NATIONAL QUALITY FORUM

Report

Behavioral Health Phase 2

TECHNICAL REPORT

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NATIONAL QUALITY FORUM

Contract HHENDORSED MEASURESSM-500-2009-00010C Task 14.2

Contents

Behavioral Health Phase 2

TECHNICAL REPORT

Introduction

In the United States, it is estimated that approximately 26.4 percent of the population suffers from a diagnosable mental disorder.[1] These disorders – which can include serious mental illnesses, substance use disorders, and depression – are associated with poor health outcomes, increased costs, and premature death.[2] Although general behavioral health disorders are widespread, the burden of serious mental illness is concentrated in about six percent of the population.[3] In addition, many people suffer from more than one mental disorder at any given time; nearly half of those suffering from one mental illness meet the criteria for at least two more.[4] By 2020, behavioral health disorders are expected to surpass all physical diseases as the leading cause of disability worldwide.[5]

In 2005, an estimated $113 billion was spent on mental health treatment in the United States. $22 billion of that amount was spent on substance use treatment alone, making substance use one of the most costly (and treatable) illnesses in the nation.[6] Financial estimates for behavioral health disorders inflate substantially when wider social costs are factored in such as criminal, welfare, juvenile, and future earnings potential.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is currently advancing the *National Framework for Quality Improvement in Behavioral Health Care* (NBHQF).[7] In the framework, SAMHSA notes that efforts to successfully implement the portions of the Affordable Care Act (ACA) relevant to Behavioral Health will require a better understanding of the current status and needs of the behavioral health population and delivery system, as well as an increased ability to adequately assess and monitor these populations over time. Of course, meaningful mental health performance measurement is a key driver to transform the healthcare system and advance both of these goals.

To date, NQF has endorsed a relatively small proportion of Behavioral Health measures. Approximately 75 are specific to mental health or substance abuse. This multi-phase project is aimed at endorsing measures of accountability for improving the delivery of behavioral health services, achieving better behavioral health outcomes, and improving the behavioral health of the U.S. population.
In Phase I, NQF sought to endorse behavioral health measures that serve as indicators of quality behavioral healthcare across all care delivery settings, including primary and specialty care. In Phase 2 –

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[1] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.

[2] Kilbourne, A., Keyser, D., & Pincus, H. (2010). Challenges and opportunities in measuring the quality of mental health care. *Canadian Journal of Psychiatry*, *55*(9), 549-557.

[3] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.

[4] Ibid.

[5] Department of Health and Human Services, Department of Mental Health and Substance Abuse. (2011). Leading change: a plan for SAMPHSA'S roles and actions 2011-2014 (1104692). Washington, D.C.

[6] Mark, T. (2011). Changes in U.S. spending on mental health and substance abuse treatment. Health Affairs, 28(6).

[7] Department of Health and Human Services, Department of Mental Health and Substance Abuse (SAMHSA). (2011). National framework for quality improvement in behavioral health care (draft). Washington, D.C.

detailed in this report – NQF sought to endorse additional measures addressing gap areas identified in Phase 1 as well to re-evaluate a number of updated measures that were not endorsed in Phase 1 but were considered to have high importance. Eleven NQF-endorsed® standards relating to behavioral healthcare that are due for endorsement maintenance were also reviewed.

Measure Evaluation

On June 5-6, 2013 the Behavioral Health Steering Committee evaluated thirteen new measures and eleven measures undergoing maintenance review against NQF's standard evaluation criteria. To facilitate the evaluation, the committee and candidate standards were divided into four workgroups for preliminary review of the measures against the evaluation sub-criteria prior to consideration by the entire Steering Committee. The Committee's discussion and ratings of the criteria are summarized in the evaluation tables beginning on page 11.

Behavioral Health Phase 2 Summary

	Maintenance	**New**	**Total**
Measures under consideration	11	13	24
Measures withdrawn from consideration	0	1	1
Endorsed Measures	9	11	20
Measures not recommended	2	2	4
Reasons for not recommending	Importance – 2	Importance - 2	Importance - 4

Overarching Issues

During the Steering Committee's discussion of the measures, several overarching issues emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail for each individual measure:

Evidence

The Steering Committee noted that NQF criteria have become more rigorous following the 2010 task force recommendations regarding evaluating evidence. In their review of a number of process measures in this phase, the Committee concluded the evidence presented did not sufficiently support the claim that the measured processes improve health outcomes. Given the lack of sufficient causal pathways for the measures, the Steering Committee was concerned that, the potential benefits to patients would not outweigh the potential burden of the measures. As a result, the Steering Committee did not recommend four measures for endorsement.

Electronic Health Record Specifications

Measures #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (AMA-PCPI), and #0104: Major Depressive Disorder (MDD) Suicide Risk Assessment (AMA-PCPI) were submitted with only electronic specifications. The specifications underwent an eMeasure format review.

Measure Specific Issues

During the Steering Committee's discussion of the measures, issues specific to individual measures emerged, detailed below:

Expansion of Measure Populations and Alignment with Meaningful Use

NQF prefers endorsement of measures that include the broadest possible target patient population for whom the measure is appropriate, as indicated by the evidence. For several tobacco, alcohol, and substance use measures, the Steering Committee recommended that developers consider expanding the target populations to include adolescent patients aged 13 years and older rather than those only aged 18 and older. The Steering Committee agreed that, if expanded, the measures would have an even greater impact by including a population that is also affected by tobacco and alcohol use, and that the measures as specified would be better aligned with the age range in the Meaningful Use clinical quality measure related to alcohol (NCQA measure #0004) and the Meaningful Use core set measure to record smoking status for patients 18 years and older.[8]

The developers explained that while the health system should work to help those under 18, virtually all of the evidence for the utility of screening for alcohol and tobacco use has been tested in individuals 18 or older. For tobacco use, there is no evidence to support any pharmacotherapeutic options for adolescents. The Steering Committee noted that developers would have to weigh the potential benefits of the expansion of the denominators against the potential provider burden, and potential system burden.

The Steering Committee recommended that developers explore expanding the target populations of the following measures, specifically related to just the screening and brief counseling elements of the measures.

- #1651 TOB-1 Tobacco Use Screening (The Joint Commission)
- #1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment (The Joint Commission)
- #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)
- #1661 SUB-1 Alcohol Use Screening (Joint Commission)
- #1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention (Joint Commission)
- #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 (Joint Commission)
- #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (AMA-PCPI)

[8] Meaningful Use Final Rule, http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf, accessed July, 2013, pp. 54069, 54045.

Harmonization of Related Measures

Resolving issues around harmonizing measures and handling competing measures remains one of the key challenges in NQF measure endorsement projects. The current quality landscape contains a proliferation of measures, including a number of measures that could be considered duplicative or overlapping, and others that measure similar, but not identical, concepts and/or patient populations.

NQF recently updated guidance around measure harmonization and competing measures. One of the proposed changes is that NQF will reach out earlier in the consensus development process to developers whose measures are identified as related to/or competing with other measures. This early outreach is intended to provide developers with sufficient time to initiate conversations with one another and begin thinking about potential plans for harmonization. The Behavioral Health project piloted the new approach to related and competing measures; comments on these changes are invited.

Although no measures in this current project were identified as directly competing with one another, measures in the following topic areas were identified as related: medication management, depression screening and diagnosis, depression follow-up, tobacco and alcohol screening and intervention. In April, 2013, the Behavioral Health team contacted developers whose measures were determined to be related and solicited preliminary statements articulating potential ways to harmonize, or justifications why harmonization is not needed. These responses are included in Appendix D.

The Steering Committee reviewed these responses at the meeting on June 5-6, and provided recommendations regarding harmonization. The related measures are detailed below, as well as the Committee discussion and final recommendations regarding measure harmonization.

Related Measures Identified & Summary of Discussion and Recommendations

MEDICATION MANAGEMENT

Measure Number	Title	Steward
0105	Antidepressant Medication Management (AMM)	NCQA
1880	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	FMQAI

Discussion: The measure developers discussed the measures and did not identify areas for harmonization. The developers explained that while both of the measures target individuals aged 18 and over, the target populations are very different: #1880 examines people with bipolar disorder, while # 0105 targets those diagnosed with major depression. The underlying concepts also differ: measure #1880 assesses chronic adherence using the Proportion of Days Covered (PDC) method for assessing medication adherence with a threshold of an 80 percent rate, while #0105 assesses persistent treatment in the acute and continuation phase, examining two specific periods of time within a measurement year. The Committee generally preferred the PDC model, noting it led to reliable and valid measure results.

Recommendation: The Steering Committee agreed with the developers' harmonization assessment but recommended NCQA consider moving to a PDC method in assessing medication adherence.

DEPRESSION SCREENING & DIAGNOSIS

Measure Number	Title	Steward
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	CMS / Quality Insights of PA
0518	Depression Assessment Conducted (Home Health)	CMS/Acumen/Abt

Discussion: The measure developers agreed maintenance measures #0418 and #0518 are related, and initiated conversations prior to the in-person meeting to determine potential areas of harmonization. They explained that measure #0518 focuses on the home health setting and is supported by OASIS data, while measure #0418 is collected in multiple settings, not including home health, and is supported by data collected from claims. Measure #0418 includes screening for depression as well as follow-up for a positive screen, while #0518 does not include follow-up and the definition of follow up differs in OASIS. The measures also have different reporting processes: #0418 is reported once per office visit for various identified encounters, while #0518 is reported per episode of care. The exclusions in each measure also differ.

However, the developers agreed harmonization is possible in some areas, noting that the home health setting could be added to measure #0418, and adding a follow-up requirement to measure #0518 is feasible as the OASIS dataset now collects information on documentation and implementation of follow-up plans, and CMS makes data available for agencies for use in their quality improvement efforts. The developers also explained that although the definition of "follow-up plan" in OASIS differs slightly from

its definition in measure #0418, they would have the opportunity to revise the OASIS definition since the OASIS-C is also undergoing revision, presenting a unique and timely opportunity for changes.

The developers discussed the differences in exclusions between the two measures and determined this is an area that cannot be harmonized. Measure #0518 excludes only episodes in which the patient was nonresponsive at the time of assessment, while measure #0418 has a number of exclusions, including patients with a previous diagnosis of depression. The Committee questioned the exclusion of patients with a previous diagnosis of depression in #0418, suggesting the exclusion be eliminated to better align with #0518, which allows for development of an "action plan" if the patient is depressed, regardless of whether they have been previously diagnosed. The developer of #0418 explained that due to differences in care settings and reporting processes, the exclusion is appropriate, and the Committee agreed.

Recommendation: The Steering Committee recommended that the developers pursue harmonizing measures #0418 and #0518 in the areas of care settings and follow-up.

DEPRESSION FOLLOW-UP

Measure Number	Title	Steward
1884	Depression Response at Six Months	MN Community Measurement
1885	Depression Response at Twelve Months	MN Community Measurement

Discussion: The measure developer explained the measures are completely harmonized and differ only on the timing of intervention.

Recommendation: The Committee agreed the measures are sufficiently harmonized, and had no further recommendations for harmonization.

TOBACCO

Measure Number	Title	Steward
1651	TOB-1 Tobacco Use Screening	The Joint Commission
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	The Joint Commission
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

Discussion: The measure developer explained that the tobacco suite of measures are complementary to one another and share a common data dictionary and common population. Therefore the measures are harmonized to the extent possible.

Recommendation: The Committee agreed the measures are harmonized to the extent possible and had no additional recommendations for harmonization.

ALCOHOL

Measure Number	Title	Steward
1661	SUB-1 Alcohol Use Screening	The Joint Commission
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	The Joint Commission
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
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI

Discussion: The measure developers collaborated prior to the meeting, agreeing to a number of areas for potential harmonization across the alcohol abuse measures. SUB-2 defines a brief intervention as, "a qualified health care professional engaging the patient in a joint decision-making process regarding alcohol use and plans for follow-up that are discussed and agreed to." This definition is based on the VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders. Measure #2152 does not describe the methodology used for brief counseling, so the developers suggested that #2152 could potentially be harmonized with the Joint Commission measures by describing the methodology used for brief counseling based on the VA/DoD Clinical Practice Guidelines.

The Steering Committee discussed that while both measure #2152 and #1661 use validated tools to screen for alcohol use, measure #2152 lists the CAGE tool as an appropriate option. The Joint Commission does not consider the CAGE tool to be a suitable screening mechanism and therefore doesn't include it as a recommended option. The AMA-PCPI explained that measure #2152 does not specify which screening tool must be used; rather, a number of examples are listed, of which the CAGE tool is one.

Other specifications such as exclusions of those with limited life expectancy remain similar across developers.

Recommendation: Following a discussion of the appropriateness of the CAGE tool, the Steering Committee recommended that AMA-PCPI remove the tool from its list of recommended screening instruments.

Recommendations for Future Measure Development

Following the meeting, the Committee identified numerous areas where additional measure development/enhancement is needed:

- Measures specific to child and adolescent behavioral health needs; in particular, a measure on primary care screening and appropriate follow-up for behavioral health disorders in children;
- Outcome measures for substance abuse/dependence that can be used by substance use specialty providers;
- Quality measures assessing care for persons with and intellectual disabilities across the lifespan;

- Quality measures that better align indicators of clinical need and treatment selection and, ideally, incorporate patient preferences
- Measures that assess aspects of recovery-oriented care for individuals with serious mental illness
- Quality measures related to coordination of care across sectors involved in the care or support of persons with chronic mental health problems (general medical care, mental health care, substance abuse care and social services).
- Adapt measure concepts that have been developed for and applied to inpatient care to other outpatient care settings (e.g., polypharmacy, follow up after discharge)
- Quality measures that assess whether evidence-based psychosocial interventions are being applied with a level of fidelity consonant with their evidence base
- Expand the number of conditions for which the quality of care can be assessed in the context of a "measurement-based care" approach (as is possible now with the suite of measures that have been endorsed for depression)
- Further develop measurement strategies for assessing the adequacy of screening and prevention interventions for general medical conditions among individuals with severe mental illness (as well as care for their co-morbid general medical conditions)

In Phase 1 of this project, the Steering Committee recognized gaps in measurement in the areas of screening for alcohol and drugs, specifically using tools such as the Screening Brief Intervention and Referral to Treatment (SBIRT). Members also noted a gap in screening for post-traumatic stress disorder (PTSD) and bipolar disorder in all patients diagnosed with depression, with an eye toward differentiating between the disorders.

Measure Evaluation Summary

Endorsed Measures

Measures not recommended

Endorsed Measures

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

0104 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Submission | Specifications

Status: Maintenance, Original Endorsement: Aug 10, 2009

Description: Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

Numerator Statement: Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

Denominator Statement: All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD)

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Psychiatric Association

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-16**; **M-4**; **L-0**; **I-0**; 1b. Performance Gap: **H-8**; **M-7**; **L-1**; **I-4;** 1c. Evidence: **Y-15**; **N-2; I-3**

Rationale:

- The Steering Committee considered the measure important as it encourages providers to proactively question patients regarding depression and complete a suicide risk assessment.
- The Steering Committee noted that the measure's aggregate performance rate was very high at 96.59 percent and questioned the opportunity for improvement.
    - The developer clarified that the performance rate was based on voluntary reporting and only 24 percent of eligible professionals were participating in the measure. Additionally, medical literature has indicated a more substantial gap in providers conducting suicide risk assessments.
- The Steering Committee reviewed the evidence cited in support of the measure and noted that while the measure only requires a suicide risk assessment to be completed during a new diagnosis or recurrent episode of MDD, the American Psychological Association (APA) guidelines are more stringent and specify that the inquiry is made at every visit for an individual with MDD.
    - The developers stated that their goal was to improve the completion of suicide risk assessment.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-12**; **L-3**; **I-4;** 2b. Validity: **H-0**; **M-14**; **L-1**; **I-6**

Rationale:

- A Steering Committee member noted that the measure does not require a specific tool for conducting the suicide risk assessment.
    - The developer explained that they chose not to endorse a particular assessment method to allow for flexibility in the use of various tools.
- The Steering Committee questioned why adolescents were not included within the measure's population.

- The developer clarified that they had a similar measure focused on adolescents that was recently endorsed in a different project.

3. Usability: H-2; M-14; L-0; I-4

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- Steering Committee members reflected that many primary care doctors are not comfortable discussing suicide risk with patients. The Steering Committee agreed this concern highlighted the importance of the measure and its usefulness for quality improvement.

4. Feasibility: H-0; M-13; L-6; I-1

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The measure was considered feasible and was submitted with e-specifications.

5. Related and Competing Measures

No related or competing measures were identified.

Steering Committee Recommendation for Endorsement: **Y-15**; **N-5**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1

Decision: Approved for continued endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for continued endorsement

FORTHCOMING

9. Appeals

0105 Antidepressant Medication Management (AMM)

Submission | Specifications

Status: Maintenance, Original Endorsement: Aug 10, 2009

Description: The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.

a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).

b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

Numerator Statement: a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the Index Prescription Start Date (IPSD) (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

Denominator Statement: Members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.

Exclusions: Exclude members who filled a prescription for an antidepressant 90 days (3 months) prior to the IPSD.

Adjustment/Stratification: No risk adjustment or risk stratification N/A NCQA asks that health plans collect the measure data for each of the three product lines each year (i.e. commercial, Medicare, Medicaid) if applicable.

Level of Analysis: Health Plan, Integrated Delivery System

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-13**; **M-6**; **L-0**; **I-0**; 1b. Performance Gap: **H-4**; **M-15**; **L-0**; **I-0;** 1c. Evidence: **Y-16**; **N-2; I-1**

<u>Rationale</u>:

- The Steering Committee questioned the relatively low performance of the measure.
    - The developer explained that over the past years of testing, a consistent increase of about one to two percent has been observed. Although this increase seems small, the developer clarified that for a long-standing measure, an increase of one to two percent is very meaningful.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-17**; **L-2**; **I-0;** 2b. Validity: **H-0**; **M-12**; **L-7**; **I-0**

<u>Rationale</u>:

- Steering Committee members questioned the inclusion of the ICD-9-CM diagnostic code 311 (depressive disorder, not otherwise specified). Certain members argued that because it is common to use the code as a default in primary care, eliminating it from the measure would exclude a large number of patients. Others felt that inclusion of the code presented a risk that an antidepressant might be prescribed to someone who may not need it. One member pointed out that use of anti-depressive medication in the general population of the United States is very high; furthermore, the meta-analysis cited in the developer's measure submission concludes that their use may provide minimal benefits for people with mild and moderate symptoms of depression.
    - The developer explained that recent testing showed that individuals are diagnosed with major depression using code 311 approximately 33 percent of the time. Based on the high use of the code in diagnosis, the developer's Behavioral Health Measurement Advisory Panel believed that the benefits of including the code to ensure relevant patients are included in the measure outweigh the benefits of achieving a more precise measure by removing the code...
- The Committee agrees that the code should remain in the measure, but recommended the developer change the brief description of the measure so that it describes members with a diagnosis of "depression" rather than those with "major depression" to better reflect the potential population captured in the measure. The developer agreed to take the recommendation back to its advisory panel.

