

NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the [submitting standards web page](#).

NQF #: 1665	NQF Project: Behavioral Health
(for Endorsement Maintenance Review)	
Original Endorsement Date:	Most Recent Endorsement Date: Last Updated Date: Sep 11, 2017
BRIEF MEASURE INFORMATION	
De.1 Measure Title: SUB-4 Alcohol & Drug Use: Assessing Status After Discharge	
Co.1.1 Measure Steward: The Joint Commission	
<p>De.2 Brief Description of Measure: Hospitalized patients age 18 years and older 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.</p> <p>This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1) Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).</p>	
2a1.1 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.	
2a1.4 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.	
<p>2a1.8 Denominator Exclusions: The following are the exclusions from the denominator for this measure</p> <ol style="list-style-type: none"> 1. Patients less than 18 years of age 2. Patients who are cognitively impaired 3. Patients who were not screened or refused to be screened for alcohol use 4. Patients who expired 5. Patients who have a length of stay less than or equal to one day or greater than 120 days 6. Patients who do not screen positive for unhealthy alcohol use 7. Patients discharged to another hospital 8. Patients who left against medical advice 9. Patients discharged to another health care facility 10. Patients discharged to home or other health care facility for hospice care 11. Patients who do not reside in the United States 12. Patients who do not have a phone or cannot provide any contact information 13. Patients discharged to a detention facility, jail, or prison 14. Patients who are readmitted within the follow-up time frame. 	
<p>1.1 Measure Type: Process</p> <p>2a1. 25-26 Data Source: Electronic Health Record (Only), Paper Records</p> <p>2a1.33 Level of Analysis: Facility, Other</p>	
1.2-1.4 Is this measure paired with another measure? No	

De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed):

Not Applicable

STAFF NOTES (issues or questions regarding any criteria)

Comments on Conditions for Consideration:

Is the measure untested? Yes ☐ No ☒ If untested, explain how it meets criteria for consideration for time-limited endorsement:

1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (check De.5):

5. Similar/related [endorsed](#) or submitted measures (check 5.1):

Other Criteria:

Staff Reviewer Name(s):

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See [guidance on evidence](#).

Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)

1a. High Impact: H ☒ M ☐ L ☐ I ☐ O

(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

De.4 Subject/Topic Areas (Check all the areas that apply): Behavioral Health : Alcohol, Substance Use/Abuse

De.5 Non-Condition Specific (Check all the areas that apply): Screening

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, A leading cause of morbidity/mortality

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact (Provide epidemiologic or resource use data):

Excessive use of alcohol and drugs has a substantial harmful impact on health and society in the United States. It is a drain on the economy and a source of enormous personal tragedy.¹ In 1998 the economic costs to society were \$185 billion for alcohol misuse and \$143 billion was attributable to drug problems.² Health care spending was \$19 billion for alcohol problems, and \$14 billion for drug problems. Nearly a quarter of one trillion dollars in lost productivity is attributable to substance use. More than 537,000 persons died as a consequence of alcohol, drug, and tobacco use, making them the cause of more than one out of four deaths in the United States.³

Patients with substance-use problems have a greater risk for serious injury and over 50 medical problems including hypertension, GI bleeding, depression, stroke, dementia, cirrhosis, multiple forms of cancer, dysrhythmias, and infections such as tuberculosis, hepatitis, endocarditis, and HIV.⁵

Hospitalization provides a prime opportunity to address substance use, and for many patients, controlling their other health problems requires addressing their substance use.⁶ Approximately 8% of general hospital inpatients and 40 to 60% of traumatically-injured inpatients and psychiatric inpatients have substance use disorders.⁷

1a.4 Citations for Evidence of High Impact cited in 1a.3:

1. The National Quality Forum, National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices; A Consensus Report; 2007.
2. Harwood, HJ, 2000. Updating Estimates of the Economic Costs of Alcohol Abuse in the United States. National Institute on Alcohol Abuse and Alcoholism. Available at: <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.
3. Mokdad AH, Marks JS, Stroup DS, Geberding JL. Actual Causes of Death in the United States, 2000. JAMA 2004;291:128-1245.
4. Madras BK, Compton WM, Avula D, Stegbauer T, Stein JB, Clark HW. Screening, Brief Intervention, Referral to Treatment (SBIRT) for Illicit Drug and Alcohol Use at Multiple Health Care Sites: Comparison at Intake and Six Months Later. Drug Alcohol Depend. 2009;99:280-295.
5. National Institute on Alcohol Abuse and Alcoholism (NIAAA), Helping Patients Who Drink Too Much: A Clinician's Guide, 2005 Edition, Rockville, MD.
6. 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.
7. Gentilello LM, Villaveces A, Ries RR, Nason KS, Daranciang E, Donovan DM, Copass M, Jurkovich GJ, Rivara FP. Detection of acute intoxication and chronic alcohol dependence by trauma center staff. J Trauma. 1999 Dec;47(6):1131-5; discussion 1135-9.

1b. Opportunity for Improvement: H● M● L● I●

(There is a demonstrated performance gap - variability or overall less than optimal performance)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:

Hospitalization is an ideal time to encourage patients who use alcohol at unhealthy levels to reduce their use or to quit. During hospitalization, patients are not allowed to use alcohol or illicit drugs, are in contact with many health professionals, and may be more willing to accept assistance in quitting. Following up with these patients post discharge may provide encouragement to comply with the prescribed treatment regimens thereby reducing substance use/abuse.

1b.2 Summary of Data Demonstrating Performance Gap *(Variation or overall less than optimal performance across providers): [For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.]*

In a study on the provision of evidence-based care and preventive services provided in hospitals for 30 different medical conditions, quality varied substantially according to diagnosis. Adherence to recommended practices for treatment of substance use ranked last, with only 10% of patients receiving proper care (McGlynn 2003, Gentilello 2005). Currently, less than one in twenty patients with an addiction is referred for treatment (Gentilello 1999).

Unfortunately, many physicians mistakenly believe that substance use problems are largely confined to the young. They are significantly less likely to recognize an alcohol problem in an older patient than in a younger one. (Curtis 1989) As a result, these problems usually go undetected, resulting in harmful, expensive, and sometimes even catastrophic consequences.

