY, PER DIEM
- H2025 SUPP MAINT EMPLOY, 15 MIN (15 MINUTES)
- H2026 SUPP MAINT EMPLOY, PER DIEM
- H2027 PSYCHOED SVC, PER 15 MIN (15 MINUTES)
- H2030 MH CLUBHOUSE SVC, PER 15 MIN (15 MINUTES)
- H2031 MH CLUBHOUSE SVC, PER DIEM

- H2035 A/D TX PROGRAM, PER HOUR
- H2036 A/D TX PROGRAM, PER DIEM
- 4060F PSYCH SVCS PROVIDED
- 4062F PT REFERRAL PSYCH DOCD
- 4306F PT TLK PSYCH & RX OPD ADDIC
- 4320F PT TALK PSYCHSOC&RX OH DPND
- G0409 CORF RELATED SERV 15 MINS EA (15 MINUTES)
- G0410 GRP PSYCH PARTIAL HOSP 45-50
- G0411 INTER ACTIVE GRP PSYCH PARTI
- 4320F PT TALK PSYCHSOC&RX OH DPND
- G0443 BRIEF ALCOHOL MISUSE COUNSEL (15 MINUTES)
- 99600 HOME VISIT NOS
- T1016 CASE MANAGEMENT (15 MINUTES)
- 99078 GROUP HEALTH EDUCATION
- S9446 PT EDUCATION NOC GROUP
- S9454 STRESS MGMT CLASS
- S9480 INTENSIVE OUTPATIENT PSYCHIA
- S9482 FAMILY STABILIZATION 15 MIN (15 MINUTES)
- S9484 CRISIS INTERVENTION PER HOUR
- S9485 CRISIS INTERVENTION MENTAL H
- T1006 FAMILY/COUPLE COUNSELING
- T1012 ALCOHOL/SUBSTANCE ABUSE SKIL
- T1017 TARGETED CASE MANAGEMENT (15 MINUTES)
- T2022 CASE MANAGEMENT, PER MONTH
- T2023 TARGETED CASE MGMT PER MONTH
- G9012 OTHER SPECIFIED CASE MGMT
- 99354 PROLONGED SERVICE OFFICE
- 99355 PROLONGED SERVICE OFFICE
- 99401 PREVENTIVE COUNSELING INDIV (15 MINUTES)
- 99402 PREVENTIVE COUNSELING INDIV
- 99403 PREVENTIVE COUNSELING INDIV
- 99404 PREVENTIVE COUNSELING INDIV
- 99411 PREVENTIVE COUNSELING GROUP
- 99412 PREVENTIVE COUNSELING GROUP
- 99510 HOME VISIT SING/M/FAM COUNS

Appendix 2: Quality Measure Specifications

1. Assess for Alcohol Use Disorders

Measure statement:

IF patient has alcohol misuse, THEN patient should be assessed for AUD.

Numerator:

Patients assessed for AUD within 30 days after the index visit

Denominator:

Patients with alcohol misuse

Phase of care:

Screening and assessment

Data sources:

Administrative data/medical record review data

Rationale and past use:

Following a positive screen for alcohol misuse, additional assessment is recommended to identify appropriate treatment pathways. The VA/DoD Clinical Practice Guideline for SUD (VA, 2009), American Psychiatric Association’s Practice Guideline for the Treatment of Patients with SUDs (American Psychiatric Association, 2006), and 2011 NICE *Clinical Guidelines* (NICE, 2011) all recommend additional assessments following a positive screen for alcohol misuse. These three guidelines emphasize that the primary goals of assessments are to identify a diagnosis and formulate an initial treatment plan, though each guideline specifies different elements to be included in the assessment.

A similar quality measure with a denominator more restrictive than a positive screen on the AUDIT-C was selected by an expert panel and implemented in a study of the quality of care for general medical conditions in the United States, noting that “The record should indicate for dependence, tolerance of psychoactive effects, loss of control, and consequences of use if the medical record indicates the patient is a daily or binge drinker” (Kerr et al., 2000).

Technical specifications:

Index visit: See KD1 in Appendix 1.

Alcohol misuse: See KD2 in Appendix 1.

AUD assessment: AUD assessment is assessed using medical record review data or administrative data. Any day in the 30-day window after the index visit (inclusive of the index visit date) on which (A), (B), or (C) are observed in the medical record review data, or (D) is observed in the administrative data, will count as a “pass” for this measure:

- A. Structured clinical assessment using a tool, including:
 - Structured Clinical Interview for DSM Disorders (SCID) part E
 - Addiction Severity Index (ASI)
 - Comprehensive Drinkers profile (CDP)
 - Alcohol Use Inventory (AUI)
- B. Assessment of at least one item at the same outpatient visit or inpatient stay from each of the social and physical impact categories (presence or absence) in the medical record
 - Social impact includes negative consequences, e.g.:
 - failure to fulfill major role obligations at work, school, or home
 - substance use in situations in which it is physically hazardous
 - continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
 - important social, occupational, or recreational activities are given up or reduced because of substance use
 - a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
 - important social, occupational, or recreational activities are given up or reduced because of substance use
 - the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
 - “Denies any social consequences” would count
 - Physical impact includes indications of physical symptoms of tolerance, dependence, or withdrawal such as
 - a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or
 - markedly diminished effect with continued use of the same amount of the substance
 - withdrawal as defined by either of the following:
 - the characteristic withdrawal syndrome for the substance, or
 - the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
 - the substance is often taken in larger amounts or over a longer period than was intended
 - there is a persistent desire or unsuccessful efforts to cut down or control substance use
 - craving or a strong desire or urge to use a specific substance

- “denies any physical impact” would count
- C. A physician note indicating patient denial of current alcohol use or that the patient is drinking within recommended limits
- D. A provider checked the optional review of the DSM-IV criteria for alcohol dependence in the follow-up to the AUDIT-C clinical reminder. Please note as discussed above in the “Guide to Measure Appendixes” that these criteria are now out of date; see the DSM-V criteria for more information (American Psychiatric Association, 2013).

Secondary specifications:

Evaluate a 60-day time frame for follow-up.

Notes on specifications:

For (A), a chart note indicating the instrument, and a score and/or interpretation, would pass; a chart note indicating an instrument, but not containing a score or interpretation, does not count. If the interview tool score is mentioned, record the score as a numeric value; if an interpretation is given with the interview, record the interpretation as free text. AUDIT-C (please see note in “Guide to Measure Appendixes” regarding the update from ICD-9 to ICD-10) scores or other forms of self-reporting do not count as a Structured Assessment. ICD-9 or DSM-IV codes for alcohol misuse or alcohol use disorder do not count as a Structured Assessment.

For (B), if assessment takes place, and falls under (B)—or if assessment does not take place but social or physical impact are assessed separately—then abstractors should enter whether social or physical impact (or both) were assessed.

Summary of technical expert panel discussion:

There was strong consensus across panel members that further assessment was recommended following a positive screen on the AUDIT-C, with the aim of determining whether a patient truly has alcohol misuse and, if so, whether they have AUD. Subsequent treatment options for AUD depend on the result of this assessment, so this is a fundamental step. Panelists did note, however, that most primary care practitioners will not be able to conduct a thorough assessment. Further, an assessment in primary care may look very different than a full intake evaluation in SUD specialty care. For this reason, panelists agreed that the assessment need not take place on the same day or be performed by the same provider who identified alcohol misuse via the screening instrument, as long as someone in the treatment system completes the assessment within a reasonable time period.

2. Screen for Depression

Measure statement:

IF patient has high-risk alcohol misuse, THEN patient should be screened for depression.

Numerator:

Patients screened for depression within 30 days before or after identification of high-risk alcohol misuse

Denominator:

Patients with high-risk alcohol misuse

Phase of care:

Screening and assessment

Data sources:

Administrative data/medical record review data

Rationale and past use:

Annual screening of primary care patients is endorsed by numerous reviews and guidelines. For example, the 2009 VA/DoD Clinical Practice Guideline for Management of Major Depressive Disorder (MDD) recommends that “the Patient Health Questionnaire (PHQ) 2-item should be completed annually by all patients seen in primary care settings” (VA, 2009). Similarly, the U.S. Preventive Services Task Force (USPSTF) recommends “screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow up” (USPSTF, 2009). Among patients from VA medical centers, 81 percent were screened for depression during the previous 12-month period (Hermann et al., 2006).

Among patients with AUDs, depression is one of the most commonly co-occurring psychiatric conditions (Grant et al., 2004). Because the prevalence of depression is greater in patients with AUDs compared with the general population, the expected benefit of screening is likely larger in this population. The American Medical Association (AMA), Physician Consortium for Performance Improvement (PCPI), and the National Committee for Quality Assurance (NCQA) have endorsed a measure entitled “Screening for depression among patients with substance abuse or dependence” (National Quality Measures Clearinghouse, 2008c); note, however, that the population for this denominator includes all patients with likely alcohol misuse rather than those with confirmed substance abuse or dependence.

Technical specifications:

High-risk alcohol misuse: See KD4 in Appendix 1.

Date of identification of high-risk alcohol misuse: See KD5 in Appendix 1.

Screen for depression: Screen for Depression can be assessed using either administrative or medical record review data. Any day in the 30-day window *before* or *after* the date of identification of high-risk alcohol misuse, inclusive of the visit date, in which any of the following (A, B, or C) are observed, will count as a “pass” for this measure:

A. Any inpatient or outpatient diagnosis of depression defined by a visit-related ICD-9 code (as primary or nonprimary, inpatient or outpatient) from the ones below (please see note in “Guide to Measure Appendices” regarding the update from ICD-9 to ICD-10):

- 296.20–296.26: Major depressive disorder, single episode
- 296.30–296.36: Major depressive disorder, recurrent episode
- 296.50–296.56: Bipolar I disorder, most recent episode (or current) depressed
- 296.90: Unspecified episodic mood disorder
- 296.99: Other specified episodic mood disorder
- 298.0: Depressive Type Psychosis
- 300.4: Dysthymic disorder
- 301.12: Chronic depressive personality disorder
- 309.0: Adjustment disorder with depressed mood
- 309.1: Prolonged depressive reaction
- 311: Depressive disorder, not elsewhere classified.

B. Documentation of a formal screen or assessment for depression. This could mean either

- Documentation in the administrative data that a PHQ-2 or PHQ-9 assessment was performed

OR

- Documentation in the medical record of any of the following assessments:
 - PRIME-MD: 2-question screen
 - PHQ-2: 2-question Patient Health Questionnaire
 - PHQ-9: 9-question Patient Health Questionnaire
 - BDI: Beck Depression Inventory
 - BDI-S: Short form of the Beck Depression Inventory (13-item version)
 - CEB-D: 5-item brief version developed for patients ≥ 60 years old
 - CES-D: Center for Epidemiologic Studies–Depression Scale (5-, 10-, or 20-item version)
 - MOS Depression Questionnaire: Medical Outcomes Study Depression Questionnaire
 - IDS-SR30: Inventory of Depressive Symptomatology 30-item screener
 - QIDS-SR16: Quick Inventory of Depressive Symptomatology 16-item screener

- HRSD17: Hamilton Rating Scale for Depression 17-item screener
 - HRSD21: Hamilton Rating Scale for Depression 21-item screener
 - HRSD24: Hamilton Rating Scale for Depression 24-item screener
 - MADRS: Montgomery Asberg Depression Rating Scale
 - Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID MDD Module)
 - Short Screen for Depression Symptoms (SSDS)
 - Any other formal screen for depression not mentioned above.
- C. An informal assessment for depression (interview) as defined by:
- Inclusion of documentation in the medical record of the presence or absence of depressive symptoms (e.g., sad mood, suicidal thoughts, hopelessness).

Notes on specifications:

For those patients who meet the diagnosis of depression criteria above (A) using administrative data, no additional medical record information should be collected. For (B), if a formal screen score is mentioned, abstractors should enter the score as a numeric value; if an interpretation is given, abstractors should enter it as free text as long as it is specifically referring to the clinician’s interpretation of the formal screen. If abstractors identify a formal screen not listed, they should note which instrument is used and verify with their annotation manager. For (C) “No depression symptoms,” “patient is depressed” or other comments about mood or interest (anhedonia) would count.

Summary of technical expert panel discussion:

Panel members noted that the VA already requires annual population screening for MDD. Thus they questioned whether, and by how much, alcohol misuse as characterized by an AUDIT-C score greater than or equal to 5 should accelerate the screening time frame beyond the normal annual screenings. Panelists felt that there was a stronger argument for accelerating the screening time frame for patients with high-risk alcohol misuse (AUDIT-C \geq 8).

Panelists suggested that the 30-day window seemed “optimistic,” with some even proposing the window be extended to 90 days. Panelists agreed, however, that most primary care providers will be able to either offer or refer patients for a full assessment for MDD. Therefore, this particular screening requirement for those with high-risk alcohol misuse represents a more feasible standard.

3. Assess for Depression

Measure statement:

IF patient has high-risk alcohol misuse AND is receiving behavioral health specialty care treatment, THEN patient should be assessed for depression.

