Proposed Changes to Existing Measure for HEDIS®[1] MY 2020
Unhealthy Alcohol Use Screening and Follow-Up (ASF)

NCQA seeks comments on the proposed update for the HEDIS *Unhealthy Alcohol Use Screening and Follow-Up (ASF)* measure:

- Revise the timing for the exclusion that removes members with an alcohol use disorder (AUD) to only exclude members who have an AUD diagnosis during the prior year.

The measure assesses the percentage of adults who were screened for unhealthy alcohol use using a standardized tool and received appropriate follow-up care if they screened positive. Two rates are reported:

1. Unhealthy Alcohol Use Screening. The percentage of members who had systematic screening for unhealthy alcohol use.
2. Counseling or Other Follow-Up. The percentage of members who screened positive for unhealthy alcohol use and received brief counseling or other follow-up care within two months of a positive screening.

Introduced into HEDIS in 2018, ASF was adapted from the NQF-endorsed PCPI *Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling* measure. It is specified for the electronic clinical data system reporting method, which leverages data from various sources such as electronic health records, registries and case management systems.

ASF currently excludes members who had an AUD diagnosis either during the measurement year or the year prior. The intent of this time frame was to define a true screening population before the onset of disorder. However, by removing members with a diagnosis during the measurement year, the measure does not provide credit for those who received the screening that led to the diagnosis of AUD. NCQA proposes to revise the timing for the AUD diagnosis exclusion to only remove members with a diagnosis during the year prior to the measurement year.

Supporting documents include the draft measure specification and evidence workup.

NCQA acknowledges the contributions of the Behavioral Health Measurement Advisory Panel and the Geriatric Measurement Advisory Panel.

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*Unhealthy Alcohol Use Screening and Follow-Up (ASF)**

***Adapted with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA) and with permission from the measure developer, the American Medical Association (AMA).**

SUMMARY OF CHANGES TO HEDIS MEASUREMENT YEAR 2020

- Revised the timing for the exclusion that removes members with an alcohol use disorder.

Description

The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care.

- *Unhealthy Alcohol Use Screening*. The percentage of members who had a systematic screening for unhealthy alcohol use.
- *Alcohol Counseling or Other Follow-Up Care*. The percentage of members receiving brief counseling or other follow-up care within two months of screening positive for unhealthy alcohol use.

Measurement Period

January 1–December 31.

Clinical Recommendation Statement

The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide brief behavioral counseling interventions to those who misuse alcohol.

References

U.S. Preventive Services Task Force. 2013. “Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care.” Annals of Internal Medicine. 159:210-18.

Characteristics

Scoring	Proportion.		
Type	Process.		
Item count	Person.		
Stratification	1. Commercial 18–44*.	4. Medicaid 18–44.	7. Medicare 18–44.
	2. Commercial 45–64*.	5. Medicaid 45–64.	8. Medicare 45–64.
	3. Commercial 65+*.	6. Medicaid 65+.	9. Medicare 65+.

**Note that “Commercial” plans can be identified via the “Private Health Insurance” Direct Reference Code.*

Risk adjustment None.

Improvement notation A higher rate indicates better performance.

Guidance

Allocation:

The member was enrolled with a medical benefit throughout the Participation Period

Requirements:

Numerator 1: Look for any record of screening with a result, regardless of the screening instrument score.

Reporting:

The total for each product line is the sum of the age stratifications.

Definitions

Unhealthy Alcohol Use Screening

A standard assessment instrument that has been normalized and validated for the adult patient population to include AUDIT, AUDIT-C and a Single-Question Screen. Screening requires completion of one or more instruments. The threshold for a positive finding is indicated below for each instrument.

Screening Instrument	Positive Finding
Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument	Total score ≥8
Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument	Total score ≥4 for men Total score ≥3 for women
Single-Question Screen: “How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?”	Response ≥1

Alcohol Counseling or Other Follow-Up Care

An encounter on, or up to 60 days after, the date of the first positive screening that includes at least one of the following:

- Feedback on alcohol use and harms.
- Identification of high-risk situations for drinking and coping strategies.
- Increase the motivation to reduce drinking.
- Development of a personal plan to reduce drinking.
- Documentation of receiving alcohol misuse treatment.