This is demonstrated by the fact that few older adults who need substance use treatment actually receive it. In 2005, persons 65 years and older made up only 11,344 out of 1.8 million substance use treatment episodes recorded.(SAMHSA 2007)

1b.3 Citations for Data on Performance Gap: *[For Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]*

- 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.
- McGlynn, EA, Asch SM, Adams J, Keesey J, et al. The New England Journal of Medicine. Boston: June 26, 2003. Vol. 348, Iss. 26; pg. 2635, 11 pgs.
- Curtis, J.R.; Geller, G.; Stokes, E.J. ; et al. Characteristics, diagnosis, and treatment of alcoholism in elderly patients. J Am Geriatr Soc 37:310-316, 1989.
- SAMHSA. Office of Applied Studies. Older adults in substance abuse treatment: 2005. The DASIS Report. Rockville MD, November 8, 2007.

1b.4 Summary of Data on Disparities by Population Group: [For Maintenance – Descriptive statistics for performance results for this measure by population group]

Unfortunately, many physicians mistakenly believe that substance use problems are largely confined to the young. They are significantly less likely to recognize an alcohol problem in an older patient than in a younger one.¹⁹ As a result, these problems usually go undetected, resulting in harmful, expensive, and sometimes even catastrophic consequences.

This is demonstrated by the fact that few older adults who need substance use treatment actually receive it. In 2005, persons 65 years and older made up only 11,344 out of 1.8 million substance use treatment episodes recorded.²⁰

Gentilello, 1999; identified that from clinical evaluations on 462 patients, 23% of acutely intoxicated patients were not identified by physicians. The miss rate increased to one third in severely injured, chemically paralyzed, or intubated patients. Specificity was also poor. Patients with a negative blood alcohol concentration were more likely to be falsely suspected of intoxication if they were either young, male, perceived as disheveled, uninsured, or having a low income ($p < 0.05$). Staff identified < 50% of patients with a positive Short Michigan Alcohol Screening Test or CAGE, and falsely identified 26% of patients as alcoholic. He concluded that formal alcohol screening should be routine because clinical detection of acute alcohol intoxication and dependence is inaccurate. Screening should also be routine to avoid discriminatory bias attributable to patient characteristics.

1b.5 Citations for Data on Disparities Cited in 1b.4: [For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]

19. Curtis, J.R.; Geller, G.; Stokes, E.J. ; et al. Characteristics, diagnosis, and treatment of alcoholism in elderly patients. J Am Geriatr Soc 37:310-316, 1989.

20. SAMHSA. Office of Applied Studies. Older adults in substance abuse treatment: 2005. The DASIS Report. Rockville MD, November 8, 2007.

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.

1c. Evidence (Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.)

Is the measure focus a health outcome? Yes ☐ No ☐ If not a health outcome, rate the body of evidence.

Quantity: H ☐ M ☐ L ☐ I ☐ Quality: H ☐ M ☐ L ☐ I ☐ Consistency: H ☐ M ☐ L ☐ I ☐

Quantity	Quality	Consistency	Does the measure pass subcriterion 1c?
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M-H	M-H	M-H	Yes●
L	M-H	M	Yes● IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No●
M-H	L	M-H	Yes● IF potential benefits to patients clearly outweigh potential harms: otherwise No●
L-M-H	L-M-H	L	No ●
Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service			Does the measure pass subcriterion1c? Yes● IF rationale supports relationship
<p>1c.1 Structure-Process-Outcome Relationship (<i>Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome</i>):</p> <p>The measure focus is the process of following-up post discharge with the patient who uses alcohol at unhealthy levels or who is either drug or alcohol dependent in order to encourage compliance with prescribed treatment and enhance better patient outcomes relevant to alcohol or drug use.</p> <p>When this process is initiated, it can lead to the desired outcome as follows: Brief intervention provided during hospitalization to risky alcohol users >> Drug or alcohol dependence assessed/identified >> Treatment provided at discharge >> Contact made post discharge to determine use status >> linked to an impact on the intermediate outcome of alcohol/drug status and morbidity/mortality >> which is ultimately linked to an impact on the overall population health outcome.</p> <p>1c.2-3 Type of Evidence (<i>Check all that apply</i>): Clinical Practice Guideline, Selected individual studies (rather than entire body of evidence)</p> <p>1c.4 Directness of Evidence to the Specified Measure (<i>State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population</i>):</p> <p>The measure focus is following up with the patient after discharge to see if they are complying with prescribed treatment and gain some information about use status. The goal is to increase the numbers of patients who attend the initial outpatient counseling and subsequent sessions.</p> <p>Some of the evidence is indirectly related to the measure focus while some is directly related. For example, Jackson et al demonstrated that those patients who were prompted by telephone were more likely to keep their initial counseling appointment. Telephone reminders virtually halved non-attendance for the start of alcohol treatment. This is consistent with previous research in substance misuse services testing the effectiveness of telephone reminders on first appointment (Booth & Bennet, 2004). This study also showed that telephone prompting also improved retention in treatment.</p> <p>Some of the references listed focus on good discharge planning and the addition of booster sessions to improve patient outcomes.</p> <p>1c.5 Quantity of Studies in the <u>Body of Evidence</u> (<i>Total number of studies, not articles</i>): 28 RCTs</p> <p>1c.6 Quality of <u>Body of Evidence</u> (<i>Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events</i>): The quality of the evidence has not been evaluated by any</p>			

particular body. In review of some of the references the following can be noted:

Anton: In general, this study had good internal validity. Study completion, drinking data collection rates, as well as therapy and medication adherence rates were acceptable. Therapy was delivered according to standardized manuals. An intent-to-treat analysis plan was followed using both traditional aggregate group drinking data as well as newer time to multiple event analyses. Craving was measured, and objective biologic markers of alcohol consumption (GGT and CDT) were obtained. The study represented one clinical service and 160 patients.

Willenbring: 105 alcoholic dependent males were randomized to receive Integrated Outpatient Treatment (IOT) or referred to standard alcoholism and medical treatment. Each group was evaluated over 2 years. Selection of patients took care to avoid sampling bias. Data on quantity and frequency of drinking were gathered using the timeline follow back procedure providing a standardized means of collecting alcohol consumption data over a specified period and has excellent reliability and validity. The IOT and control groups were well matched, however, the IOT group was younger than the control group and there were indications that IOT patients had more psychological problems. Cox survival analysis was used to determine the significance of mortality differences between groups.