Numerator:

Patients assessed for depression from 30 days before to 60 days after identification of high-risk alcohol misuse or first date of qualifying behavioral health specialty care visit, whichever comes last

Denominator:

Patients with high-risk alcohol misuse and at least one qualifying behavioral health specialty care visit

Phase of care:

Screening and assessment

Data sources:

Administrative data/medical record review data

Rationale and past use:

The rationale for this measure is similar to that of the preceding measure, “Screen for Depression.” This measure involves a more comprehensive psychiatric assessment for depression; in particular, it is related only to those patients receiving care in a specialty care setting, and it requires a full diagnostic assessment for depression. The 2009 VA/DoD Clinical Practice Guidelines for the management of SUDs recommends that providers obtain a comprehensive biopsychosocial assessment for all patients entering specialty treatment settings (VA, 2009). In an independent evaluation of VA mental health services, a similar measure was tested in a national cohort of VA patients with mental health diagnoses: “Assess for current psychiatric symptoms and/or psychiatric history for patients with SUD in specialty mental health” (Horvitz-Lennon et al., 2009). In this cohort of VA patients, the proportion with documented assessment for current psychiatric symptoms was 78.1 percent (Farmer et al., 2010).

Technical specifications:

High-risk alcohol misuse: See KD4 in Appendix 1.

Date of identification of high-risk alcohol misuse: See KD5 in Appendix 1.

Qualifying behavioral health specialty care visit: Defined as one behavioral health specialty care visit within 30 days after identification of high-risk alcohol misuse. See KD6 in Appendix 1.

Assessment for depression: Assessment for depression can rely on either administrative or medical record review data. The assessment can occur on any day in the latest of the following windows: 30 days *before* or 60 days *after* the date of identification of high-risk alcohol misuse, or of the qualifying behavioral health specialty care visit, inclusive of the date of identification/visit date (see secondary specifications below for an

alternative window tested).

Assessment for depression is said to have occurred if *any* of the following (A, B, or C) is observed during the time window described above:

A. Any inpatient or outpatient diagnosis or treatment of depression defined by a visit-related ICD-9 code (as primary or nonprimary, inpatient or outpatient) from the codes listed below:

- 296.20–296.26: Major depressive disorder, single episode
- 296.30–296.36: Major depressive disorder, recurrent episode
- 296.50–296.56: Bipolar I disorder, most recent episode (or current) depressed
- 296.90: Unspecified episodic mood disorder
- 296.99: Other specified episodic mood disorder
- 298.0: Depressive Type Psychosis
- 300.4: Dysthymic disorder
- 301.12: Chronic depressive personality disorder
- 309.0: Adjustment disorder with depressed mood
- 309.1: Prolonged depressive reaction
- 311: Depressive disorder, not elsewhere classified.

B. Documentation in the medical record that any of the following assessments were conducted:

- PHQ-9: 9-question Patient Health Questionnaire
- BDI: Beck Depression Inventory
- BDI-S: Short form of the Beck Depression Inventory (13-item version)
- CEB-D: 5-item brief version developed for patients ≥ 60 years old
- CES-D: Center for Epidemiologic Studies–Depression Scale (5-, 10-, or 20-item version)
- MOS Depression Questionnaire: Medical Outcomes Study Depression Questionnaire
- IDS-SR30: Inventory of Depressive Symptomatology 30-item screener
- QIDS-SR16: Quick Inventory of Depressive Symptomatology 16-item screener
- HRSD17: Hamilton Rating Scale for Depression 17-item screener
- HRSD21: Hamilton Rating Scale for Depression 21-item screener
- HRSD24: Hamilton Rating Scale for Depression 24-item screener
- MADRS: Montgomery Asberg Depression Rating Scale
- Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID MDD Module)
- Short Screen for Depression Symptoms (SSDS).

C. Documentation in the medical record of an interview, as demonstrated by either:

- Noting the presence or absence of at least four of the symptoms of depression, including:
 - Depressed mood
 - Loss of interest or pleasure in daily activities
 - Significant weight loss when not dieting or weight gain or decrease or increase in appetite
 - Insomnia or hypersomnia (excessive daytime sleepiness)
 - Psychomotor agitation (restlessness, pacing, tapping fingers or feet, abruptly starting and stopping tasks, meaninglessly moving objects around) or psychomotor retardation (lethargic)
 - Fatigue or loss of energy
 - Feelings of worthlessness or excessive or inappropriate guilt
 - Diminished ability to think or concentrate, or indecisiveness
 - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- SIGECAPS mnemonic would also count for an interview (the record should document at least four of the issues below to “pass”):
 - S: Sleep disturbance (insomnia, hypersomnia, excessive daytime sleepiness)
 - I: Interest/pleasure reduction
 - G: Guilt feelings or thoughts of worthlessness
 - E: Energy changes/fatigue
 - C: Cognition/Concentration/attention impairment or difficulty
 - A: Appetite/weight changes
 - P: Psychomotor agitation (restlessness, pacing, tapping fingers or feet, abruptly starting and stopping tasks, meaninglessly moving objects around) or psychomotor retardation (lethargic)
 - S: Suicidal thoughts or preoccupation with death.

Secondary specifications:

The assessment can occur on any day in the latest of the following windows: 60 days *before* or 60 days *after* the date of identification of high-risk alcohol misuse, or of the qualifying behavioral health specialty care visit.

Notes on specifications:

For those patients who meet the diagnosis and treatment of depression criteria above

(A), no additional medical record information should be collected. For (B), the PHQ-2 does not count for this measure; other tools used that are not on the list also will not count as a Formal Assessment. If the Formal Assessment score is mentioned, abstractors should record the score as a numeric value; if an interpretation is given with Formal Assessment, abstractors should record it as long as it is specifically referring to the clinician's interpretation of the Formal Assessment. A primary care physician can do the Formal Assessment; it does not have to be done by a psychiatrist or other specialty care mental health provider. For (C), there must be documentation of any combination of at least four symptoms or SIGECAPS items. A primary care physician can do the interview or SIGECAPS; it does not have to be done by a psychiatrist or other specialty care mental health provider.

Summary of technical expert panel discussion:

While there was some disagreement around the utility of including a measure related to screening for depression in primary care, the panel expressed agreement that assessment for depression made sense in behavioral health specialty care settings. They also noted that most behavioral health specialty providers will complete some sort of assessment for other substance use, so we may observe limited variability on this.

The panelists agreed that a brief screen for depression is inadequate for patients receiving care in specialty substance use disorder or mental health care settings. The panel did not discuss the specific diagnostic instruments above but agreed to include any instruments aimed at determining a diagnosis of MDD. Instruments designed for screening were not included. The panel also agreed that patients with newly identified high-risk or severe alcohol misuse should receive a full evaluation or assessment for depression, among other things.

4. Evaluate for Suicide Risk

Measure statement:

IF patient has high-risk alcohol misuse, THEN patient's suicide risk should be evaluated.

Numerator:

Patients evaluated for suicide risk within 30 days before or after identification of high-risk alcohol misuse

Denominator:

Patients with high-risk alcohol misuse

Phase of care:

Screening and assessment

Data sources:

Administrative data/medical record review data

Rationale and past use:

Individuals with AUDs have elevated risk of suicidal behavior compared to the general population (Grant and Hasin, 1999; Sher, 2006). The 2009 VA/DoD Clinical Practice Guideline for SUD, 2011 NICE *Clinical Guidelines*, and 2006 APA Practice Guideline for the Treatment of Patients with SUDs all recommend screening specifically for suicidal ideation among patients with alcohol use disorders; however, since there is currently no validated screen for suicidality, a suicide risk evaluation is recommended (American Psychiatric Association, 2006; VA, 2009; NICE, 2011). In an independent evaluation of VA mental health services, a similar measure was tested in a national cohort of VA patients with mental health diagnoses: “Percentage of patient charts that document assessment for suicide ideation” (Horvitz-Lennon et al., 2009). In this cohort of VA patients, the proportion with documented assessment for suicide ideation was 81.8 percent (Farmer et al., 2010).

Technical specifications:

High-risk alcohol misuse: See KD4 in Appendix 1.

Date of identification of high-risk alcohol misuse: See KD5 in Appendix 1.

Suicide risk evaluation: Suicide risk is assessed using medical record review data. Any day in the 30-day window *before* or *after* the date of identification of high-risk alcohol misuse, inclusive of the date of identification, in which *any* of the following (A through C) is observed will count as a “pass” for this measure:

- A. A completed VA Suicide Risk Evaluation (SRE). The SRE is a part of an annual clinical reminder system locally adapted within the Greater Los Angeles VA (GLA) as part of national VA guidance on this issue. The suicide risk evaluation addresses
 - Hopelessness
 - Suicidal thoughts (e.g., thoughts of wanting to be dead or wanting things just to end and be over)
 - Suicide plan if having suicidal thoughts
 - History of suicide attempts.
- B. The presence or endorsement of current suicidal ideation, including
 - Any reference to the patient not wanting to live anymore
 - Comments about killing oneself or doing oneself serious harm

- Overwhelming hopelessness
 - Thoughts of death as a “solution”
 - Thoughts about taking one’s life, or entertaining any similar thoughts.
- C. Absence of suicidal ideation, with documentation of specific denial (e.g., “no suicidal thoughts,” “no thoughts of self-harm”).

Notes on specifications:

None

Summary of technical expert panel discussion:

Panelists agreed that assessment for suicidal ideation would be appropriate in all care settings. Panelists also agreed that this measure did have some overlap with some, but not all, depression screening instruments.

5. Screen for Other Substance Use

Measure statement:

IF patient has alcohol misuse, THEN patient should be screened for other substance use.

Numerator:

Patients screened for other substance use 30 days before or after the index visit

Denominator:

Patients with alcohol misuse

Phase of care:

Screening and assessment

Data sources:

Administrative data/medical record review data

Rationale and past use:

Alcohol misuse and AUDs are associated with a higher likelihood of drug use (Hasin et al., 2007; Hingson, Heeren, and Edwards, 2008; Stinson et al., 2005). Higher scores on the AUDIT have been linked to increased likelihood of lifetime and past year drug use (Coulthard et al., 2002).

The National Quality Forum consensus standards on the treatment of substance use conditions support a case finding approach (as compared to routine screening) to identifying patients with substance use disorders, noting that “healthcare providers should

employ a systematic method to identify patients who use drugs, which considers epidemiologic and community factors and potential health consequences of drug use for their specific population” (National Quality Forum, 2008). This guideline does not specify whether alcohol misuse indicates sufficient risk. Furthermore, a recent review of screening and BI for unhealthy drug use in primary care settings states that the efficacy is still largely unknown (Saitz, 2010). Additionally, the 2011 NICE *Clinical Guidelines* recommends providers “consider a comprehensive assessment for all adults referred to specialist alcohol services who score more than 15 on the AUDIT,” including an assessment of “other drug misuse, including over-the-counter medication” (NICE, 2011). Finally, the USPSTF concluded in a review of screening for illicit drug use that “the current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use” (USPSTF, 2008). Thus, there is limited evidence in support of this measure, and it should be considered exploratory only.

Technical specifications:

Index visit: See KD1 in Appendix 1.

Alcohol misuse: See KD2 in Appendix 1.

Screen for other substance use: The screen for other substance use can be assessed using both administrative and medical record review data. Any day in the 30-day window *before* or *after* the date of the index visit, inclusive of the visit date, in which *any* of the following (A or B) is observed will count as a “pass” for this measure:

- A. Documentation in the administrative data of collateral/lab reports for any toxicology screen
- B. Documentation in the medical record of any attempt to assess drug use (excluding tobacco). Qualifying documentation may include
 - A note indicating “No recent drug use” or “denies all other drug use”
 - A note documenting that the provider specifically asked about
 - Marijuana
 - Cocaine
 - Heroin/narcotics
 - Methamphetamine/stimulants
 - Intravenous drug use.

Notes on specifications:

For those patients who meet the documentation of collateral/lab reports for a toxicology screen criterion above (A), no additional medical record information should be collected. For (B), addendums dated within 24 hours count as part of the same note. Documentation of the provider asking about, or a patient reporting, use of a single drug

from the above list is sufficient to pass this measure.

Summary of technical expert panel discussion:

The panel discussion focused principally on the National Quality Forum’s recommendation for using a case finding approach as opposed to a general population screen. Panelists disagreed as to whether an AUDIT-C score of 5 or greater qualified as sufficient risk to warrant this measure. The expert panel suggested that it might make clinical sense for a provider to inquire about illicit drug use in order to further understand why patients were misusing alcohol. It was understood that there is very limited empirical evidence to support universal screening for drug use. The panel further agreed that this measure is exploratory in terms of its feasibility and predictive validity.

6. Assess for Other Substance Use

Measure statement:

IF patient has high-risk alcohol misuse and has visited behavioral health specialty care, THEN patient should be assessed for other substance use.

Numerator:

Patients assessed for other substance use, including type, frequency, and recency, within 30 days before or after the index visit or the first date of the specialty care visit, whichever comes last

Denominator:

Patients with high-risk alcohol misuse with a behavioral health specialty care visit within 30 days before or after the index visit

Phase of care:

Screening and assessment

Data sources:

Administrative data/medical record review data

Rationale and past use:

The rationale for this measure is similar to that of the preceding measure, “Screen for Other Substance Use.” This measure involves a more comprehensive psychiatric assessment for substance use; in particular, it is related only to those patients receiving care in a specialty care setting, and it requires a more complete assessment for substance use.

The 2009 VA/DoD Clinical Practice Guidelines for the management of SUDs

recommends that providers obtain a comprehensive biopsychosocial assessment for all patients entering specialty treatment settings (VA, 2009), and the 2011 NICE *Clinical Guidelines* similarly recommends that patients entering specialist alcohol services be assessed for other drug use (NICE, 2011). The 2006 APA Practice Guideline for the Treatment of Patients with SUDs states that “all individuals undergoing a psychiatric evaluation should be screened for a substance use disorder, regardless of their age, presentation, or referral source” and that “patients with identified psychiatric disorders should be routinely assessed for the presence of a co-occurring substance use disorder” (APA, 2006).

