Clinical Benchmarking Program
Screening & Prevention Module

One of the key elements of college health has been our focus on preventative care and patient safety. In truth, there are many interventions, from vaccinations to healthy eating that are stressed in college health. The ACHA Benchmarking Committee received many suggestions that guided its decision on interventions that could be measured across college campuses. In its decision process, the Benchmarking Committee chose interventions that:

1. were evidenced-based
2. were low cost
3. were able to be implemented by health centers with varying types of practitioners
4. had the potential to make an impact on the health of college students
5. and were based on existing recommendations/guidelines of national entities (i.e., USPSTF: The US Preventive Services Task Force, ACIP: CDC's Advisory Committee on Immunization Practices and the AAAHC: Accreditation Association for Ambulatory Health Care.)

The six interventions chosen include:

1. documentation of allergies
2. documentation of current influenza vaccination
3. screening for tobacco/nicotine use
4. screening for unhealthy alcohol use
5. screening for unhealthy drug use
6. and screening for depression.

What follows is Background Information, Process/Instructions, and Scoring Criteria for each of the six interventions.

Background

Allergy Documentation

The listing of allergy documentation has the potential to proactively avoid drugs, contact irritants, foods and other agents where adverse outcomes could be anticipated due to prior experiences. Clinical decisions are often made based on this information, so the documentation should be meaningful, accurate, timely, and comprehensive.[1] This measure is listed as a standard (CDR 200) for accreditation by the Association for Accreditation of Ambulatory Health Care (AAAHC). While timing of this recommendation is still undefined, it is encouraged that the allergy list be reviewed and updated at every visit.

Among the 87 institutions that last participated in the ACHA Clinical Benchmarking Program in 2018, the mean compliance rate for allergy documentation among the 25 random charts they reviewed was 99%, and the median was 100%. Eighty three percent of participating institutions (n=72) were in 100% compliance, leaving only 15 schools (17%) with less than 100% compliance. Only 3 schools had less than 90% compliance for allergy documentation.

Influenza Vaccination

Since 2010, the CDC's Advisory Committee on Immunization Practices (ACIP) has recommended, that all persons aged 6 months and older who do not have contraindications, receive an influenza vaccine.[2] ACIPs specific recommendations for the 2024-2025 flu season were released in August 2024.[3]

In the Spring 2013 National College Health Assessment (NCHA), only 43.1% of college students reported receiving an influenza vaccination within the last 12 months.[4] Ten years later, the same number reported in the Spring 2023 NCHA had grown to 57.3% of students.[5] An improvement in influenza vaccination rates may have an impact on college academic performance.

Among the 87 institutions that last participated in the ACHA Clinical Benchmarking Program in 2018, the mean compliance rate for influenza vaccine among the 25 random charts they reviewed was 40%, and the median was 36%. The range of compliance scores for influenza vaccine was 0% - 100% compliance. Nine schools (10.3) reported no charts in compliance for influenza vaccine and an additional 47 schools (54%) reported compliance rates of less than 50%.

Screening for Tobacco/Nicotine Use

Tobacco use is the leading preventable cause of disease, death, and disability in the United States.[6, 7] Together, tobacco/nicotine use and second hand smoke exposure cause more than 480,000 deaths in the US each year.[6]

As measured on the NCHA, rates of cigarette use among college students has been declining steadily over the last 13 years. In Fall 2011, 15% of students reported smoking cigarettes in the *last 30 days*.[8] By Spring 2024, only 8.4% of students reported smoking cigarettes in the *last 3 months*.[9] While the rates in cigarette use have been declining, rates of electronic nicotine delivery system (ENDS) use (e.g. vaping, e-cigarettes) have been increasing. By 2018, rates of ENDS use among college students had surpassed use of cigarettes for the first time.[10] In Spring 2024, 14.2% of students indicated they had used e-cigarette or other vape products in the last 3 months.[9]

In addition, Substance Use Involvement Scores (SSIS) computed from ASSIST items embedded in the NCHA in Spring 2024 revealed that 13.7% of students were moderate-risk tobacco/nicotine users, and another 1% were high-risk users. Moderate- and high-risk users are at increased risk of health and other problems and ideal candidates for brief interventions in the primary care setting.[9]

