	Measure 0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (National Committee for Quality Assurance)
Description	This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug (AOD) abuse and dependence services and the degree to which members initiate and continue treatment once the need has been identified. Two rates are reported: • Initiation of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.
Numerator	Initiation of AOD Treatment: Initiation of treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. --- Engagement of AOD Treatment: Initiation of AOD treatment and two or more additional AOD services or medication treatment within 34 days of the initiation visit.
Numerator Details	Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. • For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification or ED visit (not resulting in an inpatient stay), the IESD is the date of service. • For an inpatient stay, the IESD is the date of discharge. • For an ED and observation visits that results in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort). • For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort). INITIATION OF AOD TREATMENT Initiation of AOD treatment within 14 days of the IESD. If the Index Episode was an inpatient discharge (or an ED visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant. If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation: • An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:

	• Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). • Identify the admission date for the stay. • IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set). • IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set). • A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An online assessment (Online Assessment Value) set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set). • If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set). For all initiation events except medication treatment (AOD Medication Treatment Value Set; Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List), initiation on the same day as the IESD must be with different providers in order to count. • If a member is compliant for the Initiation numerator for any diagnosis cohort (i.e., alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns. • Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. --- ENGAGEMENT OF AOD TREATMENT

	1) Numerator compliant for the Initiation of AOD Treatment numerator and 2) Members whose initiation of AOD treatment was a medication treatment event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List; AOD Medication Treatment Value Set). These members are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event. 3) Remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 2). These members are numerator compliant if they meet either of the following: • At least one engagement medication treatment event. • At least two engagement visits Two engagement visits can be on the same date of service, but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers). Engagement visits: Any of the following meet criteria for an engagement visit: • An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions: – Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). – Identify the admission date for the stay. • IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

	• A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An online assessment (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. Engagement Medication Treatment Events: Either of the following meets criteria for an engagement medication treatment event: • If the IESD diagnosis was a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Medication Treatment for Alcohol Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment. • If the IESD diagnosis was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment. If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total Column is not the sum of the diagnosis columns.
Denominator	Patients age 13 years of age and older as of December 31 of the measurement year who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).
Denominator Details	Identify the Index Episode. Identify all members 13 years and older as of December 31 of the measurement year who during the Intake Period had one of the following: • An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria: – IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug

	Abuse and Dependence Value Set. • An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An acute or nonacute inpatient discharge with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges: – Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). – Identify the discharge date for the stay. • A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An online assessment (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. For members with more than one episode of AOD abuse or dependence, use the first episode. For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD. Select the Index Episode Start Date.
Exclusions	Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List) during the 60 days (2 months) before the IESD. Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
Exclusion details	Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set) - For an inpatient Index Episode Start Date, use the admission date to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence. - For an ED visit that results in an inpatient event, use the ED date of service to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence. - For direct transfers, use the first admission to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

	Exclude from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) patients whose initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	The total population is stratified by age: 13-17 and 18+ years of age. • Report two age stratifications and a total rate. • The total is the sum of the age stratifications. Report the following diagnosis cohorts for each age stratification and the total rate: • Alcohol abuse or dependence. • Opioid abuse or dependence. • Other drug abuse or dependence. • Total.
Type	Process
Type of Score	Rate/proportion
Data Source	Claims
Level	Health Plan
Setting	Emergency Department and Services, Inpatient/Hospital, Outpatient Services

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	Measure 1651: TOB-1 Tobacco Use Screening (The Joint Commission)
Description	Hospitalized patients age 18 years and older who are screened within the first day of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days.
Numerator	The number of patients who were screened for tobacco use status within the first day of admission.
Numerator Details	There is one data element used to calculate the numerator: 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 (>=¼ 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 (<¼ 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. Tobacco Use Status is used to screen or examine methodologically in order to make a separation into different groups that address the various tobacco products or combinations thereof and the volume and frequency of use as well as the timeframe of use. Notes for abstraction are included along with suggested data sources. 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
Denominator	The number of hospitalized inpatients 18 years of age and older
Denominator Details	Five data elements are used to calculate 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. Discharge Date - The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay. 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. 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 (>=¼ 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 (<¼ 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.
Exclusions	The denominator has four exclusions: • Patients less than 18 years of age • Patients who are cognitively impaired • Patients who a have a length of stay less than or equal to one day or greater than 120 days • Patients who are receiving comfort measures only
Exclusion details	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 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. 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. Tobacco Use Status is used to exclude patients with cognitive impairment.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not Applicable, the measure is not stratified.
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Health Records, Paper Medical Records
Level	Facility, Other
Setting	Inpatient/Hospital

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	Measure 1654: TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment (The Joint Commission)
Description	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.
Numerator	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.
Numerator Details	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 (>=¼ 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 (<¼ 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
Denominator	The number of hospitalized inpatients 18 years of age and older identified as current tobacco users
Denominator Details	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 (>=¼ 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 (<¼ 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.
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
Exclusion details	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.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not Applicable, the measure is not stratified. However there is a subset mesure 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.
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Health Records, Paper Medical Records
Level	Facility, Other
Setting	Hospital, Inpatient/Hospital

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	Measure 1656: TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge (The Joint Commission)
Description	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age an older to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment at discharge. Treatment at discharge includes a referral to outpatient counseling and a prescription for one of the FDA-approved tobacco cessation medications.
Numerator	TOB-3: The number of patients who received or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge TOB-3a: The number of patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication at discharge.
Numerator Details	There are six data elements that are 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. Prescription for Tobacco Cessation Medication – Documentation that a FDA-approved cessation medication was prescribed at the time of discharge. There are 4 allowable values: 1 A prescription for an FDA-approved tobacco cessation medication was given to the patient at discharge. 2 A prescription for an FDA-approved tobacco cessation medication was offered at discharge and the patient refused. 3 The patient's residence is not in the USA. 4 A prescription for an FDA-approved tobacco cessation medication was not offered at discharge or unable to determine from medical record documentation. 4. Reason for No Tobacco Cessation Medication at Discharge – Documentation Reasons for not prescribing an FDA-approved tobacco cessation medication at discharge include: allergy to all of the FDA-approved tobacco cessation medications and drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking and 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 5. Referral for Outpatient Tobacco Cessation Counseling - Documentation that a referral was made at discharge for ongoing evidence-based counseling with clinicians (physician or non-physician such as nurse, psychologist, counselor). There are 5 allowable values for this data element:

	1 The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider or health care organization at any time prior to discharge. 2 Referral information was given to the patient at discharge but the appointment was not made by the provider or health care organization prior to discharge. 3 The patient refused the referral for outpatient tobacco cessation counseling treatment and the referral was not made. 4 The patient's residence is not in the USA. 5 The referral for outpatient tobacco cessation counseling treatment was not offered at discharge or unable to determine from the medical record documentation. 6. 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 (>=¼ 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 (<¼ 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. 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. Prescription for Tobacco Cessation Medication identifies those patients who were given a prescription for FDA-approved cessation medication at discharge as well as those who had documented on the discharge medication list over the counter cessation medications. This is a condition to be satisfied for the numerator. Reason for No Tobacco Cessation Medication at Discharge allows for documentation by the practitioner of a reason for not giving a prescription for tobacco cessation medication at discharge. If answered in the affirmative, the case will be in the numerator if the referral for outpatient counseling is made. Referral for Outpatient Tobacco Cessation Counseling distinguishes between a referral that was made by the health care provider and a referral that was given to the patient at discharge but arrangements/appointment not made. The data element also excludes patients who are not residents of the USA as referrals cannot be made when the patient is returning home to another country. To be in the numerator, the referral must be made by the healthcare provider prior to the patient´s discharge. Tobacco Use Status is used to identify patients who require a referral for outpatient tobacco cessation counseling