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):* Jackson et al demonstrated that those patients who were prompted by telephone were more likely to keep their initial counseling appointment. Telephone reminders virtually halved non-attendance for the start of alcohol treatment. This is consistent with previous research in substance misuse services testing the effectiveness of telephone reminders on first appointment (Booth & Bennet, 2004). This study also showed that telephone prompting also improved retention in treatment. McKay, who summarized 20 RCTs concluded that the evidence is convincing that continuing care can be effective in sustaining the positive effects of the initial phase of care. A key take home message of this study is that aggressive attempts to stay in contact with the patient for extended periods, and systematic monitoring of treatment response, are needed. The benefits of post discharge follow-up is stressed by Sharon Silow-Carroll in her article Reducing Hospital Readmission: Lessons from Top-Performing Hospitals. She stresses there is a need to ensure patients do not "fall off a cliff" after returning home. The hospitals can provide support after discharge. One of the simplest ways they do this is through telephone calls one week after discharge to answer patient' questions, reinforce disease-specific education, and confirm patients are receiving the recommended follow-up care - including reminding them to see their primary care physician.

A number of studies have shown that repeated interventions focused on the physical complications of drinking or medication management can be effective even with patients with severe unhealthy alcohol use. The first of these studies included men in Malmo, Sweden who had abnormal liver function tests (LFTs). Repeated medical interventions decreased both LFTs and alcohol-related deaths (Kristenson et al., 1983; Kristenson et al., 2002).

A study of patients with diabetes and/or hypertension showed that using percent carbohydrate deficient transferrin (%CDT) as a biomarker to provide monthly feedback on excessive drinking significantly decreased drinking and %CDT at 12-month follow-up (Fleming et al., 2004).

A study of patients willing to enter a trial for a medication to improve alcoholic liver disease, showed that nurse monitoring was associated with marked decrease in drinking from an average of 16 to an average of 2.5 drinks daily (Lieber et al., 2003).

A study of medications for alcohol dependence found that medical monitoring and placebo were as effective as acamprosate or a combined behavioral intervention among patients with alcohol dependence recruited to a trial of medications to help decrease drinking (Anton et al., 2006).

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates*

of effect; and net benefit - benefit over harms):

The USPSTF found little direct evidence regarding harms of screening or behavioral counseling interventions for alcohol misuse. In a few studies, higher attrition rates in intervention compared with control groups suggest that alcohol misuse interventions may be objectionable for some individuals. Two potential harms of these interventions among adults include a possible reduction in benefits of moderate drinking and under-treatment of drinkers with alcohol abuse or dependence who are guided toward moderate drinking rather than abstinence. The USPSTF found no data for either of these potential harms.

The USPSTF review of the entire body of evidence found that no studies showed statistically significant, long term effects on morbidity. The combined results from these studies suggest mean reductions in alcohol consumption ranging from three to nine drinks per week (13%-34% net reduction in drinking) in the intervention group compared with the control group after six to 12 months of follow up. The majority of good quality studies of primary care interventions for people with risky or harmful drinking found that 10-19% more intervention participants no longer reported drinking at levels that were harmful or risky compared with controls.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? **No**

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: **Not Applicable** although evidence for follow up related to medication therapy as graded by the DOD was Grade I A

1c.11 System Used for Grading the Body of Evidence: **Other**

1c.12 If other, identify and describe the grading scale with definitions: **The body of evidence has not been graded by guideline writers, authors, etc.**

1c.13 Grade Assigned to the Body of Evidence: **Not Applicable**

1c.14 Summary of Controversy/Contradictory Evidence: **Review of the evidence did not reveal any contradictory evidence**

1c.15 Citations for Evidence other than Guidelines(Guidelines addressed below):

Anton RF, Moak DH, Latham P, et al. Naltrexone combined with either cognitive behavioral or motivational enhancement therapy for alcohol dependence. J Clin Psychopharmacol 2005;25:349-57.

Jackson KR, Booth PG, Salmon P, McGuire J. The effects of telephone prompting on attendance for starting treatment and retention in treatment at a specialist alcohol clinic. British Journal of Clinical Psychology 2009; 48, 437-442

Longabaugh R, Woolard RF, Nirenbert TD, Minuch AP, Becker B, Clifford P, Carty K, Sparadeo F, Gogineni A. Evaluating the effects of a brief motivational intervention for injured drinkers in the emergency department. Journal of Studies on Alcohol Nov 2001;806-816.

McKay JR. Continuing care research: what we have learned and where we are going. Journal of Substance Abuse Treatment 36 (2009) 131-145.

Lieber CS, Weiss DG, Groszmann R, Paronetto F, Schenker S; Veterans Affairs Cooperative Study 391 Group. I. Veterans Affairs Cooperative Study of polyenylphosphatidylcholine in alcoholic liver disease: effects on drinking behavior by nurse/physician teams. Alcohol Clin Exp Res Nov 2003;27(11):1757-64.

Willenbring ML, Olson DH. A randomized trial of integrated outpatient treatment for medically ill alcoholic

men. Arch. Intern. Med. Sep 13 1999;159(16):1946-1952.

Willenbring ML, Olson DH, Bielinski J. Integrated outpatients treatment for medically ill alcoholic men: results from a quasi-experimental study. J. Stud. Alcohol. May 1995;56(3):337-343.

Kristenson H, Osterling A, Nilsson JA, Lindgarde F. Prevention of alcohol-related deaths in middleaged heavy drinkers. Alcohol Clin Exp Res Apr 2002;26(4):478-84.

Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. Alcohol Clin Exp Res 2002 Jan;26(1):36-43

1c.16 Quote verbatim, the specific guideline recommendation (Including guideline # and/or page #):
VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders (SUD).
Page 31 Recommendation E: Initiate Addiction-Focused Pharmacotherapy (if indicated)
2. Initiate addiction-focused pharmacotherapy if indicated and monitor adherence and treatment response.

Page 34 Recommendation I: Assess Response to Treatment/Monitor Biological Indicators
1. Reassess response to treatment periodically and systematically, using standardized and valid self report instruments(s) and laboratory tests. Indicators of treatment response include ongoing substance use, craving, side effects of medication, emerging symptoms, etc.

1c.17 Clinical Practice Guideline Citation: Department of Veteran Affairs, Department of Defense. VA/DoD clinical practice guideline for management of substance use disorders (SUD). Washington (DC): Department of Veteran Affairs, Department of Defense; 2009 Aug. 158 p.

1c.18 National Guideline Clearinghouse or other URL: National Guideline Clearinghouse URL : <http://www.guideline.gov/content.aspx?id=15676>

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? No

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:

1c.21 System Used for Grading the Strength of Guideline Recommendation: Other

1c.22 If other, identify and describe the grading scale with definitions: The recommendations have not been graded by the guideline writers.