3. Usability: H-3; M-12; L-4; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The Steering Committee agreed the measure is usable. This measure is used in public reporting plans only through HEDIS and is reported through venues such as the annual NCQA State of Healthcare Quality report, NCQA's Quality Compass, Health Plan Report Card, and Annual Health Insurance Plan Ranking. It is also part of federal programs such as Meaningful Use Stages 1 and 2, PQRS and the regional collaborative,

Aligning Forces for Quality.
4. Feasibility: H-4; M-15; L-0; I-0 *(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The Committee agreed that the measure was feasible.
5. Related and Competing Measures • This measure is related to FMQAI measure #1880 – Adherence to Mood Stabilizers for People with Bipolar I Disorder.
Steering Committee Recommendation for Endorsement: **Y-17**; **N-2**
6. Public and Member Comment
7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1 Decision: Approved for continued endorsement
8. Board of Directors (February 18, 2014): Decision: Ratified for continued endorsement
FORTHCOMING
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1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
Submission | Specifications
Status: New Submission **Description:** The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with bipolar I disorder who are prescribed a mood stabilizer medication, with adherence to the mood stabilizer medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months). **Numerator Statement:** Individuals with bipolar I disorder who filled at least two prescriptions for any mood stabilizer medication and have a Proportion of Days Covered (PDC) for mood stabilizer medications of at least 0.8. **Denominator Statement:** Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder with at least two claims for any mood stabilizer medication during the measurement period (12 consecutive months). **Exclusions:** Not Applicable **Adjustment/Stratification:** No risk adjustment or risk stratification Not Applicable Depending on the operational use of the measure, measure results may be stratified by: • State • Accountable Care Organizations (ACOs)* • Plan • Physician Group** • Age- Divided into 6 categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years • Race/E **Level of Analysis:** Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : State **Type of Measure:** Process **Data Source:** Administrative claims, Other, Electronic Clinical Data : Pharmacy **Measure Steward:** Centers for Medicare & Medicaid Services
STEERING COMMITTEE MEETING [06/5-6/2013] **1. Importance to Measure and Report: The measure meets the Importance criteria**

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-8**; **M-8**; **L-2**; **I-1**; 1b. Performance Gap: **H-10**; **M-9**; **L-0**; **I-0;** 1c. Evidence: **Y-18**; **N-1; I-0**

Rationale:

- The Steering Committee considered the measure important because it focuses on monitoring the initial treatment and medication adherence of patients with Bipolar I Disorder, which has a lifetime prevalence rate of 1-3.3 percent for the adult population in the United States.
- Seven recent studies have recorded a wide variability of adherence rates for patients, which vary from 16 -76 percent. There were also age related discrepancies noted for medication adherence with adults 18 to 64 less likely to be adherent as opposed to adults 64 years and older.
- The evidence demonstrates that low adherence rates are associated with higher rates of recurrence and relapse, psychiatric hospitalizations and suicides.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-15**; **L-3**; **I-0;** 2b. Validity: **H-0**; **M-14**; **L-5**; **I-0**

Rationale:

- The Steering Committee requested clarification regarding whether potential changes in the diagnosis of Bipolar I Disorder might affect the measure's calculation of a patient's medication adherence.
    - The developer explained that Bipolar I Disorder would not be diagnosed without the evidence of mania and that the most likely change in diagnosis would be to schizoaffective disorder, which would also involve the use of mood stabilizers. Additionally, the measure requires two claims for mood stabilizers as well as two outpatient encounters with the diagnosis of Bipolar I Disorder or one inpatient encounter with the diagnosis of Bipolar I Disorder over the course of the measurement year.
- Steering Committee members expressed concern regarding the potential of an incorrect diagnosis of Bipolar I Disorder due to a methamphetamine-induced psychosis. However, the developer noted that inpatients would presumably receive a urine toxicology screen. Yet, a Steering Committee member noted that the lack of a drug screen can be a common occurrence.
    - The developer indicated that the comorbidity between bipolar disorder and substance use is high, and explained that long-term treatment with mood stabilizers would still be indicated.
- A Steering Committee member questioned whether the measure included patients who were pregnant.
    - The developer stated that the measure did not contain any exclusions and that clinical recommendations for the use of mood stabilizers in pregnant patients vary depending on the risks and benefits to the patient. Additionally, they noted that in the past an analysis of data available from eight states had been conducted which determined that pregnancy occurred in less than one percent of the patients included in the measure.
- The Steering Committee reviewed the reliability data presented and queried the developer regarding the variability in performance by measurement unit.
    - The developer explained that statewide reliability data represents the largest unit of analysis in the measure and creates higher reliability scores, but the measure also provides data on Part D plans for Accountable Care Organizations (ACOs) and physician groups, which have greater variation and include a denominator threshold size. The measure's testing results are demonstrated by benchmarking the mean rate of performance against the reliability score.
- A Steering Committee member questioned whether reporting could be further specified to take into account socioeconomic status as Medicare patients may fill a prescription, but not file a claim. Populations with a greater socioeconomic burden may be more likely to rely on discount or free programs.
    - The developer explained that they had conducted a sensitivity analysis of this prescription program and did not find a major impact of such programs on the measure's results. The developer also stated that in the future they would consider modifications to the measure, allowing it to account for geographic diversity.

3. Usability: H-1; M-16; L-2; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- The Steering Committee found the measure usable, as the measure may be considered for CMS quality reporting programs in the future. The developer noted that should the measure be adopted into a CMS program it would have to undergo both a review and public comment period.

4. Feasibility: H-3; M-16; L-0; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee generally viewed the measure as feasible, primarily because it can be easily collected with minimal burden through claims data.

5. Related and Competing Measures

- This measure is related to NCQA measure #0105 – Antidepressant Medication Management (AMM).

Steering Committee Recommendation for Endorsement: **Y-15**; **N-4**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1

Decision: Approved for endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for endorsement

FORTHCOMING

9. Appeals

1922 HBIPS-1 Admission Screening

Submission | Specifications

Status: New Submission

Description: The proportion of patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trau

ma history and patient strengths. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.

Numerator Statement: Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths

Denominator Statement: Psychiatric inpatient discharges

Exclusions: • Patients for whom there is an inability to complete admission screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths within the first three days of admission due to the patient's inability or unwillingness to answer screening questions

- Patients with a Length of Stay = or less than 3 days or = or greater than 365 days

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable The measure is stratified by the following age groups:

- Children (1 through 12 years)
- Adolescent (13 through 17 years)
- Adult (18 through 64 years)
- Older Adult (=65 years)

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-3**; **M-16**; **L-0**; **I-0**; 1b. Performance Gap: **H-0**; **M-10**; **L-4**; **I-5** 1c. Evidence: **Y-19**; **N-0; I-0**

<u>Rationale</u>:

- The Steering Committee agreed that the measure is important and will have a high impact due to the prevalence and burden of violence, substance use, trauma, and suicide.
- Steering Committee members raised concerns regarding the narrow gap in performance. The developer presented data that since the measure has been in place, performance has improved from 79.2 percent to 89.7 percent, leaving an approximate gap of 10 percent. Steering Committee members suggested that as the gap in performance narrows, the developer consider developing measures assessing the effects of screening during hospitalizations.
- Steering Committee members questioned the directness of the evidence to the measure focus, but ultimately agreed the correlation was sufficient.
- Steering Committee members noted that the measure requires screening of patients but no further action.
    - The developer explained that the hospitals will receive a report on how they performed regarding each submitted case, however this information is not publicly reported.
    - The developer also indicated that the measure is a "building-block" measure, and they have a larger plan to move from the first step of screening patients, to potentially assessing treatment planning, and finally to assessing the effectiveness of the treatment in steering patients to ultimate outcomes.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-11**; **L-7**; **I-0;** 2b. Validity: **H-1**; **M-12**; **L-6**; **I-0**

<u>Rationale</u>:

- Steering Committee members raised concerns that a specific, validated tool is not specified in the measure.
    - The developer explained their intent is to keep the focus of the measure on specific screening elements, independent of specific tools, in order to address the existing variance in screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths.
- Steering Committee members expressed concern that the data presented regarding meaningful differences in performance showed a narrow gap in actual performance on this measure, with a mean performance score of 92.1 percent, and questioned the opportunity for improvement on the measure.
    - The developer explained that the data presented was gathered using a self-selected volunteer group, and that performance in the population as a whole is not expected to be as high. The developer also noted that evidence presented in the literature indicated that larger gaps in

performance had been identified.

- The Steering Committee accepted these explanations, noting that as this measure is adopted more broadly, a larger gap in performance will likely emerge. The Committee agreed the measure meets the Scientific Acceptability criteria.

3. Usability: H-3; M-16; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- The Steering Committee agreed the measure is usable. The measure is in use in the Joint Commission's Quality Check program and is adopted in the CMS FY 2012 Final Rule for the Inpatient Psychiatric Hospital Quality Reporting Program for FY 2014 payment determination.

4. Feasibility: H-2; M-13; L-4; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the measure is feasible as it is in use, and data is available in electronic sources.

5. Related and Competing Measures

- The measure is related to the rest of the HBIPS suite of measures. All the measures are currently harmonized to the extent possible.

Steering Committee Recommendation for Endorsement: **Y-15**; **N-4**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-8; N-4; A-1

Decision: Approved for endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for endorsement

FORTHCOMING

9. Appeals

0640 HBIPS-2 Hours of physical restraint use

Submission | Specifications

Status: Maintenance, Original Endorsement: May 05, 2010

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.

Numerator Statement: The total number of hours that all psychiatric inpatients were maintained in physical restraint

Denominator Statement: Number of psychiatric inpatient days

Denominator basis per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per

total patient days.

Exclusions: Total leave days

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable The measure is stratified by the following age groups:

- Children (1 through 12 years)
- Adolescent (13 through 17 years)
- Adult (18 through 64 years)
- Older Adult (=65 years)

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-7**; **M-12**; **L-0**; **I-0**; 1b. Performance Gap: **H-1**; **M-17**; **L-1**; **I-0;** 1c. Evidence: **Y-15**; **N-0; I-2**

<u>Rationale</u>:

- The Steering Committee agreed the measure is important and will have a high impact as restraint use is related to major adverse outcomes for both patients and staff. The Committee found the evidence presented to support the measure focus is sufficient, identified a gap in performance, and agreed there are potential benefits of measures focused on decreasing restraint use.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-1**; **M-18**; **L-0**; **I-0;** 2b. Validity: **H-0**; **M-16**; **L-3**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure has high reliability as there was a 100 percent match for the Calculated Assignment Agreement Rate, which indicates complete agreement in the assignment of the numerator and denominator. Face validity is established based on testing in 40 hospitals during May and June of 2006. The measure also shows important variations in the performance among hospitals.

3. Usability: H-5; M-14; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The Steering Committee agreed the measure is usable. The measure is in use in the Joint Commission's Quality Check program and is adopted in the CMS FY 2012 Final Rule for the Inpatient Psychiatric Hospital Quality Reporting Program for FY 2014 payment determination.

4. Feasibility: H-15; M-4; L-0; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Steering Committee agreed the measure is feasible as it is in use, and data is available in electronic sources.

5. Related and Competing Measures

- The measure is related to the other measures in the HBIPS suite. All the measures are currently

harmonized to the extent possible.
Steering Committee Recommendation for Endorsement: **Y-19**; **N-0**
6. Public and Member Comment
7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-11; N-1; A-1 Decision: Approved for continued endorsement
8. Board of Directors (February 18, 2014): Decision: Ratified for continued endorsement
FORTHCOMING
9. Appeals

0641 HBIPS-3 Hours of seclusion use
Submission | Specifications
Status: Maintenance, Original Endorsement: May 05, 2010 **Description:** The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. **Numerator Statement:** The total number of hours that all psychiatric inpatients were held in seclusion **Denominator Statement:** Number of psychiatric inpatient days Denominator basis per 1,000 hours To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days. **Exclusions:** Total leave days **Adjustment/Stratification:** No risk adjustment or risk stratification Not Applicable The measure is stratified by the following age groups: • Children (1 through 12 years) • Adolescent (13 through 17 years) • Adult (18 through 64 years) • Older Adult (=65 years) **Level of Analysis:** Facility, Population : National **Type of Measure:** Process **Data Source:** Electronic Clinical Data, Paper Medical Records **Measure Steward:** The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).
STEERING COMMITTEE MEETING [06/5-6/2013] **1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>** (1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-6**; **M-14**; **L-0**; **I-0**; 1b. Performance Gap: **H-0**; **M-20**; **L-0**; **I-0;** 1c. Evidence: **Y-16**; **N-2**; **I-1**

Rationale:

- The Steering Committee agreed that the measure is important to measure and report.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-19**; **L-1**; **I-0;** 2b. Validity: **H-0**; **M-18**; **L-2**; **I-0**

Rationale:

- The Steering Committee agreed the measure meets the criteria; however, Steering Committee members asked the developer why the measure examines seclusion use in the context of time rather than instances.
    - The developer explained that issue was a point of considerable debate as the measure was being developed, but there were some who wanted to ensure patients who are held as little as 30 to 60 seconds (as is often the case with young children) would still be counted in the measure. Ultimately, total amount of time was chosen as the variable to better determine the total number of hours of restraint use in a facility per thousand patient hours.

3. Usability: H-4; M-15; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- Overall the Steering Committee agreed the measure is usable, but asked the developer about the results of implementation and whether issues or successes had been identified as a result of measurement.
    - The developer responded that examining the balance between seclusion and restraint has been very useful to compare facilities. Cities, including Baltimore, New York and Boston have used the measures to make comparisons among facilities, which they were previously unable to do.
- The measure is in use in the Joint Commission's Quality Check program and is adopted in the CMS FY 2012 Final Rule for the Inpatient Psychiatric Hospital Quality Reporting Program for FY 2014 payment determination.

4. Feasibility: H-7; M-12; L-0; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the measure is feasible as it is currently in use, and data is available in electronic sources.

5. Related and Competing Measures

- The measure is related to the other measures in the HBIPS suite. All the measures are currently harmonized to the extent possible.

Steering Committee Recommendation for Endorsement: **Y-20**; **N-0**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-11; N-1; A-1

Decision: Approved for continued endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for continued endorsement

FORTHCOMING

9. Appeals

0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Submission | Specifications

Status: Maintenance, Original Endorsement: Aug 05, 2009

Description: The proportion of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-4 (Patients discharged on multiple antipsychotic medications).

Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.

Denominator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications

Exclusions: • Patients who expired

- Patients with an unplanned departure resulting in discharge due to elopement
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patients with a length of stay = 3 days

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable The measure is stratified by the following age groups:

- Children (1 through 12 years)
- Adolescent (13 through 17 years)
- Adult (18 through 64 years)
- Older Adult (=65 years)

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-9**; **M-8**; **L-3**; **I-0**; 1b. Performance Gap: **H-4**; **M-12**; **L-4**; **I-0;** 1c. Evidence: **Y-13**; **N-6**; **I-1**

<u>Rationale</u>:

- The Steering Committee agreed the measure is important as it addresses a critical problem and essentially acts as a medication reconciliation measure. Two common rationales for continuing multiple medications include evidence of a previous relapse when taken off the medications, and an intention to titrate; this measure helps facilitate the transfer of that information to the next level of care. Committee members noted, however, that although the measure requires that the tapering plan be documented in the continuing care plan to the next level of care provider, it does not require the transference of that information. HBIPS-7, on the other hand, measures whether or not the care plan was transmitted to the next provider.
    - The developer explained that there are three allowable values which allow a case to pass in the numerator:

- Appropriate documentation of a history of a minimum of three failed multiple trials of monotherapy is required; the medication must be named, and failed attempts must be explained;
- Recommendation of a plan to taper to monotherapy must be documented during the hospitalization or it must be noted that initiation of a tapering plan is recommended upon discharge; or
- Documentation is required that Clozapine is being augmented with another antipsychotic agent.
- If there is insufficient documentation, the measure fails.

- The Steering Committee discussed whether it would be more ideal for the suite of measures to remain separate or whether there is an opportunity to specify the measures as a set.
  - NQF staff explained that NQF does not currently endorse measure sets.
  - The developer reminded the Committee that these measures are not intended to be used as independent indicators; they are intended to be collected and reported together.
- The Steering Committee noted there are variations in performance on the measure.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-1**; **M-13**; **L-5**; **I-1;** 2b. Validity: **H-0**; **M-13**; **L-6**; **I-1**

<u>Rationale</u>:

- The Committee noted that during the testing of face validity, seven hospitals found the measure to be very good, 17 found it to be good, and 12 of the 36 facilities assessed rated the measure as average or lower.
- The Steering Committee agreed that the reliability of data elements as reported in 2011 are high: there was a 100 percent match in the calculated agreement rate for the data element, "appropriate justification for multiple antipsychotic medications," and re-abstraction data analysis showed the Category Assignment Agreement Rate (CAAR) was 100 percent – a perfect agreement rate between originally abstracted and re-abstracted data.

3. Usability: H-3; M-9; L-8; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The Steering Committee agreed that the measure is usable. The measure is in use in the Joint Commission's Quality Check program and is adopted in the CMS FY 2012 Final Rule for the Inpatient Psychiatric Hospital Quality Reporting Program for FY 2014 payment determination.

4. Feasibility: H-2; M-12; L-5; I-1

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Steering Committee agreed the measure is feasible as it is currently in use, and data is available in electronic sources.

5. Related and Competing Measures

- This measure is related to the other measures in the HBIPS suite. All measures are currently harmonized to the extent possible. This measure is paired with HBIPS-4.

Steering Committee Recommendation for Endorsement: **Y-12**; **N-8**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-10; N-1; A-2

Decision: Approved for continued endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for continued endorsement

FORTHCOMING
9. Appeals

0557 HBIPS-6 Post discharge continuing care plan created

Submission | Specifications

Status: Maintenance, Original Endorsement: Aug 05, 2009

Description: The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-7 (Post Discharge Continuing Care Plan Transmitted).

Numerator Statement: Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.

Denominator Statement: Psychiatric inpatient discharges

Exclusions: • Patients who expired

- Patients with an unplanned departure resulting in discharge due to elopement
- Patients or their guardians who refused aftercare
- Patients or guardians who refused to sign authorization to release information
- Patients with an unplanned departure resulting in discharge due to failing to return from leave

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable The measure is stratified by the following age groups:

- Children (1 through 12 years)
- Adolescent (13 through 17 years)
- Adult (18 through 64 years)
- Older Adult (=65 years)

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-16**; **M-4**; **L-0**; **I-0**; 1b. Performance Gap: **H-4**; **M-14**; **L-2**; **I-0;** 1c. Evidence: **Y-20**; **N-0; I-0**

Rationale:

- The Steering Committee agreed that this measure contributes to increased continuity in care, therefore improving quality of patient care. The Committee also agreed the measure has the potential to standardize a discharge process, noting that the measure is stronger if always reported with HBIPS-7 (as it is intended to be). Steering Committee members expressed concern that HBIPS-6 serves as the basis for the denominator in HBIPS-7, rather than serving as a stand-alone measure.

- The developer reminded the Committee that these measures are not intended to be used as independent indicators; they are intended to be collected and reported together.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2**; **M-19**; **L-0**; **I-0;** 2b. Validity: **H-1**; **M-18**; **L-2**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure meets the criteria, but questioned why the measure did not include medical problems in the continuing care plan for follow-up, noting that if fifty percent of psychiatric patients have a medical problem, that illness should be included in the continuing care plan.
  - The developer explained that this item is included in the data elements, and is precisely what would be included in the next measure, HBIPS-7, as it is transmitted to the next level of care provider.

3. Usability: H-5; M-16; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The Steering Committee agreed the measure is usable. The measure is adopted (along with HBIPS 2-5 and HBIPS-7) in the CMS FY 2012 Final Rule for the Inpatient Psychiatric Hospital Quality Reporting Program for 2014 payment determination. It has been in use since the 4th quarter of 2008.
-

4. Feasibility: H-4; M-17; L-0; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Steering Committee agreed the measure is feasible as it is currently in use, and data is available in electronic sources.

5. Related and Competing Measures

- This measure is related to the other measures in the HBIPS suite, and is paired with HBIPS-7 and is not intended to be reported alone.
- . All the measures are currently harmonized to the extent possible.

Steering Committee Recommendation for Endorsement: **Y-20**; **N-1**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-9; N-2; A-2

Decision: Approved for continued endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for continued endorsement

FORTHCOMING

9. Appeals

0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge

Submission | Specifications

Status: Maintenance, Original Endorsement: Aug 05, 2009

Description: The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of

care provider upon discharge. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-6: Post Discharge Continuing Care Plan Created) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-6 (Post Discharge Continuing Care Plan Created).

Numerator Statement: Psychiatric inpatients for whom the post discharge continuing care plan was transmitted to the next level of care.

