NATIONAL QUALITY FORUM

National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices

A CONSENSUS REPORT

Foreword

Excessive use of alcohol and drugs is a major problem in the United States. It is a substantial drain on the U.S. economy and a source of enormous personal tragedy. It also, by every measure, qualifies as a major public health problem.

Over the past 15 years, it has become clear that substance use conditions are in many ways like other chronic health conditions requiring long-term management. They are treatable by evidence-based therapies, and the knowledge of what constitutes appropriate treatment has grown markedly. Unfortunately, however, as is true of other areas of healthcare, the increase in scientific knowledge has not been accompanied by the consistent implementation of proven methods of treatment.

Because of the urgent need for quality measurement and reporting for substance use conditions, in December 2004, the National Quality Forum (NQF), with the support of the Robert Wood Johnson Foundation (RWJF), conducted a workshop to identify evidence-based treatment practices. This project builds on the 2004 workshop by assembling a set of more detailed, fully specified, evidence-based practices based on those recommended at the workshop, evaluating those practices, and pursuing consensus around them.

We thank RWJF for its commitment to raising issues regarding the treatment of substance use conditions and for its continued support of NQF as we build consensus around evidence-based practices for treatment. We also thank the Substance Use Conditions Steering Committee and its Technical Advisory Panel for their contributions and NQF Members for their participation in this project.

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President and Chief Executive Officer

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NATIONAL QUALITY FORUM

National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices

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National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices

Executive Summary

Substance use conditions have a substantial deleterious impact on health and society in the United States. It is estimated that 9.1 percent of the U.S. population age 12 or older meet the criteria for substance dependence or abuse with alcohol or illicit drugs. The personal consequences of these conditions frequently are devastating.

Over the past 15 years, scientific knowledge has increased substantially regarding the use of effective, evidence-based therapies for treating people with substance use conditions. Furthermore, substance use illness is gaining recognition as a chronic condition that must be managed through long-term, coordinated care management. However, as is true of other areas of healthcare, the increase in scientific knowledge has not been accompanied by the consistent implementation of proven methods of treatment. Many types of programs are used to treat substance use, and the background and training of the healthcare workers who provide these treatments vary greatly.

With the understanding that consensus on effective treatment practices can focus the development of measures of quality, the National Quality Forum (NQF), with support from the Robert Wood Johnson Foundation (RWJF), undertook this project as one step to address the need for performance measures for the treatment of substance use conditions. The project is intended to enhance the adoption of NQF-endorsed™ evidence-based practices for patients with substance use conditions by focusing on the practices for which the

evidence is strongest and most accepted—and that are most likely to have significant impact on improving care.

This project's roots lie in a December 2004 workshop conducted by NQF with the support of RWJF, which addressed effective treatment for patients with substance use disorders. This project builds on the results of that workshop by assembling a set of more detailed, fully specified, evidence-based practices based on the practices recommended at the workshop, evaluating those practices, and pursuing consensus around those identified practices.

This project was conducted according to the NQF Consensus Development Process, and the 11 endorsed practices and their specifications have legal status as national voluntary consensus standards for the treatment of substance use conditions.

For each endorsed practice, the target outcomes are identified, and additional specifications are provided for what a practice entails, for whom it is indicated, who performs it, and the settings where it is provided. Consistent with the priorities established, these practices are applicable across a broad range of populations (e.g., adolescents and adults), settings (e.g., primary care and substance use treatment settings), and providers (e.g., counselors and physicians).

National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices

Identification of Substance Use Conditions

Screening and Case Finding

1. During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use.
2. Healthcare providers should employ a systematic method to identify patients who use drugs that considers epidemiologic and community factors and the potential health consequences of drug use for their specific population.

Diagnosis and Assessment

3. Patients who have a positive screen for—or an indication of—a substance use problem or illness should receive further assessment to confirm that a problem exists and determine a diagnosis. Patients diagnosed with a substance use illness should receive a multidimensional, biopsychosocial assessment to guide patient-centered treatment planning for substance use illness and any coexisting conditions.