1c.23 Grade Assigned to the Recommendation: Not Applicable although evidence for follow up related to medication therapy as graded by the DOD was Grade I A

1c.24 Rationale for Using this Guideline Over Others: This guideline is in the public domain and all patients are subjected to the Preventive Services Task Force criteria for the need for level A or B evidence. The guideline is used in the largest integrated managed care system (the Veterans' Administration) and is integrated into their electronic health record. Although the guideline primarily targets the primary care setting, the target population on page 1 states that the guideline applies to adult patients with substance use conditions treated in any VA/DoD clinical setting.

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?

1c.25 Quantity: Moderate **1c.26 Quality:** Moderate **1c.27 Consistency:** High

1c.28 Attach evidence submission form:

1c.29 Attach appendix for supplemental materials:

Was the threshold criterion, *Importance to Measure and Report*, met?

(1a & 1b must be rated moderate or high and 1c yes) Yes ☐ No ☒

Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.

For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & 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. **(evaluation criteria)**

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See [guidance on measure testing](#).

S.1 Measure Web Page (*In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? **Yes**

S.2 If yes, provide web page URL:

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/

2a. RELIABILITY. Precise Specifications and Reliability Testing: H ☒ M ☒ L ☐ I ☐

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 Numerator Statement (*Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome*):

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.

2a1.2 Numerator Time Window (*The time period in which the target process, condition, event, or outcome is eligible for inclusion*):

Anytime between 7 and 30 days post hospital discharge

2a1.3 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, codes with descriptors, and/or specific data collection items/responses*):

Six data elements are used to satisfy the numerator. Follow-up Contact Date and Follow-up Contact. Follow-up contact can be made through a variety of modes including phone call, clinic visit, e-mail or letter through U.S. mail. The contact may also be made by someone other than a hospital employee, however if this is done, information must be cataloged at the hospital. The contact date must be between 7 and 30 days post discharge. The 4 post discharge 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 - Quit Status) must be answered in order to receive credit for the measure. The allowable values provide options for patient refusal to provide information and not applicable if alcohol or drug use does not apply. In the measure calculation, the hospital is not held accountable for the patient's compliance with the recommended treatment or the quit status, but is accountable for collecting the information. Full specifications can be viewed on the Joint Commission web site at the following link:

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/

2a1.4 Denominator Statement (*Brief, narrative description of the target population being measured*):
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.

2a1.5 Target Population Category (*Check all the populations for which the measure is specified and tested if any*): Elderly

2a1.6 Denominator Time Window (*The time period in which cases are eligible for inclusion*):
Any time during the hospital stay from admission to discharge.

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses*):

There are 11 data elements that define the denominator.

1. Admission Date
2. Alcohol Use Status
3. Alcohol or Drug Disorder
4. Birthdate
5. Cognitive Impairment
6. Discharge Date
7. Discharge Disposition
8. ICD-9-CM Other Diagnosis Codes,
9. ICD-9-CM Other Procedure Codes
10. ICD-9-CM Principal Diagnosis Code
11. ICD-9-CM Principal Procedure Code.

The Admission Date, Birthdate and Discharge Date are used to determine the patient age and length of stay. The data elements Alcohol Use Status, Alcohol or Drug Disorder, and the 4 ICD-9-CM diagnosis and Procedure Code data elements are used to identify patients who had an alcohol or drug use disorder or who screened positive for unhealthy alcohol use. Discharge Disposition is used to identify those patients who would be excluded for a variety of reasons such as death, transfer to another hospital for inpatient care, those who leave AMA or who are transferred to hospice, etc. Patients who do not reside in the United States are excluded by a specific value for the data element Follow up Contact.

2a1.8 Denominator Exclusions (*Brief narrative description of exclusions from the target population*):

The following are the exclusions from the denominator for this measure

1. Patients less than 18 years of age
2. Patients who are cognitively impaired
3. Patients who were not screened or refused to be screened for alcohol use
4. Patients who expired
5. Patients who have a length of stay less than or equal to one day or greater than 120 days
6. Patients who do not screen positive for unhealthy alcohol use
7. Patients discharged to another hospital
8. Patients who left against medical advice
9. Patients discharged to another health care facility
10. Patients discharged to home or other health care facility for hospice care
11. Patients who do not reside in the United States
12. Patients who do not have a phone or cannot provide any contact information
13. Patients discharged to a detention facility, jail, or prison
14. Patients who are readmitted within the follow-up time frame.

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):*

Patients who are less than 18 years of age are identified by subtracting the patient birthdate from the admission date.

Patients who do not need follow up are identified through allowable value 1 for the data element Alcohol Use Status, as well as value 5 (refused) and value 6(not screened)

Patients with a LOS one day or less and those with a stay greater than 120 days are identified by the admission and discharge date.

Patients who are not residents of the USA or who do not have contact information or a phone and those who are readmitted within the follow up time frame are excluded through allowable value 3 for the data element Follow-up Contact

Those patients who expire, are transferred to another facility for inpatient care, hospice, federal health care facility, detention, or leave AMA are identified by virtue of the data element Discharge Disposition.

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses):*

Not Applicable, the measure is not stratified.

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13):* No risk adjustment or risk stratification **2a1.12 If "Other," please describe:**

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.):*

Not Applicable

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 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 = Higher score

2a1.20 Calculation Algorithm/Measure Logic*(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; aggregating data; risk adjustment; etc.):*

SUB-4: Alcohol and Drug Use: Assessing Status After Discharge

Numerator: 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.

Denominator: 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.

