



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 3590

Corresponding Measures:

De.2. Measure Title: Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Co.1.1. Measure Steward: RTI International

De.3. Brief Description of Measure: Percentage of Medicaid discharges, ages 18 to 64, being treated for a substance use disorder (SUD) from an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD follow-up treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; SUD medication fills or administrations; or residential treatment (after an inpatient discharge). Two rates are reported: continuity within 7 and 30 days after discharge.

1b.1. Developer Rationale: Remaining in addiction treatment for an adequate period is critical for recovery (National Institute on Drug Abuse, 2018). Patients often drop out of SUD treatment during transitions from inpatient and residential setting to outpatient settings (Harris, et al. 2006; Naeger et al., 2016; Ali et al., 2016; Reif, et al., 2017; Rubinsky et al., 2017; Liu et al., 2020). Studies with Medicaid beneficiaries document that, on average, only 25% of them receive a post-discharge follow-up within 14 days of a residential or inpatient SUD stays (although rates vary significantly among states and providers) (Harris et al., 2006; Naeger et al., 2016; Ali et al., 2016; Reif et al., 2017; Rubinsky et al., 2017; Liu et al., 2020).

Research finds that post-discharge follow-up after discharge from an inpatient or residential SUD stay is associated with better outcomes, such as reduced mortality (Harris et al., 2015; Paddock et al., 2017; Schmidt et al., 2017), readmissions (Mark et al., 2013, Reif et al., 2017), substance use and improved retention in treatment (Demarce et al., 2018, Garner et al., 2010). The use of a performance measure to support post-discharge follow-up after discharge from an inpatient or residential SUD stay can support quality improvement efforts.

NQF endorsed the metric Continuity of care after inpatient or residential treatment for substance use disorder (NQF 3453) for use in Medicaid programs and health plans to stimulate improvement in post-discharge continuity rates. The measure is defined as the percentage of discharges from inpatient or residential treatment for SUD for Medicaid beneficiaries, ages 18–64, followed by a SUD treatment service.

A provider level measure is needed in addition to the Medicaid and health plan level measure for several reasons. First, there is significant variation among providers in post-discharge follow-up after inpatient and residential SUD treatment (Stein et al., 2009; Rubinsky et al., 2018). Creating a provider-level measure allows states, payers, policymakers, and others to target quality improvement to providers that need it. Second, provider-level measures can reveal why some providers have lower follow-up rates than others and identify solutions. Interventions to improve post-discharge follow-up include inpatient addiction consults (Englander et al., 2019), scheduling outpatient appointments before discharge, starting patients on medications to treat opioid use disorder mediations before discharge, using peer navigators, and facilitating obtaining housing and other social supports (Bassuk et al., 2016, Wakeman et al. 2017, Manuel et al., 2017; Liebschutz et al., Wang et al., 2020). Third, NQF SUD measures are being used at the provider-level in Centers for Medicare and Medicaid (CMS) demonstrations, such as in behavioral health home demonstrations; however, they have not been endorsed at the provider level (CMS, 2019). Finally, some states and private health plans are already using the measure at the provider level, for example, New York's Office of Addiction Services and Support is using the measure to help programs improve follow-up rates, and the measures are being reported for New York, Massachusetts, and West Virginia as part of the Shatterproof Atlas portal.

This proposed provider-level measure - Continuity of care after inpatient or residential treatment for substance use disorder - has a similar logic model endorsed at the Medicaid program level. The logic model, and associated evidence, indicates that this measure

could help to reduce hospital readmissions (Mark et al., 2013; Reif et al., 2017), decrease substance use and relapse (DeMarce et al., 2008; Garner et al., 2010), and lower mortality (Harris et al., 2015; Paddock et al., 2017; Schmidt et al., 2017). Potential benefits to society include reduced costs related to lower crime rates and decreased health care expenditures (Popovici, French, & McKay, 2008; Heslin et al., 2015).

S.4. Numerator Statement: Medicaid discharges, ages 18 to 64, with a principal/primary substance (SUD) diagnosis treated at an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; or SUD medication fills or administrations; or residential treatment (after an inpatient discharge. Two rates are reported: continuity within 7 and 30 days after discharge.

S.6. Denominator Statement: The denominator are Medicaid beneficiaries, ages 18-64, discharged from inpatient or residential provider with a principal diagnosis of SUD on the inpatient/residential treatment encounter claim.

S.8. Denominator Exclusions: Dual eligible Medicare/Medicaid beneficiaries are excluded. Rationale: Individuals who are covered under Medicare would receive coverage for follow-up treatment medications (e.g. opioid use disorder medications) under Medicare Part D and Medicare Part D claims are not captured in Medicaid claims databases. Therefore follow-up treatment would be missed.