Participation

The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.

Participation Period

The Measurement Period.

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Initial Population

Members 18 years and older at the start of the Measurement Period who also meet criteria for Participation.

Exclusions

Exclusions Exclude members with any of the following:

- Alcohol use disorder during the year prior to the Measurement Period. ~~starting between January 1 of the year prior to the Measurement Period and December 31 of the Measurement Period.~~
- History of dementia any time during the member's history through the end of the Measurement Period.
- In hospice or using hospice services during the Measurement Period.

Unhealthy Alcohol Use Screening (Population Criteria 1)

Denominator 1 The Initial Population, minus Exclusions.

Numerator 1 Members with a documented result for unhealthy alcohol use screening performed between January 1 and November 1 of the Measurement Period.

Counseling or Other Follow-Up on Positive Screen (Population Criteria 2)

Denominator 2 All members in Numerator 1 with a positive finding for unhealthy alcohol use screening between January 1 and November 1 of the Measurement Period.

Numerator 2 Members receiving alcohol counseling or other follow-up care on or up to 60 days after the date of the first positive screen (61 days total).

Data Criteria (Element Level)

Value Sets:

- Diagnosis: Alcohol Use Disorder (2.16.840.1.113883.3.464.1004.1339)
- Diagnosis: Dementia (2.16.840.1.113883.3.464.1004.1074)
- Encounter, Performed: Hospice Encounter (2.16.840.1.113883.3.464.1004.1761)
- Intervention, Order: Hospice Intervention (2.16.840.1.113883.3.464.1004.1762)
- Intervention, Performed: Alcohol Counseling or Other Follow Up Care (2.16.840.1.113883.3.464.1004.1437)
- Intervention, Performed: Hospice Intervention (2.16.840.1.113883.3.464.1004.1762)

Direct Reference Codes:

- Assessment, Performed: How often have you had five or more drinks in one day during the past year [Reported] (LOINC version 2.63 Code 88037-7)
- Assessment, Performed: How often have you had four or more drinks in one day during the past year [Reported] (LOINC version 2.63 Code 75889-6)
- Assessment, Performed: Total score [AUDIT-C] (LOINC version 2.63 Code 75626-2)

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- Assessment, Performed: Total score [AUDIT] (LOINC version 2.63 Code 75624-7)
- Participation: MEDICAID (SOP Code 2)
- Participation: MEDICARE (SOP Code 1)
- Participation: PRIVATE HEALTH INSURANCE (SOP Code 5)
- Patient Characteristic Birthdate: Birth date (LOINC Code 21112-8)
- Patient Characteristic Sex: Female (AdministrativeGender Code F)
- Patient Characteristic Sex: Male (AdministrativeGender Code M)

Data Elements for IDSS Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table ASF-A-1/2/3: Metadata Elements for Unhealthy Alcohol Use: Screening and Follow-Up

Metadata ID	Metadata Specification
MeasurementYear	Measurement year
CollectionMethod	Data collection methodology (electronic clinical data systems)

Table ASF-B -1/2/3: Data Elements for Unhealthy Alcohol Use: Screening and Follow-Up

Indicator	Age	Data Element	Data Source Logic
Unhealthy Alcohol Use Screening	18-44	Initial population	Summed over data sources
Counseling or Other Follow-Up on Positive Screen	45-64	Exclusions	Report by data source
	65+	Denominator	Summed over data sources
		Numerator	Report by data source

Unhealthy Alcohol Use Screening and Follow-Up (ASF)

Measure Workup

Topic Overview

Prevalence and Importance

Prevalence

About 30% of the U.S. population misuses alcohol, and approximately 21% of adults report that they engage in risky or hazardous drinking (Vinson, 2010). In a 2015 National Survey on Drug Use and Health, 29.6% of males and 20.5% of females reported an episode of binge drinking within the past month (HHS, 2016). Binge drinking is defined as, "for men, drinking 5 or more standard alcohol drinks, and for women, 4 or more standard alcohol drinks on the same occasion" (HHS, 2016). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly or per-occasion amounts, resulting in increased risk for health consequences.