Variable key: Patient Age

Length of Stay

Follow-up Days

Complete Plan Counter I

Complete Plan Counter II

1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.
2. Calculate Patient Age. Patient Age, in years, is equal to the Admission Date minus the Birthdate. Use the month and day portion of Admission Date and Birthdate to yield the most accurate age. Only cases with valid Admission Date and Birthdate will pass the front end edits into the measure specific algorithms.
3. Check Patient Age
 - a. If Patient Age is less than 18 years, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - b. If Patient Age is equal to or greater than 18 years, continue processing and proceed to calculate Length of Stay.
4. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.
5. Check Length of Stay
 - a. If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - b. If Length of Stay is greater than 1 day, continue processing and proceed to check Cognitive Impairment.
6. Check Cognitive Impairment
 - a. If Cognitive Impairment is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Cognitive Impairment equals Yes, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - c. If Cognitive Impairment equals No, continue processing and proceed to check Discharge Disposition
7. Check Discharge Disposition
 - a. If Discharge Disposition is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Discharge Disposition equals 2, 3, 4, 5, 6 or 7 the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - c. If Discharge Disposition equals 1 or 8, continue processing and proceed to check ICD-9-CM Principal or Other Diagnosis Code.
8. Check ICD-9-CM Principal or Other Diagnosis Code
 - a. If none of the ICD-9-CM Principal or Other Diagnosis Code is on Table 13.1 or 13.2, continue processing and proceed to check ICD-9-CM Principal or Other Procedure Code.
 - b. If any ICD-9-CM Principal or Other Diagnosis Code is on Table 13.1 or 13.2, continue processing and proceed to Step 12 to check Follow-up Contact.
9. Check ICD-9-CM Principal or Other Procedure Code
 - a. If all missing or none of the ICD-9-CM Principal or Other Procedure Code is on Table 13.3 continue processing and proceed to check Alcohol or Drug Disorder.
 - b. If any of the ICD-9-CM Principal or Other Procedure Code is on Table 13.3, continue processing and proceed to Step 12 to check Follow-up Contact.
10. Check Alcohol or Drug Disorder
 - a. If Alcohol or Drug Disorder is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Alcohol or Drug Disorder equals No, continue processing and proceed to check Alcohol Use Status.
 - c. If Alcohol or Drug Disorder equals Yes, continue processing and proceed to Step 12 to check Follow-up Contact.
11. Check Alcohol Use Status

- a. If Alcohol Use Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Alcohol Use Status equals 1, 3, 5 or 6, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - c. If Alcohol Use Status equals 2 or 4, continue processing and proceed to check Follow-up Contact.
12. Check Follow-up Contact
 - a. If Follow-up Contact is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Follow-up Contact equals 3, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population.
 - c. If Follow-up Contact equals 1, 2, or 4, continue processing and proceed to recheck Follow-up Contact.
 13. Recheck Follow-up Contact
 - a. If Follow-up Contact equals 2 or 4, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.
 - b. If Follow-up Contact equals 1, continue processing and proceed to check Follow-up Contact Date.
 14. Check Follow-up Contact Date
 - a. If Follow-up Contact Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Follow-up Contact Date equals Unable to Determine, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.
 - c. If Follow-up Contact Date equals a Non Unable to Determine Value, continue processing and proceed to calculate Follow-up Days.
 15. Calculate Follow-up Days. Follow-up Days, in days, is equal to the Follow-up Contact Date minus the Discharge Date.
 16. Check Follow-up Days
 - a. If Follow-up Days is less than zero days the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Follow-up Days is greater than 30 days, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.
 - c. If Follow-up Days is greater than or equal to 7 days and less than or equal to 30 days, continue processing and proceed to initialize Complete Plan Counter I .
 17. Initialize Complete Plan Counter I. Initialize Complete Plan Counter I to equal 0 and proceed to initialize Complete Plan Counter II.
 18. Initialize Complete Plan Counter II. Initialize Complete Plan Counter II to equal 0 and proceed to check Alcohol or Drug Use Status Post Discharge – Counseling.
 19. Check Alcohol or Drug Use Status Post Discharge – Counseling
 - a. If Alcohol or Drug Use Status Post Discharge - Counseling is missing the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Alcohol or Drug Use Status Post Discharge - Counseling equals 1, 2, 3 or 4, add 1 to Complete Plan Counter I, and the case will proceed to check Alcohol or Drug Use Status Post Discharge – Medication.
 - c. If Alcohol or Drug Use Status Post Discharge - Counseling equals 5 the case will proceed to check Alcohol or Drug Use Status Post Discharge – Medication.
 20. Check Alcohol or Drug Use Status Post Discharge – Medication
 - a. If Alcohol or Drug Use Status Post Discharge - Medication is missing the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

- b. If Alcohol or Drug Use Status Post Discharge - Medication equals 1, 2, 3 or 4, add 1 to Complete Plan Counter I, and the case will proceed to check Alcohol Use Status Post Discharge – Quit Status.
- c. If Alcohol or Drug Use Status Post Discharge - Medication equals to 5 the case will proceed to check Alcohol Use Status Post Discharge – Quit Status.

21. Check Alcohol Use Status Post Discharge – Quit Status

- a. If Alcohol Use Status Post Discharge - Quit Status is missing the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
- b. If Alcohol Use Status Post Discharge - Quit Status equals 3 the case will proceed to check Drug Use Status Post Discharge - Quit Status.
- c. If Alcohol Use Status Post Discharge - Quit Status equals 1, 2, 4 or 5 the case will proceed to recheck Alcohol Use Status Post Discharge – Quit Status.

22. Check Drug Use Status Post Discharge – Quit Status

- a. If Drug Use Status Post Discharge - Quit Status is missing or equals to 3, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
- b. If Drug Use Status Post Discharge - Quit Status equals 1, 2, 4 or 5, the case will proceed to recheck Drug Use Status Post Discharge – Quit Status.

23. Recheck Alcohol Use Status Post Discharge – Quit Status

- a. If Alcohol Use Status Post Discharge - Quit Status equals 5 the case will proceed to recheck Drug Use Status Post Discharge – Quit Status.
- b. If Alcohol Use Status Post Discharge - Quit Status equals 1, 2 or 4, add 1 to Complete Plan Counter II and proceed to recheck Drug Use Status Post Discharge – Quit Status.

24. Recheck Drug Use Status Post Discharge – Quit Status

- a. If Drug Use Status Post Discharge - Quit Status is missing the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
- b. If Drug Use Status Post Discharge - Quit Status equals 3 or 5 the case will proceed to check Complete Plan Counter I.
- c. If Drug Use Status Post Discharge - Quit Status equals 1, 2 or 4, add 1 to Complete Plan Counter II and proceed to check Complete Plan Counter I.

25. Check Complete Plan Counter I

- a. If Complete Plan Counter I equals 2 the case will proceed to check Complete Plan Counter II.
- b. If Complete Plan Counter I is less than 2, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

26. Check Complete Plan Counter II

- a. If Complete Plan Counter II is less than 1, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.
- b. If Complete Plan Counter II is greater than or equals 1 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

Attachment

SUB-4_MIF_and_algorithm.docx

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):

The Initial Patient Population is defined and identified by two data elements (Admission Date and Discharge Date). All patients discharged from acute inpatient care with Length of Stay (Discharge Date minus Admission Date less than or equal to 120 days) are included in the Initial Population and are eligible for sampling. Hospitals that choose to sample have the option of sampling quarterly or monthly. The sample is taken randomly as follows for a monthly sample.

- Average monthly Initial Patient Population > or = 510 results in a minimum random sample size of 102
- Average monthly Initial Patient Population > or = 255 – 509 results in a random sample of 20% of the population size
- Average monthly Initial Patient Population > or = 51 – 254 results in a random sample of 51
- Average monthly Initial Patient Population < 51: No sampling, 100% population required.