Tobacco dependence is a chronic, relapsing disorder. Like other chronic diseases, tobacco dependence often requires repeated intervention and long-term support.[11] The majority of people who use tobacco want to quit, but most try to quit multiple times before succeeding.[12] Health care providers in a variety of settings play a critical role in helping people quit using tobacco. Even brief advice from a provider can make patients much more likely to try to quit—and ultimately succeed.[11]

The USPSTF recommends that clinicians ask all adults 18 years and older about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy

for cessation to nonpregnant adults who use tobacco. **("A" recommendation)** The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco. **("A" recommendation)** While the USPSTF does not recommend a frequency at which the screening should be conducted, they do suggest that some clinicians treat it as a vital sign and screen at every visit.[13] Like the USPSTF, CDC encourages health care providers to screen patients for smoking and tobacco use has compiled numerous resources to assist health care providers in doing so. When screening, clinicians should consider the various modalities used for ingesting tobacco/nicotine, as described below.

Key Definitions Related to Tobacco/Nicotine Use

Tobacco use refers to use of any tobacco product. As defined by the US Food and Drug Administration, tobacco products include any product made or derived from tobacco intended for human consumption (except products that meet the definition of drugs), including, but not limited to, cigarettes, cigars (including cigarillos and little cigars), dissolvables, hookah tobacco, nicotine gels, pipe tobacco, roll-your-own tobacco, smokeless tobacco products (including dip, snuff, snus, and chewing tobacco), vapes, electronic cigarettes (e-cigarettes), hookah pens, and other electronic nicotine delivery systems.[14]

Smoking generally refers to the inhaling and exhaling of smoke produced by combustible tobacco products such as cigarettes, cigars, and pipes.[13]

Vaping refers to the inhaling and exhaling of aerosols produced by e-cigarettes. Vaping products (ie, e-cigarettes) usually contain nicotine, which is the addictive ingredient in tobacco.[15] Substances other than tobacco can also be used to smoke or vape. While the 2015 USPSTF recommendation statement used the term "electronic nicotine delivery systems" or "ENDS," the USPSTF recognizes that the field has shifted to using the term "e-cigarettes" (or "e-cigs") and uses the term e-cigarettes in the current recommendation statement. e-Cigarettes can come in many shapes and sizes, but generally they heat a liquid that contains nicotine (the addictive drug in tobacco) to produce an aerosol (or "vapor") that is inhaled ("vaped") by users.[13.15]

Among the 87 institutions that last participated in the ACHA Clinical Benchmarking Program in 2018, the mean compliance rate for tobacco/nicotine screening among the 25 random charts they reviewed was 86%, and the median was 92%. The range of compliance rates for tobacco/nicotine screening was 0% - 100%. Ten of the 87 schools (11.5%) reported compliance rates of less than 80%.

Screening for Unhealthy Drug Use

Unhealthy drug use is defined by the USPSTF as "the use of substances (not including alcohol or tobacco products) that are illegally obtained or the nonmedical use of prescription psychoactive medication". Nonmedical use of a prescription psychoactive medication refers to the use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual. There is little evidence about optimal interval for screening in adults older than 18 years. In 2018, it was estimated that in young adults ages 18-25, 24% report unhealthy drug use, significantly higher than older adults at 10% and adolescents at 8%. Unhealthy drug use is a significant factor in preventable death, injuries, and disabilities.[16]

Substance Use Involvement Scores (SSIS) computed from ASSIST items embedded in the Spring 2024 NCHA indicated that 16.7% of all students surveyed were moderate-risk cannabis users, and another

1.2% were high-risk users. When isolating only those students who reported cannabis use in the past 3 months, 43.0% reported behaviors consistent with moderate-risk, and another 3.1% reported behaviors consistent with high-risk use. Among students who reported both using cannabis in the last 30 days and driving a car in the last 30 days, 29.7% indicated that they drove within 6 hours of using cannabis.[9]