Denominator Statement: Psychiatric inpatient discharges

Exclusions: •
- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients or their guardians who refused aftercare
- Patients or guardians who refused to sign authorization to release information
- Patients with an unplanned departure resulting in discharge due to failing to return from leave

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable The measure is stratified by the following age groups:
- Children (1 through 12 years)
- Adolescent (13 through 17 years)
- Adult (18 through 64 years)
- Older Adult (=65 years)

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-15**; **M-5**; **L-0**; **I-0**; 1b. Performance Gap: **H-6**; **M-14**; **L-0**; **I-0;** 1c. Evidence: **Y-20**; **N-0; I-0**

<u>Rationale</u>:
- The Steering Committee unanimously agreed that the evidence supports the measure focus, and the measure important in improving the quality of patient care.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-1**; **M-16**; **L-3**; **I-0;** 2b. Validity: **H-1**; **M-18**; **L-1**; **I-0**

<u>Rationale</u>:
- The Steering Committee agreed the measure meets the criteria. Steering Committee members asked the developer about the kinds of transmissions allowed in the measure and whether telephone, e-mail, or letters, would be appropriate.
    - The developer explained that telephone conversations are not appropriate, as the measure is intended to encourage documentation. Therefore, methods such as e-mail, letter and fax are sufficient methods of transmitting information.
- Steering Committee members asked the developer was asked whether a subsequent provider could pull information from a health information exchange (HIE).
    - The developer responded that as long as there is documentation that the next level of care

provider has access to the information electronically, then the intent of the measure is met.

- One Committee member asked how it can be determined whether or not the care plan is transmitted to the next level of care if it's sent as a fax or a letter.
    - The developer explained that there must be documentation in the medical records stating that the provider has completed the transmission, and information provided regarding the method used. The developer considers this standard to be acceptable.
    - The Committee confirmed that the receipt of information isn't being measured, but rather whether or not the discharging group indicates they tried to convey the information. In other words, the e-mail merely needs to be sent; it does not have to be opened by the subsequent provider.
- Steering Committee members questioned what was included in "next level of care," asking specifically about what would happen if a patient is sent to multiple providers, and asked what categories (psychiatric, internal medicine, etc.) would count as "next level of care."
    - The developer clarified that the measure specifies that the next level of care provider is the clinician (or the entity that is the clinic) or another hospital that will be the entity primarily responsible for managing the patient's medication plans. In the absence of medications, the person should be the entity designated as providing primary care treatment. The developer further explained that others involved in the patient's care should still receive the information, but that this measure is intended to identify who the primary provider is, and ensure they receive the information upon the patient's discharge.
- Steering Committee members asked the developer about what occurs when a patient has no coverage or is an undocumented worker.
    - The developer explained that in those cases, the patient would be sent to the federally qualified health center in their area, which is required by law to accept everyone.

3. Usability: H-5; M-11; L-4; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- Overall, the Steering Committee agreed the measure is usable. One member noted the potential barriers in carrying out this measure, explaining that many people with serious mental illness that are hospitalized are very difficult to follow up with. These individuals may move frequently, or not have access to a phone. However, the member agreed that the importance of the measure overrides potential barriers.
    - The developer explained that this measure looks only at whether or not the care plan is transmitted to the next provider, not whether follow-up with the patient occurs.
- The measure is adopted (along with HBIPS 2 through 6) in the CMS FY 2012 Final Rule for the Inpatient Psychiatric Hospital Quality Reporting Program for 2014 payment determination. It has been in use since the 4th quarter of 2008.

4. Feasibility: H-2; M-10; L-5; I-2

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the measure is feasible; however, one member questioned the feasibility of the measure as it relates to collection of data across different EMR's.
    - The developer explained that, although arrangements had not been made with EHR vendors to include the measure's data elements, most hospitals with EHR systems have developed a recording template for the data elements.

5. Related and Competing Measures

- The measure is related to the other measures in the HBIPS suite, and is paired with HBIPS-6 and not intended to be reported alone. All the measures are currently harmonized to the extent possible.

Steering Committee Recommendation for Endorsement: **Y-18**; **N-2**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-9; N-2; A-2

Decision: Approved for continued endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for continued endorsement

FORTHCOMING

9. Appeals

0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Submission | Specifications

Status: Maintenance, Original Endorsement: Jul 31, 2008

Description: Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

Numerator Statement: Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented

The standardized screening tools help predict a likelihood of someone developing or having a particular disease. The screening tools suggested in this measure screen for possible depression. Questions within the suggested standardized screening tools may vary but the result of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as defined within the measure. If the patient has a negative screen for depression, no follow-up plan is required.

Denominator Statement: All patients aged 12 years and older

Exclusions: Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

• Patient refuses to participate

• Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

• Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases

• Patient was referred with a diagnosis of depression

• Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period

• Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Adjustment/Stratification: No risk adjustment or risk stratification N/A No stratification. All eligible patients are subject to the same numerator criteria.

Level of Analysis: Population : Community, Population : County or City, Clinician : Group/Practice, Clinician : Individual, Population : National, Population : Regional, Population : State, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records

Measure Steward: Centers for Medicare and Medicaid Services

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-14**; **M-5**; **L-1**; **I-0**; 1b. Performance Gap: **H-5**; **M-15**; **L-0**; **I-0** 1c. Evidence: **Y-18**; **N-2; I-0**

Rationale:

- The Steering Committee agreed the measure will have a high impact as a 10 percent prevalence rate of

depression is reported in primary care patients. Additionally in 2000, the United States spent an estimated $83.1 billion in direct and indirect costs related to depression.

- A Steering Committee member questioned the opportunity for improvement on the measure noting that the measure has a high aggregate performance rate of 83 percent. However, regional performance rates varied from 68.2 percent to 99.2% percent.
    - The developer explained that although performance is high for the measure, utilization of the measure is not high; a great number of providers currently do not report the measure. In addition, the measure is currently being used by a self-selected group and the performance rate is high as a result. The developer noted that the measure will be included in the CMS Meaningful Use program beginning in January 2014, and that greater uptake of the measure is expected. With a broader group of providers implementing the measure a greater gap in performance is expected. The Steering Committee agreed with this assessment.
- Steering Committee members noted that in the time since the measure was initially endorsed as an adult-only measure, the developer broadened the age range of the measure to include individuals 12 to 17 years of age, and pediatricians are included in the measure. The Committee supported this expansion, citing the United States Preventive Services Task Force (USPSTF) recommendation to screen all adolescents 12 to 18 years of age for major depressive disorder, if systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up. However, Committee members acknowledged that a number of primary care providers may not screen adolescents if they cannot meet this stipulation.
- A Steering Committee member noted the burden faced by primary care providers to conduct a variety of screenings and questioned the evidence supporting annual screening for depression. The USPSTF recommendation does not indicate the intervals for screening and other guidelines indicate screening on other bases, including when there is "an index of suspicion." The Steering Committee discussed this issue at length and ultimately reached consensus supporting annual screening, agreeing the potential benefits of screening outweighed the risks.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-4**; **M-16**; **L-1**; **I-0;** 2b. Validity: **H-3**; **M-16**; **L-0**; **I-2**

<u>Rationale</u>:

- The Steering Committee agreed the measure meets the criteria. One Steering Committee member expressed concern that the measure does not specify a specific tool for depression screening. However the Committee agreed that since the measure allows physicians to screen all eligible patients using an age-appropriate standardized tool, the measure is appropriate.

3. Usability: H-5; M-14; L-1; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The Steering Committee agrees the measure is usable. The measure will be used in a public reporting program and cited on the CMS Physician Compare website; it will also be included in the 64 outpatient measures utilized for the CMS Meaningful Use program, starting in January of 2014. A Steering Committee member noted that the measure's inclusion in meaningful use would increase uptake of the measure.
- This measure has been retooled for electronic medical records.

4. Feasibility: H-7; M-14; L-0; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee agreed the measure was moderately feasible.

5. Related and Competing Measures

- This measure is related to CMS measure #0518 – Depression Assessment Conducted.

Steering Committee Recommendation for Endorsement: **Y-19**; **N-2**

Recommendation:

- The Steering Committee suggested that in the future, the developer should extend the measure to consider not just whether a follow-up plan is in place, but also whether the follow-up plan is implemented.

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-9; N-3; A-1

Decision: Approved for continued endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for continued endorsement

FORTHCOMING

9. Appeals

0518 Depression Assessment Conducted

Submission | Specifications

Status: Maintenance, Original Endorsement: Mar 31, 2009

Description: Percent of patients who were screened for depression (using a standardized depression screening tool) at start or resumption of home health care

Numerator Statement: Number of home health episodes of care in which patients were screened for depression (using a standardized depression screening tool) at start/resumption of care.

Denominator Statement: Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.

Exclusions: Episodes in which the patient was nonresponsive at the time of assessment.

Adjustment/Stratification: No risk adjustment or risk stratification NA - process measure NA

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data

Measure Steward: Centers for Medicare and Medicaid Services Other organizations: Abt Associates, Inc.

Case Western Reserve University

University of Colorado at Denver, Division of Health Care Policy and Research

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-13**; **M-6**; **L-1**; **I-0**; 1b. Performance Gap: **H-2**; **M-12**; **L-6**; **I-0;** 1c. Evidence: **Y-18**; **N-1**; **I-0**

Rationale:

- The Steering Committee agree the measure would have a high impact due to the high prevalence of major depression in the home health care setting, which studies indicate varies from 6.4 to 14 percent.
- The measure was previously endorsed by NQF, and in practice the performance rates of agencies have increased over time, particularly among agencies who found the measure challenging. Average agency performance improved from 88 percent in 2010 to 95 percent in 2012, and agencies who found the measure challenging improved from 65 percent to 89 percent during the same time period.
- The Steering Committee noted that the USPSTF guideline recommendation presented to support the measure is based on the presence of staff-assisted depression care supports to assure accurate diagnosis, and effective treatment and follow-up; yet, no guidelines are cited specifically addressing depression screening within the home health care environment. The Steering Committee agreed that the developer has appropriately presented this in their measure.

- Steering Committee members were concerned that the performance of the measure is quite high and questioned the opportunity for improvement. However, the Committee believed that performance would change as the measure becomes more broadly implemented.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2**; **M-18**; **L-0**; **I-0;** 2b. Validity: **H-1**; **M-16**; **L-2**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure is scientifically acceptable. A Technical Expert Panel (TEP) assessed the measure's face validity; nine out of the eleven TEP members agreed that the measure accurately reflects quality of care.
- The developer used the beta binomial method, and national level reliability testing shows 75 percent of agencies have high reliability scores of greater than 0.974 for the measure. Additionally, at the level of hospital referral regions (HRRs), 75 percent of agencies have high reliability scores of greater than 0.963.

3. Usability: H-1; M-19; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The Steering Committee agreed the measure is usable; it has been publicly reported on the Home Health Compare Medicare website since 2010.

4. Feasibility: H-3; M-17; L-0; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee agreed the measure is feasible and is already in use.

5. Related and Competing Measures

- This measure is related to CMS measure #0418 – Preventive Care and Screening for Clinical Depression and Follow-Up Plan.

Steering Committee Recommendation for Endorsement: **Y-20**; **N-0**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-8; N-4; A-1

Decision: Approved for continued endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for continued endorsement

FORTHCOMING

9. Appeals

1884 Depression Response at Six Months- Progress Towards Remission

Submission | Specifications

Status: New Submission

Description: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at six months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.

Numerator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial

PHQ-9 score greater than nine who achieve a response at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.

Denominator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.

Exclusions: Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.

Adjustment/Stratification: Stratification by risk category/subgroup Risk adjustment to the statewide average severity mix based on a patient's initial PHQ-9 score.

This measure is risk adjusted based on severity band of the PHQ-9 which is based on the initial PHQ-9 score. Severity bands are defined as 10 to 14- moderate depression, 15 to 19- moderately severe depression and 20 to 27- severe depression. We also collect the following variables for potential use in future risk adjustment: gender, zip code, race & ethnicity, country of origin and primary language. This measure is currently not stratified. We are contemplating stratification functionality on our consumer facing public website, MN HealthScores at www.mnhealthscores.org that would allow results to be displayed in total or by practice specialty of behavioral health. For example, this functionality currently exists for the MNCM diabetes measure which can be filtered to a view to sort by endocrinologists.

Level of Analysis: Clinician : Group/Practice

Type of Measure: Outcome

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Registry

Measure Steward: MN Community Measurement

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-13**; **M-5**; **L-0**; **I-2**; 1b. Performance Gap: **H-9**; **M-11**; **L-0**; **I-0;** 1c. Evidence: **Y-19**; **N-0**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed that this outcome measure meets the Importance criteria. The measure will have a high impact as depression is prevalent nationally with approximately 16 percent of the population reporting it over their lifetime. There also is a significant gap in care and opportunity for improvement for patients in terms of achieving both remission and response at 6 months. The developer presents data that only 9.2 percent of patients had a response to treatment as defined by a twelve month PHQ-9 score reduced from the initial PHQ-9 score by 50 percent or greater and only 22.7 percent of patients were assessed at 12 months to measure remission. Strong evidence is presented to support the measure focus, and in practice groups adopting the measure markedly improved their screening and response rates.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-1**; **M-15**; **L-5**; **I-0;** 2b. Validity: **H-4**; **M-9**; **L-7**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure meets the criteria. However, Steering Committee members were concerned about the significant loss of patients in the denominator due to a loss of contact with them: only approximately 25 percent of patients initially in the denominator were assessed at six months. Committee members questioned whether the denominator in the measure could be modified or whether a separate measure could be developed to more clearly determine whether the significant loss of patients is due to an inability to maintain contact (follow up) or due to failure to assess the patient.
    - The developer explained that the follow up issue would still be highlighted in the measure and explained that patients who are not assessed for follow-up are included in the denominator and are assumed not to be in remission. The developer stated that removing the follow up piece from the denominator would not serve the full intent of the measure.

- The developer also noted they have developed process measures that record follow up rates at 6 and 12 months. Those measures have not been put forward for NQF endorsement.

3. Usability: H-3; M-10; L-8; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- The Steering Committee agreed the measure is usable and is publicly reported by Minnesota Community Measurement on their consumer website located on the MN HealthScores Website at www.mnhealthscores.org.

4. Feasibility: H-2; M-13; L-5; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the measure is feasible; however members expressed concern about the potential burden of collecting this measure and the companion 12-month measure, and collecting this measure along with other required measures. However, Steering Committee members also noted that once the diagnosis of depression or dysthymia and an elevated PHQ-9 are made in a clinician's office, follow-up is acceptable by other means.
- The developer explained that the use of EHRs would lessen the burden of the collecting and reporting the measure. The Steering Committee agreed and noted the burden would be offset by the benefit to patients.

5. Related and Competing Measures

- This measure relates to MN Community measure #1885 –Depression Response at Twelve Months.

Steering Committee Recommendation for Endorsement: **Y-17**; **N-3**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1

Decision: Approved for endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for endorsement

FORTHCOMING

9. Appeals

1885 Depression Response at Twelve Months- Progress Towards Remission

Submission | Specifications

Status: New Submission

Description: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.

Numerator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.

Denominator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.

Exclusions: Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded

from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.

Adjustment/Stratification: Stratification by risk category/subgroup Risk adjustment to the statewide average severity mix based on a patient's initial PHQ-9 score.

Risk adjustment to the statewide average severity mix based on a patient's initial PHQ-9 score. This measure is risk adjusted based on severity band of the PHQ-9 which is based on the initial PHQ-9 score. Severity bands are defined as 10 to 14- moderate depression, 15 to 19- moderately severe depression and 20 to 27- severe depression. We also collect the following variables for potential use in future risk adjustment: gender, zip code, race & ethnicity, country of origin and primary language. This measure is currently not stratified. We are contemplating stratification functionality on our consumer facing public website, MN HealthScores at www.mnhealthscores.org that would allow results to be displayed in total or by practice specialty of behavioral health. For example, this functionality currently exists for the MNCM diabetes measure which can be filtered to a view to sort by endocrinologists.

Level of Analysis: Clinician : Group/Practice

Type of Measure: Outcome

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Registry

Measure Steward: MN Community Measurement

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-13**; **M-6**; **L-1**; **I-0**; 1b. Performance Gap: **H-11**; **M-9**; **L-0**; **I-0;** 1c. Evidence: **Y-20**; **N-0**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure will have a high impact as depression is prevalent nationally with approximately 16 percent of the population reporting it over their lifetime. There also is a significant gap in care and opportunity for improvement for patients in terms of achieving both remission and response at 12 months. The developer presents data that only 8.2 percent of patients had a response to treatment as defined by a twelve month PHQ-9 score reduced from the initial PHQ-9 score by 50percent or greater and only 18.6 percent of patients were assessed at 12 months to measure remission. Strong evidence is presented to support the measure focus, and in practice groups adopting the measure improved their screening and response rates.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-4**; **M-13**; **L-3**; **I-0;** 2b. Validity: **H-2**; **M-12**; **L-5**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure meets the criteria. However, Steering Committee members were concerned about the significant loss of patients in the denominator due to a loss of contact with them at 12 months. Committee members questioned whether the denominator in the measure could be modified or whether a separate measure could be developed to more clearly determine whether the significant loss of patients is due to an inability to maintain contact (follow up) or due to failure to assess the patient.
    - The developer explained that the follow up issue would still be highlighted in the measure and explained that patients who are not assessed for follow-up are included in the denominator and are assumed not to be in remission. The developer stated that removing the follow up piece from the denominator would not serve the full intent of the measure.
    - The developer also noted they have developed process measures that record follow up rates at 6 and 12 months. Those measures have not been put forward for NQF endorsement.

3. Usability: H-4; M-12; L-4; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- The Steering Committee agreed the measure is usable and is publicly reported by Minnesota Community Measurement on their consumer website located on the MN HealthScores Website at www.mnhealthscores.org.
- Steering Committee members suggested the developer consider developing additional intermediate measurements to further assess depression response and manage patients.
- The developer stated they would be willing to consider this suggestion.

4. Feasibility: H-2; M-14; L-4; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the measure is feasible; however, members expressed concern about the potential burden of collecting this measure, the companion 6-month measure, and any additional intermediate measurements along with collecting this measure in conjunction with other required measures.
- The developer explained that the use of EHRs would lessen the burden of the collecting and reporting the measure. The Steering Committee agreed and noted the burden would be offset by the benefit to patients.

5. Related and Competing Measures

- This measure relates to MN Community Measurement #1885 – Depression Response at Six Months.

Steering Committee Recommendation for Endorsement: **Y-16**; **N-4**

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1

Decision: Approved for endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for endorsement

FORTHCOMING

9. Appeals

1651 TOB-1 Tobacco Use Screening

Submission | Specifications

Status: New Submission

Description: Hospitalized patients age 18 years and older who are screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days. This measure is intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-2 Tobacco Use Treatment Provided or Offered (during the hospital stay); TOB-3 Tobacco Use Treatment Provided or offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)

Numerator Statement: The number of patients who were screened for tobacco use status

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

Exclusions: The denominator has three 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

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable Not Applicable, the measure is not stratified.