Initiation and Engagement in Treatment

Brief Intervention

4. All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive a brief motivational counseling intervention by a healthcare worker trained in this technique.

Promoting Engagement in Treatment for Substance Use Illness

5. Healthcare providers should systematically promote patient initiation of care and engagement in ongoing treatment for substance use illness. Patients with substance use illness should receive supportive services to facilitate their participation in ongoing treatment.

Withdrawal Management

6. Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences related to the withdrawal process. Withdrawal management alone does not constitute treatment for dependence and should be linked with ongoing treatment for substance use illness.

Therapeutic Interventions to Treat Substance Use Illness

Psychosocial Interventions

7. Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses.

Pharmacotherapy

8. Pharmacotherapy should be recommended and available to all adult patients diagnosed with opioid dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.
9. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.
10. Pharmacotherapy should be recommended and available to all adult patients diagnosed with nicotine dependence (including those with other substance use conditions) and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with brief motivational counseling.

Continuing Care Management of Substance Use Illness

11. Patients with substance use illness should be offered long-term, coordinated management of their care for substance use illness and any coexisting conditions, and this care management should be adapted based on ongoing monitoring of their progress.

Table 1 – Practice Specifications for Treating Substance Use Conditions

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Identification of Substance Use Conditions		
Screening[23] and Case Finding	1. During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses,[24] and any tobacco use. **Target Outcome:** The identification of asymptomatic patients with alcohol use in excess of NIAAA guidelines[25] for the relevant population and/or with any tobacco use who should receive further assessment.	**What It Entails:** ■ Asking about any tobacco use. ■ Use of a validated screening instrument or interview method for alcohol use, including quantity, frequency, and pattern (preferably validated in the relevant population). ■ Following a positive screen with further assessment to identify problem use and determine who should receive a brief intervention and/or referral. ■ Biologic assays are not recommended for the routine screening of asymptomatic patients. **For Whom It Is Indicated:** All patients 10 years of age and older on new patient encounters and at least annually. **Who Should Perform It:** Any type of healthcare worker[26] with the appropriate training. **Where It Should Be Implemented:** ■ General and mental healthcare settings (for example, primary, inpatient, urgent, and emergency care; criminal justice healthcare, occupational healthcare, and school-based healthcare settings). ■ Substance use illness treatment settings should screen for tobacco use.

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[22] The additional specifications are not intended to imply a direct cause of the desired outcome, but rather are those elements that are considered to enhance the likelihood of achieving the target outcome for the practice. Some examples are provided for illustration; the examples are not all-inclusive.

[23] *Screening* is the use of a standardized examination procedure or test with asymptomatic patients to identify the probable presence of a condition requiring further assessment.

[24] In the 2006 IOM report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions,* the term *substance use condition* includes substance use problems and substance use illnesses as described above. For this project, *substance use problem* also is considered to include the potential to cause problems, that is, at-risk or hazardous use.

[25] NIAAA Maximum Drinking Limits: Healthy men up to age 65 - No more than 4 drinks in a day AND no more than 14 drinks in a week. Healthy women (and healthy men over age 65) - No more than 3 drinks in a day AND no more than 7 drinks in a week. Recommend lower limits or abstinence as medically indicated; for example, for patients who take medications that interact with alcohol, have a health condition exacerbated by alcohol, or are pregnant (advise abstinence). NIAAA, *Helping Patients Who Drink Too Much: A Clinician's Guide, 2005 Edition,* Rockville, MD: NIAAA; 2005. Available at pubs.niaaa.nih.gov/ publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm. Last accessed January 2007.

[26] The term *healthcare workers* is used to represent all personnel regardless of discipline or education. Because of varying state requirements, specific discipline or educational requirements are not specified.

Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Identification of Substance Use Conditions (continued)		
Screening[23] and Case Finding	2. Healthcare providers should employ a systematic method to identify patients who use drugs that considers epidemiologic and community factors and the potential health consequences of drug use for their specific population. **Target Outcome:** Identification of patients who show signs of substance use illness or other health consequences of drug use and should receive further assessment or treatment.	**What It Entails:** ■ Evaluation of epidemiologic factors and risks for health consequences related to drug use in the patient population and community served. ■ Employing a systematic method to identify drug use that is appropriate for the patient population and community served. Some examples of systematic methods to identify drug use include: • asking about recent drug use (quantity, frequency, and pattern) or about clinical/behavioral signs of drug use (for example, marked change in physical health, deteriorating performance in school or job, dramatic change in personality, needle track marks) as part of the health interview/history and exam, or • use of a validated screening instrument or interview method for drug use. ■ Consistent application of the systematic method developed for the patient population served. ■ A positive indication for drug use should be followed by further assessment to identify a substance use problem or illness and determine the need for treatment. **For Whom It Is Indicated:** ■ Some examples of populations with higher prevalence than in the general health-care patient population include patients with mental health conditions; patients in criminal justice healthcare settings; trauma patients; adolescents; patients with a positive screen for alcohol use in excess of NIAAA guidelines or any tobacco use; patients who are members of a community with high methamphetamine use. ■ Some examples of populations with special risks of health consequences include obstetrics patients with risk to the fetus and patients whose prescribed medication use is complicated by other drug use. **Who Should Perform It:** Any type of healthcare worker with the appropriate training. **Where It Should Be Implemented:** General and mental healthcare settings (for example, primary, inpatient, urgent, and emergency care; criminal justice healthcare, occupational healthcare, and school-based healthcare settings).

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Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Identification of Substance Use Conditions (continued)		
Diagnosis and Assessment	3. Patients who have a positive screen for—or an indication of—a substance use problem or illness should receive further assessment to confirm that a problem exists and determine a diagnosis. Patients diagnosed with a substance use illness should receive a multi-dimensional, biopsychosocial assessment to guide patient-centered treatment planning for substance use illness and any coexisting conditions.[27] **Target Outcome:** ■ Identification of patients who should receive a brief intervention. ■ Establishment of a diagnosis. ■ Initiation of, or referral for, treatment. ■ Identification of initial individualized treatment needs (including coexisting conditions).	**What It Entails:** ■ Confirming responses on a positive screening test for substance use problem or illness. ■ Assessment of all substance use. ■ Expert clinical exam or use of a validated assessment instrument or interview method (preferably validated in the relevant population). ■ Assessment of symptoms that define a disorder within a diagnostic taxonomy. ■ For diagnosed substance use illness, a multidimensional, biopsychosocial history and physical exam (one that includes, for example, substance use; general medical and psychological evaluation; presence of coexisting general medical and mental health conditions; psychosocial functioning; social factors, such as living environment, employment, and support system; and patient motivation, preferences, and cultural values related to treatment for substance use illness). **For Whom It Is Indicated:** ■ All patients who have a positive screen for alcohol use in excess of NIAAA guidelines or nicotine use. ■ Patients who are identified or who present with clinical indications or "red flags" for probable substance use problem or illness (for example, marked change in physical health, deteriorating performance in school or job, dramatic change in personality, involvement in crimes or trauma incidents, needle track marks). **Who Should Perform It:** Healthcare workers authorized to initiate and guide the treatment[28] of patients with substance use illness. **Where It Should Be Implemented:** ■ General and mental healthcare settings (for example, primary, inpatient, urgent, and emergency care; criminal justice healthcare, occupational healthcare, and school-based healthcare settings). ■ Substance use illness treatment settings.

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[27] The term *coexisting condition* refers to the concurrent existence of medical or mental health conditions along with the substance use condition.

[28] Because state regulations and licensure requirements vary, the language "healthcare workers authorized to initiate and guide treatment" was used in place of terms such as *licensed* or *professional*.

Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Initiation and Engagement in Treatment		
Brief Intervention	4. All patients identified with alcohol use in excess of NIAAA guidelines[25] and/or any tobacco use should receive a brief motivational counseling intervention by a healthcare worker trained in this technique.[29] **Target Outcome:** ■ Cessation or reduction of alcohol and/or tobacco use. ■ Acceptance of treatment when indicated.	**What It Entails:** ■ 5- to 15-minute advice/motivational counseling session. ■ Provided in one to multiple contacts. ■ Includes feedback on substance use effects on health (and for alcohol, feedback on use relative to national norms), advice to change, and goal setting. ■ Multicontact interventions are more effective and also include further assistance (for example, recommendations for treatment when indicated) and follow-up monitoring and support. **For Whom It Is Indicated:** Patients assessed with alcohol use in excess of NIAAA guidelines and/or any tobacco use. **Who Should Perform It:** Any type of healthcare worker trained in brief motivational counseling intervention. **Where It Should Be Performed:** ■ General and mental healthcare settings (for example, primary, inpatient, urgent, and emergency care; criminal justice healthcare, occupational healthcare, and school-based healthcare settings). ■ Substance use illness treatment settings should address tobacco use.

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[29] The rationale for not including brief interventions for other substance use is provided in the commentary (appendix C). The identification of other substance use should initiate diagnosis and assessment (Practice 3).

Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Initiation and Engagement in Treatment (continued)		
Promoting Engagement in Treatment for Substance Use Illness	5. Healthcare providers should systematically promote patient initiation of care and engagement in ongoing treatment for substance use illness. Patients with substance use illness should receive supportive services[30] to facilitate their participation in ongoing treatment. **Target Outcome:** ■ Initiation of treatment after first contact/inquiry. ■ Continuation of treatment beyond the admission/ intake assessment and upon transfer from one level of care to another. ■ Attendance at treatment sessions for sufficient length of time (for example, 90 days or longer).[31]	**What It Entails:** *Organizational level:* ■ Identification of organizational system barriers to the initiation of treatment after first contact/inquiry and continuation of treatment beyond the admission/intake assessment and after transfer from one level of care to another. ■ Implementation of clinical processes or organizational systems that promote flexibility, immediacy/timeliness, continuity, openness, and efficiency. *Patient level:* ■ Multidimensional assessment that identifies potential barriers to participating in treatment (for example, living environment, employment, support system, readiness for treatment, coexisting general medical and mental health conditions). ■ Provision of, or referral to, supportive services (for example, housing, legal, employment, child care, medical, or mental health services). ■ Plan developed with patient input and responsive to the patient's culture, language, and health literacy. ■ Empathic, supportive approach. ■ Active promotion of involvement with community support (some examples include family, 12-step, or other mutual help groups, spiritual support). **For Whom It Is Indicated:** All patients with substance use illness. **Who Should Perform It:** ■ Healthcare workers authorized to initiate and guide the treatment of patients with substance use illness. ■ Any healthcare worker with appropriate, ongoing methods of supervision to maintain fidelity to the implemented processes. **Where It Should Be Performed:** ■ Substance use illness treatment specialty settings (including inpatient and outpatient settings). ■ General and mental healthcare settings where patients are treated for substance use illness.

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[30] Supportive services are social, medical, or mental health services that address patient problems other than the substance use conditions.

[31] "Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery." NIDA, *Principles of Drug Addiction Treatment: A Research-Based Guide;* 1999. NIH Publication No. 99-4180. Available at www.nida.nih.gov/PODAT/PODATIndex.html. Last accessed August 2006; McKay JR, Is there a case for extended interventions for alcohol and drug disorders? *Addiction,* 2005;100:1594-1610.

Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Initiation and Engagement in Treatment (continued)		
Withdrawal Management	6. Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences related to the withdrawal process. Withdrawal management alone does not constitute treatment for dependence and should be linked with ongoing treatment for substance use illness. **Target Outcome:** ■ Control of withdrawal symptoms. ■ Prevention of serious adverse consequences of withdrawal. ■ Engagement in ongoing rehabilitation treatment.	**What It Entails:** *General Principles:* ■ Generalized support and reassurance. ■ Systematic assessment and reassessment of acute withdrawal symptoms and risk of severe symptoms to determine need for medication (for example, use of a validated instrument). ■ Medications and/or tapering protocols proven to be effective for managing substance use withdrawal. ■ Provided in adequate doses to control symptoms. ■ Monitoring of response/side effects. ■ Timely adjustment of doses when indicated. ■ Ongoing support and monitoring of medical status including coexisting conditions and medications. ■ Provision of, or referral to, ongoing treatment for dependence. *Opioid Withdrawal:* Examples of medications proven to be effective for managing opioid withdrawal—methadone or buprenorphine tapering. *Alcohol Withdrawal:* Examples of medications proven to be effective for managing alcohol withdrawal—benzodiazepines. **For Whom It Should Be Performed:** Substance-dependent patients (for example, opioids, alcohol, sedative-hypnotics) ■ for whom withdrawal is the goal, or ■ who are in the acute phase of withdrawal regardless of intent to withdraw (for example, when incarcerated or hospitalized). *Opioid Withdrawal:* Patients who have an indication for and do not have access to ongoing agonist pharmacotherapy treatment for opioid dependence. **Who Should Perform It:** ■ Healthcare workers licensed to prescribe medication. ■ Healthcare workers authorized to initiate and guide the treatment of substance-dependent patients should provide or refer for withdrawal management. ■ Licensed healthcare personnel who provide medical monitoring and support. **Where It Should Be Performed:** ■ Substance use illness treatment specialty settings, general and mental healthcare settings (for example, inpatient, urgent, and emergency care, criminal justice healthcare settings). ■ In inpatient or outpatient settings with adequate ongoing medical monitoring capabilities. ■ If dispensing medications, must meet regulatory requirements at the state and federal levels.

(more)

Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Therapeutic Interventions to Treat Substance Use Illness		
Psychosocial Interventions	7. Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses. **Target Outcome:** ■ Cessation or reduction of substance use. ■ Improved psychological and social functioning. ■ Prevention of relapse or delayed time to relapse. ■ Retention in treatment.	**What It Entails:** ■ Psychosocial therapeutic interventions empirically validated as effective for treating substance use illnesses. (Some examples from numerous and varied approaches include cognitive behavioral therapies, motivational enhancement therapy, contingency management, 12-step facilitation therapy, and marital and family therapies.) ■ Used as stand-alone treatment or in combination therapies. ■ Delivery with an empathic, supportive approach may be as important as the specific psychosocial technique. ■ Active promotion of involvement with community support (some examples include family, 12-step or other mutual help groups, spiritual support). **For Whom It Should Be Performed:** All patients with substance use illnesses. **Who Should Perform It:** All healthcare workers who have been trained in the specific psychosocial intervention and who have appropriate, ongoing methods of supervision to maintain fidelity to the psychosocial intervention. **Where It Should Be Performed:** ■ Substance use illness treatment specialty settings (including inpatient and outpatient settings). ■ General and mental healthcare settings where patients are treated for substance use illness.

(more)

Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Therapeutic Interventions to Treat Substance Use Illness (continued)		
Pharmacotherapy	8. Pharmacotherapy should be recommended and available to all adult patients diagnosed with opioid dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. **Target Outcome:** ■ Cessation of non-medical use of opioids. ■ Retention in treatment.	**What It Entails:** ■ Medications that have been proven to be effective for ongoing treatment of opioid dependence (for example, methadone, buprenorphine). ■ Provided in adequate doses to control craving. ■ Controlled dispensing of doses. ■ Regular biologic monitoring of illicit drug use. ■ Monitoring response/side effects. ■ Adjustment of doses when indicated. ■ Monitoring of medical status, including coexisting conditions and medications. ■ Provision of empirically validated psychosocial treatment or psychosocial support (including medical management).[32] **For Whom It Should Be Performed:** ■ All adult (and adolescents 16 and older) patients diagnosed with opioid dependence who meet clinical and regulatory indications; may consider for adolescents as clinically indicated. ■ Special consideration should be given before using pharmacotherapy with selected populations: those with medical contraindications, pregnant/breastfeeding women, adolescents, and the elderly. **Who Should Perform It:** ■ Healthcare workers licensed and qualified to prescribe medication to treat opioid dependence. ■ Healthcare workers authorized to initiate and guide the treatment of opioid dependent patients should recommend pharmacotherapy. ■ Providers who do not prescribe pharmacotherapy should have formal arrangements to refer patients for pharmacotherapy treatment. **Where It Should Be Performed:** ■ Substance use illness treatment specialty settings. ■ General and mental healthcare settings where patients are treated for substance use illness. ■ If dispensing medications, must meet regulatory requirements at the state and federal levels.

