



## Measure Information

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

### Brief Measure Information

**NQF #:** 1654

**Corresponding Measures:**

**De.2. Measure Title:** TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment

**Co.1.1. Measure Steward:** The Joint Commission

**De.3. Brief Description of Measure:** The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom tobacco use treatment was provided during the hospital stay, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment during the hospital stay.

**1b.1. Developer Rationale:** It was the expert opinion of our advisory panel that implementation of this measure would lead to increased rates of tobacco use cessation. Hospitalization is an ideal time to encourage smokers to quit. During hospitalization, smokers are not allowed to smoke, are in contact with many health professionals, and may be more willing to accept assistance in quitting. (1) Many smokers quit, unaided, following hospitalization. (2) A meta-analysis found that those who receive intensive treatment during hospitalization and outpatient follow-up treatment for at least one month are more likely to quit than smokers receiving no treatment.(1,3)

The guideline panel for the Clinical Practice Guideline "Treating Tobacco Use and Dependence: 2008 Update", relied on the body of evidence from the original 1996 Guideline to determine the effectiveness of physician advice to quit smoking. There were too few studies to examine advice delivered by any other type of clinician, although one study found that advice to quit from health care providers in general did significantly increase quit rates.

Three separate meta-analyses were done to evaluate the effectiveness of clinician intervention on smoking abstinence rates. First, brief clinician intervention lasting about 3 minutes was compared to no intervention. This analysis showed that brief physician advice significantly increases long-term smoking abstinence rates. Patients who received physician advice to quit had an estimated abstinence rate of 10.2 as compared to those who received no advice to quit (7.9). The second analysis addressed the amount of time the clinician spent with a smoker addressing tobacco dependence in a single contact. Minimal counseling was defined as less than 3 minutes, low intensity counseling was defined as greater than 3 minutes to 10 minutes, and higher intensity counseling interventions were defined as greater than 10 minutes. All three session lengths significantly increased abstinence rates over those produced by no contact. There was a clear trend for abstinence rates to increase across the session lengths with higher intensity counseling producing the highest rates as shown below.

No contact - estimated odds ratio 95% CI = 1.0 - Abstinence rate 10.9

Minimal counseling - estimated odds ratio 95% CI = 1.3 - Abstinence rate 13.4

Low intensity counseling - estimated odds ratio 95% CI = 1.6 - Abstinence rate 16.0

Higher intensity counseling - estimated odds ratio 95% CI = 2.3 - Abstinence rate 22.1

Another meta-analysis was also done to evaluate the effectiveness of providing counseling in addition to medication versus medication alone. The results of this 2008 meta-analysis indicate that providing counseling in addition to medication significantly enhances treatment outcomes as illustrated below:

Medication alone Estimated odds ratio 95% CI = 1.0 - Estimated abstinence rate = 21.7

Medication and counseling - Estimated odds ratio 95% CI = .14 - Estimated abstinence rate =- 27.6

**S.4. Numerator Statement:** TOB-2: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the hospital stay.

TOB-2a: The number of patients who received practical counseling to quit AND received FDA-approved cessation medications

during the hospital stay.

**S.6. Denominator Statement:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users

**S.8. Denominator Exclusions:** The denominator has six exclusions:

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who are not current tobacco users
- Patients who refused or were not screened for tobacco use during the hospital stay.
- Patients who have a duration of stay less than or equal to day or greater than 120 days
- Patients with Comfort Measures Only documented

**De.1. Measure Type:** Process

**S.17. Data Source:** Electronic Health Records, Paper Medical Records

**S.20. Level of Analysis:** Facility, Other

**IF Endorsement Maintenance – Original Endorsement Date:** Mar 04, 2014 **Most Recent Endorsement Date:** Mar 04, 2014

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

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

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** Not Applicable

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

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

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

[1654\\_Evidence\\_MSF5.0\\_Data.doc](#)