2a1.25 Data Source (*Check all the sources for which the measure is specified and tested*). If other, please describe:

Electronic Health Record (Only), Paper Records

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*): The Joint Commission developed a web-based data collection tool that was used by hospitals and for reliability testing during the pilot test. When the measures are made part of The Joint Commission's ORYX data collection and reporting program, the data will be collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy of the data collection tool with the specifications. Vendors may not offer a measure set to hospitals until they have passed the verification process.

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:

Attachment

Substance_Use_Data_Dictionary.doc

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested*):

Facility, Other

2a1.34-35 Care Setting (*Check all the settings for which the measure is specified and tested*): Behavioral Health : Inpatient, Hospital

2a2. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability.*)

2a2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

Original reliability testing of these measures was conducted in 2010. At the request of the Steering Committee, follow-up testing was carried out in November and December, 2012. A total of 77 medical records were reviewed at five hospitals across the country. Five hospitals comprised the convenience sample. Hospital types included academic, public and critical access. The hospitals ranged in bed size from 25 to 633 beds.

2a2.2 Analytic Method (*Describe method of reliability testing & rationale*):

The objectives of the reliability site visits included: assessment of data element and measure reliability;

assessment of data collection and implementation effort, and identification of potential measure specification enhancements, including data element definitions, abstraction guidelines, etc. A web-based data collection tool developed by The Joint Commission was used for the pilot test. In preparation for the reliability test, a separate section was created in the web-based tool where re-abstracted case data could be housed and compared to the pilot hospitals' previously submitted original case abstractions. During the reliability site visit, Joint Commission staff re-abstracted data from a number of cases randomly selected by the Joint Commission biostatistician. These data were entered blindly into the web-based tool and then compared to the original abstraction while on site. Data element differences were coded with respect to the reasons contributing to the differences and the differences were then adjudicated. These adjudicated results were then used as the "gold standard" for the purpose of comparing the adjudicated data with the originally abstracted data. Focus group interviews were conducted at each hospital and differences in abstraction findings were shared with each hospital for use as an opportunity for improvement. A comparison of calculated indicator rates using data originally abstracted by hospitals and the data that were re-abstracted by the Joint Commission staff and adjudicated on each measure and the individual data elements was performed. Measure data element agreement rates were calculated to assess data element accuracy. At the measure level the sensitivity and specificity were calculated with their corresponding 95% confidence interval to assess the measure reliability for both the determination of eligibility for the measure denominator and eligibility for the measure numerator.

2a2.3 Testing Results (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*):

Of the 77 cases re-abstracted, the overall measure agreement rate was 94.8% (73/77). A perfect agreement rate between originally abstracted data and reabstracted data would be 100%, and an agreement rate below 75% is considered suboptimal. Improvement from original test data was noted in the areas of follow up contact (agreement rate 85.0%) and follow up date (agreement rate 97.8%). These areas are central to the calculation of the measure rate. Application of skip logic, refinement of the data definitions and the notes for abstraction following the original development and testing of the measure contributed to the improvement. The sensitivity was 91.9% CI (78.1%, 98.3%) and the specificity was 97.5% CI (86.8%, 99.9%) for the measure denominator. For the measure numerator, given the case fell into the measure denominator, the sensitivity was 100% CI (15.8%,100%) and the specificity was 100% CI (89.1%,100%).

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H M L I NA

2b1.1 Describe how the measure specifications (*measure focus, target population, and exclusions*) **are consistent with the evidence cited in support of the measure focus (criterion 1c) and identify any differences from the evidence:**

The measure focuses on the process of having follow up contact with a patient who is discharged from the acute care setting to determine if they are following the prescribed treatment regimen and to obtain information about substance use status. The evidence cited focused on continued ongoing treatment with monitoring of biological markers and patient self reports to determine improved outcomes rather than a one time call to determine compliance with treatment. We believe that this measure is the first step in the follow up process that will improve patient compliance with treatment and result in improved outcomes.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.*)

2b2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

Early in the measure development process, face validity of the original candidate measures was assessed through public comment. The measures were rated on a 5 point scale relative to 10 characteristics. 2,177 persons responded to the public comment. Issues identified were addressed through revisions to measure specification as appropriate and a final set of measures to be pilot tested was finalized. Due to the number of changes made to the original candidate measures, an alpha test was incorporated into the last months of the pilot test so as to re-evaluate the measures. The purpose was threefold: to gather information regarding

face validity, to determine feasibility of data collection, and to gather information about each data element regarding clarity and suggested enhancement that could be made. A total of 11 hospitals completed the evaluation.

Lastly, once the final specifications were completed, the 11 members of the TAP were asked to rate each measure on a 5 point scale (disagree (1), somewhat disagree (2), neutral (3), somewhat agree (4), and agree(5)) relative to five questions. Eight TAP members responded.

Our advisory panel included six physicians, one nurse, one pharmacist, one education specialist, one research investigator, and one PhD working in the field of alcohol solutions.

Michael Fiore MD Director UW Center for Tobacco Research and Intervention University of Wi

Nancy Rigotti MD Director Tobacco Research & Treatment Harvard Medical School

Linda Sarna RN DNSC FAAN Professor of Nursing UCLA School of Nursing

Frank Vitale, MA National Director, The Pharmacy Partnership for Tobacco Cessation U of Pittsburgh

Stephen Schroeder MD Distinguished Professor of Medicine Smoking Cessation Leadership Center University of California, San Francisco

Robert Adsit, M.Ed Education and Outreach Programs Supervisor University of Wisconsin

Eric Goplerud PhD, MA Director of Ensuring Solutions to Alcohol Problems George Washington University

Larry Gentilello MD FACS Professor of Surgery UT Southwestern Medical Ctr at Dallas

Steve Bernstein MD Associate Professor Surgery Emergency Medicine Yale University

Constance Weisner DrPH, MSW Investigator, Kaiser Permanente Division of Research Kaiser

Katherine Bradley MD, MPH Core Investigator, Health Services Research and Development Veterans Affairs, Puget Sound Health Care System

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment):*

Pilot Survey: A survey was designed and made available on line during the month of July, 2010 to all participating pilot sites. Five questions relative to face validity were rated on a 5 point scale (disagree (1), somewhat disagree (2), neutral (3), somewhat agree (4), and agree (5)). Six questions were asked relative to the measure set in general and eight questions were designed to be measure specific. A table of the required data elements with specifications was also provided so respondents could comment on the clarity of the specifications and provide suggestions for enhancements.