De.1. Measure Type: Process

S.17. Data Source: Claims, Enrollment Data

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Most Recent Endorsement Date:

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

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[SUD-Follow-up_Evidence_11_19_2020.docx](#)

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

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

1b. Performance Gap

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

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

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

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

Remaining in addiction treatment for an adequate period is critical for recovery (National Institute on Drug Abuse, 2018). Patients often drop out of SUD treatment during transitions from inpatient and residential setting to outpatient settings (Harris, et al. 2006; Naeger et al., 2016; Ali et al., 2016; Reif, et al., 2017; Rubinsky et al., 2017; Liu et al., 2020). Studies with Medicaid beneficiaries document that, on average, only 25% of them receive a post-discharge follow-up within 14 days of a residential or inpatient SUD stays (although rates vary significantly among states and providers) (Harris et al., 2006; Naeger et al., 2016; Ali et al., 2016; Reif et

al., 2017; Rubinsky et al., 2017; Liu et al., 2020).

Research finds that post-discharge follow-up after discharge from an inpatient or residential SUD stay is associated with better outcomes, such as reduced mortality (Harris et al., 2015; Paddock et al., 2017; Schmidt et al., 2017), readmissions (Mark et al., 2013; Reif et al., 2017), substance use and improved retention in treatment (Demarce et al., 2018, Garner et al., 2010). The use of a performance measure to support post-discharge follow-up after discharge from an inpatient or residential SUD stay can support quality improvement efforts.

NQF endorsed the metric Continuity of care after inpatient or residential treatment for substance use disorder (NQF 3453) for use in Medicaid programs and health plans to stimulate improvement in post-discharge continuity rates. The measure is defined as the percentage of discharges from inpatient or residential treatment for SUD for Medicaid beneficiaries, ages 18–64, followed by a SUD treatment service.

A provider level measure is needed in addition to the Medicaid and health plan level measure for several reasons. First, there is significant variation among providers in post-discharge follow-up after inpatient and residential SUD treatment (Stein et al., 2009; Rubinsky et al., 2018). Creating a provider-level measure allows states, payers, policymakers, and others to target quality improvement to providers that need it. Second, provider-level measures can reveal why some providers have lower follow-up rates than others and identify solutions. Interventions to improve post-discharge follow-up include inpatient addiction consults (Englander et al., 2019), scheduling outpatient appointments before discharge, starting patients on medications to treat opioid use disorder mediations before discharge, using peer navigators, and facilitating obtaining housing and other social supports (Bassuk et al., 2016, Wakeman et al. 2017, Manuel et al., 2017; Liebschutz et al., Wang et al., 2020). Third, NQF SUD measures are being used at the provider-level in Centers for Medicare and Medicaid (CMS) demonstrations, such as in behavioral health home demonstrations; however, they have not been endorsed at the provider level (CMS, 2019). Finally, some states and private health plans are already using the measure at the provider level, for example, New York's Office of Addiction Services and Support is using the measure to help programs improve follow-up rates, and the measures are being reported for New York, Massachusetts, and West Virginia as part of the Shatterproof Atlas portal.

This proposed provider-level measure - Continuity of care after inpatient or residential treatment for substance use disorder - has a similar logic model endorsed at the Medicaid program level. The logic model, and associated evidence, indicates that this measure could help to reduce hospital readmissions (Mark et al., 2013; Reif et al., 2017), decrease substance use and relapse (DeMarce et al., 2008; Garner et al., 2010), and lower mortality (Harris et al., 2015; Paddock et al., 2017; Schmidt et al., 2017). Potential benefits to society include reduced costs related to lower crime rates and decreased health care expenditures (Popovici, French, & McKay, 2008; Heslin et al., 2015).

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Performance scores based on Medicaid claims data from 623 providers who treated 81,720 beneficiaries demonstrate a significant performance gap. The median 7-day follow-up rate was 11%, and the median 30-day follow-up rate was 24%. There was also significant variation among providers. Observed scores for the 7-day follow-up ranged from 0% to 99%, with a mean of 19% and SD of 22%. Observed scores for the 30-day follow-up ranged from 0% to 99%, with a mean of 29% and SD of 13%.