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

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

### 1b. Performance Gap

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

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

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

IF a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

It was the expert opinion of our advisory panel that implementation of this measure would lead to increased rates of tobacco use cessation. Hospitalization is an ideal time to encourage smokers to quit. During hospitalization, smokers are not allowed to smoke, are in contact with many health professionals, and may be more willing to accept assistance in quitting. (1) Many smokers quit, unaided, following hospitalization. (2) A meta-analysis found that those who receive intensive treatment during hospitalization and outpatient follow-up treatment for at least one month are more likely to quit than smokers receiving no treatment.(1,3)

The guideline panel for the Clinical Practice Guideline “Treating Tobacco Use and Dependence: 2008 Update”, relied on the body of

evidence from the original 1996 Guideline to determine the effectiveness of physician advice to quit smoking. There were too few studies to examine advice delivered by any other type of clinician, although one study found that advice to quit from health care providers in general did significantly increase quit rates.

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Another meta-analysis was also done to evaluate the effectiveness of providing counseling in addition to medication versus medication alone. The results of this 2008 meta-analysis indicate that providing counseling in addition to medication significantly enhances treatment outcomes as illustrated below:

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Medication and counseling - Estimated odds ratio 95% CI = .14 - Estimated abstinence rate = 27.6

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

Most hospitals do not systematically address tobacco and when treatment (counseling and medication) is provided, it is not evidence-based. A pooled analysis of 33 hospital studies found that smoking status was assessed in 60% of patients, 42% of identified smokers were advised to quit, 14% were given or advised to use nicotine replacement, and 12% received referrals or follow-up.(4) A study found that adding a tobacco treatment order set to an existing computerized order entry system increased identification, referral, and treatment of smokers, but referral and treatment rates remained low (2.1% and 2.5%, respectively).(5) Even patients with tobacco-related illnesses fail to receive tobacco treatment. A test of quality care measures conducted among 83 hospitals in nine states found that only 65% of smokers with acute myocardial infarction (AMI), 39% of smokers with congestive heart failure (CHF), and 35% of smokers with community-acquired pneumonia (CAP) had received any form of counseling for smoking cessation during hospitalization.(6)

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

1. Rigotti N, Munafo M, Stead L. Interventions for smoking cessation in hospitalised patients. Cochrane Database Syst Rev. 2007;CD001837.[PubMed]

2. McBride CM, Emmons KM, Lipkus IM. Understanding the potential of teachable moments: The case of smoking cessation. Health Educ Res. 2003 Apr;18:156–170.[PubMed]

3. Rigotti NA, Munafo MR, Stead LF. Smoking cessation interventions for hospitalized smokers: A systematic review. Arch Intern Med. 2008 Oct 13;168:1950–1960.[PubMed]

4. Freund M, et al. Smoking care provision in hospitals: A review of prevalence. Nicotine Tob Res. 2008;10:757–774.[PubMed]

5. Koplan KE, et al. A computerized aid to support smoking cessation treatment for hospital patients. J Gen Intern Med. 2008 Aug;23:1214–1217. Epub May 9, 2008. [PMC free article][PubMed]

6. The Joint Commission. A Comprehensive Review of Development and Testing for National Implementation of Hospital Core Measures. 2002. [last accessed Sep. 16, 2009]. <http://www.jointcommission.org/NR/rdonlyres/48DFC95A-9C05-4A44-AB05-1769D5253014/0/AComprehensiveReviewofDevelopmentforCoreMeasures.pdf>.

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

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

The US Public Health Service Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update reviewed the literature on disparate populations in detail and found that treatment for general tobacco users is effective for treating tobacco users from disparate populations (see pages 143-176). The CPG recommendation (pg 143) is: "The interventions found to be effective in this Guideline have been shown to be effective in a variety of populations. In addition, many of the studies supporting these interventions comprised diverse samples of tobacco users. Therefore, interventions identified as effective in this Guideline are recommended for all individuals who use tobacco, except when medication use is contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = B)." Also, in a July 28, 2011 presentation to the Interagency Committee on Smoking and Health, chaired by U.S. Surgeon General Regina Benjamin, the epidemiology of cessation interventions targeting vulnerable (disparate) populations was reviewed and presented showing that treatment recommendations for the general population are effective with disparate populations.

