



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 #: 1661

Corresponding Measures:

De.2. Measure Title: SUB-1 Alcohol Use Screening

Co.1.1. Measure Steward: The Joint Commission

De.3. Brief Description of Measure: Hospitalized patients 18 years of age and older who are screened within the first day of admission using a validated screening questionnaire for unhealthy alcohol use.

1b.1. Developer Rationale: It was the expert opinion of our advisory panel that implementation of this measure would lead to the provision of brief interventions for patients at risk for alcohol related illnesses.

Evidence-based screening instruments exist that can detect harmful alcohol and other drug use. Brief interventions that can be delivered during a single primary care office visit have been tested in multiple randomized trials, including a multi-center one in the Medicare eligible age group. They demonstrate that screening and intervention significantly reduce health risks, and generate cost-savings of approximately \$4 dollars for every dollar invested in providing them. (Fleming 1999)

Clinical trials have demonstrated that brief interventions, especially prior to the onset of addiction, significantly improve health and reduce costs, and that similar benefits occur in those with addictive disorders who are referred to treatment (SAMHSA 2007, NIAAA 2005, Fleming 2002).

S.4. Numerator Statement: The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first day of admission.

S.6. Denominator Statement: The number of hospitalized inpatients 18 years of age and older

S.8. Denominator Exclusions: The denominator has four exclusions:

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who have a duration of stay less than or equal to one 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

[1661_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 the provision of brief interventions for patients at risk for alcohol related illnesses.

Evidence-based screening instruments exist that can detect harmful alcohol and other drug use. Brief interventions that can be delivered during a single primary care office visit have been tested in multiple randomized trials, including a multi-center one in the Medicare eligible age group. They demonstrate that screening and intervention significantly reduce health risks, and generate cost-savings of approximately \$4 dollars for every dollar invested in providing them. (Fleming 1999)

Clinical trials have demonstrated that brief interventions, especially prior to the onset of addiction, significantly improve health and reduce costs, and that similar benefits occur in those with addictive disorders who are referred to treatment (SAMHSA 2007, NIAAA 2005, Fleming 2002).

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.

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 (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. 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.

- 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.
- Kerr E, McGlynn E, Adams J, Kessey J, Asch SM. Profiling the Quality of Care in Twelve Communities: Results from the CQI Study. *Health Affairs.* 2004 May/June; Volume 23, Number 3: 247-256.
- 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.

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.

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.*

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. 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

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.

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):*

Behavioral Health : Alcohol, Substance Use/Abuse

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

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.

The denominator exclusion was changed from a length of stay of less than or equal to 3 days to a length of stay of less than or equal to 1 day.

The numerator was updated to adjust the time frame for screening from within 3 days of admission to within one day of admission.

Updates were made to the data element: Alcohol Use Status

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

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).

The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first day of admission.

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 is one data element used to calculate the numerator:

1. Alcohol Use Status- Documentation of the adult patient's alcohol use status using a validated screening questionnaire for unhealthy alcohol use within the first day of admission. There are seven allowable values:

1 The patient is screened with a validated tool within the first day of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.

2 The patient was screened with a validated tool within the first day of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.

3 The patient was screened with a non-validated tool within the first day of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.

4 The patient was screened with a non-validated tool within the first day of admission and the score on the alcohol screen

indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.

5 The patient refused the screen for alcohol use within the first day of admission.

6 The patient was not screened for alcohol use during the first day of admission or unable to determine from medical record documentation.

7 The patient was not screened for alcohol use during the first day of admission because of cognitive impairment.

The patients in the numerator (those who were screened for alcohol use status) are a subset of the denominator. The data element "Alcohol Use Status" is used to screen or examine methodologically in order to make a separation into different groups. A validated tool has been defined as an instrument that has been psychometrically tested for reliability, validity, sensitivity and specificity. The current measure specifications give an example of a validated screening tool in the definition of the data element Alcohol Use Status. A reference list of validated tools includes tools such as the AUDIT, AUDIT-C, AUDIT-PC, ASSIST, TWEAK, CAGE, CRAFFT, MAST, G-MAST. Patients who refuse an alcohol use status screen are also included in the numerator. A note for abstraction indicates that if there is a blood alcohol test with a result of .08 or a note indicative of acute intoxication, that result may be substituted for the screen and the value indicative of benefiting from brief intervention should be selected. The full data element page may be viewed at: 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

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).

Five data elements are used to calculate the denominator:

1. Admission Date- The month, day and year of admission to acute inpatient care.

2. Alcohol Use Status- Documentation of the adult patient's alcohol use status using a validated screening questionnaire for unhealthy alcohol use within the first day of admission. There are seven allowable values:

1 The patient is screened with a validated tool within the first day of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.

2 The patient was screened with a validated tool within the first day of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.

3 The patient was screened with a non-validated tool within the first day of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.

4 The patient was screened with a non-validated tool within the first day of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.

5 The patient refused the screen for alcohol use within the first day of admission.

6 The patient was not screened for alcohol use during the first day of admission or unable to determine from medical record documentation.

7 The patient was not screened for alcohol use during the first day of admission because of cognitive impairment.

3. Birthdate- The month, day and year the patient was born.

4. 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.

5. Discharge Date- The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay.

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

The denominator has four exclusions:

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who have a duration of stay less than or equal to one 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 yield the most accurate age. If the patient age is less than 18 years of age 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 1 day or less, the patient is not in the population. 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 be excluded from the population. Alcohol Use Status is used to exclude patients with cognitive impairment.

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

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. 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 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. Stop processing.
- 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. Stop processing.
- c. If Comfort Measures Only is equal to 4, continue processing and proceed to check Alcohol Use Status.
7. 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 7, 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 1, 2, 3, 4, 5, or 6, continue processing and proceed to recheck Alcohol Use Status.
8. Recheck Alcohol Use Status
- a. If Alcohol Use Status equals 1, 2 or 5, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.
- b. If Alcohol Use Status equals 3, 4 or 6, the case will proceed to Measure Category Assignment of D and will be in the Measure Population. 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 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.

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.

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 cannot offer a measure set to hospitals until the vendor has passed verification for the measure set.

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

[1661_MeasureTesting_MS5.0_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 SUB 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.

The TAP discussed the two-phased approach to screening and determined that a single-question validated tool could be used to screen out negative cases. New allowable values were added to the data element for Alcohol Use Status to identify those screened with non validated tools so that patients who received a brief intervention (SUB-2) would get credit for it even if screened with a non-validated tool. However, such cases would fail the screening measure.

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 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?

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

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.)

Appendix

A.1 Supplemental materials may be provided in an appendix. 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.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [The Joint Commission](#)

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](#)

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

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: [2011](#)

Ad.3 Month and Year of most recent revision: [07, 2012](#)

Ad.4 What is your frequency for review/update of this measure? [Biannually](#)

Ad.5 When is the next scheduled review/update for this measure? [07, 2013](#)

Ad.6 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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manual production timelines.

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Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: