

ASAM  
**THE PERFORMANCE  
MEASURES**

For the Addiction  
Specialist Physician



**ASAM** The Voice of Addiction Medicine  
American Society of Addiction Medicine

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# INTRODUCTION

In January 2014, the American Society of Addiction Medicine (ASAM) released its Standards of Care for the Addiction Specialist Physician (Standards). These Standards were developed by the Standards and Outcomes of Care Expert Panel of ASAM's Practice Improvement and Performance Measurement Action Group (PIPMAG). In 2013, ASAM's Board of Directors approved the Standards.

After further PIPMAG Steering Committee review and refinement in 2014, the Standards were posted on the ASAM website and distributed to ASAM April 2014 conference attendees.

The Standards of six practice domains for the addiction specialist physician include:

- Assessment and Diagnosis
- Withdrawal Management
- Treatment Planning
- Treatment Management
- Care Transitions and Care Coordination
- Continuing Care Management

To assess how and if the Standards were being used in the physician's practice, an expert panel, the Addiction Specialist Physician Performance Expert Panel (the Panel) was created. Its goal was to develop performance measures in order to evaluate physician performance against the Standards. The Panel used a consensus-decision making process for the selection of specific measures for evaluation. Its goals included developing areas for further research and development.

Additional experts including a steering committee of representatives of key addiction physician specialty societies, as well as academicians, researchers and clinicians experienced in performance measures and outcome measures development were consulted. A Field Review Panel offered additional feedback as well. (see Page 4 for Steering Committee, and Standards and Performance Expert Panel members).

The PIPMAG Performance Panel has produced this report and submitted it to the ASAM Board of Directors with the goal of the performance measures being adopted by the organizations that address population health as well as the health status of individual patients and the health care services rendered to patients. This would help addiction medicine become more relevant within the broader medical field.

# I. DESCRIPTION OF THE FOCUS OF MEASUREMENT

Clear and broadly accepted performance measures are useful to physicians, patients, purchasers, and others and are now being used across the health care spectrum – in admission, treatment, discharge, consultations, care transitions, and all points in between.

Physicians use measures to establish benchmarks and for internal quality improvement. Individual practitioners may want to monitor their own practices – apart from requirements to do so – as part of Maintenance of Certification (MOC) or Maintenance of Licensure mandates or the mandates of quality improvement programs within health plans.

Payers use them for network development and financial incentive programs and to link reimbursement to performance. Performance measures are also used by health systems, by medical boards in developing MOC programs for physicians, by specialty groups in continuing medical education programs, and by patients and other purchasers to identify high quality providers.<sup>[1]</sup> A RAND survey found that public reporting and quality improvement were the most commonly reported measure uses, while payment and accreditation, certification, credentialing, or licensing were less common uses.<sup>[2]</sup>

While measures are useful, their development and implementation is complex. The design of a performance measure and its utility varies and depends on many things, such as:

- The purpose, what it measures: outcomes, quality improvement, or comparing the performance of delivery systems or health insurance plans? What type of organization's quality is measured -- individual provider, hospital, health system, health plan, etc.?
- The type of measure, what is measured: dimension and/or type of quality being measured structural, process, or outcome measure? (see next section).
- The intended audience.<sup>[3] [4]</sup>
- Source and accessibility of data. Are the data from electronic or non-electronic health records, from patient questionnaires or surveys, or from administrative/claims data?

## Definitions of Different Types of Measures <sup>[5] [6] [7]</sup>

**Structural Measures:** These measures are features of a provider, health care organization or health system that are representative of its capacity to provide health care. They reflect the conditions in which providers care for patients. Examples include the number of certified/licensed providers in a delivery system or network and/or the ratio of alcohol and other drug (AOD) treatment providers (or a subset such as addiction specialist physicians) to clients/patients.

**Process Measures:** Process measures assess how well a health care service is provided to a patient or on a patient's behalf, whether it adheres to evidence or consensus-based recommendations for clinical practice and if steps

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- 1 Physician Consortium for Practice Improvement (PCPI). Overview. American Medical Association. 2012a. <http://www.ama-assn.org/resources/doc/cqi/pcpi-overview-flyer.pdf>.
  - 2 Damberg CL, Sorbero ME, Lovejoy SL, Lauderdale K, et al. 2012. "An Evaluation of the Use of Performance Measures in Health Care." *RAND Health Quarterly*, 1(4):3.
  - 3 Eddy DM. Performance measurement: problems and solutions. *Health Affairs*. 1998;17(4):7-25.
  - 4 Sorian R. Measuring, reporting, and rewarding performance in health care. The Commonwealth Fund. March 2006.
  - 5 Garnick DW, Horgan CM, Chalk M. Performance measures for alcohol and other drug services. *Alcohol Research and Health*. 2006;29(1): 19-26
  - 6 Garnick DW, Horgan CM, Acevedo A, McCorry F, & Weisner C. Performance measures for substance use disorders – what research is needed? *Addiction Science & Clinical Practice*. 2012; 7:18.
  - 7 National Quality Forum (NQF). The ABC's of Measurement, Washington, DC: NQF; 2012a.

shown to improve outcomes are followed correctly. They measure if an action was completed, such as writing a prescription, administering a drug, ordering a diagnostic test or procedure, or having a conversation. Generally, process measures are expressed as rates, with the denominator defining a specific population, and the numerator defining the subgroup receiving specific services. Process measures include screens for depressive disorder or bipolar spectrum patients for unhealthy alcohol use.

Outcome Measures: This type of measure evaluates the actual results of care by assessing a patient's health against the health care services and interventions received. They are generally the most relevant measures for patients and the measures that providers want to change most. Examples of outcome measures for alcohol and other drug (AOD) disorders can be expanded to include: sustained reductions in AOD use, improvements in personal health, evidence of sustained abstinence (especially for persons in safety-sensitive occupations), sustained improvements in functioning (e.g., employment), and sustained reductions in threats to public health and safety.

Access Measures: These measures assess the extent to which a person who needs and wants care is able to obtain it. This type of measure is particularly important for addiction treatment because of the large gap between those who need treatment and those who receive it. Examples of data points which contribute to patient access are wait times for intake visits or follow-up visits (after an outpatient intake or after an episode of withdrawal management ["detoxification"] care) and measures of treatment system capacity which impact access (such as the number of health care providers or the number of specialty providers in a geographic area, or the number of "detoxification" beds available in that same area).

Composite Measures: These measures combine multiple performance measures results to provide a more comprehensive picture of quality care. Examples include screening for alcohol, tobacco and illicit drug use.

Contextual Measures: Contextual measures define a context or basis for interpretation of other measures. Examples include the number of patients with a psychiatric diagnosis receiving addiction treatment.

Patient Experience of Care Measures: They record patients' perspectives of their experience and satisfaction with the care received. Examples are often survey-based and include the Experience of Care and Health Outcomes Survey (ECHO), a survey that asks health plan enrollees about behavioral health care and services experiences.

### **Substance Use Disorder (SUD) Performance Measures**

SUD performance measurement encompasses four major activities:

1. Development, including specification and testing;
2. Testing and validation;
3. Endorsement and adoption; and
4. Implementation including continued evaluation of how measures are working for their intended purposes; and including occasional "tweaking" as issues are identified.

An ongoing review of an established measure after its implementation (to assure that numerators, denominators and exclusions remain accurately constructed) and align with changes in clinical knowledge is referred to as measure maintenance. Measure maintenance is an important and complex activity but can be very costly which requires committed resources to implement.

## Challenges and Opportunities

There are both challenges and opportunities associated with the implementation of measures.

Challenges include:

- Difficulties reporting the results particularly for physicians where only half of physicians have adopted electronic health records (EHRs)<sup>[8]</sup>, with the number of adopters being even lower for physicians and provider organizations in behavioral health care.
- Unintended consequences that arise from measurement and public reporting, such as providers selecting specific patients to treat. Commonly referred to as “cherry picking,” this process may “artificially” improve outcome results and present even greater challenges when evaluating practices.

Opportunities include:

- Improving patient care at the clinician and system levels;
- Linking payment to performance, in support of value based purchasing (VBP); and
- Developing more measures to assess addiction specialist physician performance so they can participate in public and private incentive programs in a meaningful way.

## Measure Development Efforts

Today, several organizations are involved in SUD measure development. These include the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), the Joint Commission (TJC), the federal Agency for Healthcare Research and Quality (AHRQ), the AMA's Physician Consortium for Performance Improvement (PCPI), and The Washington Circle, among others. (See Appendix A for these and other SUD-related measures).

### National Quality Forum

The National Quality Forum (NQF), a non-profit organization based in Washington, D.C., is dedicated to improving the quality of health care in the United States. Several groups, including the U.S Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), and other private and public sector payers recognize NQF's measure endorsement process.

NQF created the National Standards for Treatment of Substance Use Conditions, a consensus document that identifies a set of national standards for treatment of substance use conditions. ASAM used these as a model for the development of standards of care and performance measures.<sup>[9]</sup> NQF-endorsed standards and measures are vetted using a formal consensus development process with broad stakeholder representation. Many health care purchasers, including CMS, rely on NQF endorsement to ensure the measures they use are scientifically sound and meaningful and help standardize performance measures used across the industry.

To date, NQF has endorsed more than 500 measures, including measures for substance use disorders.<sup>[10]</sup> In November 2011, NQF began a two-part project. Its purpose was to endorse measures for improving the delivery of psychosocial treatments for addiction and achieve better behavioral health outcomes, especially for those with co-occurring mental illness and a substance use disorder. During Phase I, NQF sought to endorse new individual and composite behavioral health measures of process, outcomes, and structure to serve as indicators of high-quality behavioral health care across all care delivery settings, including primary and specialty care.

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8 “Doctors’ and Hospitals’ Use of Health IT more than doubles since 2012.” <http://www.hhs.gov/news/press/2013pres/05/20130522a.html>.

9 National Quality Forum (NQF). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. 2007.

10 National Quality Forum (NQF). Frequently Asked Questions. 2012c. [http://www.qualityforum.org/About\\_NQF/FAQsHelp.aspx](http://www.qualityforum.org/About_NQF/FAQsHelp.aspx).



A 25-member Behavioral Health Steering Committee was appointed to review 22 measures, and in November 2012 it endorsed 10, including three measures related to substance use screening and treatment. In Phase 2, NQF will seek to endorse more measures addressing additional gap areas identified in Phase 1, as well as review NQF-endorsed standards related to behavioral health care that are due for maintenance.<sup>[11]</sup>

### Payers and Performance Measures

Public and private payers have taken steps to implement SUD performance measures. In 2007, CMS started a program that links performance measure reporting to provider incentive payments. This program called the Physician Quality Reporting System (PQRS) offers bonus payments to physicians and other eligible providers, who successfully report data on quality measures for covered physician fee schedule (PFS) services furnished to Medicare Part B fee-for-service (FFS) beneficiaries.<sup>[12]</sup>

The PQRS 2014 four SUD-related measures include:

- counseling regarding treatment options for alcohol dependence (the 2015 Medicare Fee Schedule eliminated this measure);<sup>[13]</sup>
- screening for depression among patients with substance abuse or dependence;
- screening for tobacco use and cessation interventions; and
- screening for unhealthy alcohol use.