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[32] Medical management is a primary care approach delivered by a medical professional that includes strategies to increase medication adherence and support abstinence.

Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Therapeutic Interventions to Treat Substance Use Illness (continued)		
Pharmacotherapy	9. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. **Target Outcome:** ■ Reduction of alcohol consumption with the goal of cessation. ■ Retention in treatment.	**What It Entails:** ■ Medications proven to be effective for treating alcohol dependence (for example, naltrexone, acamprosate). ■ Provided in adequate doses to control craving. ■ Regular monitoring for alcohol use. ■ Monitoring response/side effects. ■ Timely adjustment of doses when indicated. ■ Monitoring of medical status including coexisting conditions and medications. ■ Provision of empirically validated psychosocial treatment or psychosocial support (including medical management).[32] **For Whom It Should Be Performed:** ■ All nonpregnant adults (18 and older), current alcohol dependent patients. ■ Special consideration should be given before using pharmacotherapy with selected populations: those with medical contraindications, pregnant/ breastfeeding women, adolescents, and the elderly. **Who Should Perform It:** ■ Healthcare workers licensed to prescribe medication. ■ Healthcare workers authorized to initiate and guide the treatment of alcohol dependent patients should offer pharmacotherapy. ■ Providers who do not prescribe pharmacotherapy should have formal arrangements to refer patients for pharmacotherapy treatment. **Where It Should Be Performed:** ■ Substance use illness treatment specialty settings. ■ General and mental healthcare settings where patients are treated for substance use illness. ■ If dispensing medications, must meet regulatory requirements at the state and federal levels.

(more)

Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Therapeutic Interventions to Treat Substance Use Illness (continued)		
Pharmacotherapy	10. Pharmacotherapy should be recommended and available to all adult patients diagnosed with nicotine dependence (including those with other substance use conditions) and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with brief motivational counseling. **Target Outcome:** ■ Cessation of tobacco use.	**What It Entails:** ■ Medications proven to be effective for tobacco cessation (examples include nicotine replacement therapy, bupropion, varenicline). ■ Provided in adequate doses to control craving. ■ Regular monitoring for tobacco use. ■ Monitoring of response/side effects. ■ Timely adjustment of doses when indicated. ■ Monitoring of medical status including coexisting conditions and medications. ■ Combined with brief motivational counseling or more intensive psychosocial interventions when indicated. **For Whom It Should Be Performed:** ■ All patients with nicotine dependence, including those with coexisting substance use conditions, who have a goal of abstinence from tobacco use. ■ Special consideration should be given before using pharmacotherapy with selected populations: those smoking fewer than 10 cigarettes/day, those with medical contraindications, pregnant/ breastfeeding women, adolescents. **Who Should Perform It:** ■ Healthcare workers licensed to prescribe medication (if prescription required). ■ Healthcare workers authorized to initiate and guide the treatment of substance-dependent patients should provide or refer for pharmacotherapy for tobacco cessation. ■ Healthcare workers authorized to initiate and guide general and mental healthcare treatment. **Where It Should Be Performed:** ■ Substance use illness treatment specialty settings, general and mental healthcare settings (for example, primary, inpatient, urgent, and emergency care; criminal justice healthcare, occupational healthcare, and school-based healthcare settings). ■ If dispensing medications, must meet regulatory requirements at the state and federal levels.