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-19**; **M-0**; **L-0**; **I-0**; 1b. Performance Gap: **H-11**; **M-8**; **L-0**; **I-0** 1c. Evidence: **Y-17**; **N-2; I-0**

<u>Rationale</u>:

- The Steering Committee initially reviewed and rated the Importance criteria for this measure on April 18, 2012, during the first phase of this project; accordingly, Importance to Measure and Report was not discussed during the phase two meeting. Instead, the votes from Phase 1 were carried over, and appear above.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-5**; **M-13**; **L-0**; **I-1;** 2b. Validity: **H-4**; **M-12**; **L-2**; **I-2**

<u>Rationale</u>:

- The Steering Committee agreed the measure is clearly and precisely specified. The data presented indicating reliability of the measure has improved from Phase 1 and is demonstrated with an overall measure agreement rate of 86.67 percent. Face validity is demonstrated by pilot user survey results ranging from 4.1 to 5 on a 5 point scale, and technical advisory panel survey results ranging from 4.9 to 5 on a 5 point scale. Survey respondents rated the clarity of measure specifications, usefulness, interpretability, data accessibility and ease of collection, and recommendation for national use and endorsement of the measure.
- Steering Committee members questioned the improvement in the reliability and validity testing results presented in this Phase, and asked whether a different methodology was used.
    - The developer explained that testing presented in Phase 1 was the result of a pilot test of the measure, during which questions supporting the measure were clarified for the users. At the request of the Steering Committee the developer conducted additional testing and presented the results in this phase.
    - The developer clarified that the same methodology was used to test the measure in this Phase as was used in Phase 1; the methodology was not clearly identified previously. The developer explained that in this phase testing results for the measure are presented in sensitivity and specificity terms, rather than the kappa values presented previously. Presenting the testing in terms of the sensitivity and specificity of the numerators and denominators allowed the developer to more clearly represent the validity of the measure.

3. Usability: H-7; M-13; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The Steering Committee agreed the measure is usable and understandable to the public and providers. The measure is in use on the Joint Commission public reporting website Quality Check, is noted in the recent Inpatient Prospective Payment System Rule for future consideration, and is rated highly usable by pilot users.

4. Feasibility: H-4; M-14; L-2; I-1

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Steering Committee agreed the measure is feasible to use and noted that performance should improve as the measure is implemented in EHRs.

- Steering Committee members raised concerns that the measure is not aligned with the Stage 2 Meaningful Use measure, which applies to patients 13 years and older.
    - The developer explained that the evidence base for patients 13 years and older is not as strong as that for the 18 years and older population.

5. Related and Competing Measures

- This measure is related to measures the rest of the TOB suite of measures, which are complementary to each other and already harmonized to the extent possible.

Steering Committee Recommendation for Endorsement: **Y-19**; **N-0**

- The Steering Committee recommended that the developer expand the measure population to include adolescents (aged 13 and older) to make the measure more consistent with Meaningful Use and to incorporate an age group that also struggles with tobacco use.
    - The developer noted that they would review the evidence for extending the age range of the measure in the future.

6. Public and Member Comment

Theme 1: Evidence Supporting The Joint Commission's Suites of Tobacco (TOB) and Alcohol/Substance (SUB) Use Measures

Description: Two commenters did not support the recommended endorsement of the following tobacco and substance use measures, and questioned whether the measures meet the evidence criterion relative to hospitalization and discharge: 1651 TOB-1 Tobacco Use Screening; 1654 TOB-2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment; 1656 TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge. Commenters noted that there is incomplete evidence to suggest that offering any of the measured interventions results in lower rates of alcohol and drug abuse.

Committee Response: In the first phase of this project, the Steering Committee reviewed and rated the three importance criteria - impact, performance gap and evidence - for the tobacco use measures 1651 TOB-1, 1654 TOB-2 and 1656 TOB-3. Because the tobacco and alcohol suits of measures were deferred to the second phase of this project for additional testing, ratings and recommendations were carried over from the first phase of work. The Steering Committee agreed that there is sufficient evidence to support the measures and discussed at length the fact that, generally, the evidence presented to support the measures is not related exclusively to the inpatient setting, and observed that the evidentiary picture is incomplete as there are few studies specifically related to tobacco screening and brief intervention (rather than intensive intervention) in hospitalized inpatients. The Committee noted, however, that the U.S. Preventive Services Taskforce (USPSTF) evidence presented in the measure submissions is applicable to all settings, and the Cochrane review presented does include inpatient settings. The Committee also mentioned that there is a fair body of evidence across settings specifically linking intensive intervention to desired outcomes, but noted that brief intervention could also have an impact. As a result, the Committee ultimately agreed that sufficient evidence related to the inpatient setting was presented and the measures met the evidence criterion.

Theme 2: Appropriateness of Tobacco (TOB) and Alcohol/Substance (SUB) Use Measures in the Inpatient Psychiatric Setting

Description: 14 commenters did not support the recommended endorsement of the tobacco and alcohol/substance use suites of measures for use in the inpatient psychiatric setting, citing concerns about the appropriateness of brief interventions given the intensive treatment provided to patients in this setting, and the burden of collecting data and providing referrals at discharge.

Developer Response: The Joint Commission specified this measure for use in all hospitals; therefore, since testing was conducted in psychiatric settings as well as general acute care hospitals, it is equally appropriate for use in IPFs.

Committee Response: Agree with Developer.

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1 Decision: Approved for endorsement
8. Board of Directors (February 18, 2014): Decision: Ratified for endorsement
FORTHCOMING
9. Appeals

1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment

Submission | Specifications

Status: New Submission

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. Refer to section 2a1.10 Stratification Details/Variables for the rationale for the addition of the subset measure. These measures are intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB-3 Tobacco Use Treatment Provided or Offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)

Numerator Statement: TOB-2: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications.

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

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

Exclusions: The following are excluded from the measure denominator.

1. Patients less than 18 years of age
2. Patients who are cognitively impaired
3. Patients who are not current tobacco users
4. Patients who refused or were not screened for tobacco use during the hospital stay.
5. Patients who have a duration of stay less than or equal to one day or greater than 120 days

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable 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 publically reported, it was felt transparency was important so this measure was added as a subset.**Level of Analysis:** Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-19**; **M-0**; **L-0**; **I-0**; 1b. Performance Gap: **H-18**; **M-1**; **L-0**; **I-0;** 1c. Evidence: **Y-16**; **N-0; I-3**

Rationale:

- The Steering Committee initially reviewed and rated the Importance criteria for this measure on April 18, 2012, during the first phase of this project; accordingly, Importance to Measure and Report was not discussed during the phase two meeting. Instead, the votes from Phase 1 were carried over, and appear above.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-3**; **M-15**; **L-0**; **I-1;** 2b. Validity: **H-2**; **M-12**; **L-2**; **I-3**

Rationale:

- The Steering Committee agreed the measure is clearly and precisely specified. The data presented indicating reliability of the measure has improved from Phase 1 and is demonstrated with an overall measure agreement rate of 81.1 percent. Face validity is demonstrated by pilot user survey results ranging from 4.36 to 4.9 on a 5 point scale, and technical advisory panel survey results ranging from 3.75 to 5 on a 5 point scale. Survey respondents rated the clarity of measure specifications, usefulness, interpretability, data accessibility and ease of collection, and recommendation for national use and endorsement of the measure.
- Steering Committee members raised concerns that the cognitive status exclusion could potentially exclude large numbers of individuals.
    - The developer explained the exclusion is intended to exclude patients who are so ill they could not be receptive to the counseling or brief intervention.

3. Usability: H-3; M-10; L-1; I-6

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- The Steering Committee agreed the measure is usable and understandable to the public and providers. The measure is in use on the Joint Commission public reporting website Quality Check, is noted in the recent Inpatient Prospective Payment System Rule for future consideration, and is rated highly usable by pilot users.

4. Feasibility: H-2; M-7; L-3; I-8

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the measure is feasible to use and noted that performance should improve as it is implemented in EHRs.
- Steering Committee members raised concerns that the measure is not aligned with the Stage 2 Meaningful Use measure, which applies to patients 13 years and older.
    - The developer explained that the evidence base for patients 13 years and older is not as strong as that for the 18 years and older population.

5. Related and Competing Measures

- This measure is related to measures the rest of the TOB suite of measures, which are complementary to each other and already harmonized to the extent possible.

Steering Committee Recommendation for Endorsement: **Y-13**; **N-6**

- The Steering Committee recommended that the developer expand the measure population to include adolescents (aged 13 and older) to make the measure more consistent with measures in the Meaningful Use program and to incorporate an age group that also struggles with tobacco use. The developer noted that they would review the evidence for extending the age range of the measure in the future.

6. Public and Member Comment

Please refer to the TOB-1 measure review on page 37 for discussion of comments related to the suite of tobacco measures.
7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1 Decision: Approved for endorsement
8. Board of Directors (February 18, 2014): Decision: Ratified for endorsement
FORTHCOMING
9. Appeals

1656 TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge

Submission | Specifications

Status: New Submission

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. Refer to section 2a1.10 Stratification Details/Variables for the rationale for the addition of the subset measure. These measures are intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB 2 Tobacco Use Treatment Provided or Offered During the Hospital Stay; TOB-4 Tobacco Use: Assessing Status After Discharge).

Numerator Statement: 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.

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

Exclusions: The exclusions to this measure are as follows:

1. Patients less than 18 years of age
2. Patients who are cognitively impaired
3. Patients who are not current tobacco users
4. Patients who refused or were not screened for tobacco use status during the hospital stay (as tobacco status cannot be known)
5. Patients who have a length of stay less than or equal to one day or greater than 120 days
6. Patients who expired during the hospital stay
7. Patients who left against medical advice
8. Patients discharged/transferred to another hospital for inpatient care
9. Patients discharged/transferred to a federal health care facility
10. Patients discharged/transferred to hospice
11. Patients who do not reside in the United States

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable 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 element

Prescription for Tobacco Cessation Medication through value 2 (patient refused) removes these patients from the numerator calculation in the subset measure TOB-3a.

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-16**; **M-2**; **L-0**; **I-0**; 1b. Performance Gap: **H-12**; **M-6**; **L-0**; **I-0;** 1c. Evidence: **Y-16**; **N-0**; **I-3**

<u>Rationale</u>:

- The Steering Committee initially reviewed and rated the Importance criteria for this measure on April 18, 2012, during the first phase of this project; accordingly, Importance to Measure and Report was not discussed during the phase two meeting. Instead, the votes from Phase 1 were carried over, and appear above.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2**; **M-18**; **L-0**; **I-0;** 2b. Validity: **H-0**; **M-18**; **L-1**; **I-1**

<u>Rationale</u>:

- The Steering Committee agreed the measure is clearly and precisely specified. The data presented indicating reliability of the measure has improved from Phase 1 and is demonstrated with an overall measure agreement rate of 88.9 percent. Face validity is demonstrated by pilot user survey results ranging from 3.2 to 4.8 on a 5 point scale, and technical advisory panel survey results ranging from 3.87 to 5 on a 5 point scale. Survey respondents rated the clarity of measure specifications, usefulness, interpretability, data accessibility and ease of collection, and recommendation for national use and endorsement of the measure.

3. Usability: H-2; M-13; L-4; I-1

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The Steering Committee agreed the measure is usable and generally understandable to the public and providers, although some members questioned how understandable the measures would be to the public even though the measure is useful to providers.
- The measure is in use on the Joint Commission public reporting website Quality Check, is noted in the recent Inpatient Prospective Payment System Rule for future consideration, and is rated usable by pilot users.

4. Feasibility: H-1; M-11; L-8; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Steering Committee agreed the measure is feasible to use and noted that performance should improve as it is implemented in EHRs. However, Steering Committee members raised concerns about patients not receiving adequate information about treatments that are recommended or prescribed at discharge.
    - The developer explained that patients would be educated about any medications at discharge, or they would be provided with information regarding counseling and provided with the appropriate referral.
- The Steering Committee members also raised concerns that the measure is not aligned with the Stage 2 Meaningful Use measure, which applies to patients 13 years and older.

- The developer explained that the evidence base for patients 13 years and older is not as strong as that for patients 18 years and older.

5. Related and Competing Measures

- This measure is related to measures the rest of the TOB suite of measures, which are complementary to each other and already harmonized to the extent possible.

Steering Committee Recommendation for Endorsement: **Y-14**; **N-6**

- The Steering Committee recommended that the developer expand the measure population to include adolescents (aged 13 and older) to make the measure more consistent with measures in the Meaningful Use program and to incorporate an age group that also struggles with tobacco use. The developer noted that they would review the evidence for extending the age range of the measure in the future.

6. Public and Member Comment

Please refer to the TOB-1 measure review on page 37 for discussion of comments related to the suite of tobacco measures.

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1

Decision: Approved for endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for endorsement

FORTHCOMING

9. Appeals

1661 SUB-1 Alcohol Use Screening

Submission | Specifications

Status: New Submission

Description: Hospitalized patients 18 years of age and older who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).

Numerator Statement: The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking

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

Exclusions: The denominator has three 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

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable Not Applicable, the measure is not stratified

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-18**; **M-1**; **L-0**; **I-0**; 1b. Performance Gap: **H-12**; **M-7**; **L-0**; **I-0;** 1c. Evidence: **Y-17**; **N-0**; **I-2**

Rationale:

- The Steering Committee initially reviewed and rated the Importance criteria for this measure on April 18, 2012, during the first phase of this project; accordingly, Importance to Measure and Report was not discussed during the phase two meeting. Instead, the votes from Phase 1 were carried over, and appear above.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2**; **M-16**; **L-3**; **I-0;** 2b. Validity: **H-2**; **M-17**; **L-2**; **I-0**

Rationale:

- The Steering Committee agreed the measure met the criteria. Reliability testing of the measure involved the re-abstraction of 96 medical records at five hospitals and the overall agreement rate was 75 percent. Following the re-abstraction, focus groups were conducted at each hospital and differences in abstraction were further discussed and highlighted as an opportunity for improvement on the measure.
- On a previous review of the measure the Steering Committee had indicated concern regarding the reliability of the data element focused on screening patients for alcohol use; however, the developer noted that alterations to the measure had substantially improved the measure's reliability.
- The face validity of the measure was initially assessed through a public comment period and issues identified were addressed through measure revisions. An alpha test was then incorporated into the pilot test of the measure to reevaluate its validity. Finally, an eleven member Technical Advisory Panel was asked to review the measure specifications on a five point scale. The measure score varied from 4.12 -5 based on clarity of specifications, usefulness, interpretability, data accessibility and ease of collection and national use.

3. Usability: H-4; M-17; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- The Steering Committee agreed the measure is usable. CMS has indicated that this measure will be required for reporting for inpatient psychiatric hospitals and psychiatric units in general hospitals starting in 2016.

4. Feasibility: H-4; M-17; L-0; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the measure is feasible. Some data elements are available in electronic sources, and in the future the developer plans to further develop electronic specifications for the measure.

5. Related and Competing Measures

- This measure is related to the other measures in the SUB suite of measures in addition to the AMA-PCPI measure #2152 – Preventive Care and Screening: Unhealthy Diagnosis.

Steering Committee Recommendation for Endorsement: **Y-19**; **N-2**

- The Steering Committee recommended that the developer expand the measure population to include adolescents (aged13 and older) to make the measure more consistent with Meaningful Use and to incorporate an age group that also struggles with substance use disorders. The developer noted that they would review the evidence for extending the age range of the measure in the future.

6. Public and Member Comment

Theme 1: Evidence Supporting The Joint Commission's Suites of Tobacco (TOB) and Alcohol/Substance (SUB) Use Measures

Description Commenters did not support the recommended endorsement of the following substance use measures and questioned whether the measures meet the evidence criterion relative to hospitalization and

discharge: 1661 SUB-1 Alcohol Use Screening; 1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention; 1664 SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge (The Joint Commission).

Committee Response: In the first phase of this project the Steering Committee reviewed and rated the three importance sub-criteria - impact, performance gap and evidence -for the substance use measures (1661 SUB-1, 1663 SUB-2 and 1664 SUB-3) and agreed that sufficient evidence was presented to support the measures. The Committee noted that the majority of the evidence, generally, is related to the outpatient setting. However, following substantial discussion, committee members agreed that certain evidence could be generalizable from the primary care setting to the inpatient setting, and that sufficient evidence was presented related to the inpatient setting based on the USPSTF and Cochrane review evidence to support the measures.

Theme 2: Appropriateness of Tobacco (TOB) and Alcohol/Substance (SUB) Use Measures in the Inpatient Psychiatric Setting

Description: 14 commenters did not support the recommended endorsement of the tobacco and alcohol/substance use suites of measures for use in the inpatient psychiatric setting, citing concerns about the appropriateness of brief interventions given the intensive treatment provided to patients in this setting, and the burden of collecting data and providing referrals at discharge.

Developer Response: The Joint Commission specified this measure for use in all hospitals; therefore, since testing was conducted in psychiatric settings as well as general acute care hospitals, it is equally appropriate for use in IPFs.

Committee Response: Agree with Developer.

Theme 3: Reliability of SUB-1 Measure

Description: One commenter did not support the recommended endorsement of the substance use measure 1661 SUB-1 Alcohol Use Screening, concerned by the measure's reliability. In particular, the overall agreement rate for re-abstraction (75 percent) and the agreement rate for the data element 'alcohol use status' (64.7 percent) were noted.

Committee Response: The Steering Committee reviewed the reliability of the measure 1661 SUB-1 based on additional testing presented by the Joint Commission. The additional testing gauged the sensitivity and specificity of the measure and the Committee noted improvements from previous reliability testing presented. NQF's measure evaluation criteria requires reliability testing to demonstrate that either the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period, and/or that the overall measure score is precise. The Committee noted that the overall measure agreement rate of 75 percent between the originally abstracted data and the re-abstracted data is at the threshold of an acceptable agreement rate, and ultimately determined it was sufficient to meet the criterion. The Committee also noted that further improvement is expected over time as the measure is more widely adopted.

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1

Decision: Approved for endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for endorsement

FORTHCOMING

9. Appeals

1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention

Submission | Specifications

Status: New Submission

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.

These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).

Numerator Statement: SUB-2 The number of patients who received or refused a brief intervention.

SUB-2a The number of patients who received a brief intervention.

Denominator Statement: 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).

Exclusions: The denominator has 4 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

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable 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.

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-18**; **M-1**; **L-0**; **I-0**; 1b. Performance Gap: **H-11**; **M-8**; **L-0**; **I-0;** 1c. Evidence: **Y-14**; **N-0; I-5**

<u>Rationale</u>:

- The Steering Committee initially reviewed and rated the Importance criteria for this measure on April 18, 2012, during the first phase of this project; accordingly, Importance to Measure and Report was not discussed during the phase two meeting. Instead, the votes from Phase 1 were carried over, and appear above.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2**; **M-19**; **L-0**; **I-0;** 2b. Validity: **H-0**; **M-16**; **L-5**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed that the measure meets the criteria. Reliability involved the re-abstraction of 96 medical records at five hospitals. Initial reliability testing indicated an agreement rate of 71.4 percent; however, improvements to the measure focusing on skip logic, refinement of data definitions and notes for abstraction increased the agreement rate to 80.2 percent. Following the re-

abstraction, focus groups were conducted at each hospital and differences in abstraction were further discussed and highlighted as an opportunity for improvement on the measure.

- The face validity of the measure was initially assessed through a public comment period and issues identified were addressed through measure revisions. An alpha test was then incorporated into the pilot test of the measure to reevaluate its validity. Finally, an eleven member Technical Advisory Panel was asked to review the measure specifications on a five point scale. The measure score varied from 3.87 to 4.9 based on clarity of specifications, usefulness, interpretability, data accessibility and ease of collection and national use.
- A Steering Committee member requested clarification regarding the type of individual and training required for those delivering brief interventions to patients.
    - The developer explained that they have created educational standards and core competencies, which are required for individuals who will be performing the interventions. They also stated that in general hospitals develop a cadre of trained people to provide the brief intervention. It was also noted that brief interventions are different from brief counseling.
- Steering Committee members discussed that the measure could be improved by conducting a brief intervention for patients with unhealthy alcohol use and referring patients with an alcohol disorder rate to additional services rather than using a brief intervention for all patients with unhealthy alcohol use. This approach may also lessen the burden on providers to administer brief interventions to patients. However, the Steering Committee concluded that conducting a brief intervention could help guide the referral and create a greater willingness in the patient to follow through with cessation.

3. Usability: H-2; M-14; L-5; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- The Steering Committee agreed the measure is usable. CMS has indicated that this measure will be required for reporting for inpatient psychiatric hospitals and psych units in general hospitals starting in 2016.
- A Steering Committee member noted that the measure appropriately follows *1661 SUB-1 Alcohol use screening* and would be useful for promoting brief interventions

4. Feasibility: H-0; M-14; L-7; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the measure is feasible and some data elements are available in electronic sources. In the future the developer plans to further develop electronic specifications for the measure.
- A Steering Committee member questioned whether the measure may be more feasible in sites dedicated to screening for alcohol misuse, and more difficult to implement in the general populous.