The prevalence of DSM-IV alcohol dependence in the United States is 3.5% (Esser, 2014). There are varying levels of alcohol misuse, from risky drinking to alcohol dependence (Table 1) (Jonas, 2012). The terms "alcohol misuse," "unhealthy alcohol use" and "excessive alcohol use" tend to be used synonymously. For the purpose of this workup, we use the term "alcohol misuse" to describe alcohol use that is risky, hazardous or harmful, as well as alcohol abuse or dependence.

Alcohol misuse accounts for more than 88,000 deaths per year in the U.S. (CDC, 2010b) and is associated with a number of negative health outcomes and social problems. It is responsible for 2.5 million years of potential life lost annually (Stahre, 2014) and is the third leading cause of preventable death in the U.S., after tobacco use and being overweight (CDC, 2012a). More than 2,200 deaths a year are caused by an alcohol overdose; 76% occur in adults 35–64 and of those, 76% are men (HHS, 2016). A recent meta-analysis found that alcohol dependence significantly increases risk of all-cause mortality (Laramée, 2015).

Health importance

Alcohol misuse is associated with significant increases in short-term risks to health and safety. Risks increase as drinking increases. The majority of harmful short-term effects are associated with binge drinking (blood alcohol concentration to 0.08 g/dL), which is the most common form of alcohol misuse (NIAAA, 2004). High blood alcohol levels can suppress the central nervous system and cause loss of consciousness, low blood pressure and body temperature, coma, respiratory depression or death (Sanap, 2003).

Alcohol has been shown to be a significant factor in many unintended injuries, including traffic injuries (NHTSA, 2014), drownings (Driscoll, 2004), falls, burns and unintentional firearm injuries (Smith, 1999). Alcohol misuse can promote violence and aggression. About two-thirds of incidents of intimate-partner violence are associated with excessive drinking (Greenfield, 1998). Alcohol misuse can lead to risky sexual behaviors and increased risk of sexual assault, which can result in further impacts such as unintended pregnancy or sexually transmitted diseases (Naimi, 2003). Studies have also shown a positive association between parental alcohol misuse and child maltreatment and neglect. Alcohol use during pregnancy can also increase the risk of

miscarriage, stillbirth, premature delivery and fetal outcomes such as fetal alcohol spectrum disorders and sudden infant death syndrome (AAP, 2000).

Prolonged alcohol misuse can also lead to many long-term health effects. Chronic problems include cancer of the liver, colon, breast and throat, cirrhosis of the liver, hepatitis C, pancreatitis and other gastrointestinal issues (NIAAA, 2000).

Neurological issues associated with alcohol misuse include stroke, dementia, anxiety, depression and suicide (Cargiulo, 2007). Social problems include lost productivity, disturbance of family and social communication and other problems, and unemployment (NIAAA, 2000).

Risk factors for unhealthy alcohol use

The exact cause of alcohol misuse is unknown, but many factors can increase the risk of developing a drinking problem. Alcohol misuse can begin at any age; however, early-onset drinking and the duration of alcohol use can increase development of a serious alcohol misuse issue (Brown, 2008). Family history of alcohol abuse can also affect a person's alcohol consumption through social or genetic factors. Depression and other mental health conditions are also associated with alcohol abuse; it is even higher in those with a mental health condition who have not had the condition diagnosed or treated. Social or cultural factors can also lead to increased use of alcohol. Influence from the media or from social groups can mislead an individual into believing that unhealthy amounts are appropriate (Brown, 2002).

Financial importance and cost-effectiveness

Alcohol misuse also imposes a huge financial burden, costing the U.S. $223.5 billion a year in lost productivity (72.2%), health care costs (11%), criminal justice costs (9.4%) and other inputs (7.5%) (Bouchery, 2011). Almost three-quarters of the total cost of alcohol misuse is related to binge drinking ($170.7 billion). Other costly types of drinking include underage drinking, costing $24.6 billion, and drinking during pregnancy, costing $5.2 billion. More than 1.2 million emergency room visits and 2.7 million physician office visits are due to alcohol misuse.