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

Fiore MC et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

National Health Interview Survey, United States - 1965-2009. <http://www.cdc.gov/nchs/nhis.htm>

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

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

Screening

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

Elderly

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

[https://www.jointcommission.org/assets/1/6/HIQR\\_SpecsManual\\_v52a.zip](https://www.jointcommission.org/assets/1/6/HIQR_SpecsManual_v52a.zip)

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

This is not an eMeasure Attachment:

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

No data dictionary Attachment:

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

Yes

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

Updates were made to the data elements:

Reason for No Tobacco Cessation Medication During the Hospital Stay

Tobacco Use Status

ICD codes were updated to reflect the ICD-10 code updates for Fiscal Year (FY) 2017.

Medications were removed from Table 9.1 – FDA-Approved Tobacco Cessation Medications (in Appendix C of the specifications manual).

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

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

TOB-2: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the hospital stay.

TOB-2a: The number of patients who received practical counseling to quit AND received FDA-approved cessation medications during the hospital stay.

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

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

There are six data elements used to calculate the numerator:

1. ICD-10-CM Other Diagnosis Codes- The CMS ICD-10-CM master code table for other or secondary ICD-10-CM codes associated with the diagnosis for this hospitalization.

2. ICD-10-CM Principal Diagnosis Code- The CMS ICD-10-CM master code table for the diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

3. Reason for No Tobacco Cessation Medication During the Hospital Stay- Documentation of reasons for not administering an FDA-approved tobacco cessation medication during the hospital stay which include:

- Allergy to all of the FDA-approved tobacco cessation medications.
- Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking.
- Other reasons documented by physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist.

There are two allowable values: Y (Yes) and N (No)/UTD.

4. Tobacco Use Status:

Documentation of the adult patient's tobacco use status within the past 30 days prior to the day of hospital admission. Tobacco use includes all forms of tobacco including cigarettes, smokeless tobacco products, pipe, and cigars. A tobacco use screen should identify the type of tobacco product used, the volume used, and the timeframe of use.

There are 6 allowable values:

- 1 The patient has during the past 30 days:
    - smoked, on average, 5 or more cigarettes ( $\geq \frac{1}{4}$  pack) daily, and/or
    - smoked cigars and/or pipes daily.
  - 2 The patient has during the past 30 days:
    - smoked, on average, 4 or less cigarettes ( $< \frac{1}{4}$  pack) daily, and/or
    - smoked cigarettes, cigars and/or pipes, but not daily, and/or
    - used smokeless tobacco, regardless of frequency.
  3. The patient has not used any forms of tobacco in the past 30 days.
  4. The patient refused the tobacco use screen.
  5. The patient was not screened for tobacco use during this hospitalization or unable to determine the patient's tobacco use status from medical record documentation.
  6. The patient was not screened for tobacco use during the first day of admission because of cognitive impairment.
5. Tobacco Use Treatment FDA-Approved Cessation Medication - Documentation the patient received FDA-approved tobacco cessation medication during the hospital stay. There are 3 allowable values:
- 1 The patient received one of the FDA-approved tobacco cessation medications during the hospital stay.
  - 2 The patient refused the FDA-approved tobacco cessation medications during the hospital stay.
  - 3 FDA-approved tobacco cessation medications were not offered to the patient during the hospital stay or unable to determine from medical record documentation.
6. Tobacco Use Treatment Practical Counseling- Documentation that the patient received all three components of practical counseling which requires interaction with the patient to address the following: recognizing danger situations, developing coping skills, and providing basic information about quitting. There are three allowable values:
- 1 The patient received all components of practical counseling during the hospital stay.
  - 2 The patient refused/declined practical counseling during the hospital stay.
  - 3 Practical counseling was not offered to the patient during the hospital stay or unable to determine if tobacco use treatment was provided from medical record documentation.