5. Related and Competing Measures

- This measure is related to the other measures in the SUB suite of measures in addition to the AMA-PCPI measure #2152 – Preventive Care and Screening: Unhealthy Diagnosis.

Steering Committee Recommendation for Endorsement: **Y-16**; **N-5**

- The Steering Committee recommended that the developer expand the measure population to include adolescents (aged 13 and older) to make the measure more consistent with Meaningful Use and to incorporate an age group that also struggles with substance use disorders. The developer noted that they would review the evidence for extending the age range of the measure in the future.

6. Public and Member Comment

Please refer to the TOB-1 measure review on page 37 for discussion of comments related to the suite of tobacco measures.

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1

Decision: Approved for endorsement
8. Board of Directors (February 18, 2014): Decision: Ratified for endorsement
FORTHCOMING
9. Appeals

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

Submission | Specifications

Status: New Submission

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.

These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).

Numerator Statement: 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.

Denominator Statement: The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder

Exclusions: There are 10 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 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

Adjustment/Stratification: No risk adjustment or risk 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.

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-16**; **M-2**; **L-0**; **I-0**; 1b. Performance Gap: **H-12**; **M-6**; **L-0**; **I-0;** 1c. Evidence: **Y-16**; **N-1; I-1**

<u>Rationale</u>:

- The Steering Committee initially reviewed and rated the Importance criteria for this measure on April 18, 2012, during the first phase of this project; accordingly, Importance to Measure and Report was not discussed during the phase two meeting. Instead, the votes from Phase 1 were carried over, and appear above.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-19**; **L-0**; **I-0;** 2b. Validity: **H-0**; **M-16**; **L-5**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure meets the criteria. Reliability involved the re-abstraction of 96 medical records at five hospitals and resulted in an overall agreement rate to 96.2 percent for SUB-3 and 93.8 percent for SUB-3a.
- The face validity of the measure was initially assessed through a public comment period and issues identified were addressed through measure revisions. An alpha test was then incorporated into the pilot test of the measure to reevaluate its validity. Finally, an eleven member Technical Advisory Panel was asked to review the measure specifications on a five point scale. The measure score varied from 3.85 to 5.0 based on clarity of specifications, usefulness, interpretability, data accessibility and ease of collection and national use.
- A Steering Committee member expressed concern that the measure includes alcohol as well as other drug use disorders, which creates a broad measure and potentially an additional burden for providers. Members also noted that incorporating a prescription at discharge may be problematic since use of medications for substance abuse may not be as efficacious as medications to treat other addictions, such as tobacco.
    - The developer referenced a table, linked to the measure, which indicates medications approved by the FDA that could be prescribed to patients. They also clarified that the measure only focuses on the patient's receipt of a prescription, and does not address patient compliance.
    - The Steering Committee expressed concern that medications for substance abuse may be expensive, which could deter patients from actually filling a prescription but ultimately agreed with the measure, noting the measure is constructed to allow patients to receive a prescription *OR* a referral for treatment.
- The Steering Committee reviewed the measure testing results regarding the identification of meaningful differences in performance and noted that the measure had an overall rate of 3.5 percent, a significant decrease from the baseline of 9.2 percent. This indicates that there was a reduction of differences in performance for the measure among hospitals implementing the measure.

3. Usability: H-2; M-11; L-8; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale</u>:

- The Steering Committee agreed the measure is usable. CMS has indicated that this measure will be required for reporting for inpatient psychiatric hospitals and psych units in general hospitals starting in 2016.

4. Feasibility: H-0; M-11; L-10; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the measure is feasible and some data elements are available in electronic sources. In the future the developer plans to further develop electronic specifications for the measure.
- A Steering Committee member expressed concern that the measure includes alcohol as well as other drug use disorders, which could create an additional burden for providers, and that generating the data elements requires chart review.
    - The developer clarified that providers would also need to conduct chart reviews in measures *1661 SUB-1 Alcohol use screening* and *1663 SUB-2 Alcohol use brief intervention provided or offered and Sub-2a Alcohol use brief intervention*. The developer also noted that hospitals currently implementing the substance abuse suite of measures rely on electronic health records to reduce the burden.

5. Related and Competing Measures

- This measure is related to the other measures in the SUB suite of measures in addition to the AMA-PCPI measure #2152 – Preventive Care and Screening: Unhealthy Diagnosis.

Steering Committee Recommendation for Endorsement: **Y-11**; **N-9**

- The Steering Committee recommended that the developer expand the measure population to include adolescents (aged 13 and older) to make the measure more consistent with Meaningful Use and to incorporate an age group that also struggles with substance use disorders. The developer noted that they would review the evidence for extending the age range of the measure in the future.

6. Public and Member Comment

Please refer to the TOB-1 measure review on page 37 for discussion of comments related to the suite of tobacco measures.

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1

Decision: Approved for endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for endorsement

FORTHCOMING

9. Appeals

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Submission | Specifications

Status: New Submission

Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Numerator Statement: Patients who were screened for unhealthy alcohol use* at least once during the two-year measurement period using a systematic screening method** AND who received brief counseling*** if identified as an unhealthy alcohol user

*Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men <=65 years of age.

**A systematic method of assessing for unhealthy alcohol use should be utilized. Systemic screening methods include but are not limited to:

AUDIT Screening Instrument

CAGE Screening Instrument

AUDIT-C Screening Instrument

Single Item Screening Instrument

Alternative approaches may also include questions regarding quantity/frequency of consumption (ie, drinks per week or drinks per occasion).

***Brief counseling refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking5.

Denominator Statement: All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two-year measurement period

Exclusions: Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: American Medical Association - convened Physician Consortium for Performance Improvement (AMA-convened PCPI) Other organizations: The measure was developed by a multi-disciplinary, cross-speciality work group representing all key stakeholders and including representation from the following specialties, most of whom were sponsored by their medical specialty society: family medicine, internal medicine, geriatric medicine, gastroenterology, general surgery, colon & rectal surgery, infectious disease, radiology, cardiology, obstetrics & gynecology, emergency medicine, preventive medicine, occupational medicine, nursing, psychology, occupational therapy, chiropractics, dietetics, optometry.

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-18**; **M-2**; **L-0**; **I-0**; 1b. Performance Gap: **H-6**; **M-14**; **L-0**; **I-0;** 1c. Evidence: **Y-18**; **N-0**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure addresses a significant cause of U.S. morbidity and mortality and the impact of screening and brief counseling on unhealthy alcohol use is well documented. Gaps in care exist and strong evidence is presented to support the measure focus with the U.S. Preventive Services Task Force (USPSTF) recommendation that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
- Steering Committee members recommended the developer explore expanding the age range to 13 years and older in future.
    - The developer explained that the age range for the measure is consistent with the USPSTF recommendations and that the evidence base for a lower age range is not yet established.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2**; **M-18**; **L-0**; **I-0;** 2b. Validity: **H-2**; **M-17**; **L-1**; **I-0**

<u>Rationale</u>:

- The Steering Committee agreed that the developer demonstrated the measure is reliable and valid given the EHR testing results, face validity testing results and multiple studies with positive results.

3. Usability: H-6; M-14; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- The Steering Committee agreed the developer provided meaningful data to support the usability of the measure. An abbreviated version of the measure was included in the CMS Physician Quality Reporting System (PQRS) program from 2009-2011 and is currently included in the 2012 program. That form of the measure focuses only on screening for unhealthy alcohol use; brief counseling is not included in that measure.

4. Feasibility: H-4; M-16; L-0; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee agreed the data for the measure are generated and used by healthcare personnel in the course of care.

5. Related and Competing Measures

- This measure is related to measures in The Joint Commission's suite of substance use measures, SUB 1-3.
- The Steering Committee discussion focused on the fact that while both measure #2152 and the TJC SUB-1 measure use validated tools to screen for alcohol use, measure #2152 lists the CAGE tool as an appropriate option. The Joint Commission does not consider the CAGE tool to be an appropriate screening mechanism and therefore do not include it as a recommended option. The AMA-PCPI explained that measure #2152 does not specify which screening tool is used; a number of examples are listed, of which the CAGE tool is one.
- Other specifications such as exclusions of those with limited life expectancy remain similar across developers.
- The Committee recommended that AMA-PCPI remove the CAGE tool from its list of recommended screening instruments, and the developer agreed.

Steering Committee Recommendation for Endorsement: **Y-20**; **N-0**

Rationale

- The Steering Committee also recommended that the developer expand the measure population to include adolescents (aged 13 years and older) to make the measure more consistent with the CMS Meaningful Use program. The developer noted that they would review the evidence for extending the age range of the measure in the future.

6. Public and Member Comment

7. Consensus Standards Approval Committee (CSAC) Review (January, 24): Y-12; N-0; A-1

Decision: Approved for endorsement

8. Board of Directors (February 18, 2014):

Decision: Ratified for endorsement

FORTHCOMING

9. Appeals

Measures Not Recommended

0103 Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity

Submission

Status: Maintenance, Original Endorsement: Aug 10, 2009

Description: Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

Numerator Statement: Patients with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

Denominator Statement: All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD)

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Psychiatric Association

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-X**; **M-X**; **L-X**; **I-X**; 1b. Performance Gap: **H-X**; **M-X**; **L-X**; **I-X** 1c. Evidence: **Y-2**; **N-9; I-9**

Rationale:

- The Steering Committee expressed concerns that the process specified in the measure is highly distal to the intended improvement in care.
- Steering Committee members were concerned about the diagnosis and labeling of depression severity as specified in the measure, and asked whether the Patient Health Questionnaire (PHQ-9) is an adequate tool for severity assessment and could be an alternative to this measure.
    - The developer explained that the criteria in the measure lead to a more precise diagnosis. Although the PHQ-9 is an identical replica of the nine criteria in the measure, the determination of major depressive disorder is made at a much lower threshold than what is required in the DSM-5. The DSM-5 criterion requires that all but one of the nine criteria are present nearly every day for two weeks, while the PHQ-9 allows more flexibility. Therefore patients assessed using the PHQ-9 would be included in the diagnostic threshold that wouldn't necessarily be diagnosed with major depressive disorder (MDD) in the DSM-5.
- Steering Committee members questioned the primary intent of the measure: whether it is to address the problem of individuals with mild or moderate depression that are inappropriately prescribed antidepressants, or whether the intent is to address the issue of under-identification of MDD and potential over- or under-treatment.
    - The developer explained that while there is a documented high prevalence of MDD, individuals with the disease are under-identified. There is an important need to identify patients carefully and systematically and ensure treatment modalities are appropriate.
    - The developer further explained that if a clinician is relying on an imprecise determination that a patient has depression rather than MDD, that patient could be treated inappropriately.
    - The developer also noted that the measure could potentially be used to track severity over time

and detect changes.

- Steering Committee members remained unconvinced that the measure would change clinician behavior and improve population health, noting that the severity component has not been well tested and there is a lack of empirical evidence that this measure would lead to improvement. A Committee member was also concerned about the potential harms of labeling patients and the resulting implications for their overall treatment over time.
- The Steering Committee concluded that there is a lack of evidence to support the causal pathway for this measure, and agreed the measure did not meet the evidence criterion. The Committee further agreed the measure did not need to be considered for an exception to the evidence criterion, as the potential benefits of the measure did not outweigh potential harms.

Steering Committee Recommendation for Endorsement: **This measure did not meet the Importance to Measure and Report criteria.**

0552 HBIPS-4: Patients discharged on multiple antipsychotic medications.

Submission

Status: Maintenance, Original Endorsement: Aug 05, 2009

Description: The proportion of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-5 (Patients discharged on multiple antipsychotic medications with appropriate justification).

Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications.

Denominator Statement: Psychiatric inpatient discharges

- Included populations: Patients with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.01 discharged on one or more routinely scheduled antipsychotic medications (refer to Appendix B, Table 10.0- Antipsychotic Medications) available at: http://manual.jointcommission.org

Exclusions: •
- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients with an unplanned departure resulting in discharge due to failing to return from leave

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable The measure is stratified by the following age groups:

- Children (1 through 12 years)
- Adolescent (13 through 17 years)
- Adult (18 through 64 years)
- Older Adult (=65 years)

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American

Psychiatric Association (APA).

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-X**; **M-X**; **L-X**; **I-X**; 1b. Performance Gap: **H-X**; **M-X**; **L-X**; **I-X** 1c. Evidence: **Y-5**; **N-15**; **I-0**

Rationale:

- The Steering Committee questioned the need to have this measure as a stand-alone measure, suggesting it could instead serve as the basis for the denominator in the next measure in the suite that it is paired with, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification. Given the short timeframe for hospitalizations, the Committee members felt the measure would be unable to reduce the prevalence of multiple medications during the hospital stay; rather, the next measure HBIPS-5 is able to address this and assess justification or plans for titration.
    - The developer explained that when this measure was initially tested, HBIPS-4 and HBIPS-5 were combined. However, feedback received from pilot test sites at that time indicated a desire to know the *prevalence* of the problem of multiple anti-psychotics, leading The Joint Commission to break the original measure into two distinctly reportable measures. This change allowed providers to speak to each other about baseline rates and acceptable variation between those rates. The developer's expert, Dr. Kanazi from the University of Michigan noted that both measures have had an impact on improved care at his facility. The developer further explained that the rates for this measure have declined since it was first implemented; suggesting clinicians are examining their practices.
    - The developer noted that just by monitoring practices in this measure they have seen improvement in rates at facilities. However, the developer clarified that the rates for HBIPS-4 would never be publicly reported independently of HBIPS-5, and when publicly reported only the proportion of patients discharged on multiple medications inappropriately is reported.
- The Steering Committee discussed the measure at length and concluded that while the developer presented significant evidence focused on both the negative consequences of polypharmacy and the appropriateness of polypharmacy in some instances, the measure focus does not allow for the distinction of differences in provider performance related to these issues. Because of this, standing alone, the measure is not a measure of quality of patient care and the Committee agreed there is insufficient evidence to warrant the endorsement of this measure, given the use of HBIPS-5, which addresses patients discharged on multiple antipsychotic medications with appropriate justification..

Steering Committee Recommendation for Endorsement: **This measure did not meet the Importance to Measure and Report criteria.**

1657 TOB-4 Tobacco Use: Assessing Status after Discharge

Submission

Status: New Submission

Description: Hospitalized patients 18 years of age and older who are identified through the screening process as having used tobacco products (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days who are contacted between 15 and 30 days after hospital discharge and follow-up information regarding tobacco use status is collected. This measure is intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB-2 Tobacco Use Treatment Provided or Offered (during hospital stay); TOB-3 Tobacco Use Treatment Provided or Offered at Discharge.

Numerator Statement: The number of discharged patients who are contacted between 15 and 30 days after hospital discharge and follow-up information regarding tobacco use status is collected.

Denominator Statement: The number of discharged patients 18 years of age and older identified as current tobacco users.

Exclusions: There are 15 exclusions from the denominator as follows:

1. Patients less than 18 years of age
2. Patients who are cognitively impaired
3. Patients who are not current tobacco users
4. Patients who were not screened for tobacco use
5. Patients who expired during the hospital stay - identified by Discharge Disposition
6. Patients who have a length of stay less than or equal to one day
7. Patients with a length of stay greater than 120 days
8. Patients discharged/transferred to another hospital for inpatient care
9. Patients who left against medical advice
10. Patients discharged/transferred to another health care facility.
11. Patients discharged to home or another health care facility for hospice care
12. Patients who do not reside in the United States
13. Patients who do not have a phone or cannot provide contact information
14. Patients discharged to a detention facility, jail or prison
15. Patients re-admitted to the hospital within the follow-up time frame

Patients who were not screened for tobacco use

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable Not Applicable, the measure is not stratified

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-X**; **M-X**; **L-X**; **I-X**; 1b. Performance Gap: **H-X**; **M-X**; **L-X**; **I-X** 1c. Evidence: **Y-9**; **N-5; I-7**

<u>Rationale</u>:

- The Steering Committee raised concerns about the importance of the measure, given that the measure requires contacting individuals after a hospital stay to ask about quit status, but does not require counseling or advice at the point of the contact. Committee members also questioned the evidence that such contact has an impact on outcomes.
    - The developer explained that the U.S. Preventive Services Task Force and clinical practice guidelines recommend follow-up for individuals who receive smoking cessation intervention, and that data suggest the act of follow-up increases the likelihood that smokers will take advantage of treatments. Steering Committee members noted, however that the measure focus is not arranging follow-up treatment, but rather contacting individuals to determine quit status.
- Steering Committee members discussed that there is evidence that contacting patients and discussing issues that may be preventing them from following through on a clinical recommendation has an impact, however the Committee concluded that the evidence presented does not support the intervention specified in the measure.

Steering Committee Recommendation for Endorsement: **This measure did not meet the Importance to Measure and Report criteria.**

1665 SUB-4 Alcohol & Drug Use: Assessing Status After Discharge

Submission

Status: New Submission

Description: Hospitalized patients age 18 years and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected.

This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1) Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).

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

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

Exclusions: The following are the exclusions from the denominator for this measure

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

Adjustment/Stratification: No risk adjustment or risk stratification Not Applicable Not Applicable, the measure is not stratified.

Level of Analysis: Facility, Population : National

Type of Measure: Process

Data Source: Electronic Clinical Data, Paper Medical Records

Measure Steward: The Joint Commission

STEERING COMMITTEE MEETING [06/5-6/2013]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-X**; **M-X**; **L-X**; **I-X**; 1b. Performance Gap: **H-X**; **M-X**; **L-X**; **I-X** 1c. Evidence: **Y-0**; **N-8; I-13**

<u>Rationale</u>:

- The Steering Committee reviewed the evidence presented to support the measure and concluded the quality of the evidence is low and only indirectly supports the measure focus. No studies were cited to directly support the efficacy of follow up with patients seven to 30 days after hospital discharge to ascertain unhealthy alcohol use or drug use; rather, the RCT and systematic review evidence presented related to other interventions.