(more)

Table 1 – Practice Specifications for Treating Substance Use Conditions (continued)

PRACTICE DOMAIN/ SUBDOMAIN	PRACTICE STATEMENT/ TARGET OUTCOME	ADDITIONAL SPECIFICATIONS[22]
Continuing Care Management of Substance Use Illness		
Continuing Care Management of Substance Use Illness	11. Patients with substance use illness should be offered long-term, coordinated management of their care for substance use illness and any coexisting conditions, and this care management should be adapted based on ongoing monitoring of their progress. **Target Outcome:** ■ Receives care for all conditions (substance use, medical, and mental health). ■ Stabilization of coexisting conditions. ■ Retention in treatment. ■ Engagement in long-term monitoring. ■ Prevention of relapse or delayed time to relapse.	**What It Entails:** ■ Based on findings of a multidimensional assessment and patient preference. ■ Linking to other needed services (for example, medical, mental health, supportive services); available through referral arrangements ranging from ad hoc to formal, or integration of services. ■ With patient consent, sharing of diagnostic and treatment information with any other service providers. ■ Monitoring the response to substance use illness treatment by modifying the treatment plan as indicated with patient input. ■ Continuing care with an emphasis on providing support and skills for self-management of substance use illness as a chronic condition (for example, 12-step, other mutual help programs). ■ Long-term monitoring to identify early signs of relapse. **For Whom It Should Be Performed:** Patients with substance use illness, especially those with coexisting general medical and mental health conditions. **Who Should Perform It:** Healthcare workers authorized to initiate and/or guide general medical, mental health, or substance use treatment are responsible for care management. **Where It Should Be Performed:** Wherever the patient is in the care system: ■ Substance use illness treatment specialty settings when patients are receiving specialty treatment. ■ General and mental healthcare settings if patients are not receiving specialty treatment. ■ Care management may shift from the specialty setting to general and mental healthcare settings as patients move into stabilized recovery.

National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices

Identification of Substance Use Conditions

Screening and Case Finding

1. During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use.
2. Healthcare providers should employ a systematic method to identify patients who use drugs that considers epidemiologic and community factors and the potential health consequences of drug use for their specific population.

Diagnosis and Assessment

3. Patients who have a positive screen for—or an indication of—a substance use problem or illness should receive further assessment to confirm that a problem exists and determine a diagnosis. Patients diagnosed with a substance use illness should receive a multidimensional, biopsychosocial assessment to guide patient-centered treatment planning for substance use illness and any coexisting conditions.

Initiation and Engagement in Treatment

Brief Intervention

4. All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive a brief motivational counseling intervention by a healthcare worker trained in this technique.

Promoting Engagement in Treatment for Substance Use Illness

5. Healthcare providers should systematically promote patient initiation of care and engagement in ongoing treatment for substance use illness. Patients with substance use illness should receive supportive services to facilitate their participation in ongoing treatment.

Withdrawal Management

6. Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences related to the withdrawal process. Withdrawal management alone does not constitute treatment for dependence and should be linked with ongoing treatment for substance use illness.

Therapeutic Interventions to Treat Substance Use Illness

Psychosocial Interventions

7. Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses.

Pharmacotherapy

8. Pharmacotherapy should be recommended and available to all adult patients diagnosed with opioid dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.
9. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.
10. Pharmacotherapy should be recommended and available to all adult patients diagnosed with nicotine dependence (including those with other substance use conditions) and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with brief motivational counseling.

Continuing Care Management of Substance Use Illness

11. Patients with substance use illness should be offered long-term, coordinated management of their care for substance use illness and any coexisting conditions, and this care management should be adapted based on ongoing monitoring of their progress.

Appendix A
Members and Board of Directors

Members*

CONSUMER COUNCIL

AARP
AFL-CIO
American Federation of Teachers Healthcare
American Hospice Foundation
Childbirth Connection
Consumer Coalition for Quality Health Care
Consumers Advancing Patient Safety
Consumers' Checkbook
Coordinating Center
Health Care for All
International Association of Machinists
March of Dimes
National Breast Cancer Coalition
National Citizen's Coalition for Nursing Home Reform
National Coalition for Cancer Survivorship
National Consumers League
National Partnership for Women & Families
Service Employees Industrial Union