Summary Data of Observed Scores

Measure	n	Mean	SD	Min	10th	25th	50th	75th	90th	Max
7 Days	623	19%	22%	0%	0%	4%	11%	25%	52%	99%
30 Days	623	29%	13%	0%	3%	10%	24%	43%	63%	99%

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

Not applicable.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity,

gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

The table below reveals disparities by gender and race in continuity of care after SUD treatment in a hospital or residential setting. The mean describes the mean percentage of patients receiving follow-up within 7 days of discharge from treatment for SUD in a hospital or residential setting by gender or race. Males were less likely to receive follow-up care (15% versus 23%). Blacks were less likely than Whites to receive follow-up care (22% versus 9%).

	Mean	N
Gender		
Male	15%	52,566
Female	23%	29,154
Race	Mean	N
White	22%	44,686
Black	9%	14,853
American Indian/Alaskan Native	26%	887
Asian	11%	489
Hispanic/Latino	18%	1,412
Total	18%	81,720

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Not applicable.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific(check all the areas that apply):

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

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

Not applicable

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

the specifications)

[This is not an eMeasure](#) **Attachment:**

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

Attachment **Attachment:** [Data_Dictionary_for_SUD_Follow_up_Measure.xlsx](#)

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

[No, this is not an instrument-based measure](#) **Attachment:**

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

[Not an instrument-based measure](#)

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

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

[Not applicable](#)

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) **DO NOT** include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Medicaid discharges, ages 18 to 64, with a principal/primary substance (SUD) diagnosis treated at an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; or SUD medication fills or administrations; or residential treatment (after an inpatient discharge. Two rates are reported: continuity within 7 and 30 days after discharge.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

For this measure two numerators are calculated (follow-up within 7 days of discharge and follow-up within 30 days of discharge).

For the 7-day follow up calculation, the numerator is the total discharges with an outpatient visit, intensive outpatient encounter or partial hospitalization OR telehealth visit with SUD diagnosis in principal position, or filled a prescription for or were administered a medication for SUD within 7 days after discharge. Set this variable equal to 1 if either of the following occur: (a) Follow-up visit or telehealth encounter after index discharge date and on or before index discharge date + 7. SUD diagnosis codes must be in principal position for the follow-up encounter. (b) SUD-related medication fill (see attached Appendix D) on or after index discharge date and on or before index discharge date + 7.

The same process above applies for the 30-day follow-up calculation, but within 30 days after discharge. Set the variable equal to 1 if either of the following occur: (a) Follow-up visit or telehealth encounter after index discharge date and on or before index discharge date + 30. SUD diagnosis codes must be in principal position for the follow-up encounter. (b) SUD-related medication fill (see attached Appendix D) on or after index discharge date and on or before index discharge date + 30.

The measure time period is a calendar year.

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

The denominator are Medicaid beneficiaries, ages 18-64, discharged from inpatient or residential provider with a principal diagnosis

of SUD on the inpatient/residential treatment encounter claim.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The target population for the denominator includes all Medicaid beneficiaries (non-dual eligible) age 18 through 64 years and who had a discharge from SUD inpatient or residential treatment provider with a principal/primary SUD diagnosis during the measurement year which is defined as a calendar year. Eligible discharges are identified based on discharge date.

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

Dual eligible Medicare/Medicaid beneficiaries are excluded. Rationale: Individuals who are covered under Medicare would receive coverage for follow-up treatment medications (e.g. opioid use disorder medications) under Medicare Part D and Medicare Part D claims are not captured in Medicaid claims databases. Therefore follow-up treatment would be missed.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Dual eligible (Medicare/Medicaid) beneficiaries (as identified on Medicaid enrollment/beneficiary files)

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

Not applicable.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Lower score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether higher quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Step 1: Identify denominator

Identify Medicaid- only beneficiaries age 18 through 64 years who had a discharge from SUD inpatient or residential treatment with

a principal/primary SUD diagnosis during the measurement year. Age is calculated as of December 31st of the measurement year.

Step 1A. Exclude discharge if the date of discharge (for inpatient or residential levels of care) is after December 15 of the measurement year or if the date of discharge is missing.

Step 1B. Exclude discharge if the discharge date occurs on the same day as admission to another inpatient or residential facility. Consider this a transfer; the discharge date from the transfer facility would therefore define the index date.

Step 1C. Exclude any discharges that did not have continuous enrollment with both medical and pharmacy benefits on and within the 30 days of that index discharge date.