Steering Committee Recommendation for Endorsement: **This measure did not meet the Importance to Measure and Report criteria.**

Appendix A: Measure Specifications

	0104 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
Status	Maintenance, Original Endorsement: Aug 10, 2009
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Psychiatric Association
Description	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified
Type	Process
Data Source	Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry Not Applicable Attachment AMA-PCPI_eSpecification_AMDD-2SuicideRisk_DEC2012.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic, Other, Behavioral Health/Psychiatric : Outpatient, Ambulatory Care : Urgent Care
Numerator Statement	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified
Numerator Details	Time Window: At the visit where new diagnosis or recurrent episode is identified [initial evaluation during the episode] Definitions/Instructions: Suicide risk assessment must include questions about the following: 1) Suicidal ideation 2) Patient's intent of initiating a suicide attempt AND, if either is present, 3) Patient plans for a suicide attempt 4) Whether the patient has means for completing suicide For EHR: See PCPI eSpecification attached in Data Dictionary or Code Table (2a1.30) field.
Denominator Statement	All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD)
Denominator Details	Time Window: Each episode of MDD during 12 consecutive month measurement period For EHR: See PCPI eSpecification attached in Data Dictionary or Code Table (2a1.30) field.
Exclusions	None
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure

	based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator If the patient does not meet the numerator, this case represents a quality failure. Calculation algorithm is included in data dictionary/code table attachment (2a1.30).
Copyright/ Disclaimer	Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® (PCPI®). These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, eg, use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA (on behalf of the PCPI). Neither the AMA, PCPI nor its members shall be responsible for any use of the Measures. THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND © 2012 American Medical Association. All Rights Reserved. Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the PCPI and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications. CPT® contained in the Measure specifications is copyright 2004- 2011 American Medical Association. LOINC® copyright 2004-2010 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2010 International Health Terminology Standards Development Organisation. All Rights Reserved. N/A

	0105 Antidepressant Medication Management (AMM)
Status	Maintenance, Original Endorsement: Aug 10, 2009
Steward	National Committee for Quality Assurance
Description	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via the Interactive Data Submission System (IDSS) portal. URL http://www.ncqa.org/tabid/370/default.aspx
Level	Health Plan, Integrated Delivery System
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the Index Prescription Start Date (IPSD) (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days). b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).
Numerator Details	Time Window: The time from the Index Prescription Start Date through 12 weeks after the index prescription start date and 6 months after the index prescription start date. List of Antidepressant Medications: Miscellaneous antidepressants: Bupropion, Vilazodone Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine Phenylpiperazine antidepressants: Nefazodone, Trazodone Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine SSNRI antidepressants : Desvenlafaxine, Duloxetine, Venlafaxine SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline Tetracyclic antidepressants: Maprotiline, Mirtazapine Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin,

	Imipramine, Nortriptyline, Protriptyline, Trimipramine
Denominator Statement	Members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.
Denominator Details	Time Window: The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year (i.e. Intake Period). Step 1: Identify all members who met at least one of the following criteria during the Intake Period. • At least one principal diagnosis of major depression in an outpatient, ED, intensive outpatient or partial hospitalization setting, or • At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting on different dates of service with any diagnosis of major depression, or • At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression Codes to Identify Major Depression ICD-9-CM Diagnosis: 296.20-296.25, 296.30-296.35, 298.0, 311 Codes to Identify Visit Type ED: CPT - 99281-99285: UB Revenue - 045x, 0981 Outpatient, intensive outpatient and partial hospitalization: CPT- 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 UB Revenue: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983 CPT with POS CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255 WITH POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 Step 2: Determine the Index Episode Start Date (IESD). For each member identified in step 1, identify the date of the earliest encounter during the Intake Period with any diagnosis of major depression. If the member had more than one encounter during the Intake Period, include only the first encounter. Step 3: Identify the Index Prescription Start Date. The IPSD is the date of the earliest dispensing event for an antidepressant medication during the period of 30 days prior to the Index Episode Start Date (IESD) (inclusive) through 14 days after the IESD (inclusive). Exclude members who did not fill a prescription for an antidepressant medication during this period. Step 4: Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant 90 days (3 months) prior to the IPSD. Step 5: Calculate continuous enrollment. Members must be continuously enrolled for 90 days (3 months) prior to the IESD to 245 days after the IESD. Note: Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period specified (e.g., during the Intake Period).
Exclusions	Exclude members who filled a prescription for an antidepressant 90 days (3 months) prior to the IPSD.
Exclusion	N/A

Details	
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	NCQA asks that health plans collect the measure data for each of the three product lines each year (i.e. commercial, Medicare, Medicaid) if applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Identify all members who met at least one of the following criteria during the Intake Period. • At least one principal diagnosis of major depression in an outpatient, ED, intensive outpatient or partial hospitalization setting, or • At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting on different dates of service with any diagnosis of major depression, or • At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression Step 2: Determine the IESD. For each member identified in step 1, identify the date of the earliest encounter during the Intake Period with any diagnosis of major depression. If the member had more than one encounter during the Intake Period, include only the first encounter. Step 3: Identify the IPSD. The IPSD is the date of the earliest dispensing event for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Exclude members who did not fill a prescription for an antidepressant medication during this period. Step 4: Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant 90 days (3 months) prior to the IPSD. Step 5: Calculate continuous enrollment. Members must be continuously enrolled for 90 days (3 months) prior to the IESD to 245 days after the IESD. Step 6: Determine the number of patients in the denominator who had continuous treatment with antidepressant medication for at least 84 days during the 114-day period following the IPSD. Step 7: Determine the number of patients in the denominator who had continuous treatment with antidepressant medication for at least 180 days during the 231-day period following the IPSD. Step 8: Calculate a rate by dividing both steps 6 and 7 by the total number of members in the denominator.
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	0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
Status	Maintenance, Original Endorsement: Jul 31, 2008
Steward	Centers for Medicare and Medicaid Services
Description	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Medicare Part B claims data is provided for test purposes URL Refer to section VIII Medicare Part B Claims Request Detail in attached "NQF Endorsement Measurement Submission Summary Materials" Document N/A Attachment PartB_claims_AdHocRecordLayouts.pdf
Level	Population : Community, Population : County or City, Clinician : Group/Practice, Clinician : Individual, Population : National, Population : Regional, Population : State, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented The standardized screening tools help predict a likelihood of someone developing or having a particular disease. The screening tools suggested in this measure screen for possible depression. Questions within the suggested standardized screening tools may vary but the result of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as defined within the measure. If the patient has a negative screen for depression, no follow-up plan is required.
Numerator Details	Time Window: The reporting period represents a 12 month period starting January 1st through December 31 of each year. G-codes are a defined as Quality Date Codes (QDCs), which are subset of HCPCs II codes. QDCs are non billable codes that providers will use to delineate their clinical quality actions, which are submitted with Medicare Part B Claims. There are five different G-code options for NQF measure #0418. Positive Screen for Clinical Depression, Follow-Up Plan Documented G8431: Positive screen for clinical depression using an age appropriate standardized tool and a follow-up plan documented OR Negative Screen for Clinical Depression Documented, Follow-Up Plan not Required G8510: Negative screen for clinical depression using an age appropriate standardized tool, follow-up not required OR Screening for Clinical Depression not Documented, Patient not Eligible/Appropriate G8433: Screening for clinical depression using an age appropriate standardized tool not documented, patient not eligible/appropriate OR Screening for Clinical Depression not Documented, Reason not Specified G8432: No documentation of clinical depression screening using an age appropriate standardized tool OR

	Screening for Clinical Depression Documented, Follow-Up Plan not Documented, Reason not Specified G8511: Positive Screen for clinical depression using an age appropriate standardized tool documented, follow-up plan not documented, reason not specified Definitions: Screening – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code. Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of depression screening tools include but are not limited to: • Adult Screening Tools (18 years and older) Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale Depression Scale (SDS), Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver) and PRIME MD-PHQ2 • Adolescent Screening Tools (12-17 years) Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire, Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ2 Follow-Up Plan – Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.
Denominator Statement	All patients aged 12 years and older
Denominator Details	Time Window: This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90862, 92557, 92567, 92568, 92590, 92625, 92626, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, G0101, G0402, G0438, G0439
Exclusions	Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist: • Patient refuses to participate • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases • Patient was referred with a diagnosis of depression • Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Exclusion Details	Screening for Clinical Depression not Documented, Patient not Eligible/Appropriate G8433: Screening for clinical depression using an age appropriate standardized tool not documented, patient not eligible/appropriate
Risk Adjustment	No risk adjustment or risk stratification N/A URL N/A N/A
Stratification	No stratification. All eligible patients are subject to the same numerator criteria.
Type Score	Rate/proportion better quality = higher score
Algorithm	THIS SECTION PROVIDES DEFINITIONS & FORMULAS FOR THE NUMERATOR (A), TOTAL DENOMINATOR POPULATION (TDP), DENOMINATOR EXCLUSIONS (B) CALCUATION & PERFORMANCE DENOMINATOR (PD) CALCULATION. NUMERATOR (A): HCPCS Clinical Quality Codes G8431, G8510 TOTAL DENOMINATOR POPULATION (TDP): Patient aged 12 years and older on the date of the encounter of the 12-month reporting period, with denominator defined encounter codes & Medicare Part B Claims reported HCPCS Clinical Quality Codes G8431, G8510, G8433, G8432, & G8511 DENONINATOR EXCLUSION (B): HCPCS Clinical Quality Code G8433 DENOMINATOR EXCLUSION CALCULATION:Denominator Exclusion (B): # of patients with valid exclusions # G8433 / # TDP PERFORMANCE DENOMINATOR CALCULATION:Performance Denominator (B): Patients meeting criteria for performance denominator calculation # A / (# TDP - # B) (Refer to section IX Calculation for Performance in attached “NQF Endorsement Measurement Submission Summary Materials” Document) URL N/A Refer to section IX Calculation for Performance in attached “NQF Endorsement Measurement Submission Summary Materials” Document
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	0518 Depression Assessment Conducted
Status	Maintenance, Original Endorsement: Mar 31, 2009
Steward	Centers for Medicare and Medicaid Services Other organizations: Abt Associates, Inc. Case Western Reserve University University of Colorado at Denver, Division of Health Care Policy and Research
Description	Percent of patients who were screened for depression (using a standardized depression screening tool) at start or resumption of home health care
Type	Process
Data Source	Electronic Clinical Data The measure is calculated based on data obtained from the Home Health Outcome and Assessment Information Set (OASIS-C), which is a core standard assessment data set that home health agencies integrate into their own patient-specific, comprehensive assessment to identify each patient's need for home care. The data set is the foundation for valid and reliable information for patient assessment, care planning, and service delivery in the home health setting, as well as for the home health quality assessment and performance improvement program. HH agencies are required to collect OASIS data on all non-maternity Medicare/Medicaid patients, 18 or over, receiving skilled services. Data are collected at specific time points (admission, resumption of care after inpatient stay, recertification every 60 days that the patient remains in care, transfer, and at discharge). HH agencies are required to encode and transmit patient OASIS data to the state OASIS repositories. Each HHA has on-line access to outcome and process measure reports based on their own OASIS data submissions, as well as comparative state and national aggregate reports, case mix reports, and potentially avoidable event reports. CMS regularly collects OASIS data from the states for storage in the national OASIS repository, and makes measures based on these data (including measure 0518 "Depression Assessment Conducted") available to consumers and to the general public through the Medicare Home Health Compare website. URL https://www.cms.gov/OASIS/Downloads/oasisp200.zip URL https://www.cms.gov/OASIS/Downloads/oasisp200.zip
Level	Facility
Setting	Home Health
Numerator Statement	Number of home health episodes of care in which patients were screened for depression (using a standardized depression screening tool) at start/resumption of care.
Numerator Details	Time Window: CMS systems report data on episodes that end within a rolling 12 month period, updated quarterly. Numerator is calculated based on response to item M1730 in the Home Health Outcome and Assessment Information Set (OASIS-C). See section 2a1.26. for additional information about the OASIS-C. Number of home health patient episodes of care where at start of episode: - (M1730) Depression Screening conducted = 1 (yes – PHQ2) or 2 (yes – other standardized assessment – meets criteria) or 3 (yes - other standardized assessment – does not meet criteria)
Denominator Statement	Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.
Denominator Details	Time Window: Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions. Number of home health patient episodes of care, defined as: A start/resumption of care assessment ((M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer assessment ((M0100) Reason for Assessment = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility – discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by denominator exclusions.

Exclusions	Episodes in which the patient was nonresponsive at the time of assessment.
Exclusion Details	Measure-specific exclusions: Number of home health patient episodes of care where at start of episode:(M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care); AND he value recorded on (M1700) Cognitive functioning = 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium; or the value recorded on M1710 "When Confused" or M1720 "When Anxious" is NA on the start (or resumption) of care, indicating the patient is non-responsive. Generic Exclusions: Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over) non-maternity Medicare and Medicaid patients who are receiving skilled home health care. Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. The publicly-reported data on CMS' Home Health Compare web site also repress cells with fewer than 20 observations, and reports for home health agencies in operation less than six months.
Risk Adjustment	No risk adjustment or risk stratification NA - process measure
Stratification	NA
Type Score	Rate/proportion better quality = higher score
Algorithm	Steps in calculating "Depression Assessment Conducted" 1. Construct Home Health Episodes of Care, defined as starting with an admission to home health care (M0100 Reason for assessment = 01) or resumption of home health care after an inpatient facility stay (M0100 Reason for assessment = 03), and ending with a discharge from home health care, including discharge due to death, or admission to inpatient facility for 24 hours or more (M0100 Reason for assessment = 06, 07, 08, or 09), as described in the technical specifications. 2. For each Episode of Care, do the following: IF M1700_COG_FUNCTION[1] = 04 OR M1710_WHEN_CONFUSED[1] = NA OR M1720_WHEN_ANXIOUS[1] = NA THEN Depression_Asmt = MISSING ELSE IF M1730_STDZ_DPRSN_SCRNG[1] = 01 OR M1730_STDZ_DPRSN_SCRNG[1] = 02 OR M1730_STDZ_DPRSN_SCRNG[1] = 03 THEN Depression_Asmt = 1 ELSEIF M1730_STDZ_DPRSN_SCRNG[1] = 00 THEN Depression_Asmt = 0 END IF Note that OASIS data items are referred to using field names specified in OASIS Data Submission Specifications published by CMS. "[1]" is appended to the field name to show that the value is taken from the beginning assessment (Start or Resumption of Care). 3. For each agency, the agency rate is (# of Episodes of Care with Depression_Asmt = 1)/(# of Episodes of Care with Depression_Asmt =1 or 0). For additional details, please consult the technical specifications available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-

	Instruments/HomeHealthQualityInits/Downloads/HHQI-Revision1TechnicalDocumentationofMeasures.zip URL https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQITechnicalDocOfMeasures.pdf
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	0557 HBIPS-6 Post discharge continuing care plan created
Status	Maintenance, Original Endorsement: Aug 05, 2009
Steward	The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).
Description	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-7 (Post Discharge Continuing Care Plan Transmitted).
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are 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 and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed. URL http://manual.jointcommission.org/releases/TJC2013A/DataDictionaryIntroductionTJC.html#AlphaDataElementList
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.
Numerator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Four data elements are used to calculate the numerator: 1. Continuing Care Plan-Discharge Medications - Documentation in the medical record of a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were prescribed at discharge. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge and was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge but was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge or unable to determine from medical record documentation. 2. Continuing Care Plan-Next Level of Care - Documentation in the medical record of a continuing care plan which includes next level of care recommendations. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable

	Values – 1. The medical record contains a continuing care plan which includes next level of care recommendations AND was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes next level of care recommendations but it was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes next level of care recommendations OR unable to determine from medical record documentation. 3. Continuing Care Plan-Principal Discharge Diagnosis - Documentation in the medical record of a continuing care plan which includes the principal discharge diagnosis. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes the principal discharge diagnosis AND was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes the principal discharge diagnosis but was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes the principal discharge diagnosis or unable to determine from medical record documentation. 4. Continuing Care Plan-Reason for Hospitalization - Documentation in continuing care plan includes the reason for hospitalization. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes the reason for hospitalization and was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes the reason for hospitalization but was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes the reason for hospitalization or unable to determine from medical record documentation. Patients are eligible for the numerator population when they have a continuing care plan created which includes all of the following: the discharge medications, dosage and indication for use or that no medications were prescribed at discharge, next level of care recommendations, the principal discharge diagnosis and the reason for hospitalization.
Denominator Statement	Psychiatric inpatient discharges
Denominator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Seven data elements are used to calculate the denominator: 1. Birthdate - The month, day and year the patient was born. 2. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay. 3. Discharge Disposition- The patient's discharge disposition. Allowable values: 1. Home, 2. Hospice – Home, 3. Hospice – Health Care Facility, 4. Acute Care Facility, 5. Other Health Care Facility, 6. Expired, 7. Left Against Medical Advice/AMA, 8 Not Documented or Unable to Determine (UTD). 4. ICD-9-CM Other Diagnosis Codes - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the secondary diagnoses for this hospitalization. 5. ICD-9-CM Principal Diagnosis Code - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization. 6. Patient Referral to Next Level of Care Provider - Documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting. Allowable values: 1.The medical record contains documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based

	inpatient psychiatric setting. 2. The medical record contains documentation that the patient or guardian refused the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR refused to authorize release of information. 3. The medical record contains documentation that the patient eloped OR failed to return from leave and was discharged OR that the patient has not yet been discharged from the hospital OR discharged from the hospital to another level of care outside of the hospital system from a setting other than a Psychiatric Care Setting. 4. The medical record contains documentation that the patient was not referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting for a reason other than above. 5. The medical record does not contain documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR unable to determine from medical record documentation. 7. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No. Populations: Discharges with Table 10.01 Mental Disorders in the Psychiatric Care Setting
Exclusions	• Patients who expired • Patients with an unplanned departure resulting in discharge due to elopement • Patients or their guardians who refused aftercare • Patients or guardians who refused to sign authorization to release information • Patients with an unplanned departure resulting in discharge due to failing to return from leave
Exclusion Details	• Patients who expired are identified by the data element Discharge Disposition. • Patients with an unplanned departure resulting in discharge due to elopement, refusing aftercare, refusing to sign authorization to release information and failing to return from leave are identified by the data element Patient Referral to Next Level of Care Provider
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	The measure is stratified by the following age groups: • Children (1 through 12 years) • Adolescent (13 through 17 years) • Adult (18 through 64 years) • Older Adult (=65 years)
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Run all cases that are included in the Initial Patient Population for HBIPS-1,4,5,6,7 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure 2. Check Discharge Disposition a. If Discharge Status equals 6, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-6a) and will not be in the measure population. Continue processing and proceed to step 12 and initialize the Measure Category Assignment for each strata measure. b. Discharge Disposition equals 1, 2, 3, 4, 5, 7, or 8, continue processing and proceed to Psychiatric Care Setting. 3. Check Psychiatric Care Setting a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-6a) and will not be in the measure population. Continue processing and proceed to step 12 and Initialize the Measure Category Assignment for each strata measure. b. If Psychiatric Care Setting is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-6a) and will be rejected. Continue processing and proceed to step16 and Initialize the Measure Category Assignment for each strata measure.

	c. If Psychiatric Care Setting equals Yes, the case will proceed to Patient Referral to Next Level of Care Provider. 4. Check Patient Referral to Next Level of Care Provider a. If Patient Referral to Next Level of Care Provider is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-6a) and will be rejected. Continue processing and proceed to step 12 and Initialize the Measure Category Assignment for each strata measure. b. If Patient Referral to Next Level of Care Provider equals 2 or 3, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-6a) and will not be in the measure population. Continue processing and proceed to step 12 and initialize the Measure Category Assignment for each strata measure. c. If Patient Referral to Next Level of Care Provider equals 1, 4 or 5, the case will continue processing and proceed to Initialize Missing Counter. 5. Initialize Missing Counter to equal zero. Initialize No CarePlan Counter to equal zero. Continue processing and proceed to Continuing Care Plan-Principal Discharge Diagnosis. 6. Check Continuing Care Plan-Principal Discharge Diagnosis a. If Continuing Care Plan-Principal Discharge Diagnosis equals 3, add one to No CarePlan Counter. Continue processing and proceed to Continuing Care Plan-Reason for Hospitalization. b. If Continuing Care Plan-Principal Discharge Diagnosis is missing, add one to Missing Counter. Continue processing and proceed to Continuing Care Plan-Reason for Hospitalization. c. If Continuing Care Plan-Principal Discharge Diagnosis equals 1 or 2, continue processing and proceed to Continuing Care Plan-Reason for Hospitalization. 7. Check Continuing Care Plan-Reason for Hospitalization a. If Continuing Care Plan-Reason for Hospitalization equals 3, add one to No CarePlan Counter. Continue processing and proceed to Care Plan-Discharge Medications. b. If Continuing Care Plan-Reason for Hospitalization is missing, add one to Missing Counter. Continue processing and proceed to Care Plan-Discharge Medications c. If Continuing Care Plan-Reason for Hospitalization equals 1 or 2, continue processing and proceed to Care Plan-Discharge Medications. 8. Check Continuing Care Plan-Discharge Medications a. If Continuing Care Plan-Discharge Medications equals 3, add one to No CarePlan Counter, Continue processing and proceed to Continuing Care Plan-Next Level of Care. b. If Continuing Care Plan-Discharge Medications is missing, add one to Missing Counter. Continue processing and proceed to Continuing Care Plan-Next Level of Care. c. If Continuing Care Plan-Discharge Medications equals 1 or 2, continue processing and proceed to Continuing Care Plan-Next Level of Care. 9. Check Continuing Care Plan-Next Level of Care a. If Continuing Care Plan-Next Level of Care equals 3, add one to No CarePlan Counter. Continue processing and proceed to Missing Counter. b. If Continuing Care Plan-Next Level of Care is missing, add one to Missing Counter. Continue processing and proceed to Missing Counter. c. If Continuing Care Plan-Next Level of Care equals 1 or 2, continue processing and proceed to Missing Counter. 10. Check Missing Counter a. If Missing Count is greater than zero, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-6a) and will be rejected. Continue processing and proceed to step 12 and Initialize the Measure Category Assignment for each strata measure. b. If Missing Count equals zero, continue processing and proceed to No CarePlan Counter. 11. Check No CarePlan Counter

	a. If No CarePlan Counter is greater than zero, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-6a) and will be in the measure population. Continue processing and proceed to step 12 and initialize the Measure Category Assignment for each strata measure. b. If No CarePlan Counter equals zero, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-6a) and will be in the numerator population. Continue processing and proceed to step 12 and initialize the Measure Category Assignment for each strata measure. 12. Initialize the Measure Category Assignment for each strata measure (b-e) equal 'B'. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-6a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-6a) Measure Category Assignment. Continue processing and proceed to Overall Rate Category Assignment. 13. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals B or X, retain the Measure Category Assignment for the strata measures (HBIPS-6b through HBIPS-6e) equals B. Stop processing. b. If Overall Rate Category Assignment equals D or E, continue processing and proceed to Patient Age at Discharge. 14. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 1 year and less than 13 years, set the Measure Category Assignment for the measure HBIPS-6b equal to Measure Category Assignment for measure HBIPS-6a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 13 years, continue processing and proceed to Patient Age at Discharge. 15. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 13 years and less than 18 years, set the Measure Category Assignment for the measure HBIPS-6c equal to Measure Category Assignment for measure HBIPS-6a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 18 years, continue processing and proceed to Patient Age at Discharge. 16. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 18 years and less than 65 years, set the Measure Category Assignment for the measure HBIPS-6d equal to Measure Category Assignment for measure HBIPS-6a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 65 years, set the Measure Category Assignment for the measure HBIPS-6e equal to Measure Category Assignment for measure HBIPS-6a. Stop processing. URL http://manual.jointcommission.org/releases/TJC2013A/MIF0121.html
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	0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge
Status	Maintenance, Original Endorsement: Aug 05, 2009
Steward	The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).
Description	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-6: Post Discharge Continuing Care Plan Created) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-6 (Post Discharge Continuing Care Plan Created).
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are 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 and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed. URL http://manual.jointcommission.org/releases/TJC2013A/DataDictionaryIntroductionTJC.html#AlphaDataElementList
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	Psychiatric inpatients for whom the post discharge continuing care plan was transmitted to the next level of care.
Numerator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Four data elements are used to calculate the numerator: 1. Continuing Care Plan-Discharge Medications - Documentation in the medical record of a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were prescribed at discharge. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge and was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge but was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge or unable to determine from medical record documentation. 2. Continuing Care Plan-Next Level of Care - Documentation in the medical record of a continuing care plan which includes next level of care recommendations. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable

	Values – 1. The medical record contains a continuing care plan which includes next level of care recommendations AND was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes next level of care recommendations but it was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes next level of care recommendations OR unable to determine from medical record documentation. 3. Continuing Care Plan-Principal Discharge Diagnosis - Documentation in the medical record of a continuing care plan which includes the principal discharge diagnosis. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes the principal discharge diagnosis AND was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes the principal discharge diagnosis but was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes the principal discharge diagnosis or unable to determine from medical record documentation. 4. Continuing Care Plan-Reason for Hospitalization - Documentation in continuing care plan includes the reason for hospitalization. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes the reason for hospitalization and was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes the reason for hospitalization but was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes the reason for hospitalization or unable to determine from medical record documentation. Patients are eligible for the numerator population when they have a continuing care plan transmitted which includes all of the following: the discharge medications, dosage and indication for use or that no medications were prescribed at discharge, next level of care recommendations, the principal discharge diagnosis and the reason for hospitalization.
Denominator Statement	Psychiatric inpatient discharges
Denominator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Seven data elements are used to calculate the denominator: 1. Birthdate - The month, day and year the patient was born. 2. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay. 3. Discharge Disposition- The patient's discharge disposition. Allowable values: 1. Home, 2. Hospice – Home, 3. Hospice – Health Care Facility, 4. Acute Care Facility, 5. Other Health Care Facility, 6. Expired, 7. Left Against Medical Advice/AMA, 8 Not Documented or Unable to Determine (UTD). 4. ICD-9-CM Other Diagnosis Codes - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the secondary diagnoses for this hospitalization. 5. ICD-9-CM Principal Diagnosis Code - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization. 6. Patient Referral to Next Level of Care Provider - Documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting. Allowable values: 1.The medical record contains documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based

	inpatient psychiatric setting. 2. The medical record contains documentation that the patient or guardian refused the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR refused to authorize release of information. 3. The medical record contains documentation that the patient eloped OR failed to return from leave and was discharged OR that the patient has not yet been discharged from the hospital OR discharged from the hospital to another level of care outside of the hospital system from a setting other than a Psychiatric Care Setting. 4. The medical record contains documentation that the patient was not referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting for a reason other than above. 5. The medical record does not contain documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR unable to determine from medical record documentation. 7. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No. Populations: Discharges with Table 10.01 Mental Disorders in the Psychiatric Care Setting
Exclusions	• Patients who expired • Patients with an unplanned departure resulting in discharge due to elopement • Patients or their guardians who refused aftercare • Patients or guardians who refused to sign authorization to release information • Patients with an unplanned departure resulting in discharge due to failing to return from leave
Exclusion Details	• Patients who expired are identified by the data element Discharge Disposition. • Patients with an unplanned departure resulting in discharge due to elopement, refusing aftercare, refusing to sign authorization to release information and failing to return from leave are identified by the data element Patient Referral to Next Level of Care Provider
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	The measure is stratified by the following age groups: • Children (1 through 12 years) • Adolescent (13 through 17 years) • Adult (18 through 64 years) • Older Adult (=65 years)
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Run all cases that are included in the Initial Patient Population for HBIPS-1,4,5,6,7 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure 2. Check Discharge Disposition a. If Discharge Disposition equals 6, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-7a) and will not be in the measure population. Continue processing and proceed to step 16 and initialize the Measure Category Assignment for each strata measure. b. Discharge Disposition equals 1, 2, 3, 4, 5, 7, or 8, continue processing and proceed to Psychiatric Care Setting. 3. Check Psychiatric Care Setting a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-7a) and will not be in the measure population. Continue processing and proceed to step 16 and Initialize the Measure Category Assignment for each strata measure. b. If Psychiatric Care Setting is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-7a) and will be rejected. Continue processing and

	proceed to step16 and Initialize the Measure Category Assignment for each strata measure. c. If Psychiatric Care Setting equals Yes, the case will proceed to Patient Referral to Next Level of Care Provider. 4. Check Patient Referral to Next Level of Care Provider a. If Patient Referral to Next Level of Care Provider is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-7a) and will be rejected. Continue processing and proceed to step 16 and Initialize the Measure Category Assignment for each strata measure. b. If Patient Referral to Next Level of Care Provider equals 2 or 3, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-7a) and will not be in the measure population. Continue processing and proceed to step 16 and initialize the Measure Category Assignment for each strata measure. c. If Patient Referral to Next Level of Care Provider equals 1, 4 or 5, the case will continue processing and proceed to Initialize Missing Counter. 5. Initialize Missing Counter to equal zero. Initialize Delayed Plan Counter to equal zero, Initialize No CarePlan Counter to equal zero. Continue processing and proceed to Continuing Care Plan-Principal Discharge Diagnosis. 6. Check Continuing Care Plan-Principal Discharge Diagnosis a. If Continuing Care Plan-Principal Discharge Diagnosis equals 3, add one to No CarePlan Counter. Continue processing and proceed to Continuing Care Plan-Reason for Hospitalization. b. If Continuing Care Plan-Principal Discharge Diagnosis is missing, add one to Missing Counter. Continue processing and proceed to Continuing Care Plan-Reason for Hospitalization. c. If Continuing Care Plan-Principal Discharge Diagnosis equals 1 or 2, continue processing and proceed to recheck Continuing Care Plan-Principal Discharge Diagnosis. 7. Check Continuing Care Plan-Principal Discharge Diagnosis a. If Continuing Care Plan-Principal Discharge Diagnosis equals 2, add one to Delayed Plan Counter. Continue processing and proceed to Continuing Care Plan-Reason for Hospitalization. b. If Continuing Care Plan-Principal Discharge Diagnosis equals 1, Continue processing and proceed to Continuing Care Plan-Reason for Hospitalization. 8. Check Continuing Care Plan-Reason for Hospitalization a. If Continuing Care Plan-Reason for Hospitalization equals 3, add one to No CarePlan Counter. Continue processing and proceed to Care Plan-Discharge Medications. b. If Continuing Care Plan-Reason for Hospitalization is missing, add one to Missing Counter. Continue processing and proceed to Care Plan-Discharge Medications c. If Continuing Care Plan-Reason for Hospitalization equals 1 or 2, continue processing and proceed to recheck Continuing Care Plan-Reason for Hospitalization. 9. Check Continuing Care Plan-Reason for Hospitalization a. If Continuing Care Plan-Reason for Hospitalization equals 2, add one to Delayed CarePlan Counter. Continue processing and proceed to Continuing Care Plan-Discharge Medications. b. If Continuing Care Plan-Reason for Hospitalization equal 1, continue processing and proceed to Continuing Care Plan-Discharge Medications. 10. Check Continuing Care Plan-Discharge Medications a. If Continuing Care Plan-Discharge Medications equals 3, add one to No CarePlan Counter, Continue processing and proceed to Continuing Care Plan-Next Level of Care. b. If Continuing Care Plan-Discharge Medications is missing, add one to Missing Counter. Continue processing and proceed to Continuing Care Plan-Next Level of Care. c. If Continuing Care Plan-Discharge Medications equals 1 or 2,continue processing and proceed to recheck Continuing Care Plan-Discharge Medications. 11. Check Continuing Care Plan-Discharge Medications

	a. If Continuing Care Plan-Discharge Medications equals 2, add one to Delayed CarePlan Counter. Continue processing and proceed to Continuing Care Plan-Next Level of Care. b. If Continuing Care Plan-Discharge Medications equal 1,continue processing and proceed to Continuing Care Plan-Next Level of Care. 12. Check Continuing Care Plan-Next Level of Care a. If Continuing Care Plan-Next Level of Care equals 3, add one to No CarePlan Counter. Continue processing and proceed to Missing Counter. b. If Continuing Care Plan-Next Level of Care is missing, add one to Missing Counter. Continue processing and proceed to Missing Counter. c. If Continuing Care Plan-Next Level of Care equals 1 or 2, continue processing and proceed to recheck Continuing Care Plan-Next Level of Care. 13. Check Continuing Care Plan-Next Level of Care a. If Continuing Care Plan-Next Level of Care equals 2, add one to Delayed CarePlan Counter. Continue processing and proceed to Missing Counter. b. If Continuing Care Plan-Next Level of Care equal 1, continue processing and proceed to Missing Counter. 14. Check Missing Counter a. If Missing Count is greater than zero, the case will proceed to a Measure Category Assignment of a Measure Category Assignment of X for Overall Rate (HBIPS-7a) and will be rejected. Continue processing and proceed to step 16 and Initialize the Measure Category Assignment for each strata measure. b. If Missing Count equal to zero, continue processing and proceed to Delayed Plan Counter. 15. Check Delayed Plan Counter a. If Delayed Plan Counter is greater than zero, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-7a) and will be in the measure population. Continue processing and proceed to step 16 and initialize the Measure Category Assignment for each strata measure. b. If Delayed Plan Counter equal to zero, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-7a) and will be in the numerator population. Continue processing and proceed to step 16 and initialize the Measure Category Assignment for each strata measure. 16. Initialize the Measure Category Assignment for each strata measure (b-e) equal 'B'. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-7a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-7a) Measure Category Assignment. Continue processing and proceed to Overall Rate Category Assignment. 17. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals B or X, retain the Measure Category Assignment for the strata measures (HBIPS-7b through HBIPS-7e) equals B. Stop processing. b. If Overall Rate Category Assignment equals D or E, continue processing and proceed to Patient Age at Discharge. 18. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 1 year and less than 13 years, set the Measure Category Assignment for the measure HBIPS-7b equal to Measure Category Assignment for measure HBIPS-7a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 13 years, continue processing and proceed to Patient Age at Discharge. 19. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 13 years and less than 18 years, set

	the Measure Category Assignment for the measure HBIPS-7c equal to Measure Category Assignment for measure HBIPS-7a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 18 years, continue processing and proceed to Patient Age at Discharge. 20. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 18 years and less than 65 years, set the Measure Category Assignment for the measure HBIPS-7d equal to Measure Category Assignment for measure HBIPS-7a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 65 years, set the Measure Category Assignment for the measure HBIPS-7e equal to Measure Category Assignment for measure HBIPS-7a. Stop processing. URL http://manual.jointcommission.org/releases/TJC2013A/MIF0122.html
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	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification
Status	Maintenance, Original Endorsement: Aug 05, 2009
Steward	The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).
Description	The proportion of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-4 (Patients discharged on multiple antipsychotic medications).
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are 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 and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed. URL http://manual.jointcommission.org/releases/TJC2013A/DataDictionaryIntroductionTJC.html#AlphaDataElementList
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.
Numerator Details	Time Window: Episode of care which is The entire hospitalization from admission to discharge. One data element is used to calculate the numerator: Appropriate Justification for Multiple Antipsychotic Medications - Documentation in the medical record of appropriate justification for discharging the patient on two or more routine antipsychotic medications. Allowable values: 1. The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy. 2. The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications OR documentation of a cross-taper in progress at the time of discharge. 3. The medical record contains documentation of augmentation of Clozapine. 4. The medical record contains documentation of a justification other than those listed in Allowable Values 1-3. 5. The medical record does not contain documentation supporting the reason for being discharged on two or more antipsychotic medications OR unable to determine from medical record documentation. Patients are eligible for the numerator population when they are discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.
Denominator Statement	Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications
Denominator	Time Window: Episode of care which is The entire hospitalization from admission to discharge.

Details	Eight 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. Discharge Disposition- The patient's discharge disposition. Allowable values: 1. Home, 2. Hospice – Home, 3. Hospice – Health Care Facility, 4. Acute Care Facility, 5. Other Health Care Facility, 6. Expired, 7. Left Against Medical Advice/AMA, 8 Not Documented or Unable to Determine (UTD). 5. ICD-9-CM Other Diagnosis Codes - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the secondary diagnoses for this hospitalization. 6. ICD-9-CM Principal Diagnosis Code - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization. 7. Number of Antipsychotic Medications Prescribed at Discharge- Documentation in the medical record of the number of antipsychotic medications prescribed for the patient at discharge. Allowable values: 0-99, UTD (Unable to determine) 8. Patient Referral to Next Level of Care Provider - Documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting. Allowable values: 1.The medical record contains documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting. 2. The medical record contains documentation that the patient or guardian refused the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR refused to authorize release of information. 3. The medical record contains documentation that the patient eloped OR failed to return from leave and was discharged OR that the patient has not yet been discharged from the hospital OR discharged from the hospital to another level of care outside of the hospital system from a setting other than a Psychiatric Care Setting. 4. The medical record contains documentation that the patient was not referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting for a reason other than above. 5. The medical record does not contain documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR unable to determine from medical record documentation. 9. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No. Populations: Discharges with Table 10.01 Mental Disorders in the Psychiatric Care Setting who were discharged on two or more routinely scheduled antipsychotic medications on Table 10.0.
Exclusions	• Patients who expired • Patients with an unplanned departure resulting in discharge due to elopement • Patients with an unplanned departure resulting in discharge due to failing to return from leave • Patients with a length of stay = 3 days
Exclusion Details	• Patients who expired are identified by the data element Discharge Disposition. • Patients with an unplanned departure resulting in discharge due to elopement and failing to return from leave are identified by the data element Patient Referral to Next Level of Care Provider • Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is equal to or less than 3 days the patient is excluded.
Risk	No risk adjustment or risk stratification

Adjustment	Not Applicable
Stratification	The measure is stratified by the following age groups: • Children (1 through 12 years) • Adolescent (13 through 17 years) • Adult (18 through 64 years) • Older Adult (=65 years)
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Run cases that are included in the Initial Patient Population for HBIPS-1,4,5,6,7 and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date. 3. Check Length of Stay a. If Length of Stay is less than or equal 3 days, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. b. If Length of Stay is greater than 3 days, continue processing and proceed to Discharge Status. 4. Check Discharge Disposition a. If Discharge Disposition equals 6, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. b. Discharge Disposition equals 1, 2, 3, 4, 5, 7, or 8, continue processing and proceed to Psychiatric Care Setting. 5. Check Psychiatric Care Setting a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Cat Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. b. If Psychiatric Care Setting is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure. c. If Psychiatric Care Setting equals Yes, the case will proceed to Patient Referral to Next Level of Care Provider. 6. Check Patient Referral to Next Level of Care Provider a. If Patient Referral to Next Level of Care Provider is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure. b. If Patient Referral to Next Level of Care Provider equals 3, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. c. If Patient Referral to Next Level of Care Provider equals 1, 2, 4 or 5, the case will continue processing and proceed to Number of Antipsychotic Medications Prescribed at Discharge. 7. Check Number of Antipsychotic Medications Prescribed at Discharge a. If Number of Antipsychotic Medications Prescribed at Discharge is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected.

	Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure. b. If Number of Antipsychotic Medications Prescribed at Discharge is less than or equal 1, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. c. If Number of Antipsychotic Medications Prescribed at Discharge is greater than or equal 2 or equal UTD, the case will continue processing and proceed to Number of Antipsychotic Medications Prescribed at Discharge. 8. Check Number of Antipsychotic Medications Prescribed at Discharge a. If Number of Antipsychotic Medications Prescribed at Discharge equals UTD, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-5a) and will be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. b. If Number of Antipsychotic Medications Prescribed at Discharge is greater than or equal 2, the case will proceed to Appropriate Justification for Multiple Antipsychotic Medications. 9. Check Appropriate Justification for Multiple Antipsychotic Medications a. If Appropriate Justification for Multiple Antipsychotic Medications is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure. b. If Appropriate Justification for Multiple Antipsychotic Medications equals 4 or 5, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-5a) and will be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. c. If Appropriate Justification for Multiple Antipsychotic Medications equals 1, 2 or 3, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-5a) and will be in the numerator population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. 10. Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-5a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-5a) Measure Category Assignment. 11. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals B or X, Set the Measure Category Assignment for the strata measures (HBIPS-5b through HBIPS-5e) = 'B'. Stop processing. b. If Overall Rate Category Assignment equals D or E, continue processing and proceed to Patient Age at Discharge. 12. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-5b = Measure Category Assignment for measure HBIPS-5a. Stop processing. b. If is greater than or equal 13 years, continue processing and proceed to Patient Age at Discharge. 13. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-5c = Measure Category Assignment for measure HBIPS-5a. Stop processing. b. If Patient Age at Discharge is greater than or equal 18 years, continue processing and proceed to Patient Age at Discharge.