Cannabis is by far the most common, but not the only, misused substance among college students. SSIS scores from the Spring 2024 NCHA indicated that 4% of students reported moderate- or high-risk use of one or more of the following substances: cocaine, prescription stimulants, methamphetamine, inhalant, sedative, hallucinogen, heroin, or opioids. One third of these students were also moderate- or high-risk users of cannabis.[9]

The USPSTF recommends screening by asking questions about unhealthy drug use in adults 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. Screening tools are not meant to diagnose drug dependence, only alert providers to possible further assessment. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.) The USPSTF did not find adequate evidence to recommend an optimal screening interval for unhealthy alcohol use in adults. **("B" recommendation)**.[16]

Screening for Unhealthy Alcohol Use

One in 8 deaths among adults aged 20-64 between 2015 and 2019 can be linked to excessive alcohol use.[17] In college students aged 18-24 years, unhealthy alcohol use contributed to an estimated death of 1825 student through unintentional injuries.[18] Data from the Spring 2024 NCHA revealed that 3% of students indicated that their alcohol use caused them to receive a lower grade in a class or delay progress toward their degree.[9]

In addition, Substance Use Involvement Scores (SSIS) computed from ASSIST items embedded in the NCHA revealed that in Spring 2024, 9.4% of students were moderate-risk alcohol users, and another 1% were high-risk users. Moderate- and high-risk users are at increased risk of health and other problems and ideal candidates for brief interventions in the primary care setting.[9]

Screening, Brief Intervention, and Referral to Treatment (SBIRT or SBI) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment for persons with alcohol use disorder, or those at risk of developing the disorder.[19] The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risk or hazardous drinking with brief behavioral counseling interventions to reduce use. **("B" recommendation)** The USPSTF did not find adequate evidence to recommend an optimal screening interval for unhealthy alcohol use in adults.[20] (Note that this recommendation was published in 2018 and an update is in progress.)

Screening for Depression

Research shows that depression is a leading impediment to learning and therefore a barrier to student success, wellness, and retention.[21,22,23] Mental health resources are an important part of a comprehensive strategy to address this problem, but these services alone are not enough. Many students struggling with depression never visit a mental health professional and are much more likely

to access primary care because of related physical symptoms like fatigue, insomnia, and non-specific pain. A past study suggests that over 50% of students with symptoms of major depression have not received treatment in past year.[24]

The USPSTF recommends screening for major depression disorder (MDD) in those 18 years and older, including pregnant and postpartum persons and older adults. **(B recommendation)**. If the screen is positive, they should be evaluated for a diagnosis and, if appropriate, provided or referred for care.[25,26] (Young adults 18 years old are addressed in the recommendation for children and adolescents,[25] and those 19 and older are addressed in the recommendation for adults.[26] Both are B recommendations.)

There is little evidence regarding the optimal timing for screening for depression; more evidence is needed in both perinatal and general adult populations. In the absence of evidence, a pragmatic approach might include screening adults who have not been screened previously and using clinical judgment while considering risk factors, comorbid conditions, and life events to determine if additional screening of patients at increased risk is warranted. Ongoing assessment of risks that may develop during pregnancy and the postpartum period is also a reasonable approach.

Of the 87 institutions that last participated in the ACHA Clinical Benchmarking Program in 2018, the mean compliance rate for depression screening among the 25 random charts they reviewed was 44%, and the median was 28%. Thirty-one schools (35.6%) reported that none of 25 reviewed charts had documented screening for depression. Another 17 schools (19.5%) were in compliance in less than half of the 25 reviewed charts.

Process/Instructions

Each health center should review 25 randomly selected charts that meet the following criteria:

- include at least one primary care visit between Sept 1, 2024 and February 28, 2025, AND
- patient is 18 years of age or older, AND
- without an existing diagnosis of depression.

For each chart, the reviewer should determine whether allergies, influenza vaccination, tobacco, unhealthy alcohol and other drug use screening, and depression screening have been appropriately documented using the following criteria:

Allergy Documentation

Whether there is documentation of the patient's medication or material (ie. latex) allergies, or that patient has no drug or material allergies, on the most current visit sheet or on a problem list, either in the paper or electronic chart.