Beginning in 2015, CMS will penalize providers who elect not to participate or who unsuccessfully participated in the PQRS program in 2013.<sup>[14]</sup>

### Meaningful Use

CMS also offers financial incentives to providers who participate in its “Meaningful Use” program. Run by the Office of the National Coordinator for Health IT (ONC), Meaningful Use is using certified electronic health record (EHR) technology to:

- improve quality, safety, efficiency, and reduce health disparities;
- engage patients and family;
- improve care coordination, and population and public health; and
- maintain privacy and security of patient health information.

Meaningful Use is another example of performance measure implementation. This program includes three stages of increasing requirements for participation. Currently, only five addiction-related measures are endorsed for use in the Meaningful Use Stage 1 and Stage 2 programs (see Appendix A) and four of these five measures relate to screening but not addiction treatment. SAMHSA and NIDA are currently working with the ONC to develop and specify future behavioral health clinical quality measures (CQMs). The Meaningful Use Stage 3 list of measures for consideration includes a composite measure on screening for tobacco, alcohol, and illicit drug use. ASAM is assuming stewardship for this composite measure, which has been advanced through joint support from SAMHSA and NIDA. This measure, however, is targeted for the primary care clinician rather than the addiction specialist physician. ASAM is prepared to steward the addiction measures proposed in this paper through the NQF process, if adopted.

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11 National Quality Forum (NQF). Behavioral Health Phase 1 and 2. 2012b.

[http://www.qualityforum.org/Projects/Behavioral\\_Health\\_Phase\\_1\\_and\\_2.aspx](http://www.qualityforum.org/Projects/Behavioral_Health_Phase_1_and_2.aspx).

12 Centers for Medicare & Medicaid Services (CMS). Physician Quality Reporting System. June 30, 2014.

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

13 Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models and Other Revisions to Part B for CY 2015. <https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-15948.pdf>.

14 American Medical Association (AMA). Physician Quality Measure Reporting. 2014. <http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-quality-reporting-system.page>.

### SUD Measures Specific to Addiction Specialist Physicians

While many public and private efforts are developing, endorsing, and implementing SUD measures, virtually none of the initiatives apply specifically to addiction specialist physicians. Measures developed, to date, are mostly intended for broader use—either for primary care providers, hospitals, health systems or health plans.

When they do exist, however, addiction-specific measures usually address the performance of specialty care systems or specialty provider organizations rather than individual clinical specialists. While these measures, especially those designed for primary care, can be used in specialty care, they do not address the unique role of the addiction specialist physician to identify, treat, or monitor patients with addiction, nor do they reflect the chronic nature of addiction and the long-term care modalities required to treat the disease. Measures specific to the continuum of addiction treatment therapies are also necessary to determine the value of the relevant services.

## II. DEFINING AND PRIORITIZING MEASURES

### Defining Measures

When performance is measured, there needs to be an entity that is the focus of measurement. The focus may range from the individual clinician level to the practice, hospital, or health system level, or it may be at the health plan level. Thus, a single clinician's performance can be measured; the performance of the clinician's practice group (all those who provide cross-coverage for each other on a continuous, around-the-clock basis) can be measured; the performance of all clinicians in a specialty department comprised of several practice groups can be measured; the performance of all clinicians of a given specialty within a health plan's provider network can be measured; or the performance of a provider organization or health system, with all its support staff, facilities, policies and procedures, and its multidisciplinary complement of clinicians, can be measured.

Measures that focus at the clinician level may aggregate data at the individual clinician, practice, or department levels. This level of aggregation, or focus, may be especially helpful for: (1) assessing individual or small-group level performance, comparing this to best practices or key organizational objectives; (2) improving patient management; (3) improving communication among clinicians; or (4) reducing variability in clinical care. These clinician level measures tend to be fluid and oriented around specific clinical contexts. There are challenges in clinician-based measures including the following: small numbers of patients; attribution of patients can be challenging given the large number of different providers seen; and heterogeneity of practices, which creates difficulties in comparison between interventions.

System level measures, on the other hand, are typically used to compare performance of similarly operating units within a larger system (e.g., hospital readmission rates). They reflect a different level of aggregation than clinician-level measures because they measure performance within, and across, hospitals, other provider organizations such as specialty addiction clinics or addiction treatment centers, or health systems. When large systems are the focus of measurement, there are a range of challenges. For example, it may be difficult to make performance measures at the system level meaningful to one or more individuals whose behavior is reflected in the measures, or even to one or more operational units whose activities are reflected in the measures.

The Panel was charged with defining measures that apply to individual addiction specialist physicians. The Panel, however, recognized that there are significant challenges of assigning patients to individual clinicians. Given that the Standards acknowledge that patients are frequently seen by teams, and that often the specialists' role is to assure that selected standards are met by the team as a collection of persons working toward a common goal, it is difficult to attribute the clinical status of a patient to a specific individual within the practice group, department, health system, or network. The Panel, therefore, primarily identified measures that are applied in health care settings that have more than one clinician or provider.

### Prioritizing Measures

The Panel was asked to identify measures that would improve an addiction patient's health, promote high-quality cost-efficient addiction health care, and hold addiction specialist physicians accountable to the Standards. Initial measure selection was based on a number of factors: importance, feasibility, risk of unintended consequences, scientific evidence, and usability. Each of these criteria is described in greater detail on page 12. The inventory of existing behavioral health measures in Appendix A provides a comprehensive list of existing measures. The Panel also reviewed a list of existing measures from other specialty areas that could potentially be adapted for SUD care.

### Importance

What is the prevalence of the problems in performance we are trying to measure? Is there currently a gap in the quality of care being delivered? Will use of this measure promote improvement of clinical quality and patient outcomes? Will this measure improve the public health and/or address key areas of concern in health care delivery? How does the measure assess one or more of the addiction specialist physician standards? Is there evidence of potential for improvement (e.g., less than 100% compliance at present)? Is there scientific evidence that suggests that the selected measure will have an impact on improved patient and health care outcomes? How does the measure address a documented treatment gap?

### Feasibility

How easy or difficult is this measure to develop, implement, and monitor? Are there existing measures that can be used as templates for these new addiction measures, i.e., existing measures that can be adapted for use in the treatment of substance use disorders? Is there a reasonable idea that payment codes exist and are used that would support a physician's use of this measure – short of detailed specification? How significant are the barriers to the measure's implementation, for example, significant costs associated with integrating this measure into electronic health records?

### Risk of Unintended Consequences

Could this measure yield unintended, negative consequences, i.e., could the measure promote treatment practices that are counterproductive to other areas of healthcare? What would be the consequences of not utilizing the measure?

### Scientific Acceptability of Measure Properties

Does the measure have sufficient scientific acceptability, i.e., does the measure, as specified, produce consistent (reliable) and credible (valid) results about the quality of care when implemented? The goal is to make valid conclusions about quality; if not reliable and valid, there is risk of improper interpretation.

### Usability

Is this an actionable measure? Can the measure be easily adopted into current practices, workflows and current measurement protocols?

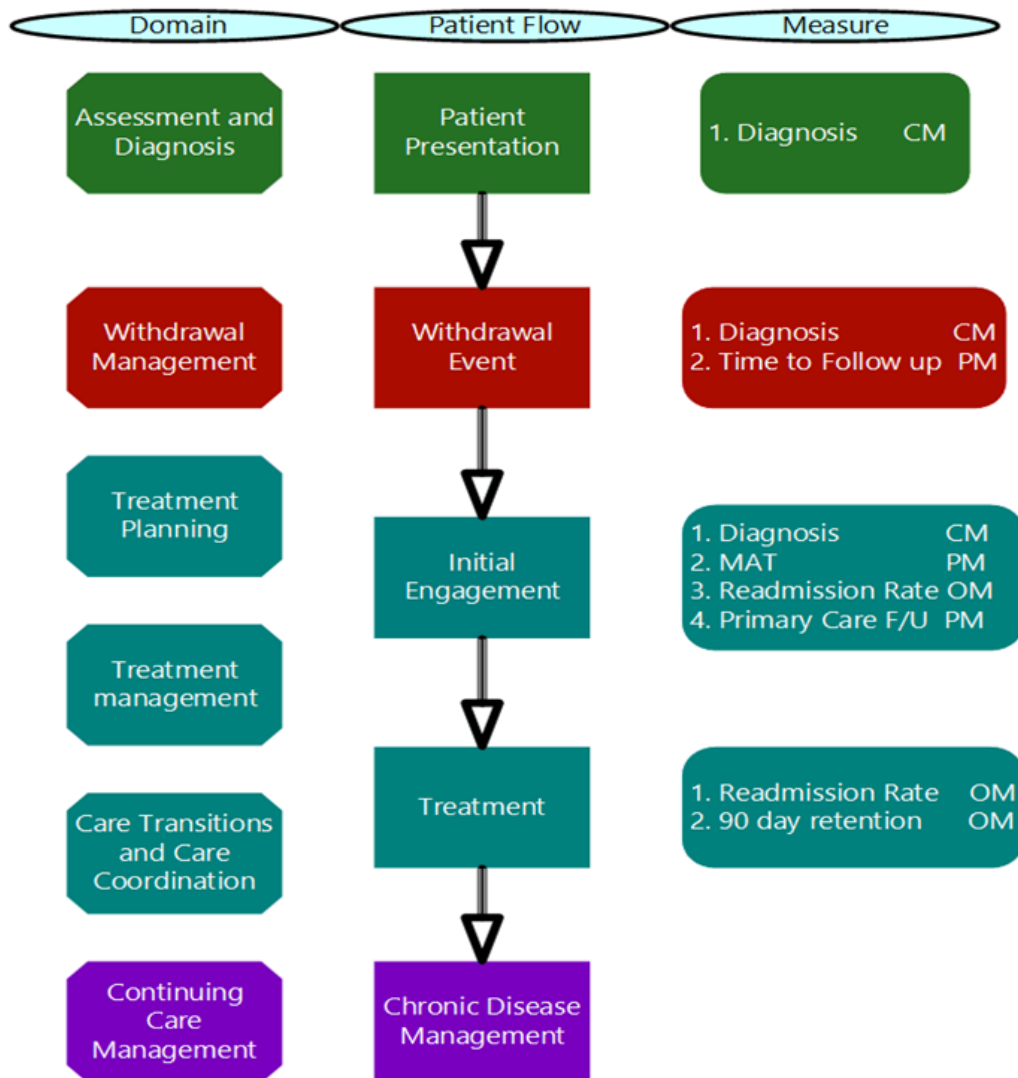
### III. INITIAL MEASURES

#### Aligning Measures

The goal of the Panel was to develop performance measures that align with the six domains in the Standards. In selecting its measures, the Panel used the prioritization criteria described in Section II, which include:

- importance of the problem;
- feasibility of implementation and monitoring;
- risk for unintended consequences;
- evidence backing the performance metric; and
- whether the measure is currently actionable.