Technical specifications:

Index visit: See KD1 in Appendix 1.

High-risk alcohol misuse: See KD4 in Appendix 1.

Behavioral health specialty care visit: See KD6 in Appendix 1.

Substance use assessment: Substance use can be assessed using both administrative and medical record review data. Any day in the 30-day window *before* or *after* the date of the index visit, inclusive of the visit date, or the specialty care provider visit (most recent) in which *any* of the following (A, B, or C) is observed will count as a “pass” for this measure:

- A. Completion of the Brief Addiction Monitor Item #6:
 - In the past 30 days, how many days did you use any illegal/street drugs or abuse any prescription medications?
- B. Documentation in the patient medical record of all of the following:
 - Type: A note documenting the patient’s use of illegal drugs or misuse of prescription medications, which could include marijuana, cocaine/crack, heroin/narcotics/benzodiazepines/opiates, methamphetamine/stimulants, intravenous drug use, poly-substance use (multiple substances—with no specific substance names/types listed)
 - Frequency: A note documenting how often the substance is used (e.g., daily, weekly, monthly, occasionally, “as often as I can get it”)
 - Recency: A note documenting when the substance was last used (e.g., last month, yesterday, Saturday night, five months ago).
- C. Documentation in the patient medical record of no substance use, including
 - A note documenting “denies all use” and similar items indicating that the patient denies use of illicit drugs or misuse of prescription medication.

Notes on specifications:

The completion of Brief Addiction Monitor item #6 criterion above (A) should be examined first in the administrative data. If it is not found in the administrative data, the medical record should still be examined for the Brief Addiction Monitor assessment. For (B), abstractors should code the type of substance if substance use is noted (B, Type); if

substance use is noted but no specific substance is identified, this should be recorded, but abstractors would not pass on this measure. For multiple substances on same date, abstractors should record each substance individually using the same date. If only Type is found in a note, abstractors should still highlight any documentation of Type and continue reviewing the record until an instance is found where the patient meets the full criteria. Abstractors should document only the first time Frequency is mentioned and Recency is mentioned. Exclude appropriate use of prescribed drugs, such as opiates and benzodiazepines, and exclude substance use that is part of a computer-generated “problem list” or diagnostic code.

Summary of technical expert panel discussion:

The panel emphasized the importance of the quantification of other substance use but expressed concern that requiring type, frequency, and recency may be overly burdensome and inconsistently documented even when assessed.

7. Test Liver Function

Measure statement:

IF patient has high-risk alcohol misuse, THEN patient should be screened for liver disease.

Numerator:

Patients screened for liver disease within 90 days before or after identification of high-risk alcohol misuse

Denominator:

Patients with high-risk alcohol misuse

Phase of care:

Screening and assessment

Data sources:

Administrative data

Rationale and past use:

The single most significant risk factor for cirrhosis of the liver is the amount of alcohol ingested (O’Shea, Dasarathy, and McCullough, 2010), and nearly half of all cirrhosis deaths in the United States are alcohol-related (Yoon, Yi, and Grant, 2008). Following an initial BI for alcohol misuse, the 2009 VA/DoD Clinical Practice Guideline for SUD recommends that patients be frequently re-evaluated to monitor progress, and

that biomarkers of unhealthy alcohol use, which can include liver function, be monitored as a part of that clinical engagement (VA, 2009). Additionally, the 2011 NICE *Clinical Guidelines* recommends the assessment of alcohol-related physical harm (NICE, 2011). In an independent evaluation of VA mental health services, a similar measure was tested in a national cohort of VA patients with mental health diagnoses: “Proportion of patients who have appropriate laboratory screening tests” (Horvitz-Lennon et al., 2009). Among patients in all mental health diagnostic cohorts nationally, the proportion who received a liver function test was 83.2 percent (Sorbero et al., 2010).

Technical specifications:

High-risk alcohol misuse: See KD4 in Appendix 1.

Date of identification of high-risk alcohol misuse: See KD5 in Appendix 1.

Lab tests for liver disease: The liver function test can be assessed using administrative data. Any day in the 90-day window *before* or *after* the date of identification of high-risk alcohol misuse, inclusive of the date of identification, in which *any* of the following liver function tests (A through G) is administered will count as a “pass” for this measure:

- A. Aspartate Transaminase—AST
- B. Transferase Alanine Amino—ALT
- C. Phosphatase Alkaline
- D. Albumin
- E. Gamma-glutamyl Transpeptidase (GGT)
- F. Carbohydrate Deficient Transferrin (CDT).

Notes on specifications:

None

Summary of technical expert panel discussion:

The panel agreed on the importance of liver function tests (LFTs), given that liver disease is the most common cause of death for individuals with severe alcohol problems. Some panelists believed that a time frame of 30 days was overly “optimistic,” resulting in this measure’s 90-day time frame. Panelists noted that liver function tests can be incorporated into a BI and serve as a motivating factor for both patients and providers. They also noted, however, that LFTs have low sensitivity, and many heavy drinkers yield normal tests, which could in turn discourage change. Additionally, experts pointed out that many primary care providers may not be able to effectively incorporate these test findings into an intervention. There was also disagreement amongst the panelists with regards to the optimal biomarkers. Several panelists argued that the gamma-glutamyl transpeptidase test would suffice, while others suggested inclusion of the mean

corpuscular volume, aspartate transaminase, and transferase alanine amino tests.

8. Conduct Brief Intervention

Measure statement:

IF patient has alcohol misuse, THEN patient should receive a brief intervention.

Numerator:

Patients who receive a BI within seven days before or 30 days after the index visit, or SUD specialty care within 30 days before or after the index visit

Denominator:

Patients with alcohol misuse

Phase of care:

Treatment

Data sources:

Administrative data/medical record review data

Rationale and past use:

A study of Operations Enduring Freedom and Iraqi Freedom veterans found that BIs led to reductions in quantity and frequency of alcohol consumption, as well as reduced frequency of binge drinking and occurrence of alcohol-related consequences (McDevitt-Murphy et al., 2014). In a cohort of veterans with documented SUD, the proportion with documented BI was 71.3 percent (Watkins et al., 2011). Several practice guidelines and clinical reviews support the use of BI for alcohol misuse, excluding those with AUD.

VA announced a new performance measure in 2007 that would require all patients who scored 5 or greater on the AUDIT-C screener to receive a documented BI, including advice to reduce or abstain from drinking plus feedback linking drinking to health. Adherence to this measure grew from 5.5 percent at baseline to 7.6 percent after announcement, 19.1 percent after implementation and to 29.0 percent immediately after clinical reminder dissemination. Currently 70 percent of VA patients who screened positive had documented BI (Chavez et al., forthcoming).

The 2009 VA/DoD Clinical Practice Guideline for SUD describes BI for alcohol use as a counseling approach focused on (1) increasing patient awareness of the health risks of alcohol misuse, and (2) motivating patient behavior change with respect to drinking. The 2006 APA Clinical Practice Guidelines highlight that “brief therapies have been shown to be effective in reducing alcohol use and improving general health and social

functioning.” BIs conducted in a VA setting following screening for alcohol misuse have been associated with minor reductions in drinking. The VA assesses the percentage of patients screening positive for alcohol misuse (AUDIT-C of 5 or greater) and who have not been seen in an SUD addiction program in the prior 90 days who have brief alcohol counseling within 14 days of the positive screen (Office of Quality and Performance, 2010). The Physician Consortium for Performance Improvement developed a measure to assess the percentage of patients who received brief counseling if identified as unhealthy alcohol users during systematic screening over a two-year measurement period (PCPI, 2008; National Quality Measures Clearinghouse, 2008a).

Technical specifications:

Alcohol misuse: See KD2 in Appendix 1.

Index visit: See KD1 in Appendix 1.

SUD specialty care: See KD7 in Appendix 1.

Brief intervention: Patients who receive *both* (A and B) of the following in the same outpatient visit or inpatient stay, within seven days *before* or 30 days *after* the index visit, inclusive of the index visit date, or who receive (C), would receive a “pass” on this measure:

A. Advice to drink less or abstain from alcohol

- Note from provider stating that s/he recommended to the patient to drink less or abstain (e.g., recommendation may be documented in the treatment planning note)

B. Feedback about risks of alcohol use to health or normative feedback

- Note in medical record that states that the provider and patient discussed the risks associated with alcohol and the patient’s current medical condition

OR

- Note in medical record indicating how the patient’s use of alcohol compares to recommended limits (“gave normative feedback” would count)

C. Patients who receive substance use specialty care treatment or have an inpatient stay for SUD of greater than 24 hours within 30 days before or after index visit.

Secondary specifications:

Another data point should also be collected but is not required as a “pass” for BI:

D. Discussion of goals/patient response

- Note from provider stating that s/he discussed the patient’s goals as far as alcohol reduction or patient’s response to the BI. Any discussion of drinking-related goals (e.g., “discussed goals with patient”), reference to reduced quantity of drinking (e.g., “willing to drink only in the evenings or on weekends”), and response to BI or behavior change the patient is willing to do in response to the information s/he is drinking above recommended limits will count. Any indication of patient’s response to the BI would also count (e.g.,

patient agrees to reduce drinking, patient is not interested in reducing drinking, patient was defensive when receiving feedback, patient was interesting in learning more about his or her drinking and how it impacts his or her health)

OR

- Note that “Not interested in reducing drinking” and related notes would pass.

Notes on specifications:

Abstractors collect MRR BI data on everyone, including those receiving AUD specialty care. Abstractors should review phone notes and treatment-planning notes as well. Abstractors should look for each element of BI (A, B, and D) in the MRR for every visit, as these elements are allowed to occur during different visits during the 30-day period. For (A), reinforcing sobriety or healthy drinking levels would count; abstractors should not highlight advice to limit alcohol if it is part of a medication list. For (B), risk feedback can be personalized (i.e., specific to patient’s medical concerns or medications) or general feedback on health risks associated with drinking; in the subsection “Note in medical record indicating how the patient’s use of alcohol compares to recommended limits,” the definition does not include normative feedback. If only (A) or (B) is found in a note, abstractors should still record any documentation of (A) or (B) as appropriate. If abstractors find a note with both (A) and (B), they should continue reviewing the chart until they have found all instances. For (C), inpatient treatment will not be sufficient to count if it is 24 hours or less. Abstractors should collect BI data on everyone regardless of possible pass-out based on (C). (D) is not a necessary or sufficient element but rather should be collected separately as additional information for analysis. “Not interested in reducing drinking” and related notes would count, as well as any mention of a drinking-related goal passes (as long as it is not “boilerplate”). The patient should be involved in generating and agreeing to the goal, though this can be difficult to discern from chart notes. Once abstractors have found a note where Discussion of Goals/Patient Response is documented, they should continue reviewing the chart and highlight all instances.

Summary of technical expert panel discussion:

There was consensus that there was strong evidence for providing a BI to all patients with alcohol misuse. The main question panelists discussed was whether BIs work for patients with AUD. While the evidence is limited, it can be difficult to identify patients with dependence, and there is no evidence that it is harmful. Panelists recommended inclusiveness. In addition, some patients who screen positive for alcohol misuse over the prior 12 months will not be actively drinking, and thus a BI is of questionable value. A positive screen should be followed by a more thorough assessment, followed by a BI and other treatment options, if necessary. Therefore one should not target an adherence of 100 percent for this measure.

9. Discuss Treatment Options

Measure statement:

IF patient has high-risk alcohol misuse, THEN patient should receive counseling regarding multiple treatment options for alcohol use.

Numerator:

Patients who receive counseling regarding multiple treatment options for alcohol use from the date of the index visit through 30 days after identification of high-risk alcohol misuse

Denominator:

Patients with high-risk alcohol misuse

Phase of care:

Treatment

Data sources:

Administrative data/medical record review data

Rationale and past use:

While there is little experimental evidence that informed decisionmaking improves symptom reduction (effectiveness), a recent review of shared decisionmaking found 11 trials that compared shared decisionmaking interventions with nonshared decisionmaking controls. Six studies showed positive effects on patient outcomes, including two among mental health patients, and five found no differences (Joosten et al., 2008). None of the studies specifically considered patients with alcohol use disorders.

The 2009 VA/DoD Clinical Practice Guideline for SUD recommends that health care providers discuss appropriate treatment options with patients in a manner that motivates cooperation with the provider and supports recovery. The APA, PCPI, and NCQA developed a measure to assess the percentage of adult patients with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within a 12-month reporting period (National Quality Measures Clearinghouse, 2008b).

Technical specifications:

High-risk alcohol misuse: See KD4 in Appendix 1.

Date of identification of high-risk alcohol misuse: See KD5 in Appendix 1.

Receipt of counseling: To receive a “pass” for this measure, there must be indication

in the medical record that multiple treatment options for alcohol were offered and/or discussed within 30 days *after* the date of identification of high-risk alcohol misuse, inclusive of the date of identification.

Treatment options should include **at least two** of the following, or “discussed treatment options”:

- A. Medication, e.g., Naltrexone or Acamprosate
- B. Psychotherapy or counseling
- C. Referral to outpatient SUD specialty care
- D. Referral to Alcoholics Anonymous (AA) or other recovery support (e.g., Narcotics Anonymous [NA], Cocaine Anonymous [CA], Dual Recovery Anonymous [DRA])
- E. Domiciliary (dom)/residential rehabilitation/mental health rehabilitation/residential treatment program (MH RRTP).

Secondary specifications:

Patient preferences: If treatment options are discussed, then look for evidence of the patient’s preference in that same note/visit (or an addendum for same). For patient preference, there must be documentation that the patient’s preference among treatment options was documented in the same note (or addendum) as the “discussed treatment options.”