TAP Survey: A survey was e-mailed to each of the TAP members by the TAP chair. Five questions relative to face validity were rated on a 5 point scale (disagree (1), somewhat disagree (2), neutral (3), somewhat agree (4), and agree (5)). The surveys were returned via e-mail and analyzed. The mean score was calculated for each question as well as the frequency distribution noted.

2b2.3 Testing Results *(Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment):*

Pilot Survey: Eleven hospitals completed the evaluation. The measure rated 4.62 on a 5 point scale with respect to clarity of measure specifications; 3.71 with respect to its usefulness; 4.42 regarding interpretability, 2.14 with respect to data accessibility and ease of collection, and 3.85 regarding a recommendation for national use and endorsement.

Seven TAP members completed the evaluation. The measure rated 5 on a 5 point scale with respect to clarity of measure specifications; 4.85 with respect to its usefulness; 4.71 regarding interpretability, 3.57 with respect to data accessibility and ease of collection, and 4.42 regarding a recommendation for national use and endorsement.

POTENTIAL THREATS TO VALIDITY. *(All potential threats to validity were appropriately tested with adequate results.)*

2b3. Measure Exclusions. *(Exclusions were supported by the clinical evidence in 1c or appropriately*

tested with results demonstrating the need to specify them.)

2b3.1 Data/Sample for analysis of exclusions *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

The data sample was the 9038 records submitted from the 19 pilot hospitals during the six month pilot test (March through August). Pilot test hospitals ranged in size from 15 to 900 beds. Eight of the hospitals were Veterans Administration (VA) Hospitals, and six hospitals were participating in the SBIRT (Screening, Brief Intervention, and Referral to Treatment) project. Seven hospitals used electronic health records and seven used paper medical records; the remainder used a combination of electronic and paper records.

2b3.2 Analytic Method *(Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference):*

The data was analyzed to determine the frequency and percentage of those patients unable to be screened as well as those patients who had a length of stay less than or equal to one day because hospitals in the pilot test found it quite difficult to reach patients with such a short length of stay. Data was also analyzed to determine the frequency and percentage of the various values for discharge status which are used to determine transfers to another acute care facility, expiration, leaving AMA, transfer to hospice, etc. The measure excludes such cases as it is difficult to refer to outpatient counseling, provide prescriptions and conduct follow-up for these patients.

Not analyzed in this analysis was the exclusion for cases with a length of stay greater than 120 days which is a standard exclusion for all TJC and CMS aligned measures. The decision to exclude this population was made jointly by the two organizations to prevent cases from spanning more than 1 specification manual, and therefore, potentially slightly different measure specifications. Revisions are made only twice each year and it is possible that some cases could fail still providing the appropriate care if this exclusion was not provided.

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*

There were 1266 (14%) patients with a length of stay of one day or less. Combining all of the exclusions identified through discharge status, we found 1444 patients at 15.9%. A breakdown of the individual status is as follows:

1. Transfer to hospice = 121 patients at 1.3%
2. Transfer to acute care facility = 555 patients at 6%
3. Expired = 205 patients at 2.6%
4. AMA = 190 patients at 2%
5. Transfer to another healthcare facility = 373 patients at 4%

While these percentages may seem small, this represents only 19 hospitals in a pilot test. In light of the expected use of the measure for public reporting, there has been significant push from the healthcare community for measure developers to make “perfect measures”. There is little tolerance from the field at this point for keeping inappropriate cases in a measure population that can easily be excluded through data elements such as Discharge Status. The balance between data collection and abstraction and inclusion of false positive or negative cases must always be weighed and in this case the ease of excluding such cases outweighed their inclusion.

2b4. Risk Adjustment Strategy. *(For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.)*

2b4.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

Not Applicable, the measure is not risk adjusted

2b4.2 Analytic Method *(Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables):*

Not Applicable

2b4.3 Testing Results *(Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata):*

Not Applicable

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: Not Applicable

2b5. Identification of Meaningful Differences in Performance. *(The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.)*

2b5.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

The data sample was the 9038 records submitted from the 19 pilot hospitals during the six month pilot test (March through August). Pilot test hospitals ranged in size from 15 to 900 beds. Eight of the hospitals were Veterans Administration (VA) Hospitals, and six hospitals were participating in the SBIRT (Screening, Brief Intervention, and Referral to Treatment) project. Seven hospitals used electronic health records and seven used paper medical records; the remainder used a combination of electronic and paper records.

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance):*

The overall measure rate was calculated as well as analyzed in subsets of SBIRT (Screening, Brief Intervention and Referral to Treatment), non-SBIRT and VA Hospitals. SBIRT hospitals are those who have engaged in a national initiative to identify and treat substance use issues. It was felt that their processes might be more rigorous and measure rates might be different from the other subsets. The VA is a single system where follow-up with patients is easier than with other facilities. It was felt that measure rates might also be different with this subset of facilities. A secondary analysis was performed by plotting each hospitals rate (within each subset) on dot plots to identify variability.

2b5.3 Results *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningful differences in performance):*

The overall measure rate was 33.3%, down from the baseline of 40.2%. The baseline is the rate of compliance with the measure prior to the implementation of the measure set. The VA hospitals demonstrated the best performance (40.9%) although a decline from baseline (58.1%) and the SBIRT hospitals while demonstrating the lowest rates (24.2%) showed the greatest increase from baseline (2.3%). The rate for non-SBIRT hospitals was 36.2% down from a baseline of 47.8%. The dot plot analysis showed little variability among non-VA hospitals, however there was greater variability among the VA hospitals with measure rates ranging from 18-100%. The SBIRT hospitals showed some variation with rates ranging from 0-50%.

2b6. Comparability of Multiple Data Sources/Methods. *(If specified for more than one data source, the various approaches result in comparable scores.)*

2b6.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

The medical record is the only data source for this measure

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure):*

Not Applicable

2b6.3 Testing Results (Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted):

Not Applicable

2c. Disparities in Care: H ☐ M ☐ L ☐ I ☐ NA ☐ (If applicable, the measure specifications allow identification of disparities.)

2c.1 If measure is stratified for disparities, provide stratified results (Scores by stratified categories/cohorts): The measure is not stratified for disparities

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:

No disparities have been identified with respect to following up with patients identified with unhealthy alcohol use or alcohol or drug dependence. Disparities were noted in the process of identification (screening) which was not routinely done. With the implementation of routine screening, such disparities for treatment and follow should be eliminated.