Step 2: Identify numerator

Step 2A. Use the Analytic Sample to Create the 7- and 30- day follow-up variables:

a. 7_day_follow-up: Identify discharges with an outpatient visit, intensive outpatient encounter or partial hospitalization OR telehealth visit with SUD diagnosis in principal position, or filled a prescription for or were administered medication for SUD within 7 days after discharge. Set this variable equal to 1 if either of the following occurs:

i. Follow-up visit or telehealth encounter (Appendix C) after index discharge date and on or before index discharge date + 7. SUD diagnosis codes must be in principal position for the follow-up encounter

ii. SUD-related medication fill (Appendix D) on or after index discharge date and on or before index discharge date + 7.

b. 30_day_follow-up: Identify discharges with an outpatient visit, intensive outpatient encounter, or partial hospitalization OR telehealth visit with SUD diagnosis in principal position or filled a prescription for or were administered medication for SUD within 30 days after discharge. Set this variable equal to 1 if either of the following occurs:

i. Follow-up visit or telehealth encounter (Appendix C) after index discharge date and on or before index discharge date + 30. SUD diagnosis codes must be in principal position for the follow-up encounter.

ii. SUD-related medication fill (Appendix D) on or after index discharge date and on or before index discharge date + 30.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

Not applicable. The measure is not based on a sample

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

Not applicable. The measure is not based on survey or patient-reported data.

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

If other, please describe in S.18.

Claims, Enrollment Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

The Medicaid Analytic Extract (MAX) files were used to identify discharges from inpatient substance use disorder (SUD) or residential specialty SUD treatment programs with a principal/primary SUD diagnosis on the discharge record (denominator) and the receipt of SUD outpatient or prescription medication treatment within 7 and/or 30 days after discharge (numerator). The Medicaid MAX files used include the following types of files: personal summary (PS), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. Data from the PS IP, LT and OT files were used to construct the measure denominator. We used the PS file to limit the analytic sample based on age and enrollment criteria, and then we used the IP, LT, and OT files to determine whether those beneficiaries met the criteria for the measure denominator. The OT and Rx files enabled us to identify the numerator events (e.g., receipt of SUD outpatient treatment within 7 and/or 30 days after discharge). The PS file contained additional demographic and enrollment information, such as beneficiaries' state, age, sex, and race or ethnicity.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

S.21. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

Not applicable.

2. Validity – See attached Measure Testing Submission Form

[SUD_follow_up_testingform_092720.docx](#)

2.1 For maintenance of endorsement

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

2.2 For maintenance of endorsement

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

2.3 For maintenance of endorsement

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

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

[Coded by someone other than person obtaining original information \(e.g., DRG, ICD-9 codes on claims\)](#)

If other:

3b. Electronic Sources

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

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

ALL data elements are in defined fields in electronic claims

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

Not applicable.

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

Attachment:

3c. Data Collection Strategy

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

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

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

Not applicable.

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

None.

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
	Quality Improvement (external benchmarking to organizations) New York, Massachusetts and West Virginia Medicaid https://www.treatmentatlas.org/
	Quality Improvement (Internal to the specific organization) New York, Massachusetts and West Virginia Medicaid https://www.treatmentatlas.org/

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor

- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

•Name of program and sponsor: New York Office of Addiction Supports and Services, Shatterproof ATLAS

•Purpose: Quality improvement

•Geographic area and number and percentage of accountable entities and patients included: New York state (approximately 90 addiction treatment facilities), Shatterproof ATLAS (approximately 130 addiction treatment providers across 3 states, New York, Massachusetts, and West Virginia).

•Level of measurement and setting: Specialty addiction treatment facility

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

Not applicable.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

See above. The measure is being reported in several states as part of quality improvement efforts.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

All Medicaid participating substance use disorder specialty facilities in New York, New York, Massachusetts, and West Virginia

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

The data are presented in a portal only accessible to providers, state policymakers, and providers. Providers are offered technical assistance material and training to help improve follow-up rates.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

The measure was developed with feedback from state Medicaid programs, commercial health plans, addiction treatment providers, patients, families, and other experts. Experts reviewed the measure as part of a NQF sponsored Strategy session. Focus groups were held with providers, patients, and families to obtain feedback on the measures. One Medicaid program and one commercial health plan helped to test and refine the initial specification. The measure was then implemented by three Medicaid programs as part of Shatterproof's Addiction Treatment Locator, Assessment, and Standards (ATLAS) Platform. New York State's Office of Addiction Supports and Services has integrated the measure into its quality improvement activities.

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

Not applicable.