HEALTH PROFESSIONAL, PROVIDER, AND HEALTH PLAN COUNCIL

Academy of Managed Care Pharmacy
Administrators for the Professions
Adventist HealthCare
Advocate Health Partners
Aetna
Alegent Health
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association of Ambulatory Surgery Centers
American Association of Nurse Anesthetists
American Clinical Laboratory Association
American College of Cardiology
American College of Chest Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Geriatrics Society
American Heart Association
American Hospital Association
American Medical Association
American Medical Group Association
American Nurses Association
American Optometric Association
American Organization of Nurse Executives
American Osteopathic Association
American Society for Gastrointestinal Endoscopy
American Society for Therapeutic Radiology and Oncology
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society of Health-System Pharmacists

*When voting under the NQF Consensus Development Process occurred for this report.

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American Society of Interventional Pain Physicians
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[2] Appointed to the Board of Directors and named Chair-Elect in May 2005; became Chair in January 2006
[3] Since March 2006
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[5] NQF President and CEO since February 2006
[6] Since March 2006
[7] Since February 2006
[8] Since August 2006
[9] Since February 2006
[10] Through October 2006
[11] Since March 2006
[12] Through October 2006
[13] Since January 2005
[14] October 2005 to August 2006
[15] Since January 2005
[16] Since October 2005
[17] Through December 2005
[18] Since August 2005
[19] October 2005 to June 2006
[20] Since April 2006

Appendix B
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Liza Greenberg, RN, MPH
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Kristyne E. McGuinn
Research Analyst

[1] Since February 2006
[2] Through December 2006
[3] Since January 2007

Appendix E
Consensus Development Process: Summary

The National Quality Forum (NQF), a voluntary consensus standards-setting organization, brings together diverse healthcare stakeholders to endorse performance measures and other standards to improve healthcare quality. Because of its broad stakeholder representation and formal Consensus Development Process (CDP), NQF-endorsed™ products have special legal standing as voluntary consensus standards. The primary participants in the NQF CDP are NQF member organizations, which include:

- consumer and patient groups;
- healthcare purchasers;
- healthcare providers, professionals, and health plans; and
- research and quality improvement organizations.

Any organization interested in healthcare quality measurement and improvement may apply to be a member of NQF. Membership information is available on the NQF web site, www.qualityforum.org.

Members of the public with particular expertise in a given topic also may be invited to participate in the early identification of draft consensus standards, either as technical advisors or as Steering Committee members. In addition, the NQF process explicitly recognizes a role for the general public to comment on proposed consensus standards and to appeal healthcare quality consensus standards endorsed by NQF. Information on NQF projects, including information on NQF meetings open to the public, is posted at www.qualityforum.org.

Each project NQF undertakes is guided by a Steering Committee (or Review Committee) composed of individuals from each of the four critical stakeholder perspectives. With the assistance of NQF staff and

technical advisory panels and with the ongoing input of NQF Members, a Steering Committee conducts an overall assessment of the state of the field in the particular topic area and recommends a set of draft measures, indicators, or practices for review, along with the rationale for proposing them. The proposed consensus standards are distributed for review and comment by NQF Members and non-members.

Following the comment period, a revised product is distributed to NQF Members for voting. The vote need not be unanimous, either within or across all Member Councils, for consensus to be achieved. If a majority of Members within each Council do not vote approval, staff attempts to reconcile differences among Members to maximize agreement, and a second round of voting is conducted. Proposed consensus standards that have undergone this process and that have been approved by all four Member Councils on the first ballot or by at least two Member Councils after the second round of voting are forwarded to the Board of Directors for consideration. All products must be endorsed by a vote of the NQF Board of Directors.

Affected parties may appeal voluntary consensus standards endorsed by the NQF Board of Directors. Once a set of voluntary consensus standards has been approved, the federal government may utilize it for standardization purposes in accordance with the provisions of the National Technology Transfer and Advancement Act of 1995 (P.L. 104-113) and the Office of Management and Budget Circular A-119. Consensus standards are updated as warranted.

For this report, the NQF CDP, version 1.7, was in effect. The complete process can be found at www.qualityforum.org.

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