Last Updated: New Measure Version 4.2

Measure Information Form

Collected For: The Joint Commission Only

CMS Informational Only

**Measure Set:** Substance Use (SUB)

**Set Measure ID #:** SUB-4

**Performance Measure Name:**  Alcohol and Drug Use: Assessing Status After Discharge

**Description:** Discharged patients who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected.

**Rationale:** Excessive use of alcohol and drugs has a catastrophic impact on health and society in the United States (The National Quality Forum, A Consensus Report 2007). In 1998 the costs to society were 185 billion dollars for alcohol misuse, and 143 billion dollars for drugs (Harwood 2000). This includes annual health care spending of over 19 billion dollars for consequences of alcohol problems, and 14 billion dollars related to drugs. Businesses suffer from one-quarter of a trillion dollars per year in lost productivity. Alcohol, drug, and tobacco use cause over one out of four of the 2.4 million annual deaths in the U.S (Office of National Drug Control Policy).

An estimated 22.6 million adolescents and adults meet criteria for a substance use disorder, but addictions are not the most common type of problem. For every patient with alcohol dependence there are six who drink in an excessive manner that harms their health. For every patient with a drug addiction there are three who risk their health through use, but are not dependent. In a multi-state study that screened 459,599 patients in general hospital and medical settings, 23% were positive. Of these, 16% used alcohol or drugs above safe limits, an additional 3% were very heavy users, but only 4% had an addictive use pattern (Mokdad 2000).

Clinical trials have demonstrated that brief interventions significantly improve health and reduce costs in non-dependent drinkers; similar benefits occur in those with addictions who are referred to treatment (Madras 2009).

Substance use contributes to over 50 medical problems commonly treated in hospitals (Fleming 2002). A hospital admission provides a unique opportunity to address substance use. For many patients, addressing substance use is the only way to control their other health problems (Gentilello 2005).

**Type of Measure:** Process

**Improvement Noted As:** Increase in the rate

**Numerator Statement:** The number of discharged patients that are contacted between 7 and 30 days after hospital discharge and follow-up information regarding alcohol or drug use status is collected.

**Included Populations:** Not applicable

**Excluded Populations:** None

**Data Elements:**

* *Alcohol or Drug Use Status Post Discharge – Counseling*
* *Alcoho****l*** *or Drug Use Status Post Discharge – Medication*
* *Alcohol Use Status Post Discharge – Quit Status*
* *Drug Use Status Post Discharge – Quit Status*
* *Follow-up Contact*
* *Follow-up Contact Date*

**Denominator Statement:** The number of discharged patients 18 years of age and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug use disorder during their hospital stay.

**Included Populations:**

* Patients with an ICD-9-CM Principal or Other Diagnosis Code for alcohol or drug use disorder listed in Appendix A on Table 13.1or 13.2
* Patients with an ICD-9-CM Principal or Other Procedure Code listed in Appendix A on Table 13.3
* Patients who screened positive for unhealthy alcohol use or who were identified with an alcohol or drug disorder

**Excluded Populations:**

* Patients less than 18 years of age
* Patients who are cognitively impaired
* Patients who were not screened or refused to be screened for alcohol use
* Patient who expired
* Patients who have a duration of stay less than or equal to one day or greater than 120 days
* Patients who do not screen positive for unhealthy alcohol use
* Patients discharged to another hospital
* Patients who left against medical advice
* Patients discharged to another health care facility
* Patients discharged to home or other health care facility for hospice care
* Patients who do not reside in the United States
* Patients who do not have a phone or cannot provide any contact information
* Patients discharged to a detention facility, jail, or prison
* Patients who are readmitted within the follow-up time frame.

**Data Elements:**

* *Admission Date*
* *Alcohol Use Status*
* *Alcohol or Drug Disorder*
* *Birthdate*
* *Cognitive Impairment*
* *Discharge Date*
* *Discharge Disposition*
* *ICD-9-CM Other Diagnosis Code*s
* *ICD-9-CM Other Procedure Codes*
* *ICD-9-CM Principal Diagnosis Code*
* *ICD-9-CM Principal Procedure Code*

**Risk Adjustment:** No

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal and other ICD-9-CM diagnoses which require retrospective data entry.