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

Not applicable.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Not applicable.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

This measure is being considered for initial endorsement. Adoption of this performance measure has the potential to improve the quality of care for Medicaid beneficiaries, who are discharged from inpatient or residential treatment for SUD. Currently the overall rate of continuity of care after inpatient and residential treatment for 7-day follow-up is 17% and 27% for 30-day follow-up, suggesting room for improvement. The Continuity of care after inpatient or residential treatment for substance use disorder measure may be useful for monitoring the rate of continuing care and encourage states to put interventions in place to increase the rates. This is important because continuity of care (defined in time frames ranging from 7 days to one year post-discharge) has been shown to be related to better outcomes including decreased rates of substance use and relapse (DeMarce, Lash, Stephens, Grambow, & Burden, 2008; McKay & Hiller-Sturmhofel, 2011; Garner et al., 2010), fewer readmissions for inpatient treatment (Mark et al., 2013; Reif et al., 2017), lower risk of death (Harris et al., 2015; Paddock et al., 2017; Schmidt et al., 2017), less involvement in criminal justice (McKay, 2009), and improved employment outcomes (McKay, 2009).

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

There were no unexpected findings identified during testing and early use of this measure in the 3 states.

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

No unexpected benefits were observed during early implementation.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

Yes

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

3453 : Continuity of Care after Inpatient or Residential Treatment for Substance Use Disorder (SUD)

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

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

No

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

The measure is harmonized with the parallel measure that was developed for use at the health plan or Medicaid program level (NQF 3453). In both measures, the population is Medicaid beneficiaries age 18 – 64. The same diagnosis codes are used to identify substance use disorders. The same services and procedures are included to define follow-up treatment. While NQF# 3453 examines post-discharge follow-up at 7 and 14 days, we are proposing that #3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment be reported at 7 and 30 days. This is because review of the evidence and discussion with addiction professionals supported measuring follow up for an extended period of time. Also, NQF# 3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, NQF#3489 Follow-up after Emergency Department Visit for MH, and NQF# 0577 Followup after a hospitalization for a mental illness indicated that these measures are reported at 7 and 30 days. Finally, HEDIS has implemented NQF #3453 as measuring following-up at 7 and 30 days, not at 7 and 14 days (https://www.ncqa.org/wp-content/uploads/2019/02/20190208_06_FUI.pdf). This difference between using a 14 or 30 day follow-up does not impact interpretability or data collection burden.

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

Not applicable.

Appendix

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

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): RTI International

Co.2 Point of Contact: Tami, Mark, tmark@rti.org, 240-636-2410-

Co.3 Measure Developer if different from Measure Steward: RTI International

Co.4 Point of Contact: Tami, Mark, tmark@rti.org, 240-636-2410-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

An expert panel, supported by NQF, was assembled as a part of a day-long Quality Innovation Measuring Quality of Care in Substance Use Disorder (SUD) Treatment Programs Strategy Session.

The meeting objectives included discussion of considerations for measuring the quality of care for purposes of rating substance use disorder (SUD) treatment programs, gathering feedback on the proposed measure, provision of guidance for adapting the measure

for use at the facility-level, and aligning with related measures.
Expert panel members included the following:
Jennifer B. Atkins, MBA
Vice President, Network Solutions, Blue Cross Blue Shield Association
Ellen Bouchery, MS
Principal Program Analyst, Mathematica Policy Research
Teresita Camacho-Gonsalves, PhD, MA
Co-Director of Behavioral Health Team, Human Services Research Institute
Vitka Eisen, EdD, MSW
President & CEO, HealthRight 360
Joseph Lee, MD
Medical Director, Hazelden Betty Ford Foundation Youth Continuum
Miriam Komaromy, MD, FACP, DFASAM
Professor of Medicine, Director of Addiction and Community Health Worker Programs at the ECHO Institute, University of New Mexico Health Sciences Center
Tami Mark, Ph.D., MBA
Senior Director, Behavioral Health Financing and Quality Measurement, RTI International
Tiffany McCaslin, MPP
Senior Policy Analyst, Public Policy, National Business Group on Health
Thomas McLellan, PhD
Founder, Treatment Research Institute
Kirk Moberg, MD, PhD, FASAM, FACP, FAAPL, CPE
Executive Medical Director, UnityPoint Health Illinois Institute for Addiction Recovery
Douglas Nemecek, MD, MBA
Chief Medical Officer – Behavioral Health, and National Medical Officer – Coverage Policy and Trend Review, Cigna
Andre Ostrovsky, MD
Chief Executive Officer, Concerted Care Group
Justin Luke Riley, MBA
President & CEO, Young People in Recovery
Patricia Santora, PhD
Public Health Analyst, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Service Administration (SAMHSA)
Sarah Wattenberg, MSW
Director of Quality and Addiction Services, National Association of Behavioral Healthcare

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2020

Ad.3 Month and Year of most recent revision: 10, 2020

Ad.4 What is your frequency for review/update of this measure? Annual

Ad.5 When is the next scheduled review/update for this measure? 10, 2021

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