The ICD-10-CM Principal and Other Diagnosis Codes are used to identify pregnant tobacco users as this is one of the populations that is excluded from receiving the FDA approved cessation medications. For ease of data collection burden, the codes are used to remove this group from the need for FDA approved cessation medication. Reason for No Tobacco Cessation Medication During the Hospital Stay will allow those cases with good reason to not receive cessation medication to still receive credit for the measures. If counseling is provided these cases will flow to the numerator. Tobacco Use Status is used if a value is selected that indicates the patient uses tobacco products, he/she will be in the measure population and eligible to receive treatment. However this data element is also used to exclude certain populations (light smokers and smokeless tobacco users) from receiving FDA approved medications (a numerator condition). Tobacco Use Treatment Practical Counseling and Tobacco Use Treatment FDA-Approved Cessation Medication will flow cases to the numerator if the patient receives the treatment. Practical counseling must include a bedside discussion with the clinician, and address danger situations, developing coping skills and provide basic information about quitting. If these components are not addressed, credit cannot be given. For all data elements, notes for abstraction are included along with suggested data sources in the data dictionary. Full specifications for version 5.2a of the Specifications Manual for National Hospital Inpatient Quality Measures Discharges 01-01-17 through 12-31-17 can be viewed on the Joint Commission web site at the following link: [https://www.jointcommission.org/assets/1/6/HIQR\\_SpecsManual\\_v52a.zip](https://www.jointcommission.org/assets/1/6/HIQR_SpecsManual_v52a.zip)

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

The number of hospitalized inpatients 18 years of age and older identified as current tobacco users

**S.7. Denominator Details** *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with*



*descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

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

There are five data elements that define the denominator:

1. Admission Date - The month, day and year of admission to acute inpatient care.
2. Birthdate - The month, day and year the patient was born.
3. Comfort Measures Only- Documentation that the patient was receiving medical treatment where the natural dying process is permitted to occur while assuring maximum comfort. There are four allowable values:
  - 1 Day 0 or 1: The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).
  - 2 Day 2 or after: The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).
  - 3 Timing unclear: There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.
  - 4 Not Documented/UTD: There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.
4. Discharge Date - The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay.

5. Tobacco Use Status:

Documentation of the adult patient's tobacco use status within the past 30 days prior to the day of hospital admission. Tobacco use includes all forms of tobacco including cigarettes, smokeless tobacco products, pipe, and cigars. A tobacco use screen should identify the type of tobacco product used, the volume used, and the timeframe of use.

There are 6 allowable values:

- 1 The patient has during the past 30 days:
  - smoked, on average, 5 or more cigarettes ( $\geq \frac{1}{4}$  pack) daily, and/or
  - smoked cigars and/or pipes daily.
- 2 The patient has during the past 30 days:
  - smoked, on average, 4 or less cigarettes ( $< \frac{1}{4}$  pack) daily, and/or
  - smoked cigarettes, cigars and/or pipes, but not daily, and/or
  - used smokeless tobacco, regardless of frequency.
- 3 The patient has not used any forms of tobacco in the past 30 days.
- 4 The patient refused the tobacco use screen.
- 5 The patient was not screened for tobacco use during this hospitalization or unable to determine the patient's tobacco use status from medical record documentation.
- 6 The patient was not screened for tobacco use during the first day of admission because of cognitive impairment.

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

The denominator has six exclusions:

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who are not current tobacco users
- Patients who refused or were not screened for tobacco use during the hospital stay.
- Patients who have a duration of stay less than or equal to day or greater than 120 days
- Patients with Comfort Measures Only documented

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

The patient age in years is equal to the admission date minus the birthdate. The month and day portion of the admission date and

birthdate are used to calculate the most accurate age. If the patient age is less than 18 years the patient is not in the population. Length of stay (LOS) in days is equal to the discharge date minus the admission date. If the LOS is greater than 120 days or equal to or less than 1 day, the patient is not in the population. Tobacco Use Status is used to exclude patients who have not used tobacco products, patients who refused the tobacco use screen or patients with cognitive impairment. If the patient is receiving comfort measures only which is medical treatment where the natural dying process is permitted to occur while assuring maximum comfort, the patient will also be excluded from the population.

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

Not Applicable, the measure is not stratified. However there is a subset measure TOB-2a which removes patients from the numerator who refused the bedside counseling and an FDA-approved tobacco cessation medication. This measure was added as a result of a sub-analysis performed on the pilot data. Because those who refuse counseling or medication are put in the numerator, we looked at the numerator to determine how many patients actually received the counseling and FDA approved medications. Only 45% of those who were in the numerator received both counseling and medication. For measures that are to be publicly reported, it was felt transparency was important so this measure was added as a subset.