**Data Accuracy:** Data accuracy is enhanced when all definitions are used without modification. The data dictionary should be referenced for definitions and abstraction notes when questions arise during data collection.

The measure intent as described in the measure description and numerator statement is that information gathered during the follow-up contact regarding the patient’s compliance with prescribed outpatient treatment and post discharge status relevant to substance use will be cataloged at the hospital. The 4 data elements for *Alcohol or Drug Use Status Post Discharge* should be referenced and pertinent allowable values recorded on follow up documentation as determined appropriate by the hospital and recorded in the medical record.

Measure Analysis Suggestions: Hospitals may wish to analyze the measure data using the data elements Alcohol or Drug Use Status Post Discharge – Counseling, Alcohol or Drug Use Status Post Discharge – Medication, Alcohol Use Status Post Discharge – Quit Status, and Drug Use Status Post Discharge to determine the difference in use status related to interventions made during the hospital stay or referrals at discharge.

**Sampling:** Yes, please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion

**Selected References:**

* The National Quality Forum, National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices; A Consensus Report; 2007.
* Harwood, HJ, 2000. Updating Estimates of the Economic Costs of Alcohol Abuse in the United States. National Institute on Alcohol Abuse and Alcoholism. Available from: <http://pubs.niaaa.nih.gov/publications/economic-2000>/,
* Office of National Drug Control Policy. The Economic Costs of Drug Abuse in the United States: 1992–2002. Washington, DC: Executive Office of the President (Publication No. 207303), 2004.
* Mokdad AH, Marks JS, Stroup DS, Gerberding JL. Actual Causes of Death in the United States, 2000. JAMA. 2004 Mar 10;291(10):1238-45 (Erratum in: *JAMA*. 2005 Jan 19;293(3):293-4.)
* Madras BK, Compton WM, Avula D, Stegbauer T, Stein JB, Clark HW. Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. *Drug Alcohol Depend*. 2009 Jan 1;99(1-3):280-95. Epub 2008 Oct 16.
* Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: Long-term efficacy and cost-benefit analysis. *Alcohol Clin Exp Res*. 2002 Jan;26(1):36-43.
* Gentilello LM, Ebel BE, Wickizer TM, Salkever DS Rivera FP. Alcohol interventions for trauma patients treated in emergency departments and hospitals: A cost benefit analysis. *Ann Surg*. 2005 Apr;241(4):541-50.
* Gentilello LM, Villaveces A, Ries RR, Nason KS, Daranciang E, Donovan DM Copass M, Jurkovich GJ Rivara FP. Detection of acute alcohol intoxication and chronic alcohol dependence by trauma center staff. J Trauma. 1999 Dec;47(6):1131-5; discussion 1135-9.
* Bernstein J, Bernstein E, Tassiopoulos K, Heren T, Levenson S, Hingson R. Brief motivational interventions at a clinic visit reduces cocaine and heroin use. *Drug Alcohol Depend*. 2005 Jan 7;77(1):49-59.
* McGlynn EA, Asch SM, Adams J. The Quality of Healthcare Delivered to Adults in the United States. *N Engl J Med*. 2003 Jun 26;348(26):2635-45.
* Smothers BA, Yahr HT, Ruhl CE. Detection of alcohol use disorders in general hospital admissions in the United States. *Arch Intern Med*. 2004 Apr 12;164(7):749-56.
* Kirchner JE, Owen RR, Nordquist C, Fischer EP. Diagnosis and management of substance use disorders among inpatients with schizophrenia. *Psychiatric Serv*. 1998 Jan;49(1):82-5.
* Havassy BE, Alvidrez J, Owen KK. Comparisons of patients with comorbid psychiatric and substance use disorders: implications for treatment and service delivery. Am J Psychiatry. 2004 Jan;161(1):139-45.
* Prochaska JJ, Gill PH, Stephen E, Hall SM. Identification and Treatment of Substance Misuse on an Inpatient Psychiatry Unit. *Psychiatric Serv.* 2005 Mar;56(3):347-9.