Influenza Vaccination

For each chart, the reviewer should determine whether the patient has:

a. received their influenza vaccination for the **2024-25 flu season** (either given by the health center or documented from another provider) **OR**
b. documentation of the refusal of receiving an influenza vaccination in the chart **OR**
c. a documented allergy to influenza vaccine

Screening for Tobacco/Nicotine Use

For each chart, the reviewer should determine:

1. Whether the patient has ever been screened for tobacco/nicotine use.
2. If screening was positive, was the patient was advised to quit?
3. If screening was positive, did the clinician provide (or offer) behavioral or pharmacotherapy interventions (e.g. behavioral support and counseling, SBIRT, telephone counseling, self-help materials, NRT, bupropion SR, varenicline, or referral) to support the patient in quitting?

Screening for Unhealthy Drug Use

For each chart, the reviewer should determine:

1. Whether the patient has ever been screened for unhealthy drug use (examples include NIDA (National Institute on Drug Abuse) Quick Screen or the 8 item ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)

2. If the screening was positive, were they offered (or referred for) further assessment, treatment, and care?

Screening for Unhealthy Alcohol Use

For each chart, the reviewer should determine:

1. Whether the patient has ever been screened for unhealthy alcohol use (instruments recommended include AUDIT-C (Alcohol Use Disorders Identification Test-Consumption) and the SASQ (Single Alcohol Screening Question)

2. If the screening was positive, was the patient offered brief behavioral counseling and referral to treatment?

Screening for Depression

For each chart, the reviewer should determine whether:

1. There is documentation of screening for depression using a standardized screening instrument or question on depression (i.e., PHQ-2/9, Beck, CES-D, etc.),
2. If the screening was positive, were they evaluated for a diagnosis and, if appropriate, provided (or referred) for care?

Scoring Criteria

Allergy Documentation: Compliance — total number of patient charts with documentation of allergy to medications or materials, or documentation of "no known allergies"/25. **Non-compliance** is the number of patient charts without documentation of medication or material allergies/25.

Influenza Vaccination: Compliance — total number of patient charts with documentation of receiving influenza vaccination, refusal to vaccinate, or allergy to vaccine/25. **Non-compliance** is the number of patient charts without documentation of influenza vaccine, vaccine refusal, or allergy to vaccine/25.

Screening for Tobacco/Nicotine Use: Compliance – total number of patient charts with documentation of tobacco/nicotine screening AND, for those who screen positive, documentation of a behavioral or pharmacotherapy intervention, or referral for such is documented in the chart/25. **Non-compliance** is the number of patient charts without documentation of smoking status, plus the number of patient charts documenting tobacco/nicotine use without documentation of follow up as defined in the instructions /25. Patients screened but not provided behavioral or pharmacotherapy interventions when the screen is positive, will be reported as a portion of the non-compliance score.

Screening for Unhealthy Drug Use: Compliance - total number of patient charts with documentation of unhealthy drug use screening AND, for those who screened positive, documentation for referral for assessment/25. **Non-compliance** is the number of charts without documentation of unhealthy drug use screening, plus the number of patient charts documenting a positive screening without documentation of follow up as defined in the instructions/25. Patients screened, but not provided appropriate referral when screen is positive, will be reported as a portion of the non-compliance score.

Screening for Unhealthy Alcohol Use: Compliance - total number of patient charts with documentation of unhealthy alcohol use AND, for those who screened positive, patients offered brief behavioral counseling interventions/25. **Non-compliance** is the number of charts without documentation of unhealthy alcohol use screening, plus the number of patient charts documenting a positive screening without documentation of follow up as defined in the instructions/25. Patients screened but not provided brief behavioral counseling when the screen is positive, will be reported as portion of the non-compliance score.

Depression Screening Compliance – total number of patient charts with documentation of depression screen AND, for those who screen positive, documentation they were evaluated for a diagnosis and provided (or referred) for care/25. **Non-compliance** is the number of patient charts without documentation of depression screening, plus the number of patient charts documenting a positive screening without documentation of follow up as defined in the instructions/25. Patients screened but not evaluated for a diagnosis and provided (or referred) for care, will be reported as portion of the non-compliance score.

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