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

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Rate/proportion

If other:

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

Better quality = Higher score

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

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 for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB-2a.
  - 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 for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB-2a.
  - b. If Length of Stay is greater than 1 day, continue processing and proceed to check Comfort Measures Only.
6. Check Comfort Measures Only
  - a. If Comfort Measures Only is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB-2a.
  - b. If Comfort Measures Only is equal to 1, 2, or 3, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure



Category Assignment for sub-measure TOB-2a.

- c. If Comfort Measures Only is equal to 4, continue processing and proceed to check Tobacco Use Status.
7. Check Tobacco Use Status
  - a. If Tobacco Use Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB-2a.
  - b. If Tobacco Use Status equals 3, 4, 5, or 6, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB-2a.
  - c. If Tobacco Use Status equals 1 or 2, continue processing and proceed to check Tobacco Use Treatment Practical Counseling.
8. Check Tobacco Use Treatment Practical Counseling
  - a. If Tobacco Use Treatment Practical Counseling is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB-2a.
  - b. If Tobacco Use Treatment Practical Counseling equals 3, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB 2a.
  - c. If Tobacco Use Treatment Practical Counseling equals 1 or 2, continue processing and proceed to ICD-10-CM Principal or Other Diagnosis Codes.
9. Check ICD-10-CM Principal or Other Diagnosis Codes
  - a. If at least one of ICD-10-CM Principal or Other Diagnosis Codes is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB 2a.
  - b. If none of ICD-10-CM Principal or Other Diagnosis Codes is on Table 12.3 continue processing and proceed to recheck Tobacco Use Status.
10. Recheck Tobacco Use Status
  - a. If Tobacco Use Status equals 2, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB 2a.
  - b. If Tobacco Use Status equals 1, continue processing and proceed to Tobacco Use Treatment FDA-Approved Cessation Medication.
11. Check Tobacco Use Treatment FDA-Approved Cessation Medication
  - a. If Tobacco Use Treatment FDA-Approved Cessation Medication is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB-2a.
  - b. If Tobacco Use Treatment FDA-Approved Cessation Medication equals 3 continue processing and proceed to Reason for No Tobacco Cessation Medication During Hospital Stay.
  - c. If Tobacco Use Treatment FDA-Approved Cessation Medication equals 1 or 2 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB 2a.
12. Check Reason for No Tobacco Cessation Medication During Hospital Stay
  - a. If Reason for No Tobacco Cessation Medication During Hospital Stay is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB-2a.
  - b. If Reason for No Tobacco Cessation Medication During Hospital Stay equals N, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB-2a.
  - c. If Reason for No Tobacco Cessation Medication During Hospital Stay equals Y, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate TOB-2. Continue processing and proceed to Step 13 to Initialize Measure Category Assignment for sub-measure TOB 2a.
13. Initialize Measure Category Assignment for sub-measure TOB-2a to Measure Category Assignment of B. Do not change the Measure Category Assignment that was already calculated for the overall measure TOB-2. The rest of the algorithm will reset the appropriate Measure Category Assignment to TOB-2a.
14. Check Overall Rate Category Assignment