Supporting Evidence

USPSTF recommendations

The United States Preventive Services Task Force (USPSTF) grade B recommendation states that clinicians should screen adults aged 18 years or older for unhealthy alcohol use and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse (USPSTF, 2018). Screening, Brief Intervention, and Referral to Treatment (SBIRT) is the most common prevention and early intervention model. SBIRT has shown to be an effective and cost-efficient way to identify or halt various forms of addiction in adults (Quanbeck et al., 2010). A summary of evidence taken from 12 controlled trials found that 6–12 months after receiving brief, multi-contact behavioral counseling, patients reduced their average number of drinks per week by 13%–34% more than those who did not receive an intervention (Whitlock, 2004).

Effective screening tools for alcohol misuse

The USPSTF identified three standardized and validated screening tools for identifying the full spectrum of unhealthy alcohol use in the primary care setting: The Alcohol Use Disorders Identification Test (AUDIT), the abbreviated AUDIT-Consumption (AUDIT-C) and the Single Alcohol Screening Question (SASQ) (USPSTF, 2018).

Each tool has good sensitivity and specificity for detecting the full spectrum of alcohol misuse across multiple populations, but the AUDIT is the most widely

studied instrument for detecting alcohol misuse in the primary care setting. AUDIT comprises 10 questions and requires approximately 2–5 minutes to administer; AUDIT-C includes only 3 questions and takes 1–2 minutes to complete. The Single-question screening requires less than 1 minute to administer and asks, “How many times in the past year have you had 5 [for men] or 4 [for women and all adults older than 65 years] or more drinks in a day?” (USPSTF, 2018).

Brief behavioral counseling

Behavioral counseling interventions for alcohol misuse include cognitive behavioral strategies, such as action plans, drinking diaries, stress management or problem solving. Patients can participate in interventions through in-person sessions, written self-help materials, computer- or web-based programs or telephone counseling. The USPSTF uses the following definitions of intervention intensity: very brief single contact (≤5 minutes), brief single contact (6–15 minutes), brief multicontact (each contact is 6–15 minutes) and extended multicontact (≥1 contact, each >15 minutes). Brief multicontact behavioral counseling seems to have the best evidence of effectiveness; very brief behavioral counseling has limited effect (USPSTF, 2018).

The USPSTF found that counseling interventions in the primary care setting can reduce weekly alcohol consumption and improve long-term adherence to recommended drinking limits. Screening and brief counseling interventions are also associated with better health outcomes, such as decreasing the probability of traumatic injury or death, especially related to motor vehicles, by decreasing the proportion of persons who engage in episodes of heavy drinking which results in high blood alcohol concentration.

Other effective treatments of alcohol misuse

Although the USPSTF did not formally evaluate other interventions for alcohol abuse or dependence, specialty treatments are recommended for persons meeting the diagnostic criteria for alcohol dependence, including 12-step programs, intensive outpatient or inpatient treatment programs and pharmacotherapy (Willenbring, 2009). The effectiveness of these approaches has not been systematically examined in randomized trials in the primary care setting; they are most often used by patients with alcohol dependence, some of whom may not find primary care counseling effective. Medications used to treat alcohol dependence have negative side effects, can interact with other frequently used medications and can be very expensive for the patient (Baltieri, 2008).

Health care disparities

Although evidence on the disparities in alcohol screening and brief counseling is limited, there appear to be differences across racial/ethnic groups in both the prevalence of alcohol misuse and the receipt of treatment. The pattern of racial/ ethnic differences in misuse varies by the type of problem assessed. Compared with other racial/ethnic groups, Native Americans have the highest prevalence of heavy drinking (five or more drinks on the same occasion for 5 or more of the past 20 days) and binge drinking (five or more drinks on the same occasion); Caucasians have a higher prevalence of lifetime alcohol abuse disorder than African American, Hispanics or Asians; and African Americans have a higher prevalence of recurrent or persistent alcohol dependence (Chartier, 2010). Access to care also varies, with lower use of care for alcohol misuse among Alaskan Natives, which one study suggested could be due to a lack of relevant professionals in Alaska (Hesselbrook, 2003).