Notes on specifications:

Receipt of counseling is required, whereas patient preferences are just being collected for scoring; if abstractors find a discussion of treatment options, then they should also look for patient preference in that same note/visit/addendum. “Discussed treatment options” is sufficient to count as having discussed at least two treatment options.

Summary of technical expert panel discussion:

The panelists did not identify specific treatment options required to be discussed or the number of options that should be discussed to pass the measure. Panelists noted that providers commonly note “discussed treatment options” in the clinical record and that this documentation should pass for this measure. This measure is about whether providers offer a variety of treatment options and opportunity for patients to elect the treatment that they prefer. Panelists discussed evidence for different types of recovery support, noting that the evidence for AA is strongest for patients with dependence.

10. Offer Psychosocial Intervention

Measure statement:

IF patient has newly identified high-risk alcohol misuse, THEN patient should be offered psychosocial intervention for alcohol misuse within 30 days after identification.

Numerator:

Patients offered psychosocial intervention for alcohol misuse from the date of the index visit through 30 days after identification of high-risk alcohol misuse

Denominator:

Patients with high-risk alcohol misuse

Phase of care:

Treatment

Data sources:

Administrative data/medical record review data

Rationale and past use:

Several clinical practice guidelines endorse the use of psychotherapy for alcohol misuse. The 2009 VA/DoD Clinical Practice Guideline recommends various types of first-line psychosocial interventions within the first 90 days for alcohol abuse or dependence, including Cognitive Behavioral Coping Skills Training, motivational enhancement therapy, and behavioral couples therapy (VA, 2009). The 2006 APA Practice Guideline for Treatment of Patients with SUDs suggests multiple psychosocial treatments with “substantial clinical confidence,” such as 12-step facilitation and behavioral therapies (APA, 2006). Lastly, the 2011 NICE *Clinical Guidelines* also encourages health care providers to offer psychological interventions of appropriate length and duration focused on alcohol-related cognition, behavior, problems, and social networks (NICE, 2011). The APA, PCPI, and NCQA developed a measure to assess the percentage of adult patients with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within a 12-month reporting period (National Quality Measures Clearinghouse, 2008b).

Technical specifications:

High-risk alcohol misuse: See KD4 in Appendix 1.

Date of identification of high-risk alcohol misuse: See KD5 in Appendix 1.

Psychosocial intervention offer: Receipt of counseling offer can be assessed through

administrative and medical record review data. To receive a “pass” for this measure, either “A” or “B” below must be met:

- A. In administrative data, psychosocial intervention received within 30 days after the date of identification of high-risk alcohol misuse (and primary or nonprimary diagnosis is alcohol misuse) would count. See KD8 in the Key Definitions appendix for more details.
- B. There must be indication in the medical record that psychosocial intervention for alcohol misuse was offered and/or discussed within 30 days *after* the date of identification of high-risk alcohol misuse. This time frame is inclusive of the date of identification. This could include
 - motivational enhancement therapy (MET)
 - cognitive behavioral therapy (CBT)
 - relapse prevention therapy (RPT)
 - 12-step facilitation (TSF)
 - behavioral couples therapy
 - individual psychotherapy
 - group psychotherapy
 - psycho-education.

Notes on specifications:

(A) is an automatic pass, in which case MRR should not be done—though it may be impossible to know whether the intervention was truly related to alcohol use. For (B), it must be clear that the psychosocial intervention is related to alcohol use. “Discussed psychosocial intervention” and related comments would also count. “Dual diagnosis” program referral would also count. A *refusal* by the patient to accept referrals for counseling would still count as long as an offer was made by the provider related specifically to alcohol misuse. Recovery support such as “AA” or “self-help” would *not* count. A general referral to undergo a mental health and evaluation process would *not* count.

Summary of technical expert panel discussion:

Panelists suggested breaking a proposed psychosocial intervention measure into three parts: offer, frequency/dose, and quality, and that is reflected here.

11. Offer Pharmacotherapy

Measure statement:

IF patient has newly identified AUD, THEN patient should be offered pharmacotherapy for alcohol misuse within 30 days after identification.

Numerator:

Patients offered pharmacotherapy for alcohol dependence within 30 days following the first date of AUD diagnosis

Denominator:

Patients diagnosed with AUD within 90 days after and including the index visit date

Phase of care:

Treatment

Data sources:

Administrative data/medical record review data

Rationale and past use:

Convincing evidence exists to support the use of pharmacotherapy for AUD treatment. Naltrexone, for example, has been shown to decrease the likelihood of treatment discontinuation (Srisurapanont and Jarusuraisin, 2002) and reduce the amount of alcohol consumed (Kranzler and Van Kirk, 2001; Pettinati et al., 2006). Similarly, systematic reviews highlight the ability of acamprosate to improve the likelihood of abstinence and retention in treatment in recently withdrawn patients (Bouza et al., 2004; Kranzler and Van Kirk, 2001; Mann, Leher, and Morgan, 2004; Jonas et al., 2014).

The 2009 VA/DoD Clinical Practice Guideline for SUDs states that “addiction-focused pharmacotherapy should be considered, available and offered if indicated for all patients with opioid dependence and/or alcohol dependence.” Furthermore, the guideline specifically recommends health care providers “routinely consider oral naltrexone, an opioid antagonist, and/or acamprosate for patients with alcohol dependence.” The 2011 NICE *Clinical Guidelines* provides a similar recommendation and suggests combining pharmacotherapy with psychosocial intervention: “After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone in combination with an individual psychological intervention (cognitive behavioral therapies, behavioral therapies, or social network and environment-based therapies) focused specifically on alcohol misuse” (NICE, 2011). The APA, PCPI, and NCQA developed a measure to assess the percentage of adult patients with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within a 12-month reporting period (National Quality Measures Clearinghouse, 2008b). An independent evaluation of VA mental health services suggested measurement of pharmacotherapy for alcohol dependence being (a) offered, (b) filled, (c) refused, and/or (d) contraindicated (Watkins et al., 2011).

Technical specifications:

Index visit: See KD1 in Appendix 1.

Diagnosis of AUD: See KD3 in Appendix 1.

Offered pharmacotherapy: An offer of pharmacotherapy can be assessed using either medical record or administrative data. Any day in the 30-day window *after and including* the date of identification of AUD in which any of the following (A or B or C) is observed will count as a “pass” for this measure:

A. Any indication in the administrative record that there was a filled prescription for alcohol dependence:

- Acamprosate calcium/Campral
- Naltrexone
- Disulfiram/Antabuse
- Nalmefene/Revex
- ReVia
- Vivitrol

OR

B. Indication in the medical record that pharmacotherapy for alcohol dependence was offered and/or discussed. This could include

- Acamprosate calcium/Campral
- Naltrexone/ReVia/Vivitrol
- Disulfiram/Antabuse
- Nalmefene/Revex
- “Discussed pharmacotherapy/medication for alcohol abuse” should also pass

OR

C. Indication in the medical record that the patient refused pharmacotherapy or that it was contraindicated.

Secondary specifications:

Pharmacotherapy offered within 90 days after and including the date of identification of AUD.

Notes on specifications:

If the patient receives a pass based on (A) above, there is no need for MRR. For (B), mention of “on the medication in past” does NOT count. However, “patient will consider medication” DOES count as long as the medication is specifically for AUD. It is also critical that the medical record note be explicit that pharmacotherapy is for alcohol dependence specifically (as opposed to medication for a different condition). Topiramate (Topamax) and Gabapentin (Neurontin) do NOT count for this quality measure. Refusal and contraindication DOES count, so abstractors should look for it whether or not there is an offer of pharmacotherapy. Any addendum to the chart note for refusal/contraindication

would also count. Abstractors must note whether refusal/contraindication was mentioned.

Summary of technical expert panel discussion:

Panelists noted that all evidence is for patients with moderate to severe AUD, as are all U.S. Food and Drug Administration (FDA) approvals, and thus patients with alcohol abuse may need to be removed from the denominator. In practice, however, many providers code dependence as abuse (for various reasons, including stigma), and the distinction is clinically questionable. Panelists recommended including patients with abuse and dependence but conducting sensitivity analyses where possible. The panelists also argued that “received” is a simpler proxy for “offered,” which can be collected via pharmacy records rather than MMR. They recommended specifying the measure as “received” but conducting sensitivity analyses where possible and emphasize that target adherence rate should be below 100 percent. A further limitation of this measure is that it includes only FDA-approved medications for this indication. There are several other prescription medications commonly prescribed for this indication (e.g., Topirimate and Gabapentin); however, these are commonly prescribed for other indications as well and thus do not clearly identify pharmacotherapy for alcohol use.

12. Psychosocial Intervention Dose

Measure statement:

IF patient has newly identified high-risk alcohol misuse and 1+ psychosocial intervention visit within 90 days from the index date, THEN patient should receive at least four visits within the first 90 days after first psychosocial intervention visit.

Numerator:

Patients who receive 4+ visits within the first 90 days after first psychosocial intervention visit. Only visits taking place within the 183-day (six-month) study period will count.

Denominator:

Patients with high-risk alcohol misuse and at least one psychosocial intervention visit occurring within 90 days after the index visit

Phase of care:

Treatment

Data sources:

Administrative data

Rationale and past use:

The 2011 NICE *Clinical Guidelines* recommends the appropriate number and duration of sessions for alcohol misuse psychotherapy treatment. Cognitive behavioral, behavioral, and behavioral couples therapies should consist of one 60-minute session per week for 12 weeks. Social network and environment-based therapies, however, should consist of eight 50-minute sessions over 12 weeks (NICE, 2011). The most rigorous evidence is for four total visits of MET over 12 weeks from Project MATCH (Project MATCH Research Group, 1998).

Technical specifications:

Diagnosis of AUD: See KD3 in Appendix 1.

High-risk alcohol misuse: See KD4 in Appendix 1.

Psychosocial intervention: See KD5 in Appendix 1.

Receive at least four psychosocial intervention visits: Psychosocial intervention dose can be assessed through administrative data. In order to “pass” for this measure, at least one of the two following criteria must be met.

A. Received at least four qualifying psychosocial intervention visits (on separate visit days) within the first three months (90 days) including the first visit on which a psychosocial intervention takes place. Four visits are inclusive of initiating visit and must take place in the 183-day study period.

OR

B. Residential treatment admission within three months (90 days) after the date of identification of high-risk alcohol misuse where length of stay is greater than or equal to four days. Residential treatment defined as: MedicalService= “DOMICILIARY,” which includes the following bed sections:

- DOM/GEN (general domiciliary)
- DOM/DCHV (Domiciliary Care for Homeless Veterans)
- DOM/SUD (Domiciliary care for SUD).

Secondary specifications:

Broaden time frame to include visits at any point during the study period.

Notes on specifications:

Both data elements should be collected for (A) and (B) above.

Summary of technical expert panel discussion:

Panelists suggested breaking a psychosocial intervention measure into three parts: offer, frequency/dose, and quality, and that is reflected here. Regarding dose, the panel noted that the best evidence is for four total visits of MET over 12 weeks from Project MATCH (Project MATCH Research Group, 1998).

13. Psychosocial Intervention Quality

Measure statement:

IF patient has newly identified high-risk alcohol misuse and 1+ psychosocial intervention visit, THEN the visit should include elements of an evidence-based psychosocial intervention.

Numerator:

Patients with at least one visit within the study period including elements of an evidence-based psychosocial intervention

Denominator:

Patients with high-risk alcohol misuse and at least one psychosocial intervention visit within the study period

Phase of care:

Treatment

Data sources:

Administrative data/medical record review data

Rationale and past use:

The rationale for this measure is similar to that of the aforementioned measure, “Psychosocial Intervention Offer.” Several clinical practice guidelines endorse the use of psychotherapy or other psychosocial interventions (for example, contingency management) for alcohol misuse; please refer to the previous measure for a more detailed discussion of the rationale for this measure.

Technical specifications:

High-risk alcohol misuse: See KD4 in Appendix 1.

Psychosocial intervention: See KD8 in Appendix 1.

Evidence-based psychosocial intervention: Psychosocial intervention quality can be assessed through medical record review data. In order to “pass” for this measure, any one of the below criteria (A through C) must be observed in the medical record during the study period, starting on the first date of psychosocial intervention:

- A. To be coded as relapse prevention therapy/cognitive behavioral therapy, there must be documentation of two of the three following components at some point in the study period
- Coping skills
 - Cognitive therapy (identify/evaluate/change thoughts)

- Lifestyle modification.
- B. To be marked as MET, there must be documentation of both of the following:
- Normative feedback related to alcohol misuse (over one or more sessions)
 - Feedback of personal risk or impairment
 - Use of Personal Feedback Report (PFR)
 - Collaborative goal-oriented discussion related to behavior change
 - Discussion of desire, ability, reason, or need to change behavior
 - Discussion of commitment, readiness, willingness to change
 - Discussion of specific actions to be undertaken related to behavior change.
- C. To be marked as Contingency Management/Contingency Contracting (CM/CC), there must be documentation of a contract or explicit incentives for behavior change that indicates the following:
- Rewards: Voucher or privileges given for achieving specific treatment goals such as appointment attendance or abstinence based on urine or breath drug screen monitoring.
 - Withdraw reward/negative reinforcement: Withdrawal of rewards or privileges or other negative reinforcement for not meeting treatment goals (e.g., noncompliance with therapy or medication regimen).