The chart below demonstrates how the measures align with the Standards and patients' flow through treatment. Because pilot testing is initially limited to claims data sets, the Panel selected measures that could be tested



through the use of administrative data sets. The Panel also recognized that coding for addiction services is virtually non-existent in claims data sets due to the lack of CPT codes specific to the practice of addiction treatment. The need to develop these codes is a key recommendation included in the summary and research agenda section of this report. Finally, the Panel focused on substance use disorder rather than behavioral addiction, such as gambling, due to coding issues. It recognized that addiction involving the pathological pursuit of reward or relief via engagement in addictive behaviors other than substance use or gambling does not appear in any diagnostic coding system, such as an ICD-10 diagnostic code and hence should be excluded (e.g., an ICD-10 diagnostic code for internet gaming addiction) and thus use of existing claims data sets would not be useful in understanding services offered for such conditions.

The coding issue also prevented the panel from developing a measure specifically tracking utilization of psychosocial interventions, such as social skills training, individual, group and couples counseling, cognitive behavioral therapy, motivational enhanced therapy and family therapy. It is difficult to determine which, if any of these are administered during a psychosocial intervention. Furthermore, this would not be feasible without a chart review.

## IV. MEASURES SELECTED FOR IMPLEMENTATION

Of those performance measures evaluated, the Panel selected a total of nine measures. These measures include six process measures, one utilization-outcome based measure and two contextual measures:

MEASURE #1: Percent of patients prescribed a medication for alcohol use disorder (AUD)

MEASURE #2: Percent of patients prescribed a medication for opioid use disorder (OUD)

MEASURE #3: 7-day follow-up after withdrawal management

MEASURE #4: Presence of screening for psychiatric disorder

MEASURE #5: Presence of screening for tobacco use disorder

MEASURE #6: Primary care visit follow-up

MEASURE #7: All cause inpatient, residential re-admission

MEASURE #8: SUD diagnosis documentation in addiction treatment

MEASURE #9: Psychiatric disorder diagnosis presence

### Process Measures

Measures 1 and 2 met the criteria of high importance with a greater likelihood of being implemented by groups, such as the NQF, the CMS, the ONC, or TJC. Measures that met the criteria of appropriate scientific evidence, low risk of unintended consequences, and would be relatively simple to adapt into current practice and workflow include:

MEASURE #1: Percent of patients prescribed a medication for alcohol use disorder (AUD)

MEASURE #2: Percent of patients prescribed a medication for opioid use disorder (OUD)

MEASURE #3: 7-day follow-up after withdrawal management

The Panel identified three other process measures, which link to the Standards, but are more complicated to implement than the three described above. These three measures are:

MEASURE #4: Presence of screening for psychiatric disorder

MEASURE #5: Presence of screening for tobacco use disorder

MEASURE #6: Primary care visit follow-up after SUD treatment

## **Outcome Measures**

The Panel also selected one utilization-based outcome measure:

MEASURE #7: All cause inpatient, residential re-admission

After reviewing other outcome measures such as patient abstinence, sustained reduction in patient substance use, patient functioning (e.g., return to school, return to work), readmission rates, ER utilization, and medication adherence, the Panel determined that utilization-based outcomes are the most feasible to measure. These measures are easily tracked, can draw from existing data sets, and have appropriate evidence for improving both patient health and population health. Other standardized methods such as urine drug testing and clinical assessments to evaluate patient-level outcomes were identified as important research needs (see Summary and Research Agenda).

## **Contextual Measures**

The Panel identified two additional measures which are “contextual”—i.e., they define a context or basis for interpretation of other measures. These include:

MEASURE #8: SUD diagnosis documentation in addiction treatment

MEASURE #9: Psychiatric disorder diagnosis presence

These contextual measures will help with the interpretation of other addiction-related measures and the gaps within an SUD diagnosis.

## **Specification and Pilot Testing**

Details about each of the nine measures follow. They vary in development stage and origin and testing. Some have been applied in the public but not private setting. Most, however, are descriptive in nature only, and have not been tested. With additional funding support, ASAM can specify, update, and test these measures.



# MEASURE #1: PERCENT OF PATIENTS PRESCRIBED A MEDICATION FOR ALCOHOL USE DISORDER (AUD)

<p><b>Description:</b> This measure will be used to assess the extent to which clinicians prescribe medications to treat AUD to their patients.</p>
<p><b>Measure Type (Process, Contextual or Outcome):</b> Process</p>
<p><b>Standard:</b> III.2 Providing Therapeutic Alternatives</p>
<p><b>Numerator Description and Discussion:</b> Number of patients receiving a medication for alcohol use disorder. The numerator for AUD should include all FDA-approved medications, as well as off-label medications (i.e., topiramate and nalmefene) if there is enough meta-analysis to support off-label medications. Data from providers will capture the number of prescriptions written or medications dispensed. Data from payers will capture number of prescriptions filled or paid for based on pharmacy and medical claims.</p>
<p><b>Denominator Description and Discussion:</b> Number of patients with an alcohol use disorder diagnosis. Since many patients in treatment lack a diagnosis, it is likely that the denominator will understate the number of potential patients. This will improve over time with the proposed diagnosis documentation measure.</p>
<p><b>Rationale:</b> There is strong evidence on the benefit of initiation of alcohol medications, including off-label medications<sup>[15]</sup> and opioid medications.<sup>[16]</sup> There is less evidence specifying the time period within which medications should be initiated once a diagnosis made; therefore, no time period from diagnosis to initiation is included in the measure. This measure can build on some of the specification work already done with the Washington Circle measure on medication initiation, with the removal of the time period from diagnosis to initiation and updating the specification using ICD-10.</p>
<p><b>Other Comments:</b> It is too early to set a benchmark on a prevalence percentage (e.g., greater than 0% and less than 100%), particularly given the research on the relatively low use of pharmacotherapies in practice.<sup>[17][18]</sup> Time will be needed to test the measure to set this kind of benchmark. Over time, the measure may also evolve to look at prevalence of other medications prescribed concurrently with addiction treatment medications (e.g., benzodiazepines) and dosage levels. It is too soon, however, to add these other components. The panel also chose not to address medication adherence, at this time. There is a lack of consensus on the duration of treatment of either alcohol or opioid pharmacotherapies<sup>[19]</sup>; hence, it would be inappropriate to set a benchmark at this time for adherence. The panel recognizes the difficulty assessing compliance; therefore it requires measuring whether a prescription has been paid for and filled. There are PCPI measures on patient counseling about medication and psychosocial options for alcohol dependence (see Appendix); however, the panel believes that initiation of pharmacotherapy treatment is a more meaningful measure for addiction specialist physician care given the issues with psychosocial interventions described in an earlier section. The future development of a CPT code for outpatient detoxification/withdrawal management would aid in the “capture rate” of this measure.</p>

15 Jonas, Daniel E. MD, et. al. “Pharmacotherapy for Adults With Alcohol Use Disorders in Outpatient Settings A Systematic Review and Meta-analysis.” JAMA 2014: 311(18): 1889-1900.

16 TRI Clinical Effectiveness of Medications to Treat Opioid Addiction, June 2013.

17 Thomas, Cindy Parks, PhD, et. al. (2013). “Establishing the feasibility of measuring performance in use of addiction pharmacotherapy.” Journal of Substance Abuse Treatment 45. 11-18.

18 Knudsen, H. K., Abraham, A. J., & Roman, P. M. (2011). Adoption and implementation of medications in addiction treatment programs. J Addict Med, 5(1), 21-27.

19 Thomas, *ibid.*

## MEASURE #2: PERCENT OF PATIENTS PRESCRIBED A MEDICATION FOR OPIOID USE DISORDER (OUD)

<p><b>Description:</b> This measure will be used to assess the extent to which clinicians make medications available to their patients with an OUD.</p>
<p><b>Measure Type (Process, Contextual or Outcome):</b> Process</p>
<p><b>Standard:</b> III.2 Providing Therapeutic Alternatives</p>
<p><b>Numerator Description and Discussion:</b> Number of patients receiving a medication for opioid use disorder. The numerator for OUD should include all FDA approved medications. Data from providers will capture the number of prescriptions written or medications dispensed. Data from payers will capture number of prescriptions filled or paid for based on pharmacy and medical claims. Methadone dispensed in Opioid Treatment Programs (OTPs) will require data from OTPs on doses administered.</p>
<p><b>Denominator Description and Discussion:</b> Number of patients with an opioid use disorder diagnosis. Since many patients in treatment lack a diagnosis, it is likely that the denominator will understate the number of potential patients. This will improve over time with the proposed diagnosis documentation measure.</p>
<p><b>Rationale:</b> There is insufficient evidence specifying the time period within which medications should be initiated once a diagnosis made; therefore, no time period from diagnosis to initiation is included in the measure. This measure can build on some of the specification work already done with the Washington Circle measure on medication initiation, with the removal of the time period from diagnosis to initiation and updating the specification using ICD-10.</p>
<p><b>Other Comments:</b> It is too early to set a benchmark on a prevalence percentage (e.g., greater than 0% and less than 100%), particularly given the research on the relatively low use of pharmacotherapies in practice.<sup>[20]</sup><sup>[21]</sup> Time will be needed to test the measure to set this kind of benchmark. Over time, the measure may also evolve to look at prevalence of other medications prescribed concurrently with addiction treatment medications (e.g., benzodiazepines) and dosage levels. It is too soon, however, to add these other components. The panel also chose not to address medication adherence, at this time. There is a lack of consensus on the duration of treatment of either alcohol or opioid pharmacotherapies<sup>[22]</sup>; hence, it would be inappropriate to set a benchmark at this time for adherence. The panel recognizes the difficulty assessing compliance; therefore it requires measuring whether a prescription has been paid for and filled. There are PCPI measures on patient counseling about medication and psychosocial options for opioid dependence (see Appendix); however, the panel believes that initiation of pharmacotherapy treatment is a more meaningful measure for addiction specialist physician care given the issues with psychosocial interventions described in an earlier section.</p>

20 Thomas, Cindy Parks, PhD, et. al. "Establishing the feasibility of measuring performance in use of addiction pharmacotherapy." *Journal of Substance Abuse Treatment* 45 (2013) 11-18.

21 Knudsen, H. K., Abraham, A. J., & Roman, P. M. (2011). Adoption and implementation of medications in addiction treatment programs. *J Addict Med*, 5(1), 21-27.

22 Thomas, *ibid*.

## MEASURE #3: 7-DAY FOLLOW-UP AFTER WITHDRAWAL MANAGEMENT

**Description:** This measure assesses the extent to which patients initiate treatment within 7 days after receiving withdrawal management services. Because this measure focuses solely on how patients are engaged in addiction treatment post-withdrawal management, this measure will exclude patients engaged in methadone maintenance treatment, patients engaged in office-based opioid treatment that utilizes partial agonist maintenance pharmacotherapy, and patients who enter treatment via intensive outpatient placement with no inpatient/residential or outpatient withdrawal management services. Thus, a patient who never received withdrawal management services, e.g., because they were not clinically indicated, or because the patient underwent induction onto agonist maintenance pharmacotherapy without undergoing any phase of “withdrawal management,” would not be identified via this measure.

The purpose of the continuity measure is to assess treatment system contact and engagement beyond the initial follow-up contact within 7 days. Continuity refers to the provision of timely and complementary services within a shared management plan. Disease-specific literature emphasizes the need for care plans to ensure consistency across these treatment locations and providers. Nursing and mental health literature goes further, emphasizing the importance of consistent implementation, especially when patients cross organizational boundaries. However, flexibility in adapting to changes in an individual’s needs is equally important, especially in mental health and addiction care.

**Measure Type (Process, Contextual or Outcome):** Process

**Standard:** II.3 Assuring Intoxication/Withdrawal Psychosocial Interventions; III.2 Providing Therapeutic Alternatives; and V.4 Providing Referral

### Numerator Descriptions and Discussion:

#### Withdrawal Management:

- Initiation measure numerator: Number of patients who initiate treatment at the next level of care within 7 days after completing withdrawal management.
- Continuity measure numerator: Number of patients with 2 or more claims (medical, pharmacy, etc.) within 90 days after 7-day follow-up.

### Denominator Description and Discussion:

- Initiation measure denominator: Number of patients receiving withdrawal management
- Continuity measure denominator: Number of patients receiving withdrawal management

**Rationale:** Given the high percentage of patients who relapse after a withdrawal management event an acute engagement in treatment measurement will help to indirectly measure effective transitions of care from a high acuity environment to a low acuity environment. While this differs from an evaluation of long-term engagement in treatment, it was felt to be as or more important given the high mortality rate associated with relapse *Cont...*

immediately after a withdrawal management event. There is significant literature about patients not receiving treatment after withdrawal management, resulting in relapse, re-admission and death. [23][24][25][26][27][28][29] The VA has developed and validated a measure on detox follow-up within 7 days (see appendix) so the panel chose this number for initiation. Given the inability to currently track outpatient detoxification or induction onto buprenorphine or methadone these will not be included in the measure.

**Other Comments:** Initiation of treatment is generally defined as a provider encounter that results in a service billing or receipt of a prescription that is filled. Receiving a prescription filled notification would assume follow-up where physician billing is not trackable (e.g. cash pay or out of network). Withdrawal management can occur in all settings and levels of care (e.g., outpatient, residential, hospital, etc.). Outpatient withdrawal management may not be coded separately and may require the use of pharmacy claims for medications used for withdrawal in combination with medical claims.

The 90-day period for continuity was determined by consensus and may require re-consideration after pilot testing.

Patients who are started on agonist medications for OUD, and who have not gone through withdrawal management, are excluded from this measure. It is recognized, however, that there are patients who do go through opioid withdrawal and are then started on an agonist medication. This measure will identify when this occurs and learnings from such data tabulation and analysis can be used for quality improvement.

The future development of a CPT code for outpatient detoxification/withdrawal management would aide in the “capture rate” of this measure.

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- 23 Mark, Dilonardo, Chalk, Coffey.(2002)."Substance Abuse Detoxification: Improvements Needed in Linkage to Treatment," DHHS 02-3748.  
24 Zaller, ND et al. 2006, Nov-Dec (6)"Linkage to Methadone Treatment from Acute Opioid Detoxification Treatment," J Opioid Manag.  
25 Wood, E. et al.(2007) Rate of Detoxification Service Use and Its Impact Among a Cohort of Supervised Injecting Drug Users," Addiction. (102)  
26 Ford, L., Zarate, E.(2010)" Closing the Gaps: Impact of Inpatient Detoxification and Continuity of Care on Client Outcomes," J. Psychoactive Drugs, 42 Supplement  
27 Stein, B; Orlando, M.; & Sturm, R. (2000).The Effect of Copayments on Drug and Alcohol Treatment Following Inpatient Detoxification Under Managed Care, Psychiatric Services, Vol. 51.  
28 Blondell, RI et al.(2006).Differences Among Those Who Complete and Fail to Complete Inpatient Detoxification, J. AddicDis, Vol. 25.  
29 Smyth BP, Barry J, Keenan E, Ducray K. (2010). Lapse and relapse following inpatient treatment of opiate dependence. Irish Medical Journal, 103(6): 176-9.

## MEASURE #4: PRESENCE OF SCREENING FOR PSYCHIATRIC DISORDER

<p><b>Description:</b> This measure assesses the extent to which patients with an SUD diagnosis, receiving addiction treatment, are formally assessed for a psychiatric diagnosis.</p>
<p><b>Measure Type (Process, Contextual or Outcome):</b> Contextual</p>
<p><b>Standard:</b> I. Assessment and Diagnosis</p>
<p><b>Numerator Description and Discussion:</b> Number of patients formally assessed for a psychiatric diagnosis.</p>
<p><b>Denominator Description and Discussion:</b> Number of patients with SUD diagnosis receiving addiction treatment.</p>
<p><b>Rationale:</b> The prevalence of psychiatric disorders among patients in addiction treatment has been well documented. Psychiatric disorders co-exist in 20-30 percent of individuals with SUD and those rates double (40-60%) for individuals in addiction treatment.<sup>[30]</sup> Depression, anxiety, PTSD, social anxiety disorder, and bipolar disorder are the most common conditions found among patients in addiction treatment.<sup>[31][32]</sup> Furthermore, one of the six dimensions of <i>The ASAM Criteria</i> includes assessment of the need for interventions for emotional/behavioral/cognitive conditions or complications.<sup>[33]</sup></p> <p>While there is a PCPI measure for depression screening among patients with substance abuse or dependence (see appendix) within a 12-month reporting period, the panel prefers to select a measure that is both feasible and comprehensive. This measure will expand upon the PCPI depression screening measure.</p> <p>A diagnosis in the medical claims record will have required that screening and assessments were conducted to reach the diagnosis using a variety of recognized screening tools.</p>
<p><b>Other Comments:</b> The absence of a diagnosis for patients in addiction treatment may also result in a lower than expected percentage for this measure.</p>

- 30 McGovern, Mark PhD. (2008). Screening and Assessment for People with Co-Occurring Disorders. Hazelden, Center City, MN.
- 31 Cacciolo, J.S., A.I. Alterman, J.R. McKay, and M.J. Rutherford. (2001). Psychiatric Comorbidity in Patients with Substance Use Disorders: Do Not Forget Axis II Disorders. *Psychiatric Annals*. 31:321-31.
- 32 Ross, H.E., F.B. Glaser, and T. Germanson. (1988). The Prevalence of Psychiatric Disorders in Patients with Alcohol and Other Drug Problems. *Archives of General Psychiatry* 45: 1023-31.
- 33 Mee-Lee D, Shulman GD, Fishman, MJ, Gastfriend, DR, Miller MM, eds. (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies

## MEASURE #5: PRESENCE OF SCREENING FOR TOBACCO USE DISORDER

<p><b>Description:</b> This measure assesses the extent to which patients with an SUD diagnosis, receiving addiction treatment, are screened for a tobacco use disorder diagnosis.</p>
<p><b>Measure Type (Process, Contextual or Outcome):</b> Process</p>
<p><b>Standard:</b> I. Assessment and Diagnosis</p>
<p><b>Numerator Descriptions and Discussion:</b> Number of patients screened for a tobacco use disorder.</p>
<p><b>Denominator Description and Discussion:</b> Number of patients with an SUD diagnosis receiving addiction treatment.</p>
<p><b>Rationale:</b> The US Preventive Services Task Force (USPSTF) recognizes screening for tobacco use disorders as a best practice and strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions (A recommendation) (USPSTF, 2003). The USPSTF found good evidence that brief smoking cessation interventions, including screening, brief behavioral counseling (less than 3 minutes), and pharmacotherapy delivered in primary care settings, are effective in increasing the proportion of smokers who successfully quit smoking and remain abstinent after 1 year.<sup>[34]</sup></p> <p>In addition, a significant percentage of patients in addiction treatment use tobacco. A seminal 11-year retrospective cohort study of 845 people who had been in addiction treatment found that 51 percent of deaths were the result of tobacco-related causes.<sup>[35]</sup> Therefore, screening for tobacco use in patients with an SUD diagnosis who are receiving addiction treatment could improve health outcomes.</p>
<p><b>Other Comments:</b> Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (0028) is an NQF-endorsed measure. This measures the percentage of patients aged 18 years or older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention.<sup>[36]</sup></p>

- 34 US Preventive Services Task Force (USPSTF). (2003). Counseling to Prevent Tobacco Use and Tobacco-Caused Disease. Recommendation Statement. Retrieved from: <http://www.uspreventiveservicestaskforce.org/3rduspstf/tobaccoun/tobcounrs.htm>
- 35 Hurt, R., Offord, K., Croghan, I., Gomez-Dahl, L., Kottke, T., Morse, R. M., et al. (1996). Mortality following inpatient addictions treatment. *JAMA*, 275, 1097–1103
- 36 Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. (2014). PQRS Options for Individual Measures: Claims, Registry. Retrieved from: [http://www.acr.org/~media/ACR/Documents/P4P/Resources/2014/Specs/Measure226\\_specs\\_2014.pdf](http://www.acr.org/~media/ACR/Documents/P4P/Resources/2014/Specs/Measure226_specs_2014.pdf)

## MEASURE #6: PRIMARY CARE VISIT FOLLOW-UP

<p><b>Description:</b> This measure identifies the proportion of individuals who have a primary care visit after an SUD treatment encounter, and assesses the extent to which clinicians assure comprehensive patient care.</p>
<p><b>Measure Type (<i>Process, Contextual or Outcome</i>):</b> Process</p>
<p><b>Standard:</b> III.4 Addressing Comorbidity; IV.1 Assuring Quality of Care; V. Care Transitions and Care Coordination; VI. Continuing Care Management</p>
<p><b>Numerator Description and Discussion:</b> Number of individuals who receive a primary care visit within 6 months of initiation of SUD treatment.</p>
<p><b>Denominator Description and Discussion:</b> All individuals with an SUD encounter within a specified time period.</p>
<p><b>Rationale:</b> It has been documented that individuals who engage in SUD treatment have had suboptimal involvement with the health care system and have developed other co-morbid conditions that require attention. The addiction specialist physician is responsible for assuring that all comorbid conditions are addressed concurrently with treatment of their patients' addiction.</p> <p>Some initial research on continuing care following SUD specialty care, including an observational study of patients over 9 years, shows promising SUD and cost outcomes for a continuing care model that uses primary care as an anchor.<sup>[37][38]</sup></p>
<p><b>Other Comments:</b> The six-month period was based on consensus; however, there is research underway looking at outcomes related to this time period, which is expected to be published.<sup>[39]</sup></p> <p>This measure excludes addiction specialists who are also certified in a primary care specialty.</p>

- 37 Chi, FW; Parthasarathy, S; Mertens, JR; & Weisner, CM. (2011). Continuing care and long-term substance use outcomes in managed care: early evidence for a primary care-based model. *Psychiatric Services*, October 2011: 62(10): 1194–1200.. Doi: 10.1176/appi.ps.62.10.1194
- 38 Parthasarathy, S; Chi, FW; Mertens, JR; & Weisner, C. (2012). The role of continuing care in 9-year cost trajectories of patients with intakes into an outpatient alcohol and drug treatment program. *Med Care*. 2012 Jun; 50(6):540-6. Doi: 10.1097/MLR.0b013e318245a66b.
- 39 Thomas, Cindy Parks, PhD. Et al. (2013). "Establishing the feasibility of measuring performance in use of addiction pharmacotherapy." *Journal of Substance Abuse Treatment*: 45 11-18.

## MEASURE #7: ALL CAUSE INPATIENT, RESIDENTIAL RE-ADMISSION

<p><b>Description:</b> This measure is used to assess the rate of all-cause unplanned readmissions, 90 days following an initial episode of residential/inpatient SUD treatment and assesses the clinician’s management of the patient’s entire medical condition.</p>
<p><b>Measure Type (Process, Contextual or Outcome):</b> Outcome (Utilization-based)</p>
<p><b>Standard:</b> III. Treatment Planning; IV. Treatment Management; and V. Care Transitions and Care Coordination</p>
<p><b>Numerator Descriptions and Discussion:</b> Individuals admitted for any cause to any inpatient or residential facility within 90 days after initial residential/inpatient SUD treatment.</p>
<p><b>Denominator Description and Discussion:</b> Individuals receiving residential/inpatient SUD treatment within the past year.</p>
<p><b>Rationale:</b> All cause readmissions may be an indicator of relapse or complications after initial treatment and could be interpreted as a direct outcome of poor coordination of services and/or an indirect outcome of poor continuity of services. 90 days was chosen to allow for extended evaluation. And given the long wait lists many inpatient facilities have, this may help to decrease the false negative rate. Meaning that if a patient is on a waiting list to go back into a detoxification facility the institution or provider would not be penalized if this happen after 30 days but before 90 days.</p> <p>In the acute general medical care setting, studies have estimated the rate of preventable readmissions to be as low as 12% and as high as 76%.<sup>[40][41]</sup> Given that studies have shown hospital readmissions to be related to quality of care, and that interventions have been able to reduce 30-day readmission rates, it is reasonable to consider an all-condition readmission rate for SUD patients as a significant measure of quality addiction specialist physician care.</p> <p>There are existing performance measures on all cause readmissions that can potentially be adapted for SUD patients.<sup>[42]</sup></p>
<p><b>Other Comments:</b> NQF has recently released a measure on all-cause readmission rates and the specification excludes consideration of patients coming from psychiatric and addiction treatment. Existing readmission measures, therefore, would not capture information relevant to the population treated by addiction specialist physicians. This measure excludes emergency room visits that don’t result in inpatient admissions. While this additional component may be an additional utilization-based outcome, it would further complicate the measure and make it less feasible to implement. Re-admissions on a self-pay basis to some form of residential or inpatient care, and for which there is no insurance claims data, would be “missed” via this measure. Admissions funded by a direct public-sector payment or grant would also be “missed” via this measure if no insurance claim were submitted for such care.</p>

40 Benbassat J, Taragin M. 2000 Apr 24. Hospital readmissions as a measure of quality of health care: advantages and limitations. Arch Intern Med. 160(8):1074-81.

41 Medicare Payment Advisory Commission. 2007 Jun 15. Report to the Congress: promoting greater efficiency in Medicare. [internet]. Washington (DC): Medicare Payment Advisory Commission (MedPac).

42 Agency for Healthcare Research and Quality (AHRQ). (2012). All-cause readmissions: the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission, for patients 18 years of age and older. National Committee for Quality Assurance (NCQA) HEDIS 2013 technical specifications for ACO measurement. Washington (DC): National Committee for Quality Assurance (NCQA); Retrieved from: <http://www.qualitymeasures.ahrq.gov/content.aspx?f=rss&id=47012&osrc=12>



## MEASURE #8: SUD DIAGNOSIS DOCUMENTATION IN ADDICTION TREATMENT

<p><b>Description:</b> This measure will assess the extent to which clinicians document an SUD diagnosis for the patients they are treating, regardless of treatment setting.</p>
<p><b>Measure Type (Process, Contextual or Outcome):</b> Contextual</p>
<p><b>Standard:</b> I. Assessment and Diagnosis</p>
<p><b>Numerator Description and Discussion:</b> Number of patients with an SUD diagnosis.</p>
<p><b>Denominator Description and Discussion:</b> Number of patients receiving SUD treatment.</p>
<p><b>Rationale:</b> Literature has documented patients in addiction treatment often lack an ascribed and documented diagnosis. In the VA, it has been estimated that 2.5% of patients in SUD programs lack a diagnosis.<sup>[43]</sup> It is critical that specialists document their patients' diagnoses to assure that selected treatment options match the patients' diagnoses. Furthermore, regular documentation will support measure implementation and appropriate third-party payment for specialty care. The reason for requiring the second visit is to eliminate those patients who were evaluated and found to not meet criteria for addiction, thus not requiring a second visit. This is a common occurrence for those that work with Department of Transportation and/or workers compensation.</p> <p>There is already a specified measure from the Institute for Clinical Systems Improvement on diagnosing patients with primary headache using the appropriate diagnosis criteria; this could be adapted for SUD.</p>
<p><b>Other Comments:</b> There is concern that the gaps between DSM-5 and ICD-10 will make specification of this measure difficult. For example, ICD-10 still uses abuse and dependence whereas DSM-5 uses mild, moderate, and severe SUD. Over time the measure may also look at whether correct specifiers are applied—not just whether or not there is a diagnosis, but whether or not the clinician specifies the SUD severity (i.e., mild, moderate, severe). In addition, testing and specifying this measure may help determine when the diagnosis should be made (number of encounters) which would benefit and improve practice. The measure will exclude diagnoses for gambling disorder.</p>

43 Harris, AHS, Reeder, R, Ellerbe, L, and Bowe, T (2010). Are VHA administrative location codes valid indicators of specialty substance use disorder treatment? *Journal of Rehabilitation Research and Development*, 47, 699-708

## MEASURE #9: PSYCHIATRIC DISORDER DIAGNOSIS PRESENCE

<p><b>Description:</b> This measure will assess the extent to which patients with an SUD diagnosis, receiving addiction treatment, have a documented psychiatric diagnosis or an explicit entry of “no mental disorder diagnosis” or “mental disorder diagnosis deferred.”</p>
<p><b>Measure Type (Process, Contextual or Outcome):</b> Contextual</p>
<p><b>Standard:</b> I. Assessment and Diagnosis</p>
<p><b>Numerator Descriptions and Discussion:</b> Number of patients with a psychiatric diagnosis.</p>
<p><b>Denominator Description and Discussion:</b> Number of patients with an SUD diagnosis receiving addiction treatment.</p>
<p><b>Rationale:</b> The prevalence of psychiatric disorders among patients in addiction treatment has been well documented. Psychiatric disorders co-exist in 20-30 percent of individuals with SUD and those rates double (40-60%) for individuals in treatment for their SUD.<sup>[45]</sup> Depression, anxiety, PTSD, social anxiety disorder, and bipolar disorder are the most common conditions found among patients in addiction treatment.<sup>[45]</sup><sup>[46]</sup> Furthermore, one of the six dimensions of <i>The ASAM Criteria</i> includes assessment of the presence and severity of emotional, behavioral, or cognitive conditions or complications in a person receiving SUD services.<sup>[47]</sup></p> <p>A diagnosis in the medical claims record will have required that screening and assessments were conducted to lead to the assignment of the diagnosis, using a variety of recognized screening tools.</p>
<p><b>Other Comments:</b> As discussed under Measure #4, the absence of a diagnosis for patients in addiction treatment may also result in a lower than expected percentage for this measure.</p>

- 44 McGovern, Mark PhD. (2008). *Screening and Assessment for People with Co-Occurring Disorders*. Hazelden, Center City, MN.
- 45 Cacciolo, J.S., A.I. Alterman, J.R. McKay, and M.J. Rutherford. (2001). Psychiatric Comorbidity in Patients with Substance Use Disorders: Do Not Forget Axis II Disorders. *Psychiatric Annals*. 31:321-31.
- 46 Ross, H.E., F.B. Glaser, and T. Germanson. (1988). The Prevalence of Psychiatric Disorders in Patients with Alcohol and Other Drug Problems. *Archives of General Psychiatry* 45: 1023-31.
- 47 Mee-Lee D, Shulman GD, Fishman, MJ, Gastfriend, DR, Miller MM, eds. (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies.

## IV. MEASURES SELECTED FOR IMPLEMENTATION CONT.

### Considerations in Selecting the Initial Measures

The Panel recognizes that not all of the domains in the Standards are covered by the nine measures. There are many items listed in the Standards from which a performance measure could be derived, such as performance of a comprehensive bio-psychosocial assessment, the use of toxicological screening, and routine access of prescription drug monitoring program databases. However, there is currently a lack of evidence and guidelines to help define how and when to utilize these components of clinical addiction practice. While many states require the use of such evaluations for payment, the Panel concludes a state mandate or the use of these measures by entities such as NQF is premature given the lack of empirical evidence these activities directly improve outcomes in the daily practice of an addiction specialist physician.

Future work continues including evaluating and resolving other challenges with additional performance and outcome. One example includes a treatment plan as a potentially good performance measure to track. There is evidence that the presence of the treatment plan has a positive effect on patient outcomes. The Panel, however, determined it is difficult to track the presence of a treatment plan without directed chart review and that until electronic medical records (EMRs) are more widely used in the addiction treatment field, this measure is premature.

Appropriate referral and utilization of psychosocial services in conjunction with medications was also discussed. Yet the Panel felt it impossible to accurately track referrals, attendance or utilization frequency of psychosocial interventions given that these may take place at an off-site facility and not be documented in an EMR.

Tracking clinician referral to, patient attendance at, or participation in, mutual-help/peer-support activities such as Alcoholics Anonymous and Narcotics Anonymous, is also another valuable performance measurement. Yet it is not feasible due to the lack of procedural framework. In time, and with greater use of the EMR, the Panel hopes the addiction field will develop and implement performance measures related to psychosocial services for addiction and peer-support activities that fall outside the rubric of professional treatment interventions.