Alcohol misuse remains a significant public health problem among adults ages 18–24. Compared with older adults, this group is more likely to engage in

binge drinking and to participate in a range of risky behaviors involving alcohol, including driving while intoxicated (Dayan, 2010). Data from the Nationwide Inpatient Sample showed that hospitalization rates for alcohol overdoses alone among 18–24 year-olds increased 25% from 1999–2008, reaching 29,412 cases in 2008 at a cost of $266 million (White, 2011).

Gaps in care

Despite the high prevalence of alcohol misuse and the availability of effective treatment, providers often fail to address this condition with patients. Even when alcohol misuse has been identified, many patients do not receive appropriate substance abuse treatment. According to data from NIAAA's 2012–2013 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), only 20% of people who misuse alcohol or are alcohol dependent seek treatment (Grant, 2015). Although some people can recover on their own without formal treatment, some achieve only partial remission and many are vulnerable to relapse throughout their lives. Primary care physicians are inadequately trained about substance abuse and recovery, and are concerned about the stigma and health insurance issues encountered by patients diagnosed with alcohol use disorders (Turner, 2009). Primary care practices also have limited organizational and financial support to identify and address alcohol problems and deliver coordinated care (Turner, 2009).

Treatment of alcohol misuse is currently focused on addressing alcohol dependency and not on at-risk drinking (Willenbring, 2014); however, the prevalence of risky drinking is much higher than that of more severe disorders, and these conditions account for the majority of excess health burdens and costs attributable to alcohol consumption (CDC, 2012b).

Heavy drinkers who have not had a "crisis" may not seek assistance with alcohol cessation if they do not perceive that their condition is severe enough. In general, people tend to wait until their condition is very severe before they seek medical assistance (Willenbring, 2014). Alcohol dependence tends to "wax and wane," which can hinder a person's ability to decipher when it is severe enough to seek assistance. Of those who suffer from alcohol dependence in their lives, only 12% seek treatment in a treatment program (Willenbring, 2014). These factors support the need for early screening and intervention, to help patients understand when they are at risk for alcohol dependency and to provide the opportunity for a physician to help them understand the associated risks.

Harms and benefits

The USPSTF found no harms that would outweigh the benefits associated with alcohol screening and brief intervention. A meta-analysis for the USPSTF examined possible adverse effects such as "illegal substance use, increased smoking, anxiety, stigma, labeling, discrimination or interference with the physician-patient relationship" (Jonas, 2012). Study results revealed no evidence for most of these harms, except in limited cases of increased smoking rates and anxiety. The only other associated harm is the opportunity cost of interventions, which ranged from 5 minutes to 2 hours.

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Appendix

Table 1. Definitions of the Spectrum of Alcohol Misuse (Jonas, 2012)

Term	Definition
Risky or hazardous use	Consumption of alcohol above recommended daily, weekly, or per-occasion amounts. Consumption levels that increase the risk for health consequences.
Harmful use	A pattern of drinking that is already causing damage to health; the damage may be either physical (e.g., liver damage from chronic drinking) or mental (e.g., depressive episodes secondary to drinking).
Alcohol abuse	A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by 1 of the following within a 12-month period: • Recurrent alcohol use resulting in a failure to fulfill major obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; or neglect of children or household). • Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine). • Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct). • Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol (e.g., arguments with spouse about consequences of intoxication or physical fights). • The symptoms have never met the criteria for alcohol dependence.
Alcohol dependence (alcoholism, alcohol addiction)	A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by 3 of the following at any time in the same 12-month period: • Tolerance, as defined by any of the following: – A need for markedly increased amounts of alcohol to achieve intoxication or desired effect. – Markedly diminished effect with continued use of the same amount of alcohol. – Withdrawal, as manifested by either of the following: ▪ The characteristic withdrawal syndrome for alcohol. ▪ Alcohol (or a closely related drug) is taken to relieve or avoid withdrawal symptoms. • Alcohol is often taken in larger amounts or over a longer period than was intended. • A persistent desire or unsuccessful efforts to cut down or control alcohol use. • A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. • Important social, occupational, or recreational activities are given up or reduced because of alcohol use. • Use continues despite knowledge of a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

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