- a. If Overall Rate Category Assignment equals X, the case will proceed to a Measure Category Assignment of X and will not be in the Measure Population for sub-measure TOB-2a. Stop processing.
  - b. If the Overall Rate Category Assignment equals B, the case will proceed to Measure Category Assignment of B and will not be in the Measure Population for sub-measure TOB-2a. Stop processing.
  - c. If Overall Rate Category Assignment equals D or E, continue processing and proceed to recheck Referral for Tobacco Use Treatment Practical Counseling.
15. Recheck Tobacco Use Treatment Practical Counseling
- a. If Tobacco Use Treatment Practical Counseling equals 2 or 3, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for sub-measure TOB-2a. Stop processing.
  - b. If Tobacco Use Treatment Practical Counseling equals 1, continue processing and proceed to recheck ICD-10-CM Principal or Other Diagnosis Codes.
16. Recheck ICD-10-CM Principal or Other Diagnosis Codes
- a. If at least one of ICD-10-CM Principal or Other Diagnosis Codes is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-2a. Stop processing.
  - b. If none of ICD-10-CM Principal or Other Diagnosis Codes is on Table 12.3 continue processing and proceed to recheck Tobacco Use Status.
17. Recheck Tobacco Use Status
- a. If Tobacco Use Status equals 2, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-2a. Stop processing.
  - b. If Tobacco Use Status equals 1, continue processing and proceed to recheck Tobacco Use Treatment FDA-Approved Cessation Medication.
18. Recheck Tobacco Use Treatment FDA-Approved Cessation Medication
- a. If Tobacco Use Treatment FDA-Approved Cessation Medication equals 2, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for sub-measure TOB-2a. Stop processing.
  - b. If Tobacco Use Treatment FDA-Approved Cessation Medication equals 1, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-2a. Stop processing.
  - c. If Tobacco Use Treatment FDA-Approved Cessation Medication equals 3, continue processing and proceed to recheck Reason for No Tobacco Cessation Medication During Hospital Stay.
19. Recheck Reason for No Tobacco Cessation Medication During Hospital Stay
- a. If Reason for No Tobacco Cessation Medication During Hospital Stay equals N, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for sub-measure TOB-2a. Stop processing.
  - b. If Reason for No Tobacco Cessation Medication During Hospital Stay equals Y, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-2a. Stop processing.

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

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

The global 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 Global 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.

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

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

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

*If other, please describe in S.18.*

Electronic Health Records, Paper Medical Records

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

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Each data element in the data dictionary includes suggested data sources.

The Joint Commission developed a web-based data collection tool that was used by hospitals during the pilot test and for reliability testing. 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. Measure sets cannot be offered to hospitals by the vendor until verification has been passed.

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

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

Facility, Other

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

Hospital, Inpatient/Hospital

If other:

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

## **2. Validity – See attached Measure Testing Submission Form**

[1654\\_MeasureTesting\\_MSF5.0\\_Data.doc](#)

### **2.1 For maintenance of endorsement**

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

### **2.2 For maintenance of endorsement**

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

### **2.3 For maintenance of endorsement**

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of  $p < 0.10$ ; correlation of  $x$  or higher; patient factors should be present at the start of care)

*What were the statistical results of the analyses used to select risk factors?*

*Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)*

### 3. Feasibility

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

#### 3a. Byproduct of Care Processes

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

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

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)

If other:

#### 3b. Electronic Sources

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

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

Some data elements are in defined fields in electronic sources

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

The Joint Commission is in the process of preparing for conversion to eMeasure specifications beginning in 2013 for the TOB measure set, including this measure.

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

Attachment:

#### 3c. Data Collection Strategy

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

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

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

There was some question as to how often a patient should be screened for cognitive impairment as this condition can be transient. The TAP decided that the patient should be screened once at the designated time of screening and if impaired the case would be

excluded. This will exclude some patients whose cognitive impairment is temporary, but the larger advantage would be easing the burden of data collection/abstraction.

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.

A secondary analysis of the pilot data indicated that only 45% of the patients in the numerator actually received both a referral and prescription for one of the FDA approved medications. As a result, a subset measure was added which will report only those who received the recommended treatment (practical counseling and one of the FDA approved medications). Those who refuse are not included in the rate.

Additional notes for abstraction were added to data elements such as Tobacco Use Treatment Practical Counseling to give more definition to the required components that are to be covered by counseling. New notes for abstraction also addressed how to handle FDA approved cessation medications that are ordered PRN.

The Joint Commission plans on seeking funding for the development of electronic specifications for the measure set.

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

## 4. Usability and Use

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

### 4a. Accountability and Transparency

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

#### 4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	
Regulatory and Accreditation Programs	
Quality Improvement (Internal to the specific organization)	

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

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

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

access to performance results or impede implementation?)

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

#### Improvement

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

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

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

#### 4c. Unintended Consequences

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

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

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

**4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

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

Not applicable. Not seeking endorsement + designation at this time.

**4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

Not applicable. Not seeking endorsement + designation at this time.

**4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

Describe how feedback was obtained.