Another measure discussed was clinical performance to assess treatment duration. However, there are concerns regarding the data available to link time in treatment to outcomes. While the Drug Abuse Treatment Outcome Studies (DATOS) commissioned by NIDA in the 1990s found that treatment retention for 90 days was associated with enhanced outcomes,<sup>[48]</sup> many components of addiction treatment (various modalities of psychosocial intervention, various pharmacotherapies for several specific categories of substance use disorder) “should be” applied before the treatment condition at a given level of intensity or “dosage” is withdrawn. Furthermore, this kind of measure would be difficult to track and can be complicated by patients assigned to mandated treatment, such as those used in drug court programs versus treatment without formally imposed contingencies. The Panel also discussed concerns about payers setting arbitrary lengths of stay by level of care, and the potential for a measure that had a time period linked to “length of stay” to have unintended consequences.

Lastly, the Panel discussed expanding the screening measure for co-morbid psychiatric disorder among patients in addiction treatment to also include screening for co-morbid medical conditions among patients in addiction treatment, such as screening for Hepatitis C, HIV, tuberculosis and sexually transmitted diseases (STDs). The Panel believes that developing such a measure would be useful, but the success of having organizations such as NQF adopt these measures for addiction treatment is limited due to the breadth of measures offered to such entities at this time. The Panel is comfortable proposing the measure on screening for co-morbid psychiatric disorder among patients in addiction treatment and recognizes that expanding screening for other co-morbid medical conditions may be considered at a later time.

48 Simpson, D. D., Joe, G. W., Broome, K. M., Hiller, M. L., Knight, K., & Rowan-Szal, G. A. (1997). Program diversity and treatment retention rates in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, 11, 279 – 293.

## V. SUMMARY AND RESEARCH AGENDA

Following a comprehensive review of standards and performance measures and input from the PIPMAG panels and committee, ASAM Board of Directors, and other sources, the Panel created a research agenda for further review. Its findings are summarized in the remainder of this section.

### **Lack of Guidelines/Limited Use of Existing Guidelines in Practice**

Currently, there is a dearth of guideline-based research from which to develop meaningful performance and outcomes measures for the addiction treatment field. The Practice Guideline for Substance Use Disorders was adopted and published by the American Psychiatric Association, but existing guidelines and consensus statements are not regularly updated.<sup>[49]</sup> Further, the extent that providers and treatment programs are practicing using these guidelines and consensus statements, and medical necessity criteria being used to determine frequency and length of treatment is unknown. For example, there is virtually no data that shows organizations offering ASAM Criteria Level 2 or Level 3 services. In short, no one has evaluated treatment organizations to see what they are actually doing versus what they claim to offer patients.

### **Link between Process and Outcomes**

Research is needed to clarify the connection between process and outcome measures and to develop evidence that patient care and outcomes improve when addiction treatment-related performance measures are used. Development of standard methods, such as urine drug testing to assess functional outcomes, return to school or work and other patient-level outcomes are needed to link addiction specialist physician care with patient improvement. Research is also needed to assess the relationship between lengths of time in treatment across levels of care and patients.

### **Severity and Complexity**

Additional research is needed to determine the impact of severity of illness, the presence of co-occurring medical conditions and mental disorders and the effect of non-disease issues such as employment or housing on patient treatment and outcomes and associated performance measures. The impact of these variables may be substantial as performance is compared across clinicians, practice groups, etc. The potential for unintended consequences without such work could pose a significant problem.

### **Policy and Organizational Research**

There are a number of public policies that can have an impact on the utility of performance and outcome measures. Yet, further research is needed to understand how these policies that support separate financing streams for behavioral health and physical health, or state licensing policies that disallow treatment centers to hire physicians as employees, affect a payer's and provider's willingness to adopt these performance measures. There is also greater need for research to establish the development of structural measures to support improved physician performance, system delivery, and patient outcomes relative to addiction treatment. Such structural measures include: care coordination among providers/facilities, transition of care from one level of care or one facility to another, physician staff requirements, physician-to-staff ratio requirements, provider training protocols, and use of physician assistants and nurse practitioners as part of a treatment team.

### **Implementation**

There are several barriers to the implementation of these measures. These include:

- lack of research networks available to test the measures;
- policies that may stymie reimbursement based on these measures;
- poor measures for patient preference;

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49 American Psychiatric Association. *Practice Guideline for the Treatment of Patients with Substance Use Disorders, Second Edition*; 2006. <http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1675010>.

- poor patient treatment adherence; and
- lack of incentives for physicians/systems to use the measure or to improve their performance over time.

There are also data-based barriers including a lack of specificity for psychosocial treatments for addiction codes (e.g., CPT codes) and challenges in reconciling data systems between medical and behavioral health systems and between private payer and block grant-funded systems.

A lack of CPT specific codes of certain types of addiction creates challenges in the outpatient clinical setting. These include, but are not limited to, outpatient withdrawal management for AUD or OUD, buprenorphine induction and medication transitions (i.e. methadone to naltrexone or methadone to buprenorphine). The development and use of CPT codes for these and others would enable outpatient addiction treatment to be tracked and measured to a much greater extent. Adding specific CPT codes for addiction may also help to eliminate the industry perception of addiction being invisible or unnoticed in health care. As a start, these codes should include outpatient detoxification, buprenorphine and naltrexone induction, medication management for addictive disorders and relapse intervention.

Research on all of these issues is critical for measure implementation. One important step would be to develop a national addiction treatment outcome registry, akin to “tumor registries” in cancer care, as envisioned in the current activities of the AMA’s Physician Consortium on Performance Improvement.

### **Recovery-Based Activities**

There is a significant research gap in measuring engagement and outcomes associated with recovery-based activities, such as a patient’s participation in mutual help programs. This includes the relationship between the length of time in recovery-based activities and patient outcomes. There is a small amount of data from well-designed studies regarding Alcoholics Anonymous, but even less for non-professional intervention, which professional societies such as ASAM define as often useful for patients. However, non-professional intervention is not considered treatment and cannot be evaluated based on rates of patient engagement, durations of engagement, or the extent to which such engagement could affect outcomes from professional treatment.<sup>[50]</sup> The Panel also discussed the research and measurement gap associated with patients who are initially treated outside the health care system, through mutual help and self-directed recovery programs, or even via complementary/alternative medicine approaches such as acupuncture alone, and those that access professional treatment after alternative therapies.

### **Practice-Based Research Network**

The Panel identified a need for a practice-based research network comprised of addiction specialist physicians. This network would allow for easier testing of measures with patients in clinician-based settings.

### **Future Addiction Specialist Physician Performance Measures**

The Panel agrees to a subsequent phase of work to include development of simple clinical performance measures or “accountabilities” for physicians (such as, did the physician document family history of addiction as part of the comprehensive initial assessment of the patient) that can be derived from the Standards document.

For addiction specialist physicians to participate in public and private sector incentive programs in a meaningful way, more measures to assess their performance, in the settings in which they are employed and in their unique roles, are needed. New funding from public and private sector stakeholders with jurisdiction over addiction-related policies have an interest in improving addiction care which is also needed to support the development of additional relevant measures.

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50 Relationship between Treatment and Self Help: a Joint Statement of the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, and American Psychiatric Association: Dec. 1, 1997.

## VI. NEXT STEPS

The Panel identified measures that are descriptive with future hope these measures will be developed and tested. Once developed, the measures may be used to:

- provide a benchmark to assess effectiveness of quality improvement efforts;
- identify weaknesses in current processes and care;
- improve patient care and outcomes while reducing costs;
- evaluate progress;
- help identify the best performing clinics and health systems; and
- improve the system—use by large systems or state governments can increase attention and resources.

The Panel believes specification and testing using one or more administrative data sets will be a year-long process. Developing the technical specifications will involve an iterative process including, but not limited to, the following:

- determining the inclusions and exclusions for the numerator and denominator;
- developing a standardized approach for capturing data; and
- defining a clear mathematical expression to calculate the measure.

Following these specifications, ASAM will pilot test and evaluate for feasibility, validity and unintended consequences. This initial testing phase will only be based on one or more administrative data sets. ASAM will work with data sets from multiple settings (e.g. private payer, VA, and HMO) in these necessary future endeavors.

During specification and testing, ASAM will disseminate this report to its members, allied organizations, government and other stakeholders, and to patients and their families. Copies will be made available on ASAM's website and hard copies will be distributed at ASAM's annual meetings and other events.

ASAM looks forward to future support by its federal partners to continue this important work and to advance to subsequent phases of measure specification and pilot testing. Support from funders is important for professional societies such as ASAM to carry out this complex work.

# APPENDIX A: INVENTORY OF BEHAVIORAL HEALTH PERFORMANCE MEASURES

(Adapted from Garnick and Horgan (10/8/2011))

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
<b>Screening for Alcohol and Other Drug Use</b>									
Alcohol Screening and Brief Intervention (ASBI; adults)	Measure of alcohol screening using a validated instrument, including documentation of a brief intervention. Percentage of patients aged 18 – 21 years seen for a visit within the reporting period who were screened for any alcohol use. Percentage of patients aged 21 years and older seen for a visit within the reporting period who were screened for binge drinking ( $\geq 5$ drinks per occasion for men; $\geq 4$ drinks per occasion for women).	VA; IHS; AMA; JC		✓					
Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment	<ul style="list-style-type: none"> <li>a. Patients screened annually for alcohol misuse with the 3-item AUDIT-C with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in medical record.</li> <li>b. Patients screened for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.</li> </ul>	VHA			✓				

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Preventive Care and Screening: Unhealthy Alcohol Use – Screening	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method within 24 months.	AMA-PCPI						✓ (#173)	
Alcohol Use Screening	Hospitalized patients who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use.	JC							
Alcohol Use Brief Intervention	Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay.	JC							
Major Depression and Bipolar Disorder: Appraisal for Alcohol or Chemical Substance Use	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	AMA–Center for Quality Assessment and Improvement in Mental Health (AMA-CQAIMH) (NQF #0110)		✓					
HIV/AIDS: Screening for Injection Drug Use	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for injection drug use at least once within 12 months.	AMA-PCPI/NCQA						✓ (#207)	



MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Illicit substance use primary care single question screener (including illegal drugs and non-medical use of prescription drugs)	Measure needs to be e-specified.	NIDA		✓					
Composite measure on screening for alcohol, tobacco, and illicit drug use (included on MUC3 list)	Percentage of patients who were screened for unhealthy alcohol use, screened for tobacco use and cessation intervention, and screened for nonmedical prescription drug use illicit drug use	ASAM							
Assessment and management of chronic pain	Percentage of patients diagnosed with chronic pain who are screened for chemical dependency before being prescribed opioid medication	Institute for Clinical Systems Improvement							
Assessment and management of chronic pain	Percentage of patients diagnosed with chronic pain with documentation of screening for major depression and chemical dependency	Institute for Clinical Systems Improvement							
Assessment and management of chronic pain	Percentage of patients diagnosed with chronic pain who are prescribed an opioid who have an opioid agreement form and urine toxicology screen documented in the medical record	Institute for Clinical Systems Improvement							

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
<b>Treatment for Substance Use Disorders</b>									
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	<p>The percentage of adolescents and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:</p> <ol style="list-style-type: none"> <li>Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.</li> <li>Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of initiation visit.</li> </ol>	NCQA (NQF #0004)	✓		✓				
Overall use of pharmacotherapy (measured separately for alcohol dependence and opioid dependence)	<p><b>Numerator:</b> Number of individuals with at least one prescription for appropriate pharmacotherapy at any time during the measurement year</p> <p><b>Denominator:</b> Number of individuals with any encounter associated with diagnosis of alcohol dependence (primary or other) at any time during the measurement year</p>	Washington Circle							

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Initiation of pharmacotherapy within 30 days of index visit (new episodes of alcohol dependence or opioid dependence, measured separately)	<p><b>Numerator:</b> Number of individuals who initiate pharmacotherapy within 30 days following index visit with relevant diagnosis of alcohol dependence</p> <p><b>Denominator:</b> Number of individuals with index visit associated with relevant diagnosis (e.g., alcohol dependence or opioid dependence) after 60 day period with no SUD claims.</p>	Washington Circle							
Counseling regarding psychosocial AND pharmacologic treatment options for alcohol.	Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence that were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period.	American Psychiatric Association (APA), PCPI, NCQA.							
Counseling regarding psychosocial AND pharmacologic treatment options for opioid addiction.	Percentage of patients aged 18 years and older with a diagnosis of current opioid addiction that were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.	American Psychiatric Association (APA), PCPI, NCQA.							