Notes on specifications:

For (A), if two of the three components are present during the study period, abstractors should record the first date any component occurred. To count, documentation needs to include not only the therapy piece, but also the behavioral changes/new skills/coping strategies to implement. RPT/CBT could be group or individual therapy. RPT intervention strategies can be grouped into three categories: (1) coping skills training (which includes both behavioral and cognitive techniques, (2) cognitive therapy (designed to provide clients with ways to reframe the habit change process as a learning experience, with errors and setbacks expected as mastery develops), and (3) lifestyle modification (such as meditation, exercise, and spiritual practices, which are designed to strengthen a client's overall resilience). CPT (cognitive processing therapy) is different from CBT; CPT alone would not count because it is a type of CBT for PTSD/trauma, not a treatment for alcohol or drugs.

For (B), MET is an adaptation of motivational interviewing (MI) that includes one or more client feedback sessions in which personalized feedback is presented and discussed in an explicitly nonconfrontational manner.

For (C) above, a contract alone is not sufficient; it has to also include the reward for remaining sober or attendance. That is, it must include the goal/agreement and the reward/voucher for attaining the goal.

Summary of technical expert panel discussion:

Panelists suggested breaking a psychosocial intervention measure into three parts: offer, frequency/dose, and quality, and that is reflected here. Regarding quality specifically, panelists emphasize the exploratory nature of this measure. Most providers will not document details of the content of specific psychotherapy sessions. Twelve-step facilitation was discussed as a type of recovery support with strong evidence but was considered infeasible to identify via medical record review.

14. Receipt of Pharmacotherapy for Alcohol Dependence

Measure statement:

IF patient is diagnosed with AUD, THEN patient should receive pharmacotherapy for alcohol dependence/AUD.

Numerator:

Patients who receive pharmacotherapy for alcohol dependence within 90 days of AUD diagnosis

Denominator:

Patients diagnosed with AUD within 90 days after index visit

Phase of Care:

Treatment

Data Sources:

Administrative Data

Rationale and past use:

The rationale for this measure is similar to that of the measure No. 11, “Offer Pharmacotherapy.”

Technical specifications:

Index visit: See KD1 in Appendix 1.

Diagnosis of AUD: See KD3 in Appendix 1.

Receipt of pharmacotherapy: Receipt of pharmacotherapy can be assessed through administrative data. In order to “pass” for this measure, the below criterion (A) must be observed in the 90 days following the first date of AUD diagnosis, inclusive of the date of diagnosis.

- A. Any indication in the administrative record that there was a filled prescription for alcohol abuse, including Acamprosate calcium/Campral, Naltrexone

(injection/oral), Disulfiram/Antabuse, Nalmefene/Revex, ReVia, Vivitrol.

Notes on specifications:

Abstractors should collect information on Topirimate and Gabapentin, although this will not qualify for the measure.

Summary of technical expert panel discussion:

See panel discussion for previously mentioned measure, “Offer Pharmacotherapy.”

15. Refer to Recovery Support in the Community

Measure statement:

IF patient is diagnosed with AUD, THEN patient should be referred to recovery support.

Numerator:

Patients referred to recovery support (e.g., AA) within 183 days following the index visit

Denominator:

Patients diagnosed with AUD within 30 days after and including the index visit

Phase of care:

Treatment

Data sources:

Administrative data/medical record review data

Rationale and past use:

Several clinical guidelines support referral to such groups. The 2006 APA Practice Guideline for the Treatment of Patients with SUDs recommends “with substantial clinical confidence” that “patients participate in self-help groups, such as Alcoholics Anonymous (AA).” Similarly, the 2011 NICE *Clinical Guidelines* suggests that providers not only share information on the value and availability of community support meetings with those seeking help for alcohol misuse, but also encourage and provide support for attendance (NICE, 2011). The 2009 VA/DoD Clinical Practice Guideline for SUD also endorses referral to community support networks and self-help groups across both primary and specialty care treatment settings (VA, 2009).

There have been numerous reviews and meta-analyses of the effectiveness of AA

with conflicting conclusions (Ferri, Amato, and Davoli, 2006; Kelly, 2003). While there is limited experimental evidence (Ferri, Amato, and Davoli, 2006), one randomized controlled trial of intensive referral to self-help groups for VA patients with SUD found significantly higher rates of attendance and abstinence after one year for patients in the intensive referral group (Timko, DeBenedetti, and Billow, 2006).

Technical specifications:

Index visit: See KD1 in Appendix 1.

Diagnosis of AUD: See KD3 in Appendix 1.

Referral to recovery support: Referral to recovery support can be assessed through medical record review data. In order to “pass” for this measure, one of the below criteria (A or B) must be observed during the study period:

A. Any indication in the medical record that the patient was referred to recovery support in the 183-day study period. This may include mention of any of the following:

- community support networks
- self-help groups
- Alcoholics Anonymous (AA)
- SMART recovery
- Narcotics Anonymous (NA)
- Cocaine Anonymous (CA)
- Dual Recovery Anonymous (DRA)

OR

B. Documented attendance at recovery support groups during a residential stay in the 183-day study period.

Notes on specifications:

For (A), a suggestion with refusal to attend would count. A note that the patient is planning to attend in the future would also count. Abstractors should determine whether there are names/groups that are not included in this list that would count.

Summary of technical expert panel discussion:

The evidence for AA attendance is strong but lacking randomized controlled trials and only for patients with dependence. Twelve-step facilitation has the strongest evidence but is likely infeasible to identify via medical records. This measure will capture any suggestion or referral to AA. The panelists further agreed that patient report will be important for this measure because a memorable referral is a good indication that it was made in good faith by the provider and not simply documented.

16. Offer of Housing Services

Measure statement:

IF patient has high-risk alcohol misuse and has a documented housing need, THEN patient should be offered housing services.

Numerator:

Patients offered housing services within 30 days before or after identification of housing need

Denominator:

Patients with high-risk alcohol misuse and a housing need documented (time frame to enter denominator may vary depending on use of administrative versus MMR data for denominator qualification).

Phase of care:

Treatment

Data sources:

Administrative data/medical record review data

Rationale and past use:

Inadequate or unstable housing is an important sociological factor that can impede the effectiveness and accessibility of alcohol misuse treatment. Friedmann et al. (2004) considered 3,103 addiction treatment patients who reported service needs beyond core rehabilitative services and found that addressing vocational and housing needs exerted the greatest effects of the five service domains (also included medical, mental health, and family). Studies of the Housing First program, designed to provide housing to homeless individuals with alcohol problems, found mixed results; while one study found that the program was associated with decreased service use and costs (Larimer et al., 2009), other studies have found no effect on substance use (Kertesz et al., 2009).

To this end, the 2009 VA/DoD Clinical Practice Guideline for SUD recommends that “individuals with SUD should be assessed for any significant unmet need or situation stressor,” including inadequate or no housing. Furthermore, the 2011 NICE *Clinical Guidelines* found lack of stable housing to be a predictor of worse alcohol-related treatment outcomes (NICE, 2011). Another research team conducting an independent evaluation of VA mental health services proposed assessment of the number of patients with identified need who receive housing services (Watkins et al., 2011). Taken together, these guidelines and measures highlight the importance of addressing inadequate or unstable housing for people seeking help with alcohol misuse.

Technical specifications:

High-risk alcohol misuse: See KD4 in Appendix 1.

Documented housing need: Documented housing need can be assessed through medical record and administrative data. In order to “pass” for this measure, one of the below criteria (A or B) must be observed:

A. Indication of a documented housing need in the administrative data *within 60 days after* the date of identification of high-risk alcohol misuse (see KD #9):

- V60.0 Lack of housing
- V60.1 Inadequate housing
 - Lack of heating
 - Restriction of space
 - Technical defects in home preventing adequate care
- V60.2 Inadequate material resources
 - Economic problem
 - Poverty not otherwise specified
- V60.3 Person living alone
- V60.4 No other household member able to render care
 - Person requiring care (has) (is):
 - Family member too handicapped, ill, or otherwise unsuited to render care
 - Partner temporarily away from home
 - Temporarily away from usual place of abode
- V60.5 Holiday relief care
 - Provision of health care facilities to a person normally cared for at home, to enable relatives to take a vacation
- V60.6 Person living in residential institution
 - Boarding school resident
- V60.8 Other specified housing or economic circumstances
- V60.9 Unspecified housing or economic circumstance

OR

B. Indication of a documented housing need in the medical record within 30 days from the date of identification of high-risk alcohol misuse (see KD #9)

- The VA considers the patient to have a housing need/deficit if s/he is not independently housed (house or single room occupancy [SRO] setting) or not living in a residential treatment facility. These are the two acceptable settings for housing.
- Acceptable documentation could include statements such as
 - Currently homeless, needs immediate housing
 - Wife recently kicked patient out of the house, doesn't have a place to stay lined up yet
 - Patient needs to change to an environment more conducive to recovery

- Patient reports that s/he is homeless
- Patient is observably psychotic and needs immediate care/housing.

Housing offer: Housing offer can be assessed through medical record and administrative data. In order to “pass” for this measure, one of the below criteria (A or B) must be observed within 30 days *before or after* the earliest data of identification of housing need, inclusive of the date of identification of housing need.

A. Defined as one or more outpatient visits with the following stop codes or an inpatient or residential facility admission using the following bed section codes during the 30 days before/after earliest identification of need (in administrative data)

- Clinic stop codes:
 - 522 U.S. Department of Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH)
 - 528 Telephone—Homeless Mentally Ill
 - 529 Health Care for Homeless Veterans/Homeless Chronically Mentally Ill (HCHV/HCMI)
 - 530 Telephone—HUD-VASH
 - 590 Community Outreach to Homeless Veterans by Staff Other Than HCHV and RRTP Programs
 - 593 Residential Rehabilitation Treatment Program (RRTP) Outreach Services
 - 594 RRTP Aftercare—Community
 - 595 RRTP Aftercare—VA
 - 596 RRTP Admission Screening Services
 - 597 Telephone—RRTP
- Bed Sections: MedicalService= “DOMICILIARY,” which includes the following bed sections:
 - DOM/GEN (general domiciliary)
 - DOM/DCHV (Domiciliary Care for Homeless Veterans)
 - DOM/SUD (domiciliary care for SUD)

B. Any documentation in medical records that indicates the provider attempted to help patient with housing situation within 30 days before/after identification of housing need.

- For example, some comments that would be sufficient evidence include:
 - Provider provides suggestions for alternative living situation to promote recovery
 - Provider intervenes to find safe housing for patient who is psychotic and unaware of his/her need for shelter
 - Discussed alternative living situations that would be a more appropriate recovery environment
 - Encouraged patient to apply for housing assistance
 - Patient receiving housing assistance
 - Offered patient housing assistance, but patient refused.

Notes on specifications:

For Denominator (A), abstractors should consider examining service receipt rate through administrative data analysis. Also, all patients should be “passed” into this measure automatically if they meet this requirement, but abstractors should still look in the chart for an earlier note identifying need; if that note is found, use that as the date of identification. For medical record data, abstractors should look for at least a semi-permanent housing arrangement: if less than that, then it is a need/deficit. Living in a shelter would not be considered appropriately housed. If patient is sleeping on the couch/floor at parent’s/friend’s home, there is a need/deficit. If Homelessness is checked “Yes” on the Suicide Assessment, this would count as need. For Denominator (B), the first assessment of need counts, even if this changes later in the window. For Numerator (A), if the criterion is observed, it “passes” out of MRR (no longer required). For Numerator (B), a suggestion with refusal to attend would count as a “pass.”

Summary of technical expert panel discussion:

Panelists discussed that, while there is a strong association between homelessness and substance use, the causal evidence between offering housing services and improved outcomes is weak and limited to patients with alcohol dependence.

17. Receipt of Housing Services

Measure statement:

IF patient has high-risk alcohol misuse and a documented housing need, THEN patient should receive housing services.

Numerator:

Patients receiving housing services during the study period

Denominator:

Patients with high-risk alcohol misuse and a housing need identified in administrative records

Phase of care:

Treatment

Data sources:

Administrative data

Rationale and past use:

The rationale for this measure is similar to that of the preceding measure, “Offer of

Housing Services.”

Technical specifications:

High-risk alcohol misuse: See KD4 in Appendix 1.

Documented housing need: Documented housing need can be assessed through administrative data. In order to “pass” for this measure, the below criterion (A) must be observed:

A. Indication of a documented housing need in the administrative data *within 60 days after* the date of identification of high-risk alcohol misuse (see KD #9):

- V60.0 Lack of housing
- V60.1 Inadequate housing
 - Lack of heating
 - Restriction of space
 - Technical defects in home preventing adequate care
- V60.2 Inadequate material resources
 - Economic problem
 - Poverty not otherwise specified
- V60.3 Person living alone
- V60.4 No other household member able to render care
 - Person requiring care (has) (is)
 - Family member too handicapped, ill, or otherwise unsuited to render care
 - Partner temporarily away from home
 - Temporarily away from usual place of abode
- V60.5 Holiday relief care
 - Provision of health care facilities to a person normally cared for at home, to enable relatives to take a vacation
- V60.6 Person living in residential institution
 - Boarding school resident
- V60.8 Other specified housing or economic circumstances
- V60.9 Unspecified housing or economic circumstance.

Housing receipt: Housing receipt can be assessed through administrative data. In order to “pass” for this measure, one of the below criteria (A) must be observed within 30 days *before or after* the earliest data of identification, inclusive of the date of identification of housing need.