	and/or a prescription for tobacco cessation medication. 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
Denominator	The number of hospitalized inpatients 18 years of age and older identified as current tobacco users
Denominator Details	There are six data elements that are used to calculate 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. Discharge Disposition- The place or setting to which the patient was discharged. 6. 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 (>=¼ 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 (<¼ 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.
Exclusions	There are 12 exclusions to the measure: 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 status during the hospital stay (as tobacco status cannot be known) Patients who have a length of stay less than or equal to one day or greater than 120 days Patients who expired Patients who left against medical advice Patients discharged to another hospital Patients discharged to another health care facility Patients discharged to home for hospice care Patients who do not reside in the United States Patients with Comfort Measures Only documented
Exclusion details	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. 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. The data element Tobacco Use Status is used to exclude patients who do not use tobacco products, refused a tobacco use screen or are cognitively impaired Discharge disposition is used to exclude patients who expire, leave AMA, are discharged to another hospital or another health care facility, or who are discharged to hospice care. Patients who do not reside in the USA are excluded by virtue of allowable value 4 in the Data Element Referral for Outpatient Tobacco Cessation Counseling, or value 3 for the data element Prescription for Tobacco Cessation Medication.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	The measure is not stratified, however there is a subset measure that removes from the overall rate those patients who refused the referral to outpatient counseling and refused the FDA approved medications. A secondary analysis of the pilot data indicated that only 21% 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 receive the recommended treatment (referral and prescription). Those who refuse are not included in the rate. The data element Referral for Outpatient Tobacco Cessation Counseling through value 3 (patient refused) and the data element Prescription for Tobacco Cessation Medication through value 2 (patient refused) removes

	these patients from the numerator calculation in the subset measure TOB-3a.
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Health Records, Paper Medical Records
Level	Facility, Other
Setting	Hospital, Inpatient/Hospital

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	Measure 1661: SUB-1 Alcohol Use Screening (The Joint Commission)
Description	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.
Numerator	The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first day of admission.
Numerator Details	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
Denominator	The number of hospitalized inpatients 18 years of age and older
Denominator	Five data elements are used to calculate the denominator:

Details	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.
Exclusions	The denominator has four exclusions: • Patients less than 18 years of age • Patients who are cognitively impaired • Patients who a have a duration of stay less than or equal to one day or greater than 120 days • Patients with Comfort Measures Only documented
Exclusion details	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.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not Applicable, the measure is not stratified
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Health Records, Paper Medical Records
Level	Facility, Other
Setting	Hospital, Inpatient/Hospital

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	Measure 1663: SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention (The Joint Commission)
Description	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included.
Numerator	SUB-2 The number of patients who received or refused a brief intervention. SUB-2a The number of patients who received a brief intervention.
Numerator Details	One data element is used to calculate the numerator. 1. A brief Intervention is a single session or multiple sessions conducted by a qualified healthcare professional or trained peer support person with the patient, following a positive screen for unhealthy alcohol use. The intervention includes motivational discussion focused on increasing insight and awareness regarding alcohol use and motivation toward behavioral change. Brief interventions can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at risk as well as a vehicle for engaging those in need of more extensive levels of care. A brief intervention focuses on increasing the patient's understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to. The brief intervention may be given by a variety of healthcare professionals such as physician, nurse, certified addictions counselor, psychologist, social worker, or health educator with training in brief intervention. There are three allowable values: 1. The patient received the components of a brief intervention. 2. The patient refused/declined the brief intervention. 3. Brief counseling was not offered to the patient during the hospital stay or unable to determine if a brief intervention was provided from medical record documentation. Full specifications can be viewed on the Joint Commission web site at www.jointcommission.org at the following link: https://www.jointcommission.org/assets/1/6/HIQR_SpecsManual_v52a.zip
Denominator	The number of hospitalized inpatients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence).
Denominator Details	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.
Exclusions	The denominator has five exclusions as follows: • Patients less than 18 years of age • Patient who are cognitively impaired • Patients who refused or were not screened for alcohol use during the hospital stay • Patients who have a length of stay less than or equal to one day and greater than 120 days • Patients receiving Comfort Measures Only documented
Exclusion details	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 the patient is not in the population. Length of

	stay (LOS) in days is equal to the discharge date minus the admission date. Patients with a length of stay of one day or less or who have a length of stay of greater than 120 days are not in the population. Patients who are cognitively impaired will be excluded from the measure population with the data element Alcohol Use Status. The definition for Cognitive Impairment is as follows: Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set relates to documentation that the patient cannot be screened for alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss). Temporary cognitive impairment due to acute substance use such as overdose or acute intoxication is excluded from the definition and will not qualify as cognitive impairment. Alcohol Use Status is used to identify patients who were no risk or low risk, refused a screen or were not screened for alcohol use during the hospital, so they will not be included in the measure 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.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not Applicable, the measure is not stratified. However there is a subset measure SUB-2a which removes patients from the numerator who refused the brief intervention. The subset measure has overlapping populations and this is different from a stratum where the measure population is mutually exclusive. This measure was added as a result of the pilot experience and a sub-analysis performed on the pilot data. Because those who refuse a brief intervention are put in the numerator, it was felt that this could open the door to possible gaming. We looked at the numerator to determine how many patients actually received the brief intervention. Only 6%of those who were in the numerator did not receive the brief intervention due to refusal. For measures that are to be publically reported, it was felt transparency was important so this measure was added as a subset.
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Health Records, Paper Medical Records
Level	Facility, Other
Setting	Hospital, Inpatient/Hospital