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment.	JC							
Alcohol and Drug Use: Assessing Status After Discharge	Discharged patients who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted within 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected.	JC							
Detox: follow-up	% of inpatient detox episodes that have 7 day follow-up % of outpatient detox episodes that have 7 day follow-up	VA							

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Identification of alcohol and other drug services	Summary of the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED.	NCQA							
<b>Tobacco</b>									
Inquiry Regarding Tobacco Use	Percentage of patients aged 18 years or older who were queried about tobacco use one or more times within 24 months.	NCQA						✓ (#114)	
Advising Smokers and Tobacco Users to Quit	Percentage of patients aged 18 years or older and are smokers or tobacco users who received advice to quit smoking.	NCQA						✓ (#115)	
Measure Pair: a. Tobacco Use Assessment b. Tobacco Cessation Intervention	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period. Percent of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	AMA-PCPI (NQF #0027 & NQF #0028)	✓				✓	✓	✓

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Tobacco Use Screening	Hospitalized patients who are screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days.	JC							
Tobacco Use Treatment Provided or Offered	Patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit <u>AND</u> receive or refuse FDA-approved cessation medications during the hospital stay  Patients who received counseling <u>AND</u> medication as well as those who received counseling and had reason for not receiving the medication.	JC							
Tobacco Use Treatment Provided or Offered at Discharge	Patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling <u>AND</u> received or refused a prescription for FDA-approved cessation medication upon discharge.  Patients who were referred to evidence-based outpatient counseling <u>AND</u> received a prescription for FDA-approved cessation medication upon discharge as well as those who were referred to outpatient counseling and had reason for not receiving a prescription for medication.	JC							

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Tobacco Use: Assessing Status after Discharge	Discharged patients who are identified through the screening process as having used tobacco products (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days who are contacted within 30 days after hospital discharge and follow-up information regarding tobacco use status is collected.	JC							
Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation. <ul style="list-style-type: none"> <li>a. Advising Smokers and Tobacco Users to Quit. A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.</li> <li>b. Discussing Cessation Medications. A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.</li> <li>c. Discussing Cessation Strategies. A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.</li> </ul>	NCQA			✓				

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Diabetes Mellitus: Tobacco Non Use	Tobacco use assessment and cessation.	EHR Incentive Program— Clinical Quality Measure (NQF #0028)					✓		
<b>Depression, Bipolar, and Schizophrenia</b>									
Screening for depression among those with a diagnosis of current substance abuse or dependence	Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence that were screened for depression within the 12 month reporting period.	American Psychiatric Association (APA), PCPI, NCQA							
Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 18 years or older screened for clinical depression using a standardized tool AND follow-up documented.	NCQA CMS/QIP			✓			✓ (#134)	
Depression Screening	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	PQRI (NQF #0418)					✓		



MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Depression Screening (PHQ-2 and PHQ-9) for Primary Care	Measure of depression screening using a validated instrument, including documentation of a follow-up plan. Percentage of patients aged 12 years and older who were seen for a visit within the reporting period who were screened for depression at least once.	VA; IHS; AMA; TJC		✓					
New Episode of Depression: a. Optimal Practitioner Contacts for Medication Management b. Effective Acute Phase Treatment c. Effective Continuation Phase Treatment	<p>a. Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner during the 84-day (12-week) Acute Treatment Phase.</p> <p>b. Percentage of patients who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant during the entire 84-day Acute Treatment Phase.</p> <p>c. Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days.</p>	NCQA (NQF #0105)	✓						
Nested Measures: Depression Remission at 6 & 12 Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at 6 and 12 months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	Minnesota Community Measurement (MCM) (NQF #OT3-011-10, #OT3-012-10)		✓					

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Depression Screening By 13 Years of Age	The percentage of adolescents who turn 13 years of age in the measurement year who had a screening for depression using a standardized tool.	NCQA (NQF Review #1394)		✓					
Major Depressive Disorder (MDD): Diagnostic Evaluation	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period.	AMA-PCPI (NQF #0103)		✓			✓ (#106)		
Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.	AMA-PCPI (NQF #0104)		✓			✓ (#107)		
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Percentage of patient visits for those patients aged 6 through 17 years within a diagnosis of major depressive disorder with an assessment for suicide risk.	AMA (NQF Review #1365)		✓					

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Antidepressant Medication Management	<p>a. Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner during the 84-day (12-week) Acute Treatment Phase.</p> <p>b. Percentage of patients who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day Acute Treatment Phase.</p> <p>c. Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days.</p>	NCQA			✓			✓ (#9)	
Bipolar 1 Disorder 2: Annual Assessment of Weight or BMI, Glycemic Control, and Lipids	Annual assessment of weight or BMI, glycemic control, and lipids.	VHA				✓			
Bipolar 1 Disorder C: Proportion of Patients with Bipolar 1 Disorder Treated with Mood Stabilizer Medications During the Course of Bipolar 1 Disorder Treatment	Proportion of patients with bipolar 1 disorder treated with mood stabilizer medications during the course of bipolar 1 disorder treatment.	VHA				✓			

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Bipolar Disorder: Appraisal for Risk of Suicide	Percentage of patients with bipolar disorder who had an initial assessment that includes an appraisal for suicide risk.	AMA–Center for Quality Assessment and Improvement in Mental Health (AMA-CQAIMH) (NQF #0111)		✓					
Schizophrenia 2: Annual Assessment of Weight/BMI, Glycemic Control, Lipids	Annual assessment of weight/BMI, glycemic control, lipids.	VHA			✓				
Schizophrenia B: Proportion of Schizophrenia Patients with Long-term Utilization of Antipsychotic Medications	Proportion of schizophrenia patients with long-term utilization of antipsychotic medications.	VHA			✓				
Schizophrenia C: Proportion of Selected Schizophrenia Patients with Antipsychotic Polypharmacy Utilization	Proportion of selected schizophrenia patients with antipsychotic polypharmacy utilization.	VHA			✓				

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
<b>Mental Health</b>									
Follow-Up After Hospitalization for Mental Illness	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health provider. Two rates are reported:  a. Rate 1. The percentage of members who received follow-up within 30 days of discharge. b. Rate 2. The percentage of members who received follow-up within 7 days of discharge.	NCQA/HEDIS			✓	✓			
Mental Health Utilization	The number and percentage of members receiving the following mental health services during the measurement year:  a. Any service b. Inpatient c. Intensive outpatient or partial hospitalization d. Outpatient or ED	NCQA			✓				

Documentation										
MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET			ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child				
Documentation and Verification of Current Medications in the Medical Record	Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements) and verification with the patients or authorized representative is documented by the provider.	CMS/QIP							✓ (#130)	
Care Coordination (See NQF list of 25 Preferred Practice and 10 Performance Measures. Five relevant ones listed below. Not specific to SUDs)										
Reconciled Medication List received by discharged patients	Reconciled medication list received by discharged patients (inpatient discharges to home/self-care or any other site of care)	NQF # 554						✓		
Transition Record with Specified Elements Received by Discharged Patients (inpatient discharges to home/self-care or any other side of care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including at a minimum, all of the specified elements.	NQF coordination AMA-PCPI NQF coordination						✓		

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Timely Transmission of Transition Record (In patient discharges to home/self -care or any other site of care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI NQF #0648  NQF coordination			✓				
Timely Transmission of Transition Record (emergency department discharges to ambulatory care (home/self -care)		NQF coordination							
Care transition survey	Uni-dimensional self –reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one’s self-care role in the post-hospital setting 2. Medication management 3. Having one’s preferences incorporated into the care plan.	NQF #228					✓		

MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
<b>Experience of Care</b>									
Several ACO measures in April 7th Federal Register from Clinician/Group Survey of CAPHS (Not specific to substance use disorders.)	<ul style="list-style-type: none"> <li>• Getting Timely Care – Appointments and Information</li> <li>• How well your doctors communicate</li> <li>• Helpful, courteous, respectful office staff</li> <li>• Patients rating of doctor</li> <li>• Health promotion and education</li> <li>• Shared decision making</li> <li>• Health Status/functional status</li> </ul>	<a href="https://www.cahps.ahrq.gov/clinician_group/cgsurvey/patientexperience/measurecgsurvey.pdf">https://www.cahps.ahrq.gov/clinician_group/cgsurvey/patientexperience/measurecgsurvey.pdf</a>					✓		
Experience of Care and Health Outcomes Survey (ECHO™)	<p>Consumer experience with specialty behavioral health at the health plan level, including care for mental or emotional illness, substance abuse, family problems, and developmental conditions. Assesses several aspects of care, including:</p> <ul style="list-style-type: none"> <li>• Getting treatment and counseling quickly.</li> <li>• Communications with clinicians.</li> <li>• Information provided by clinicians on medication side effects.</li> <li>• Family involvement in care.</li> <li>• Information about self-help groups and treatment options.</li> <li>• Cultural competency of providers of care.</li> <li>• Treatment effectiveness.</li> <li>• Health plan administrative and office staff services.</li> </ul>	<a href="http://www.ahrq.gov/chttoolb/x/measure9.htm#mentalecho">http://www.ahrq.gov/chttoolb/x/measure9.htm#mentalecho</a>							



MEASURE	DEFINITION	MEASURE STEWARD	MU 1	MU 2	MEDICAID CORE SET		ACO	PQRI	ELECTRONIC SUBMISSION BY MEDICARE OR MEDICAID
					Adults	Child			
Modular Survey		Forum on Performance Measures and Washington Circle <a href="http://modularsurvey.org/">http://modularsurvey.org/</a>							

**Sources: Adapted from Garnick and Horgan (10/8/2011)**

1. Behavioral Health Quality Measures for Stage 1 Meaningful Use [MU Stage 1]
2. Proposed Behavioral Health Quality Measures for State II Meaningful Use [MU Stage 2]
3. Final Recommendations to the Initial Core Quality Measures for Adults in Medicaid as required under the Affordable Care Act, AHRQ's subcommittee [Medicaid Adult Core Measures]
4. Initial Core Set of Children's Quality Measures for Voluntary Reporting [Children's measures]
5. Proposed Measures for Use in Establishing Quality Performance Standards that Accountable Care Organizations (ACOs) Must Meet for Shared Savings [ACO]
6. 2010 Physician Quality Reporting Initiative (PQRI) Measures List [PQRI]
7. National Quality Forum, Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination [NQF coordination]
8. All NQF Mental Health Measures [NQF MH list]
9. The Joint Commission (JC). Specifications Manual for National Hospital Inpatient Quality Measures v4.1\_1. 2012

## APPENDIX B: COMPILATION OF REFERENCES

- 1 Physician Consortium for Practice Improvement (PCPI). Overview. 2012a. American Medical Association. <http://www.ama-assn.org/resources/doc/cqi/pcpi-overview-flyer.pdf>.
- 2 Damberg CL, Sorbero ME, Lovejoy SL, Lauderdale K, et al. 2012. "An Evaluation of the Use of Performance Measures in Health Care." *RAND Health Quarterly*, 1(4):3.
- 3 Eddy DM. (1998). Performance measurement: problems and solutions. *Health Affairs*. 17(4):7-25.
- 4 Sorian R. Measuring, reporting, and rewarding performance in health care. The Commonwealth Fund. March 2006.
- 5 "Doctors' and Hospitals' Use of Health IT more than doubles since 2012." U.S. Department of Health and Human Services. <http://www.hhs.gov/news/press/2013pres/05/20130522a.html>.
- 6 Garnick DW, Horgan CM, Chalk M. Performance measures for alcohol and other drug services. *Alcohol Research and Health*. 2006; 29(1): 19-26.
- 7 Garnick DW, Horgan CM, Acevedo A, McCorry F, & Weisner C. Performance measures for substance use disorders – what research is needed? *Addiction Science & Clinical Practice*. 2012; 7:18.
- 8 The ABC's of Measurement. (2012). National Quality Forum (NQF).
- 9 *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. National Quality Forum (NQF). 2007.
- 10 Frequently Asked Questions. 2012c. National Quality Forum (NQF). [http://www.qualityforum.org/About\\_NQF/FAQsHelp.aspx](http://www.qualityforum.org/About_NQF/FAQsHelp.aspx).
- 11 Behavioral Health Phase 1 and 2. 2012b. National Quality Forum (NQF). Available at: [http://www.qualityforum.org/Projects/Behavioral\\_Health\\_Phase\\_1\\_and\\_2.aspx](http://www.qualityforum.org/Projects/Behavioral_Health_Phase_1_and_2.aspx).
- 12 Centers for Medicare & Medicaid Services (CMS). Physician Quality Reporting System. June 30, 2014. <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.
- 13 American Medical Association (AMA). Physician Quality Measure Reporting. 2014. <http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-quality-reporting-system.page>.
- 14 Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models and Other Revisions to Part B for CY 2015. Accessed from: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-15948.pdf>
- 15 Simpson, DD., Joe, GW., Broome, KM, Hiller, M L, Knight, K, & Rowan-Szal, GA (1997). Program diversity and treatment retention rates in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, 11, 279 – 293.
- 16 Jonas, Daniel E MD, et. al. "Pharmacotherapy for Adults with Alcohol Use Disorders in Outpatient Settings A Systematic Review and Meta-analysis." *JAMA* 2014: 311(18): 1889-1900.
- 17 TRI Clinical Effectiveness of Medications to Treat Opioid Addiction, June 2013.
- 18 Thomas, Cindy Parks, PhD, et. al. "Establishing the feasibility of measuring performance in use of addiction pharmacotherapy." *Journal of Substance Abuse Treatment* 45 (2013) 11-18.
- 19 Knudsen, HK, Abraham, AJ, & Roman, PM (2011). Adoption and implementation of medications in addiction treatment programs. *J Addict Med*, 5(1), 21-27.
- 20 Thomas, *ibid*.
- 21 Thomas, Cindy Parks, PhD, et. al. "Establishing the feasibility of measuring performance in use of addiction pharmacotherapy." *Journal of Substance Abuse Treatment* 45 (2013) 11-18.
- 22 Knudsen, HK Abraham, AJ & Roman, PM (2011). Adoption and implementation of medications in addiction treatment programs. *J Addict Med*, 5(1), 21-27.
- 23 Thomas, *ibid*.
- 24 Mark, Dilonardo, Chalk, Coffey. 2002. "Substance Abuse Detoxification: Improvements Needed in Linkage to Treatment," DHHS 02-3748.
- 25 Zaller, ND et al. 2006, Nov-Dec (6). "Linkage to Methadone Treatment from Acute Opioid Detoxification Treatment," *J Opioid Manag*.
- 26 Wood, E et al. (2007) Rate of Detoxification Service Use and Its Impact Among a Cohort of Supervised Injecting Drug Users," *Addiction*, (102).
- 27 Ford, L Zarate, E. (2010). "Closing the Gaps: Impact of Inpatient Detoxification and Continuity of Care on Client Outcomes," *J. Psychoactive Drugs*, 42 Supplement.
- 28 Stein, B; Orlando, M; & Sturm, R (2000). The Effect of Copayments on Drug and Alcohol Treatment Following Inpatient Detoxification Under Managed Care, *Psychiatric Services*, Vol. 51.
- 29 Blondell, RI et al. (2006). Differences Among Those Who Complete and Fail to Complete Inpatient Detoxification, *J. AddicDis*, Vol. 25.

- 30 Smyth BP, Barry J, Keenan E, Ducray K. (2010). Lapse and relapse following inpatient treatment of opiate dependence. *Irish Medical Journal*, 103(6): 176-9.
- 31 McGovern, Mark PhD. (2008). *Screening and Assessment for People with Co-Occurring Disorders*. Hazelden, Center City, MN.
- 32 Caccioloa, JS, Al Alterman, JR McKay, and MJ Rutherford. 2001. Psychiatric Comorbidity in Patients with Substance Use Disorders: Do Not Forget Axis II Disorders. *Psychiatric Annals*. 31:321-31.
- 33 Ross, HE, FB. Glaser, and T. Germanson. 1988. The Prevalence of Psychiatric Disorders in Patients with Alcohol and Other Drug Problems. *Archives of General Psychiatry* 45: 1023-31.
- 34 Mee-Lee D, Shulman GD, Fishman, MJ, Gastfriend, DR, Miller MM, eds. (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies.
- 35 US Preventive Services Task Force (USPSTF). (2003). Counseling to Prevent Tobacco Use and Tobacco-Caused Disease. Recommendation Statement. <http://www.uspreventiveservicestaskforce.org/3rduspstf/tobaccoun/tobcounrs.htm>.
- 36 Hurt, R., Offord, K., Croghan, I., Gomez-Dahl, L., Kottke, T., Morse, R. M., et al. (1996). Mortality following inpatient addictions treatment. *JAMA*, 275, 1097–1103.
- 37 Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. 2014 PQRS Options for Individual Measures: Claims, Registry. Retrieved from: [http://www.acr.org/~media/ACR/Documents/P4P/Resources/2014/Specs/Measure226\\_specs\\_2014.pdf](http://www.acr.org/~media/ACR/Documents/P4P/Resources/2014/Specs/Measure226_specs_2014.pdf).
- 38 Chi, FW; Parthasarathy, S; Mertens, JR; & Weisner, CM. (2011). Continuing care and long-term substance use outcomes in managed care: early evidence for a primary care-based model. *Psychiatric Services*, October 2011: 62(10): 1194–1200.. Doi: 10.1176/appi.ps.62.10.1194.
- 39 Parthasarathy, S; Chi, FW; Mertens, JR; & Weisner, C. (2012). The role of continuing care in 9-year cost trajectories of patients with intakes into an outpatient alcohol and drug treatment program. *Med Care*. 2012 Jun; 50(6):540-6. Doi: 10.1097/MLR.0b013e318245a66b.
- 40 Thomas, Cindy Parks, PhD. Et al. (2013).“Establishing the feasibility of measuring performance in use of addiction pharmacotherapy.” *Journal of Substance Abuse Treatment*: 45:11-18.
- 41 Benbassat J, Taragin M. 2000 Apr 24. Hospital readmissions as a measure of quality of health care: advantages and limitations. *Arch Intern Med*. 160(8):1074-81.
- 42 Medicare Payment Advisory Commission. 2007 Jun 15. Report to the Congress: promoting greater efficiency in Medicare. [internet]. Washington (DC): Medicare Payment Advisory Commission (MedPac).
- 43 Agency for Healthcare Research and Quality (AHRQ). (2012). All-cause readmissions: the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission, for patients 18 years of age and older. *National Committee for Quality Assurance (NCQA) HEDIS 2013 technical specifications for ACO measurement*. Washington (DC): National Committee for Quality Assurance (NCQA). Retrieved from: <http://www.qualitymeasures.ahrq.gov/content.aspx?f=rss&id=47012&osrc=12>.
- 44 Harris, AHS, Reeder, R, Ellerbe, L, and Bowe, T (2010). Are VHA administrative location codes valid indicators of specialty substance use disorder treatment? *Journal of Rehabilitation Research and Development*, 47, 699-708.
- 45 McGovern, Mark PhD. (2008). *Screening and Assessment for People with Co-Occurring Disorders*. Hazelden, Center City, MN.
- 46 Caccioloa, JS, Al Alterman, J.R. McKay, and M.J. Rutherford. (2001). Psychiatric Comorbidity in Patients with Substance Use Disorders: Do Not Forget Axis II Disorders. *Psychiatric Annals*. 31:321-31.
- 47 Ross, HE, FB Glaser, and T. Germanson. (1988). The Prevalence of Psychiatric Disorders in Patients with Alcohol and Other Drug Problems. *Archives of General Psychiatry* 45: 1023-31.
- 48 Mee-Lee D, Shulman GD, Fishman, MJ, Gastfriend, DR, Miller MM, eds. (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. The Change Companies.
- 49 American Psychiatric Association. (2006). *Practice Guideline for the Treatment of Patients with Substance Use Disorders, Second Edition*. <http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1675010>.
- 50 Relationship between Treatment and Self Help: a Joint Statement of the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, and American Psychiatric Association: Dec. 1, 1997.

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