Not applicable. Not seeking endorsement + designation at this time.

**4d2.2. Summarize the feedback obtained from those being measured.**

Not applicable. Not seeking endorsement + designation at this time.

**4d2.3. Summarize the feedback obtained from other users**

Not applicable. Not seeking endorsement + designation at this time.



**4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

Not applicable. Not seeking endorsement + designation at this time.

## 5. Comparison to Related or Competing Measures

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

### 5. Relation to Other NQF-endorsed Measures

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

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

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

### 5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

No

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

A conference call was held between NCQA, TJC and the University of Wisconsin to discuss the differences between the measures. The Joint Commission measure and the University of Wisconsin measure are harmonized however there are still differences with the NCQA measure. Attempts were made to discuss harmonization with the AMA and e-mails were exchanged with the University of Wisconsin indicating the AMA would consider harmonization if the measures were endorsed by the NQF. The target population for the AMA and NCQA measure is outpatient rather than inpatient. Our measure requirement for counseling includes recognizing danger situations, developing coping skills, and providing basic information about quitting. These components are taken directly from the guidelines. It is not clear that measure 0027 covers the same components. Our measure also requires that both counseling and FDA approved medications be given which is also a reflection of the guidelines. We don't believe that measure 0027 requires both.

### 5b. Competing Measures

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

**OR**

Multiple measures are justified.

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

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

Not applicable because the target population is different.

<b>Appendix</b>
<p><b>A.1 Supplemental materials may be provided in an appendix.</b> All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.</p> <p><b>Attachment:</b></p>
<b>Contact Information</b>
<p><b>Co.1 Measure Steward (Intellectual Property Owner):</b> <a href="#">The Joint Commission</a></p> <p><b>Co.2 Point of Contact:</b> <a href="#">JohnMarc, Alban, jalban@jointcommission.org, 630-792-5304-</a></p> <p><b>Co.3 Measure Developer if different from Measure Steward:</b> <a href="#">The Joint Commission</a></p> <p><b>Co.4 Point of Contact:</b> <a href="#">Jerod M, Loeb, jloeb@jointcommission.org, 630-792-5920-</a></p>
<b>Additional Information</b>
<p><b>Ad.1 Workgroup/Expert Panel involved in measure development</b>  <b>Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.</b>  <a href="#">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.</a></p>
<p><b>Measure Developer/Steward Updates and Ongoing Maintenance</b></p> <p><b>Ad.2 Year the measure was first released:</b> <a href="#">2011</a></p> <p><b>Ad.3 Month and Year of most recent revision:</b> <a href="#">07, 2012</a></p> <p><b>Ad.4 What is your frequency for review/update of this measure?</b> <a href="#">Biannually</a></p> <p><b>Ad.5 When is the next scheduled review/update for this measure?</b> <a href="#">07, 2013</a></p>
<p><b>Ad.6 Copyright statement:</b> <a href="#">The Specifications Manual for National Hospital Inpatient Quality Measures (Specifications Manual) is the result of the collaborative efforts of the Centers for Medicare &amp; 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.</a></p> <p><a href="#">No royalty or use fee is required for copying or reprinting this manual, but the following are required as a condition of usage: 1) disclosure that the Specifications Manual is periodically updated, and that the version being copied or reprinted may not be up-to-date when used unless the copier or printer has verified the version to be up-to-date and affirms that, and 2) users participating in the QIO supported initiatives, the Hospital Inpatient Quality Reporting Program, and Joint Commission accreditation; including performance measures systems; are required to update their software and associated documentation based on the published manual production timelines.</a></p> <p><a href="#">Example Acknowledgement: The Specifications Manual for National Hospital Inpatient Quality Measures [Version xx, Month, Year] is the collaborative work of the Centers for Medicare &amp; Medicaid Services and The Joint Commission. The Specifications Manual is periodically updated by the Centers for Medicare &amp; Medicaid Services and The Joint Commission. Users of the Specifications Manual for National Hospital Inpatient Quality Measures must update their software and associated documentation based on the published manual production timelines.</a></p>
<p><b>Ad.7 Disclaimers:</b></p>
<p><b>Ad.8 Additional Information/Comments:</b></p>