A. Defined as one or more outpatient visits with the following stop codes or an inpatient or residential facility admission using the following bed section codes during the 30 days before/after earliest identification of need (in administrative data)

- Clinic stop codes:
 - 522 HUD-VASH
 - 528 Telephone—Homeless Mentally Ill
 - 529 Health Care for Homeless Veterans/Homeless Chronically Mentally Ill (HCHV/HCMI)
 - 530 Telephone—HUD-VASH
 - 590 Community Outreach to Homeless Veterans by Staff Other Than HCHV and RRTP Programs
 - 593 Residential Rehabilitation Treatment Program (RRTP) Outreach Services
 - 594 RRTP Aftercare—Community
 - 595 RRTP Aftercare—VA
 - 596 RRTP Admission Screening Services
 - 597 Telephone—RRTP
- Bed sections: MedicalService= “DOMICILIARY,” which includes the following bed sections:
 - DOM/GEN (general domiciliary),
 - DOM/DCHV (Domiciliary Care for Homeless Veterans)
 - DOM/SUD (Domiciliary care for SUD).

Notes on specifications:

N/A

Summary of technical expert panel discussion:

See panel discussion for previously mentioned measure, “Offer of Housing Services.”

18. Treatment for Co-occurring Mental Health and Substance Use

Measure statement:

IF patient is diagnosed with AUD and has a current mental health (MH) diagnosis, THEN both conditions should be addressed.

Numerator:

Patients with evidence that both MH and AUD conditions are addressed during the study period as evidenced by at least two visits where each condition is addressed during the study period

Denominator:

Patients with AUD diagnosis and a current MH diagnosis

Phase of care:

Treatment

Data sources:

Administrative data

Rationale and past use:

This measure is an administrative data–based version of a subsequent measure, “integrated co-occurring disorder treatment.” The 2006 APA Practice Guideline highlights that “integrated psychosocial treatments that combine traditional therapies for the psychiatric condition with therapies for the alcohol use disorder have been shown to be effective.” The Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol for Substance Abuse Treatment for Persons with Co-Occurring Disorders also endorses the use of an integrative treatment approach for substance abuse and mental health, and states that “this approach reflects the longstanding concern within substance abuse treatment programs for treating the whole person, and recognizes the importance of ensuring that entry into any one system can provide access to all needed systems (SAMHSA, 2008).

Technical specifications:

Index visit: See KD1 in Appendix 1.

Diagnosis of AUD: See KD3 in Appendix 1.

Current mental health diagnosis: Patients with at least one Axis-I mental health diagnosis as a primary or nonprimary diagnosis on any inpatient or outpatient visit *within three months (90 days) prior to and including* index visit. Axis-I mental health diagnoses included are transient mental disorders such as psychotic, mood, and anxiety disorders including schizophrenia; episodic mood disorders such as bipolar disorder, major depressive disorder, and manic affective disorder; delusional disorders such as paranoid state and delusional disorder; psychosis; persistent depressive disorder; obsessive-compulsive disorder; posttraumatic stress disorder; and attention deficit disorders.

Visits where each condition is addressed: Visits in which each condition is addressed can be assessed through administrative data.

A. At least one inpatient visit of greater than one day, at least two one-day inpatient stays (on separate dates), or at least two outpatient visits (on separate days) where Axis-I MH diagnosis is a primary or nonprimary diagnosis during the study period

AND

B. At least one inpatient stay of greater than one day or at least two one-day inpatient stays (on separate days) or at least two outpatient visits (on different days) where

SUBSTANCE USE diagnosis is a primary or nonprimary diagnosis during the study period, where substance use disorder codes include

- 292.9 Unspecified drug-induced mental disorder
- 303.90–303.92 Other and unspecified alcohol dependence
- 304.00–304.02 Opioid type dependence
- 304.10–304.12 Barbiturate and similarly acting sedative or hypnotic dependence
- 304.20–304.22 Cocaine dependence
- 304.30–304.32 Cannabis dependence
- 304.40–304.42 Amphetamine and other psychostimulant dependence
- 304.50–304.52 Hallucinogen dependence
- 304.60–304.62 Other and unspecified drug dependence
- 304.70–304.72 Combinations of opioid type with any other
- 304.80–304.82 Combinations of drug dependence excluding opioid type
- 304.90–304.92 Unspecified drug dependence
- 305.00–305.02 Alcohol abuse
- 305.20–305.22 Cannabis abuse
- 305.30–305.32 Hallucinogen abuse
- 305.40–305.42 Barbiturate and similarly acting sedative or hypnotic abuse
- 305.50–305.52 Opioid abuse
- 305.60–305.62 Cocaine abuse
- 305.70–305.72 Amphetamine or related acting sympathomimetic abuse
- 305.90–305.92 Other, mixed, or unspecified drug abuse.

Notes on specifications:

For *current mental health diagnosis* above, we have included only those MH diagnoses identified prior to and including the index visit date for the sake of this specific study; patients identified with an MH diagnosis subsequent to the index date will not have the same amount of time to “pass” this measure (i.e., the study period).

For Numerator (A) above, in order for participants to “pass,” it does not have to be the same two diagnoses across visits: ANY TWO MH diagnoses will pass. For Numerator (B) above, in order for participants to “pass,” it does not have to be the same two diagnoses across visits: ANY TWO SUD diagnoses will pass.

Summary of technical expert panel discussion:

Panelists agreed that moving toward a more integrated model is desirable for most conditions, even though there is limited empirical evidence (strongest for severe mental illness and MDD, weakest for PTSD). On the other hand, panelists opined that doing everything at once may dilute the effectiveness of any one intervention, and it is often acceptable to focus on one condition at a time. This measure is intended to assess whether anything happened for both conditions rather than any subtle notions of integration. For this reason, this measure should be considered exploratory.

19. Receipt of Integrated Co-occurring Disorder Treatment

Measure statement:

IF patient is identified with AUD AND has a current MH diagnosis, THEN there should be evidence of integrated treatment for both conditions.

Numerator:

Patients with evidence that both conditions are addressed during the study period as evidenced by

- Integrated treatment plan with goals for both conditions documented during the study period

OR

- Integrated treatment as indicated by two visits where both conditions are addressed in the same visit in the 30 days prior to the index date through six months after the index date (the end of the study period)

Denominator:

Patients with AUD diagnosis and a current MH diagnosis

Phase of care:

Treatment

Data sources:

Administrative data/medical record review data

Rationale and past use:

The rationale for this measure is similar to that of the preceding measure, “Treatment for Co-occurring Mental Health and Substance Use.” While the previous measure is based on administrative data and measures whether both conditions were addressed, this measure is based on medical record review data and measures whether both conditions were addressed in an integrated way.

Technical specifications:

Index visit: See KD1 in Appendix 1.

Diagnosis of AUD: See KD3 in Appendix 1.

Current mental health diagnosis: Patients with at least one Axis-I mental health diagnosis as a primary or nonprimary diagnosis on any inpatient or outpatient visit *within three months (90 days) prior* to and including index visit. Axis-I mental health diagnoses included are transient mental disorders such as psychotic, mood, and anxiety disorders including schizophrenia, episodic mood disorders such as bipolar disorder, major depressive disorder and manic affective disorder, delusional disorders, psychosis,

obsessive-compulsive disorder, posttraumatic stress disorder, and attention deficit disorder.

Integrated treatment: Integrated treatment can be assessed through medical record data. The fulfilling of either criterion (A) during the *entire* study period, **OR** criterion (B) during the period 30 days *prior* to the study period through the end of the study period, will result in a “pass.”

A. Documentation of a treatment plan with goals for either alcohol **OR** substance use issues **AND** for mental health issues **in the same visit** during the study period. If only one issue is addressed in a visit, do not annotate.

OR

B. Documentation of **two visits** where either alcohol or substance use issues **AND** mental health issues were treated **in the same visit** during the study period.

Notes on specifications:

For Numerator (A), Plans/Goals for Integrated Co-Occurring Disorders (COD) is indicated when goals or plans for future treatment related to both alcohol/substance use disorders (AUD/SUD) and mental health issues are captured in the same visit note (or in an addendum dated the same day as the note). Abstractors should note that, if there are three conditions, ANY MH and ANY SUD addressed together will count. Treatment plans are often found at the end of an intake or diagnostic interview (e.g., biopsychosocial). For Numerator (B), integrated treatment (Visit 1 and Visit 2) is indicated by two visits where both the mental health diagnosis and the alcohol/substance use disorder are addressed in terms of actual treatment (versus only a plan for treatment) in the same visit. The visits do not have to be with the same provider. It does not need to be the same two conditions in the two visits to “pass,” but it has to be one SUD and one MH diagnosis. If only one visit is found, abstractors should keep the annotated visit that was found and mark the record as “No evidence found.”

We have included only those MH diagnoses identified prior to and including the index visit date for the sake of this specific study; patients identified with a MH diagnosis subsequent to the index date will not have the same amount of time to “pass” this measure (i.e., the study period).

Summary of technical expert panel discussion:

The technical expert panel discussion for this measure is encompassed in the discussion for the previous measure. This measure captures a more complete version of integrated care than the previous, so it is more in line with the expert panel recommendations that moving toward a more integrated model is good for most conditions.

20. Treatment Initiation (Primary)

Measure statement:

IF patient has a new AUD diagnosis, THEN patient should have either an inpatient alcohol or other drug dependence (AOD) admission or an AOD-related visit within 14 days of the earliest AUD diagnosis date.

Numerator:

Patients with an AOD-related inpatient/outpatient visit within 14 days of the earliest AUD diagnosis date

Denominator:

Patients with a new AUD diagnosis

Phase of care:

Treatment

Data sources:

Administrative data

Rationale and past use:

The rationale behind this measure stems from the HEDIS performance measure entitled “Initiation and engagement of alcohol and other drug dependent treatment” (National Quality Measures Clearinghouse, 2015b). This measure was developed by the Washington Circle, an organization supported by federal Center for Substance Abuse Treatment (Harris, Bowe, et al., 2009a). Initiation is defined as the percentage of patients newly diagnosed with SUD who have either an inpatient SUD admission or both an initial SUD-related outpatient visit and additional SUD-related visit within 14 days. This measure has been adopted by the National Committee for Quality Assurance, the state of Oklahoma Department of Mental Health and Substance Abuse Services (Garnick et al., 2007), and the HEDIS Vol. 2. McCorry et al. (2000) note that only a small fraction of the population with AOD disorders enters treatment, and while identification is an important first step in the process of care, more extensive frameworks should be created to ensure that identification of AOD is linked to treatment initiation.

Technical specifications:

Index visit: See KD1 in Appendix 1.

Diagnosis of AUD: See KD3 in Appendix 1.

AOD treatment: AOD treatment can be assessed by using administrative data. The measure will pass if either of the criteria below (A or B) is met within 14 days following

index visit, or index service respectively:

A. If AOD was identified at an inpatient encounter, the inpatient stay is considered to be treatment initiation.

- Inpatient service with both a qualifying ICD-9 code and a qualifying bed section in the same inpatient stay within 14 days following index service, which includes
 - ICD-9-CM codes
 - 291, 291.0, 291.1, 291.2, 291.3, 291.4, 291.5, 291.8, 291.81, 291.82, 291.89, 291.9x
 - 292, 292.0, 292.1, 292.11, 292.12, 292.2, 292.8, 292.81, 292.82, 292.83, 292.84, 292.85, 292.89, 292.9.X
 - 303.0, 303.00, 303.01, 303.02, 303.9
 - 304.0, 304.00, 304.01, 304.02, 304.1, 304.10, 304.11, 304.12, 304.2, 304.20, 304.21, 304.22, 304.3, 304.30, 304.31, 304.32, 304.4, 304.40, 304.41, 304.42, 304.5, 304.50, 304.51, 304.52, 304.6, 304.60, 304.61, 304.62, 304.7, 304.70, 304.71, 304.72, 304.8, 304.80, 304.81, 304.82, 304.9, 304.90, 304.91, 304.92, 305.0, 305.00, 305.01, 305.02, 305.2, 305.20, 305.21, 305.22, 305.3, 305.30, 305.31, 305.32, 305.4, 305.40, 305.41, 305.42, 305.5, 305.50, 305.51, 305.52, 305.6, 305.60, 305.61, 305.62, 305.7, 305.70, 305.71, 305.72, 305.8, 305.80, 305.81, 305.82
 - 305.9, 305.90, 305.91, 305.92
 - Bed section codes
 - DOM/SUD

OR

B. An outpatient service for AOD abuse or dependence and any additional AOD services within 14 days following index service (all three of the below in the same visit):

- Outpatient service with BOTH a qualifying CPT code:
90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99510, 90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, G0155, G0176, G0177, G0396, G0397, G0409, G0410, G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012

AND

- ICD-9-CM codes—291, 291.0, 291.1, 291.2, 291.3, 291.4, 291.5, 291.8, 291.81, 291.82, 291.89, 291.9, 292, 292.0, 292.1, 292.11, 292.12, 292.2, 292.8, 292.81, 292.82, 292.83, 292.84, 292.85, 292.89, 292.9, 303.00, 303.01, 303.02, 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.2, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92

AND

- Clinic stop codes
 - 513
 - 514
 - 519
 - 545
 - 547
 - 560.

Notes on specifications:

As discussed in the “rationale” section below, these specifications are based on the specifications for the Washington Circle performance measure entitled “Initiation and engagement of alcohol and other drug dependent treatment” (National Quality Measures Clearinghouse, 2015b). The measure as specified here is specified to fit most closely with VA coding standards while preserving the intent of the original measure. Below are summarized key differences between this primary version and the subsequent secondary version of the treatment initiation measures:

Denominator: In this, the primary version of the treatment initiation measure, the denominator is composed of patients with a new AUD diagnosis within 135 days after and inclusive of the index visit. The secondary version of this measure, specified in the subsequent section, includes patients with a new qualifying visit for AOD diagnosis (no AOD diagnosis or AOD-related services) in the 60 days preceding the qualifying visit (60-day “clean period”). A qualifying visit is defined as the earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification, or emergency department (ED) encounter during the study period with a diagnosis of AOD.