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met? (Reliability and Validity must be rated moderate or high) Yes ☐ No ☐

Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (**evaluation criteria**)

C.1 Intended Actual/Planned Use (Check all the planned uses for which the measure is intended): Public Reporting, Quality Improvement (external benchmarking to organizations), Quality Improvement (Internal to the specific organization), Regulatory and Accreditation Programs

3.1 Current Use (Check all that apply; for any that are checked, provide the specific program information in the following questions): Public Reporting, Regulatory and Accreditation Programs

3a. Usefulness for Public Reporting: H ☐ M ☐ L ☐ I ☐ (The measure is meaningful, understandable and useful for public reporting.)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large (If used in a public reporting program, provide name of program(s), locations, Web page URL(s)). If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: **[For Maintenance** – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.]

The Joint Commission website for Quality Check:
<http://www.qualitycheck.org/consumer/searchQCR.aspx>

The Alcohol Measure Set was noted in the recent IPPS rule for future consideration.

3a.2. Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: [The measure will be publicly reported on the Joint Commission's website "Quality Check" as one of 4 measures in a set. All 4 measure rates will be reported which together tell a story of performance related to substance use treatment.](#)

[The measure was rated 3.71 on a 5 point scale by pilot test users with respect to its ability to be used for benchmarking and identifying best practices, and its support for quality improvement efforts. Respondents also scored the measure at 4.42 with respect to its ability to be easily interpreted and reported in a way that is useful and meaningful to various stakeholders.](#)

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s): [Used in the Joint Commission Accreditation Program](#)
[Internal reports generated for hospitals](#)

3b. Usefulness for Quality Improvement: H ☐ M ☐ L ☐ I ☐

(The measure is meaningful, understandable and useful for quality improvement.)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):

[For Maintenance – *If not used for QI, indicate the reasons and describe progress toward using performance results for improvement***].**

[Not Applicable](#)

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated (e.g., QI initiative), describe the data, method and results:

[Not Applicable](#)

Overall, to what extent was the criterion, *Usability*, met? H ☐ M ☐ L ☐ I ☐

Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (**evaluation criteria**)

4a. Data Generated as a Byproduct of Care Processes: H ☐ M ☐ L ☐ I ☐

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*

Data used in the measure are:

[generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information \(e.g., DRG, ICD-9 codes on claims\), Abstracted from a record by someone other than person obtaining original information \(e.g., chart abstraction for quality measure or registry\)](#)

4b. Electronic Sources: H ☐ M ☐ L ☐ I ☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields):* [Some data elements are in electronic sources](#)

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

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electronic capture, OR provide a rationale for using other than electronic sources: The Joint Commission plans to begin work on electronic specifications for the measure in the near future. Plans are already underway once the funding is received to begin the electronic specifications for SUB 1 and 2.

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H ☐ M ☒ L ☐ I ☐

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:

No unintended consequences of measurement were identified during testing or in review of the literature/RCTs.

A few reliability issues surfaced because abstractors accepted follow up phone calls for reasons other than gaining information about tobacco use status. While it was clear in the specifications that follow up must be for tobacco use status, this has been re-enforced by addressing it in the data element question.

4d. Data Collection Strategy/Implementation: H ☐ M ☒ L ☐ I ☐

A.2 Please check if either of the following apply (regarding proprietary measures):

4d.1 Describe what you have learned/modified 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 (e.g., fees for use of proprietary measures):

During the pilot test it became clear that implementation of the follow-up measure was difficult to achieve for a variety of reasons. The measure specifically specified that follow-up had to be done by hospital employees and must be done by phone or post discharge clinic visit. The TAP and staff agreed that it was necessary to allow more flexibility in the final specifications for meeting the intent of the measures. As a result, the follow up need not always be done by hospital staff, for example, hospitals could choose to contract the service, or the Quitline could provide the follow up information back to the hospital. Secondly, a greater variety of follow up methods are allowed in the final specifications including phone calls, clinic visits, e-mail, and letters via U.S. mail. If using e-mail and U.S. mail, the contact date would be the date information was received by the hospital not the date the e-mail or letter was sent.

Sampling was not allowed during the pilot test so that sufficient data could be collected during the six month pilot test. A sampling scheme has been introduced for implementation on a national scale. The sampling is described in the specifications section.

The Joint Commission plans on seeking funding to develop electronic specifications for the measure set.

Overall, to what extent was the criterion, *Feasibility*, met? H ☐ M ☒ L ☐ I ☐

Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes ☐ No ☒

Rationale:

If the Committee votes No, STOP.

If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND 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 before a final recommendation is made.

5.1 If there are related measures (*either same measure focus or target population*) or competing measures (*both the same measure focus and same target population*), list the NQF # and title of all related and/or competing measures:

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as [NQF-endorsed measure\(s\)](#): Are the measure specifications completely harmonized?

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

5b. Competing Measure(s)

5b.1 If this measure has 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*):

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): [The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois, 60181](#)

Co.2 Point of Contact: [JohnMarc, Alban, jalban@jointcommission.org, 630-792-5304-](#)

Co.3 Measure Developer if different from Measure Steward: [The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois, 60181](#)

Co.4 Point of Contact: [Jerod M., Loeb, PhD, jloeb@jointcommission.org, 630-792-5920-](#)

Co.5 Submitter: [Ann, Watt, MBA, RHIA, awatt@jointcommission.org, 630-792-5944-, The Joint Commission](#)

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Co.7 Public Contact: [Celeste, Milton, MPH, BSN, RN, cmilton@jointcommission.org, 630-792-5925-, The Joint Commission](#)

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development

Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

[The technical advisory panel determined priority areas in substance abuse for measure development. They reviewed public comments and were actively involved in all phases of the project to identify and develop the numerator and denominator statements. Measure recommendations for National Quality Forum](#)

endorsement were made after careful review of the pilot results and site feedback.

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.3 Year the measure was first released: 2011

Ad.4 Month and Year of most recent revision: 07, 2012

Ad.5 What is your frequency for review/update of this measure? Biannually

Ad.6 When is the next scheduled review/update for this measure? 07, 2013

Ad.7 Copyright statement: The Specifications Manual for National Hospital Inpatient Quality Measures (Specifications Manual) is the result of the collaborative efforts of the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission to publish a uniform set of national hospital quality measures. A primary objective of this collaborative effort is to promote and enhance the utility of these measures for all hospitals.

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Ad.8 Disclaimers:

Ad.9 Additional Information/Comments:

Date of Submission (MM/DD/YY): 07/12/2011