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	Measure 1664: SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge (The Joint Commission)
Description	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.
Numerator	SUB-3: The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder OR received or refused a referral for addictions treatment. SUB-3a: The number of patients who received a prescription at discharge for medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment.
Numerator Details	Two data elements are used to calculate the numerator: 1. Referral for Addiction Treatment- Documentation that a referral was made at discharge for addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor). 2. Prescription for Alcohol or Drug Disorder Medication- Documentation that an FDA-approved medication for alcohol or drug disorder was prescribed at hospital discharge. The referral may be to an addictions treatment program, to a mental health program or mental health specialist for follow up for substance use or addiction treatment, or to a medical or health professional for follow up for substance use or addiction. A referral to Alcoholics Anonymous does not meet the intent of the measure. The patient does not need to receive both a referral to addictions treatment and a prescription for one of the FDA approved medications, one or the other will meet the intent of the measure. Full specifications can be viewed on the Joint Commission web site at www.jointcommission.org at the following link: https://www.jointcommission.org/assets/1/6/HIQR_SpecsManual_v52a.zip
Denominator	The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder
Denominator Details	There are 10 data elements used to calculate the denominator: 1. Admission Date The month, day and year of admission to acute inpatient care. 2. Alcohol Use Status 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. 6. Discharge Disposition The place or setting to which the patient was discharged. 7. ICD-10-CM Other Diagnosis Codes The other or secondary ICD-10-CM codes associated with the diagnosis for this hospitalization. 8. ICD-10-PCS Other Procedure Codes The other or secondary ICD-10-PCS codes identifying all significant procedures other than the principal procedure. 9. ICD-10-CM Principal Diagnosis Code The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

	10. ICD-10-PCS Principal Procedure Code- The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.
Exclusions	There are 11 exclusions to the denominator as follows: • Patients less than 18 years of age • Patient drinking at unhealthy levels who do not meet criteria for an alcohol use disorder • Patients who are cognitively impaired • Patients who expire • Patients discharged to another hospital • Patients who left against medical advice • Patients discharged to another healthcare facility • Patients discharged to home or another healthcare facility for hospice care • Patients who have a length of stay less than or equal to one day or greater than 120 days • Patients who do not reside in the United States • Patients receiving Comfort Measures Only documented
Exclusion details	Patients who are less than 18 years of age are identified by subtracting the patient birthdate from the admission date. Patients who are cognitively impaired and cannot be screened to identify alcohol use are excluded through the data element Alcohol Use Status. Patients with a LOS of one day or less and those with a stay greater than 120 days are identified by the admission and discharge dates. Patients who are not residents of the USA are excluded through specific allowable values for the data elements Referral for Addictions Treatment and Prescription for Alcohol or Drug Disorder Medication. Those patients who expire, are transferred to another facility for inpatient care, hospice, federal health care facility, detention, or leave AMA are identified by virtue of the data element Discharge Disposition. Patients who do not have a principal or other diagnosis code for alcohol or drug dependence listed on Table 13.2 or a procedure on table 13.3 in Appendix A of the specifications manual would not be included in the measure 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.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not Applicable, the measure is not stratified. However there is a subset measure SUB-3a which removes patients from the numerator who refused either the prescription or the addictions treatment referral. The subset measure has overlapping populations and this is different from a stratum where the measure population is mutually exclusive. Since 31.5% of the cases in the numerator refused at least one of the treatments (referral or prescription for medications) a subset measure was added which reports only those that received treatment.
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Health Records, Paper Medical Records
Level	Facility, Other

Setting	Hospital, Inpatient/Hospital

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