Numerator: The primary version of the measure includes patients in the numerator with an AOD-related inpatient/outpatient visit within 14 days of the earliest AUD diagnosis date. The secondary version includes patients with either an inpatient AOD inpatient admission or both an initial AOD-related outpatient visit and an additional AOD-related visit within 14 days after and including the qualifying visit.

Summary of technical expert panel discussion:

Panelists tended to agree with Washington Circle’s relatively inclusive specification: including primary care visits, including alcohol abuse, and allowing 14 days. They also encouraged sensitivity analyses by treatment setting and number of visits:

- by treatment setting because initiation rates vary significantly across settings. Additionally, prior studies have found that initiation via inpatient treatment is more strongly associated with improved outcomes (Harris, Bowe, et al., 2009b; Harris, Humphreys, et al., 2010)
- by visit count and time frame because prior studies have found that more visits in the first month are associated with improved outcomes—but not beyond the first month (Harris, Humphreys, et al., 2009).

Panelists further agreed that 3+ visits would be an appropriate stretch goal and consistent with literature documenting large treatment effects in early-phase treatment that dissipates over time.

21. Treatment Initiation (Secondary)

Measure statement:

IF patient has a new AOD diagnosis, AND no AOD diagnoses in the 60 days preceding the qualifying visit, THEN patient should have either an inpatient AOD admission or an AOD-related visit within 14 days of the qualifying visit.

Numerator:

Patients with either an inpatient AOD admission or both an initial AOD-related outpatient visit and an additional AOD-related visit within 14 days of the qualifying visit (inclusive)

Denominator:

Patients with a new qualifying visit for AOD diagnosis AND no AOD diagnoses or AOD-related services in the 60 days preceding the qualifying visit

Phase of care:

Treatment

Data sources:

Administrative data

Rationale and past use:

The rationale for this measure is the same as that of the preceding measure, “Treatment Initiation (Primary).” See notes on specifications above for differences between the primary and secondary versions of the measure.

Technical specifications:

Diagnosis of AOD: Defined as any of the following AOD diagnoses within 5.5 months (165 days) after the index visit (inclusive):

- An inpatient facility code in conjunction with (same stay) ICD-9-CM codes—291, 291.0, 291.1, 291.2, 291.3, 291.4, 291.5, 291.8, 291.81, 291.82, 291.83, 292.84, 292.85, 292.89, 292.9, 303.00, 303.01, 303.02, 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92, 535.3, 571.1

OR

- An inpatient facility code in conjunction with (same stay) ICD-9-CM Procedure Codes 94.61, 94.63, 94.64, 94.66, 94.67, 94.69

OR

- An outpatient visit, intensive outpatient encounter or partial hospitalization with a diagnosis of AOD in the same visit:
 - CPT Codes—90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99510, 90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, G0155, G0176, G0177, G0396, G0397, G0409, G0410, G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012

AND

- AOD diagnoses as defined by ICD-9-CM codes—291.0, 291.1, 291.2, 291.3, 291.4, 291.5, 291.8, 291.81, 291.82, 291.83, 292.84, 292.85, 292.89, 292.9, 303.00, 303.01, 303.02, 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60,

305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92, 535.3, 571.1

OR

- Detoxification visit:
 - HCPCS codes H0008–H0014 or
 - ICD-9-CM procedure codes 94.62, 94.65, 94.68

OR

- ED visit with a diagnosis of AOD (same stay):
 - CPT codes 99281–99285

AND

- ICD-9-CM codes—291, 291.0, 291.1, 291.2, 291.3, 291.4, 291.5, 291.8, 291.81, 291.82, 291.83, 292.84, 292.85, 292.89, 292.9, 303.00, 303.01, 303.02, 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92, 535.3, 571.1

AND

- No AOD diagnosis or AOD-related services in the 60 days preceding the earliest qualifying visit (exclusive).

Index visit: See KD1 in Appendix 1.

AOD treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis (either A or B or C below).

A. If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant:

- an inpatient facility code in conjunction with (same stay) ICD-9-CM codes—291–292, 303.00–303.02, 303.90–303.92, 304.00–304.02, 304.10–304.12, 304.20–304.22, 304.30–304.32, 304.40–304.42, 304.50–304.52, 304.60–304.62, 304.70–304.72, 304.80–304.82, 304.90–304.92, 305.00–305.02, 305.20–305.22, 305.30–305.32, 305.40–305.42, 305.50–305.52, 305.60–305.62, 305.70–305.72, 305.80–305.82, 305.90–305.92, 535.3, 571.1

OR

B. If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive):

- an inpatient facility code in conjunction with (same stay) ICD-9-CM codes—291–292, 303.00–303.02, 303.90–303.92, 304.00–304.02, 304.10–304.12, 304.20–304.22, 304.30–304.32, 304.40–304.42, 304.50–304.52, 304.60–304.62, 304.70–304.72, 304.80–304.82, 304.90–304.92, 305.00–305.02,

305.20–305.22, 305.30–305.32, 305.40–305.42, 305.50–305.52, 305.60–305.62, 305.70–305.72, 305.80–305.82, 305.90–305.92, 535.3, 571.1

OR

C. If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization with an AOD diagnosis within 14 days of the index episode start date (IESD) (inclusive):

- ICD-9-CM codes—291–292, 303.00–303.02, 303.90–303.92, 304.00–304.02, 304.10–304.12, 304.20–304.22, 304.30–304.32, 304.40–304.42, 304.50–304.52, 304.60–304.62, 304.70–304.72, 304.80–304.82, 304.90–304.92, 305.00–305.02, 305.20–305.22, 305.30–305.32, 305.40–305.42, 305.50–305.52, 305.60–305.62, 305.70–305.72, 305.80–305.82, 305.90–305.92, 535.3, 571.1

OR

- CPT codes—90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99510, 90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, G0155, G0176, G0177, G0396, G0397, G0409, G0410, G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, within 14 days after the IESD.

Notes on specifications:

As discussed in the preceding measure, these secondary specifications are an alternate version of the primary specifications, and the key differences between the primary and secondary versions of this measure are discussed above. This version of the measure represents an attempt to most closely mirror the Washington Circle measures. The measure described here does deviate from the exact Washington Circle specifications due to the idiosyncrasies of VA data. The following describes the differences between the measure as specified here and the original Washington Circle measure:

- intake period differs
- direct transfers not considered as they are not captured in data

- uniform billing (UB) revenue codes are not used at the VA so are not included here
- 2013 CPT codes were used
- we did not consider continuous enrollment.

Summary of technical expert panel discussion:

The technical expert panel discussion for this measure is the same as that of the preceding measure, “Treatment Initiation (Primary).”

22. Treatment Engagement (Primary)

Measure statement:

IF patient has a new AUD diagnosis and has initiated treatment (see treatment initiation [primary]), THEN patient should receive two additional alcohol-related visits within 30 days following treatment initiation visit.

Numerator:

Patients who receive two additional AOD-related visits within 30 days following the earliest treatment initiation visit

Denominator:

Patients with a new AUD who have initiated treatment for AOD (see treatment initiation [primary]).

Phase of Care:

Treatment

Data Sources:

Administrative Data

Rationale and past use:

The basis for this measure stems from the Washington Circle performance measure entitled “Initiation and engagement of alcohol and other drug dependence treatment.” Engagement refers to the percentage of outpatients newly diagnosed with SUD who meet the initiation criteria and receive two additional SUD-related visits within 30 days following initiation. The measure has been adopted by the NCQA, the state of Oklahoma Department of Mental Health and Substance Abuse Services (Garnick et al., 2007), and HEDIS Vol. 2. The NCQA has also developed a measure on the percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit (National Quality Measures Clearinghouse,

2015a).

Empirical evidence highlights the moderate importance of treatment engagement in patient outcomes. Garnick et al. (2007) found that outpatients who met engagement criteria were significantly less likely to be arrested during the following year, though they observed no significant association for patients who initiated but did not engage in treatment. Harris, Humphreys, and Finney (2007) examined rates of initiation and engagement across VA facilities and found that higher initiation rates were associated with facility-level improvements in Addiction Severity Index (ASI) drug composite scores but not ASI alcohol composite scores over seven months. Engagement rates were unrelated to either outcome at the facility level. Harris, Humphreys, et al. (2010) further found that VA patients who engaged in treatment had significantly larger improvements in ASI alcohol, drug, and legal composites scores, with larger associations for patients seen in outpatient settings. Studies of alcohol-dependent clients have shown that longer stays in treatment and treatment completion are associated with greater reduction in alcohol use, even after controlling for severity at admission (McCorry et al., 2000). Given these findings, it is clear that patients with AOD should not only be identified and initiate treatment, but should also be actively engaged in order to increase the likelihood of positive alcohol-related outcomes.

Technical specifications:

Patients with a new AUD who have initiated treatment for AOD: Denominator includes those that have “passed” the treatment initiation (primary) measure.

Treatment engagement: Treatment engagement can be assessed through administrative data.

- Patients receive two additional AOD-related visits within 30 days following the earliest date of treatment initiation (note that both visits must fall within the 30 days) (inpatient or outpatient care where the primary or nonprimary diagnosis is AOD. See treatment initiation [primary] for qualifying codes).

Notes on specifications:

Visits must occur on separate days to count for engagement. Include members in the numerator for the engagement of AOD treatment who had two or more services with an AOD abuse or dependence diagnosis within 30 days after the date of the treatment initiation visit (see treatment initiation). Use the codes noted above to identify inpatient and day/night or outpatient services. For members who initiated treatment via an inpatient stay, the 30 days starts at the member’s inpatient discharge date. To determine whether the 30-day criterion is met for subsequent inpatient stays, use the admission date, not the discharge date.

As discussed in the “rationale” section below, these specifications are based on the

specifications for the Washington Circle performance measure entitled “Initiation and engagement of alcohol and other drug dependent treatment” (National Quality Measures Clearinghouse, 2015b). The measure as specified here is specified to fit most closely with VA coding standards while preserving the intent of the original measure. Below are summarized key differences between this primary version and the subsequent secondary version of the Treatment Engagement measures:

Denominator: In the primary version of these specifications, the denominator includes patients with a new AUD who have initiated treatment for AOD, while the denominator of the secondary version includes patients with a new AOD who have initiated treatment for AOD.

Numerator: The numerators are the same for these measures.

Summary of technical expert panel discussion:

Panelists tended to agree with Washington Circle’s relatively inclusive specification: including primary care visits, including alcohol abuse, and allowing 14 days. They also encouraged sensitivity analyses by treatment setting and number of visits:

- by treatment setting because initiation rates vary significantly across settings. Additionally, prior studies have found that initiation via inpatient treatment is more strongly associated with improved outcomes (Harris, Bowe, et al., 2009b; Harris, Humphreys, et al., 2010).
- by visit count and time frame because prior studies have found that more visits in the first month are associated with improved outcomes—but not beyond the first month (Harris, Bowe, et al., 2009b).

Panelists further agreed that 3+ visits would be an appropriate stretch goal and consistent with literature documenting large treatment effects in early-phase treatment that dissipate over time.

23. Treatment Engagement (Secondary)

Measure statement:

IF patient has a new AOD diagnosis and has initiated treatment (see treatment initiation [secondary]), THEN patient should receive two additional alcohol-related visits within 30 days following treatment initiation visit.

Numerator:

Patients who receive two additional AOD-related visits within 30 days following the earliest treatment initiation visit

Denominator:

Patients with a new AOD who have initiated treatment for AOD (see treatment initiation [secondary])

Phase of care:

Treatment

Data sources:

Administrative data

Rationale and past use:

The rationale for this measure is the same as that of the preceding measure, “Treatment Engagement (Primary).” See notes on specifications above for differences between the primary and secondary versions of the measure.

Technical specifications:

Patients with a new AUD who have initiated treatment for AOD: Denominator includes those who have “passed” the treatment initiation (secondary) measure.

Treatment engagement: Patients receive two additional AOD-related visits within 30 days following the earliest date of treatment initiation (note that both visits must fall within the 30 days). Inpatient or outpatient care where the primary or nonprimary diagnosis is AOD. See treatment initiation (secondary) for qualifying codes:

- include members in the numerator for the engagement of AOD treatment who had two or more services with an AOD abuse or dependence diagnosis within 30 days after the date of the treatment initiation visit (see treatment initiation). Use the codes noted above to identify inpatient and day/night or outpatient services. For members who initiated treatment via an inpatient stay, the 30 days starts at the member’s inpatient discharge date. To determine whether the 30-day criterion is met for subsequent inpatient stays, use the admission date, not the discharge date
- initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive)
 - multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

Notes on specifications:

As discussed in the preceding measure, these secondary specifications are an alternate version of the primary specifications, and the key differences between the primary and secondary versions of this measure are discussed above. This version of the measure represents an attempt to most closely mirror the Washington Circle measures. The

measure described here does deviate from the exact Washington Circle specifications due to the idiosyncrasies of VA data. The following describes the differences between the measure as specified here and the original Washington Circle measure:

- intake period differs
- direct transfers not considered as they are not captured in data
- UB revenue codes are not used at the VA so are not included here
- 2013 CPT codes were used
- we did not consider continuous enrollment
- we did not exclude December 1 members
- visits are not required to be with different providers.

Summary of technical expert panel discussion:

The technical expert panel discussion for this measure is the same as that of the preceding measure, “Treatment Engagement (primary).”

24. Reassess Alcohol Use

Measure statement:

IF patient has alcohol misuse, THEN patient should have his or her quantity and frequency of drinking reassessed.

Numerator:

Patients whose quantity and frequency of alcohol use were reassessed between 30 and 90 days after the index visit

Denominator:

Patients with alcohol misuse

Phase of care:

Follow Up

Data sources:

Administrative data/medical record review data

Rationale and past use:

Reassessment of alcohol use allows the provider to monitor the impact of treatment on the patients’ drinking. This measure is based primarily on recommendations in the 2009 VA/DoD Clinical Practices Guideline for SUD, which suggests providers in primary and specialty care settings “reassess response to treatment periodically and systematically, using standardized and valid instrument(s) whenever possible. Measures of treatment response include ongoing substance use, craving, side effects of medication,

emerging symptoms, etc.” These guidelines also suggest different time lines for reassessment, based on care settings: daily in the acute inpatient care setting, at least weekly in the residential care setting, and weekly during the first few weeks of care in the outpatient setting, followed by monthly monitoring. The practice guidelines note that reassessment is associated with reduced drinking in alcohol-dependent patient populations and reduced risky drinking behaviors in university students (VA, 2009). Note that this guideline is intended for patients with AUD who are engaged in treatment. For this reason, this measure is exploratory only.

Technical specifications:

Alcohol misuse: See KD2 in Appendix 1.

AUD assessment: AUD assessment can be assessed through both administrative and medical record review data. This measure receives a “pass” if any of the criteria below (A through C) is met in the 30–90-day window following the index visit:

A. Structured clinical assessment of quantity and frequency of alcohol use:

- AUDIT-C
- AUDIT
- Brief Addiction Monitor (BAM): days of any alcohol use in past 30 days and days of heavy alcohol use in past 30 days
- ASI: days of alcohol use/alcohol use to intoxication in the past 30 days/lifetime

OR

B. Note in the medical record indicating that the provider assessed quantity AND frequency of alcohol use within 30/90 days of index visit.

- Quantity may include documentation of any of the following:
 - number of drinks per day
 - number of drinks per week
 - any note about binge drinking (>5 drinks per day)
 - number of bottles or cases of beer
 - any evidence of quantity.
- To be marked as Frequency, documentation of how often the patient drinks should be found. This may include
 - daily
 - monthly
 - weekly
 - occasional use
 - comments such as “as often as I can”

OR

C. Physician note indicating one of the following

- no current alcohol use
- the patient is drinking within recommended limits

- the patient denies current drinking
- a statement that the patient had alcohol abuse in the past, but is now in full remission
 - must be documented as “full” or “complete” remission. If only “remission” or “partial remission” is stated, it does not count as Denies/Within Limit.

Notes on specifications:

For (A), one of these instruments would be sufficient to fulfill the measure. Abstractors should highlight the name of the measure, the numeric score, and the interpretation of the score where possible; the interpretation may be something like “improved” or “above recommended limits,” as long as it is specifically referring to the clinician’s interpretation of the structured assessment.

For (B), both frequency and quantity must be found in the same outpatient visit or inpatient stay. If *frequency and quantity* cannot be found together in a note, abstractors should continue reviewing the record until an instance is found where the patient meets the full criteria for B (both *frequency and quantity*) or A or C. If only *frequency* or only *quantity* is found in a note, abstractors should still highlight any documentation of *frequency* or *quantity*.

Summary of technical expert panel discussion:

There was strong panel consensus that a new AUDIT-C ≥ 5 is an indication for further assessment with the aim of confirming alcohol misuse and potentially identifying an AUD. This is a fundamental step because most other treatment decisions depend on the result of this assessment. Furthermore, the panel opined that feasibility from the provider’s perspective is an issue. While panelists agreed that the patient should receive further evaluation or assessment, they thought most primary care practitioners will not do this, and will not be able to conduct a thorough assessment. Furthermore, panelists suggested that an assessment in primary care may look very different from a full intake evaluation in SUD specialty care. Providers noted that the assessment does not have to happen on the same day or be performed by the same provider, so long as someone in the treatment system completes the assessment within a reasonable time period.

25. Repeat Brief Intervention

Measure statement:

IF patient has alcohol misuse, THEN patient should receive TWO brief interventions.

Numerator:

Patients who receive TWO BIs in the seven days prior to the index visit through 60

days after the index visit, or have two visits to SUD specialty care within 30 days before through two months after the index visit

Denominator:

Patients with alcohol misuse

Phase of care:

Follow Up

Data sources:

Administrative data/medical record review data

Rationale and past use

This measure is based primarily on recommendations in the 2009 VA/DoD Clinical Practices Guideline for SUD, which suggests providers in primary and specialty care settings “Repeat brief intervention at the follow-up visit if the patient has not responded to a previous brief intervention” (VA, 2009). These guidelines note, in particular, that “most patients will not respond to a single brief intervention and that repeated brief interventions can be efficacious.”

Technical specifications:

Alcohol misuse: See KD2 in Appendix 1.

SUD specialty care: See KD7 in Appendix 1.

BI: Patients who receive *both* (A and B) of the following in the same outpatient visit or inpatient stay, within seven days *before* or 30 days *after* the index visit, inclusive of the date of the index visit, or who receive (C), would receive a “pass” on this measure:

A. Advice to drink less or abstain from alcohol

- note from provider stating that s/he recommended to the patient to drink less or abstain (e.g., recommendation may be documented in the treatment planning note)

B. Feedback about risks of alcohol use to health or normative feedback

- note in medical record that states that the provider and patient discussed the risks associated with alcohol and the patient’s current medical condition
OR
- Note in medical record indicating how the patient’s use of alcohol compares to recommended limits (“gave normative feedback” would count)

C. Patients who receive substance use specialty care treatment within 30 days before or after index visit.

Secondary specifications:

Another data point should be collected but is not required as a “pass” for BI:

D. Discussion of goals/patient response:

- note from provider stating that s/he discussed the patient's goals as far as alcohol reduction or patient's response to the BI. Any discussion of drinking-related goals (e.g., "discussed goals with patient"), reference to reduced quantity of drinking (e.g., "willing to drink only in the evenings or on weekends"), and response to BI or behavior change the patient is willing to do in response to the information s/he is drinking above recommended limits will count. Any indication of patient's response to the BI would also count (e.g., patient agrees to reduce drinking, patient is not interested in reducing drinking, patient was defensive when receiving feedback, patient was interested in learning more about his/her drinking and how it impacts his/her health)

OR

- note that "not interested in reducing drinking" and related notes would pass.

Notes on specifications:

Abstractors collect MRR BI data on everyone, including those receiving AUD specialty care. Abstractors should review phone notes and treatment-planning notes as well. Abstractors should look for each element of BI (A, B, and D) in the MRR for every visit, as these elements are allowed to occur during different visits during the 30-day period. For (A), reinforcing sobriety or healthy drinking levels would count; abstractors should not highlight advice to limit alcohol if it is part of a medication list. For (B), Risk Feedback can be personalized (i.e., specific to patient's medical concerns or medications) or general feedback on health risks associated with drinking; in the subsection "Note in medical record indicating how the patient's use of alcohol compares to recommended limits," the definition does not include normative feedback. If only (A) or (B) is found in a note, abstractors should still record any documentation of (A) or (B) as appropriate. If abstractors find a note with both (A) and (B), they should continue reviewing the chart until they have found all instances. For (C), inpatient treatment will not be sufficient to count if it is 24 hours or less. Abstractors should collect BI data on everyone regardless of possible pass-out based on (C). (D) is not a necessary or sufficient element, but rather should be collected separately as additional information for analysis. "Not interested in reducing drinking" and related notes would count, as would any mention of a drinking-related goal (as long as it is not "boilerplate"). The patient should be involved in generating and agree to the goal, though this can be difficult to discern from chart notes. Once abstractors have found a note where Discussion of Goals/Patient Response is documented, they should continue reviewing the chart and highlight all instances.

Summary of technical expert panel discussion:

There was some disagreement within the panel over the importance of repeat BIs, especially over longer time frames. The best suggestive/indirect evidence is for multiple

BIs quickly. For example, the panel noted, one common approach includes one phone call and one follow-up visit in the month following the initial BI. The panel also pointed out that some patients will reduce their drinking after the first BI. Furthermore, panelists mentioned that scheduling an appointment for repeat BI is not currently clinically indicated, and this would apply only to patients whose drinking has not resolved and who also have an appointment within the appropriate window. Therefore providers should not target an adherence rate of 100 percent for this measure.

26. Medication Evaluation and Management

Measure statement:

IF patient started on new medication for alcohol dependence, THEN s/he should have at least one alcohol-related follow-up encounter.

Numerator:

Patients with at least one alcohol-related follow-up encounter within 60 days after the earliest date that the prescription was filled (exclusive)

Denominator:

Patients started on new medication for alcohol dependence in 90 days after index visit

Phase of care:

Follow Up

Data sources:

Administrative data

Rationale and past use:

Empirical evidence also suggests that more management visits improve outcomes for patients undergoing pharmacotherapy for alcohol dependence. The COMBINE Study included a primary care medical management component that included nine patient visits during four months of treatment with medications, and researchers found more medical management visits were associated with more days of abstinence from alcohol, reductions in heavy alcohol drinking, and a higher likelihood of clinical improvement (Ernst et al., 2008).

Technical specifications:

Index visit: See KD1 in Appendix 1.

Patients started on a new medication for alcohol dependence: Any indication in the administrative record that there was a filled prescription for alcohol use, defined as not

having a medication for alcohol dependence in the 90 days preceding and not including the index visit, in the 90 days following the index visit, including Acamprosate calcium/Campral, Naltrexone, Disulfiram/Antabuse, Vivitrol, Nalmefene/Revex.

Alcohol-related follow-up encounter: A patient qualifies if his or her administrative data show an inpatient AUD-related admission or outpatient encounter where the primary or nonprimary diagnosis is AUD in the 60 days after the new prescription was filled.

Secondary specifications:

Look for the follow-up encounter within 30 days after the prescription was filled. Alternatively, look for the follow-up encounter within 90 days after the prescription was filled.

Notes on specifications:

N/A

Summary of technical expert panel discussion:

There was strong consensus for this measure among the panel. Evidence from clinical trials has included weekly evaluation and management visits, but 30 days was acceptable to most panelists (secondary specifications for this measure include a 30-day window). Panelists emphasized that the follow-up visit does not have to be with the prescribing provider or even a licensed prescribing provider.

27. Conduct Any Alcohol-Related Follow-up

Measure statement:

IF patient has alcohol misuse, THEN alcohol should be addressed during at least one visit from the day after the index visit to six months after the index visit.

Numerator:

Patients for whom alcohol was addressed during at least one visit during the study period

Denominator:

Patients with alcohol misuse

Phase of Care:

Treatment

Data Sources:

Administrative Data/Medical Record Review Data

Rationale and past use:

This measure includes a broad definition of follow-up and is considered a necessary but insufficient step in the process of improving patient outcomes. In 2005, approximately 93 percent of VA outpatients were screened for alcohol misuse (Bradley et al., 2006). Among those who screened positive, 42 percent had documentation in their medical records of any follow-up assessment for alcohol use disorders, and only 28 percent reported receiving any alcohol-related advice.

Technical specifications:

Alcohol misuse: See KD2 in Appendix 1.

Index visit: See KD1 in Appendix 1.

Alcohol-related follow-up during the study period: Alcohol-related follow-up can be assessed through administrative and medical record review data. Participants will “pass” if *either* of the conditions below (A or B) is met during the study period:

A. Any visit during the study period (excluding the index visit) with a primary or nonprimary diagnosis of any of the following diagnosis codes:

- 303.9 Other and unspecified alcohol dependence
- 303.9 Other and unspecified alcohol dependence, unspecified
- 303.91 Other and unspecified alcohol dependence, continuous
- 303.92 Other and unspecified alcohol dependence, episodic
- 303.93 Other and unspecified alcohol dependence, in remission
- 305.0 Nondependent alcohol abuse
- 305.00 Alcohol abuse, unspecified
- 305.01 Alcohol abuse, continuous
- 305.02 Alcohol abuse, episodic
- 305.03 Alcohol abuse, in remission

OR

B. Any visit, chart note or diagnosis related to unhealthy alcohol use during the study period and following the index visit would count.

- Any documentation such as “drinks within recommended limits” or “not currently drinking” would count.

Secondary specifications:

None

Notes on specifications:

(A) is an automatic pass for this measure. For (B), abstractors should look for any attention to alcohol use including more screening, further assessment, or any treatment (individual or group) that addresses alcohol use or the lack thereof.

Passing on criteria from several other MRR measures would pass for this measure if these previous measures were passed within the appropriate time frame (i.e., starting the

day after the index visit until six months after the index visit). These include

- Assess for Alcohol Use Disorders
- Conduct Brief Intervention
- Discuss Treatment Options
- Offer Psychosocial Intervention
- Offer Pharmacotherapy
- Psychosocial Intervention Quality
- Refer to Recovery Support in the Community
- Receipt of Integrated Co-Occurring Disorder (COD) Treatment
- Reassess Alcohol Use
- Repeat Brief Intervention.

Summary of technical expert panel discussion:

The panelists suspected that many positive screens go completely unrecognized and unacknowledged between annual screens, so this is a “low bar” measure intended to capture any future recognition of a positive screen for alcohol misuse. Any visit, chart note, or diagnosis code related to alcohol misuse and following the index visit would count. The panelists further noted that the next routine visit does not need to be with the same provider but may have to exclude certain specialty settings.

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