	14. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-5d = Measure Category Assignment for measure HBIPS-5a. Stop processing. b. If Patient Age at Discharge is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-5e = Measure Category Assignment for measure HBIPS-5a. Stop processing. URL http://manual.jointcommission.org/releases/TJC2013A/MIF0120.html
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	0640 HBIPS-2 Hours of physical restraint use
Status	Maintenance, Original Endorsement: May 05, 2010
Steward	The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).
Description	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are 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 and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed. URL http://manual.jointcommission.org/releases/TJC2013A/DataDictionaryIntroductionTJC.html#AlphaDataElementList
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	The total number of hours that all psychiatric inpatients were maintained in physical restraint
Numerator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Three data elements are used to calculate the numerator: 1. Event Date* - The month, day and year of the event. 2. Event Type* - The measure-related event being identified. Allowable values: 1. Physical Restraint 2. Seclusion 3. Minutes of Physical Restraint - The total minutes recorded in the medical record that a patient was maintained in Event Type 1 (physical restraint(s)) for the associated Event Date. Allowable values 1-1440 minutes *Event Date and Event Type are used for both HBIPS-2 and HBIPS-3: Seclusion Use Patients are eligible for the numerator population when a physical restraint event occurs. A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. This definition is noted in the data element Minutes of Physical Restraint included with the submission.
Denominator Statement	Number of psychiatric inpatient days Denominator basis per 1,000 hours To compute this measure rate, a base of 1000 hours has been applied to total patient days in the

	denominator (i.e., total patient days are divided by 1000). The purpose of this is to
Denominator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Seven 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. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No. 4. Psychiatric Inpatient Days - Medicare Only* - The sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status). 5. Psychiatric Inpatient Days – Non-Medicare Only* - The sum of the number of days each non-Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status). 6. Total Leave Days - Medicare Only* - The aggregate number of leave days for Medicare patients during the month. 7. Total Leave Days – Non-Medicare Only* - The aggregate number of leave days for non-Medicare patients during the month. * The distinction between Medicare and Non-Medicare was added, in anticipation of future adoption of the HBIPS measures by the Centers for Medicare and Medicaid Services (CMS) Inpatient Psychiatric Facilities Quality Reporting Program Populations: All psychiatric inpatient days.
Exclusions	Total leave days
Exclusion Details	• Patients who are on leave defined as an authorized or unauthorized absence of the patient from a psychiatric care setting, excluding discharges, during which the patient is absent from the psychiatric care setting at the time of the daily census and is not under the direct supervision of psychiatric care setting staff while absent.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
Stratification	The measure is stratified by the following age groups: • Children (1 through 12 years) • Adolescent (13 through 17 years) • Adult (18 through 64 years) • Older Adult (=65 years)
Type Score	Ratio better quality = lower score
Algorithm	1. Run all cases that are included in the Initial Patient Population for HBIPS-2 and 3 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure. 2. Check Event Type a. If Event Type equals 2, the case will proceed to a Measure Category Assignment of U for Overall Rate (HBIPS-2a) and will not be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure b. If Event Type equals 1, continue processing and proceed to Minutes of Physical Restraint. 3. Check Minutes of Physical Restraint a. If Minutes of Physical Restraint is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-2a) and will be rejected. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure. b. If Minutes of Physical Restraint equals UTD, the case will proceed to a Measure Category Assignment of Y for Overall Rate (HBIPS-2a) and will be in the measure population. Continue

	processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure. c. If Minutes of Physical Restraint equals a Not able to Determine Value, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-2a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure. 4. Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'. Do not change the Measure Category Assignment or Total Overall Restraint Minutes that was already calculated for the overall rate (HBIPS-2a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-2a) Measure Category Assignment. 5. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals X, Set the Measure Category Assignment for the strata measures (HBIPS-2b through HBIPS-2e) = 'B'. Stop processing. b. If Overall Rate Category Assignment equals E, Y or U, continue processing and proceed to Patient Age at Time of Event. 6. Check Patient Age at Time of Event a. If Patient Age at Time of Event is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-2b = Measure Category Assignment for measure HBIPS-2a. Stop processing. b. If Patient Age at Time of Event is greater than or equal 13 years, continue processing and proceed to Patient Age at Time of Event. 7. Check Patient Age at Time of Event a. If Patient Age at Time of Event is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-2c = Measure b. Category Assignment for measure HBIPS-2a. Stop processing. If Patient Age at Time of Event is greater than or equal 18 years, continue processing and proceed to Patient Age at Time of Event. 8. Check Patient Age at Time of Event a. If Patient Age at Time of Event is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-2d = Measure Category Assignment for measure HBIPS-2a. Stop processing. b. If Patient Age at Time of Event is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-2e = Measure Category Assignment for measure HBIPS-2a. Stop processing URL http://manual.jointcommission.org/releases/TJC2013A/MIF0117.html
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	0641 HBIPS-3 Hours of seclusion use
Status	Maintenance, Original Endorsement: May 05, 2010
Steward	The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).
Description	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are 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 and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed. URL http://manual.jointcommission.org/releases/TJC2013A/DataDictionaryIntroductionTJC.html#AlphaDataElementList
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	The total number of hours that all psychiatric inpatients were held in seclusion
Numerator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Three data elements are used to calculate the numerator: 1. Event Date*- The month, day and year of the event. 2. Event Type* - The measure-related event being identified. Allowable values: 1. Physical Restraint 2. Seclusion 3. Minutes of Seclusion - The total minutes recorded in the medical record that a patient was held in Event Type 2 (seclusion) for the associated Event Date. Allowable values 1-1440 minutes *Event Date and Event Type are used for both HBIPS-2: Physical Restraint Use and HBIPS-3 Patients are eligible for the numerator population when a seclusion event occurs.
Denominator Statement	Number of psychiatric inpatient days Denominator basis per 1,000 hours To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to
Denominator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Seven 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. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No. 4. Psychiatric Inpatient Days - Medicare Only* - The sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status). 5. Psychiatric Inpatient Days – Non-Medicare Only* - The sum of the number of days each non-Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status). 6. Total Leave Days - Medicare Only* - The aggregate number of leave days for Medicare patients during the month. 7. Total Leave Days – Non-Medicare Only* - The aggregate number of leave days for non-Medicare patients during the month. * The distinction between Medicare and Non-Medicare was added, in anticipation of future adoption the HBIPS measures by the Centers for Medicare and Medicaid Services (CMS) Inpatient Psychiatric Facilities Quality Reporting Program Populations: All psychiatric inpatient days.
Exclusions	Total leave days
Exclusion Details	• Patients who are on leave defined as an authorized or unauthorized absence of the patient from a psychiatric care setting, excluding discharges, during which the patient is absent from the psychiatric care setting at the time of the daily census and is not under the direct supervision of psychiatric care setting staff while absent.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
Stratification	The measure is stratified by the following age groups: • Children (1 through 12 years) • Adolescent (13 through 17 years) • Adult (18 through 64 years) • Older Adult (=65 years)
Type Score	Ratio better quality = lower score
Algorithm	1. Run all cases that are included in the Initial Patient Population for HBIPS-2 and 3 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure. 2. Check Event Type a. If Event Type equals 1, the case will proceed to a Measure Category Assignment of U for Overall Rate (HBIPS-3a) and will not be in the measure population. Continue processing and proceed to step x, Initialize the Measure Category Assignment for each strata measure. b. If Event Type equals 2, continue processing and proceed to Minutes of Seclusion. 3. Check Minutes of Seclusion a. If Minutes of Seclusion is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-3a) and will be rejected. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure. b. If Minutes of Seclusion equals UTD, the case will proceed to a Measure Category Assignment of Y for Overall Rate (HBIPS-3a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure. c. If Minutes of Seclusion equals a Not able to Determine Value, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-3a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

	4. Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'. Do not change the Measure Category Assignment or Total Overall Restraint Minutes that was already calculated for the overall rate (HBIPS-3a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-3a) Measure Category Assignment. 5. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals X, Set the Measure Category Assignment for the strata measures (HBIPS-3b through HBIPS-3e) = 'B'. Stop processing. b. If Overall Rate Category Assignment equals E, Y or U, continue processing and proceed to Patient Age at Time of Event. 6. Check Patient Age at Time of Event a. If Patient Age at Time of Event is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-3b = Measure Category Assignment for measure HBIPS-3a. Stop processing. b. If Patient Age at Time of Event is greater than or equal 13 years, continue processing and proceed to Patient Age at Time of Event. 7. Check Patient Age at Time of Event a. If Patient Age at Time of Event is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-3c = Measure Category Assignment for measure HBIPS-3a. Stop processing. b. If Patient Age at Time of Event is greater than or equal 18 years, continue processing and proceed to Patient Age at Time of Event. 8. Check Patient Age at Time of Event a. If Patient Age at Time of Event is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-3d = Measure Category Assignment for measure HBIPS-3a. Stop processing. b. If Patient Age at Time of Event is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-3e = Measure Category Assignment for measure HBIPS-3a. Stop processing. 9. Measure Calculation for Aggregated Denominator. Denominator: For the overall measure and each strata measure calculate the denominator rate by aggregating the Psychiatric Inpatient Days and Leave Days. Number of Denominator Cases for the overall measure = (Psychiatric Inpatient Days – Leave Days), for all patients for the reporting month. Number of Denominator Cases for each strata measure = (Psychiatric Inpatient Days – Leave Days), for all patients with a Patient Age (Reporting Date - Birthdate) appropriate for the strata for the reporting month where Reporting Date is the last date of the reporting month that the census data is being reported. Performance Measurement Systems can refer to the Joint Commission's ORYX Technical Implementation Guide for information concerning the aggregation of HCO level data, including the Observed Rate and Population Size for this measure. URL http://manual.jointcommission.org/releases/TJC2013A/MIF0118.html
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	1651 TOB-1 Tobacco Use Screening
Status	New Submission
Steward	The Joint Commission
Description	Hospitalized patients age 18 years and older who are screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days. This measure is intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-2 Tobacco Use Treatment Provided or Offered (during the hospital stay); TOB-3 Tobacco Use Treatment Provided or offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The Joint Commission developed a web-based data collection tool that was used by hospitals 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. The vendor may not offer the measure set to hospitals until verification has been passed. Attachment Tobacco Treatment Data Dictionary.doc
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	The number of patients who were screened for tobacco use status
Numerator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. The patients in the numerator (those who were screened for tobacco use status) are a subset of the denominator. The data element "Tobacco Use Status" is used to screen or examine methodologically in order to make a separation into different groups. “Tobacco Use Status” is the only data element used to calculate the numerator. There are 14 allowable values that address the various tobacco products or combinations thereof and the volume used as well as the timeframe of use. Notes for abstraction are included along with suggested data sources. Full specifications can be viewed on the Joint Commission web site at the following link: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/
Denominator Statement	The number of hospitalized inpatients 18 years of age and older
Denominator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Four data elements are used to calculate the denominator: Admission Date, Birthdate, Discharge Date and Cognitive Impairment. 1. Admission Date - this is used to define the length of stay and to calculate the patient age 2. Birthdate - this data element calculates the patient age by subtracting the birthdate from the admission date. Patients less than 18 are excluded from the population 3. Discharge Date - this data element is used to calculate the hospital length of stay and exclude patients with a length of stay (LOS) of less than or equal to one day and those with LOS greater than 120 days. 4. Cognitive Impairment - Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for tobacco and 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 does not meet the definition of cognitive impairment. This is a yes/no data element.
Exclusions	The denominator has three 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
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 determined to be cognitively impaired when initially assessed and cannot be screened and answer reliably for tobacco use and the data element is answered with a "yes" value, the patient will not be in the population. Again, temporary cognitive impairment due to acute substance use such as overdose or acute intoxication will require another assessment later in the stay.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
Stratification	Not Applicable, the measure is not stratified.
Type Score	Rate/proportion better quality = higher score
Algorithm	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 older 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 more than 1 day, continue processing and proceed to check Cognitive Impairment status. 6. Check Cognitive Impairment a. If Cognitive Impairment is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b. If Cognitive Impairment equals Yes, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. c. If Cognitive Impairment equals No, continue processing and proceed to Tobacco Use Status. 7. Check Tobacco Use Status

	a. If Tobacco Use Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b. If Tobacco Use Status equals 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing. c. If Tobacco Use Status equals 8, the case will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing. Attachment TOB1.docx
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	1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment
Status	New Submission
Steward	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. Refer to section 2a1.10 Stratification Details/Variables for the rationale for the addition of the subset measure. These measures are intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB-3 Tobacco Use Treatment Provided or Offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The Joint Commission developed a web-based data collection tool that was used by hospitals during the pilot test and for reliability testing. When the measures are made part of The Joint Commission's ORYX data collection and reporting program, the data will be collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy of the data collection tool with the specifications. Measure sets cannot be offered to hospitals by the vendor until verification has been passed. Attachment Tobacco Treatment Data Dictionary-634455462826267678.doc
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	TOB-2: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications. TOB-2a: The number of patients who received practical counseling to quit AND received FDA-approved cessation medications.
Numerator Details	Time Window: Episode of Care which is the entire hospitalization from admission to discharge. There are six data elements that are required to calculate the numerator: ICD-9-CM Other Diagnosis Codes, ICD-9-CM Principal Diagnosis Code, Reason for No Tobacco Cessation Medication During the Hospital Stay, Tobacco Use Status, Tobacco use Treatment FDA-Approved Cessation Medication, and Tobacco Use Treatment Practical Counseling. “Tobacco Use Status”: for this element there are 14 allowable values that address the various tobacco products or combinations thereof and the volume used as well as the timeframe of use. 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 users) from receiving FDA approved medications (a numerator condition). The ICD-9-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 medication. The data element 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. The data elements 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 can be viewed on the Joint Commission web site at the following link: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/
Denominator Statement	The number of hospitalized inpatients 18 years of age and older identified as current tobacco users
Denominator Details	Time Window: Episode of Care which is the entire hospitalization from admission to discharge. There are five data elements that define the denominator: 1. Admission Date - this is used to define the length of stay and to calculate the patient age. 2. Birthdate - This data element calculates the patient age by subtracting the birthdate from the admission date. 3. Cognitive Impairment - a yes/no data element that excludes those who could not be screened for tobacco use. Temporary cognitive impairment due to acute substance use does not meet the definition for cognitive impairment. 4. Discharge Date - This data element is used to calculate the hospital length of stay and exclude patients with a length of stay (LOS) of less than or equal to one day and those with LOS greater than 120 days. 5. Tobacco Use Status - This data element identified those patients who use tobacco products and are appropriate for tobacco cessation treatment and follow-up.
Exclusions	The following are excluded from the measure denominator. 1. Patients less than 18 years of age 2. Patients who are cognitively impaired 3. Patients who are not current tobacco users 4. Patients who refused or were not screened for tobacco use during the hospital stay. 5. Patients who have a duration of stay less than or equal to one day or greater than 120 days
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 orless than 1 day, the patient is not in the population. If the patient is determined to be cognitively impaired and cannot be screened and answer reliably regarding tobacco use and the data element is answered with a “yes” value, the patient will not be in the population unless the impairment is due to acute substance use such as overdose or acute intoxication which is considered to be temporary. The data element Tobacco Use Status is used to exclude patients who have not used tobacco products (allowable value 6: The patient has not used any forms of tobacco in the past 30 days). This data element also excludes patients who refused the tobacco use screen by virtue of allowable value 7 (the patient refused the tobacco use screen).
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
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
Type Score	Rate/proportion better quality = higher score

Algorithm	Numerator: The number of patients who received or refused practical counseling to quit and received or refused FDA-approved cessation medications. Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users. Variable key: Patient Age Length of Stay 1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Calculate Patient Age. Patient Age, in years, is equal to the Admission Date minus the Birthdate. Use the month and day portion of admission date and Birthdate to yield the most accurate age. Only cases with valid Admission Date and Birthdate will pass the front end edits into the measure specific algorithms. 3. Check Patient Age a. If Patient Age is less than 18 years, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-2a. b. If Patient Age is equal to or older than 18 years, continue processing and proceed to calculate Length of Stay. 4. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date. 5. Check Length of Stay a. If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-2a. b. If Length of Stay is more than 1 day, continue processing and proceed to check Cognitive Impairment status. 6. Check Cognitive Impairment a. If Cognitive Impairment is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-2a. b. If Cognitive Impairment equals Yes, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-2a. c. If Cognitive Impairment equals No, continue processing and proceed to check Tobacco Use Status. 7. Check Tobacco Use Status a. If Tobacco Use Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-2a. b. If Tobacco Use Status equals 6, 7 or 8 the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-2a. c. If Tobacco Use Status equals 1, 2, 3, 4, 5, 9, 10, 11, 12, 13 or 14, continue processing and proceed to check Tobacco Use Treatment Practical Counseling. 8. Check Tobacco Use Treatment Practical Counseling a. If Tobacco Use Treatment Practical Counseling is missing, the case will proceed to a

	Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-2a. b. If Tobacco Use Treatment Practical Counseling equals 3, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 2a. c. If Tobacco Use Treatment Practical Counseling equals 1 or 2, continue processing and proceed to ICD-9-CM Principal Diagnosis Code. 9. Check ICD-9-CM Principal Diagnosis Code a. If ICD-9-CM Principal Diagnosis Code is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 2a. b. If ICD-9-CM Principal Diagnosis Code is not on Table 12.3, continue processing and proceed to ICD-9-CM Other Diagnosis Code. 10. Check ICD-9-CM Other Diagnosis Code a. If at least one of the ICD 9 CM Other Diagnosis Code is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 2a. b. If all ICD-9-CM Other Diagnosis Code are missing or none is on Table 12.3, continue processing and proceed to recheck Tobacco Use Status. 11. Recheck Tobacco Use Status a. If Tobacco Use Status equals 2, 3, 4 or 11, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 2a. b. If Tobacco Use Status equals 1, 5, 9, 10, 12, 13 or 14, continue processing and proceed to Tobacco Use Treatment FDA Approved Cessation Medication. 12. Check Tobacco Use Treatment FDA Approved Cessation Medication a. If Tobacco Use Treatment FDA Approved Cessation Medication is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-2a. b. If Tobacco Use Treatment FDA Approved Cessation Medication equals 3, continue processing and proceed to the case will proceed to Reason for No Tobacco Cessation Medication During Hospital Stay. c. If Tobacco Use Treatment FDA Approved Cessation Medication equals 1 or 2, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 2a. 13. Check Reason for No Tobacco Cessation Medication During Hospital Stay a. If Reason for No Tobacco Cessation Medication During Hospital Stay is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-2a. b. If Reason for No Tobacco Cessation Medication During Hospital Stay equals 2, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population for the overall measure rate (TOB 2). Continue processing and proceed to Initialize Measure Category

	Assignment for sub-measure TOB-2a. c. If Reason for No Tobacco Cessation Medication During Hospital Stay equals 1, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-2). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 2a. TOB-2a: Tobacco Use Treatment Numerator: The number of patients who received practical counseling to quit and received FDA-approved cessation medications. Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users. 14. Initialize Measure Category Assignment for sub-measure TOB-2a to Measure Category Assignment of B. Do not change the Measure Category Assignment that was already calculated for the overall measure (TOB-2). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall measure's (TOB 2) Measure Category Assignment. 15. Check Overall Rate Category Assignment a. If the Overall Rate Category Assignment equals B or X, the case will proceed to Measure Category Assignment of B and will not be in the Measure Population for the sub-measure TOB-2a. Stop processing. b. If Overall Rate Category Assignment equals D or E, continue processing and proceed to recheck Referral for Tobacco Use Treatment Practical Counseling. 16. Recheck Tobacco Use Treatment Practical Counseling a. If Tobacco Use Treatment Practical Counseling equals 2 or 3, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for sub-measure TOB-2a. Stop processing. b. If Tobacco Use Treatment Practical Counseling equals 1, continue processing and proceed to recheck ICD-9-CM Principal Diagnosis Code. 17. Recheck ICD-9-CM Principal Diagnosis Code a. If ICD-9-CM Principal Diagnosis Code is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-2a. Stop processing. b. If ICD-9-CM Principal Diagnosis Code is not on Table 12.3, continue processing and proceed to recheck ICD-9-CM Other Diagnosis Code. 18. Recheck ICD-9-CM Other Diagnosis Code a. If at least one of the ICD 9 CM Other Diagnosis Code is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-2a. Stop processing. b. If all ICD-9-CM Other Diagnosis Code are missing or none is on Table 12.3, continue processing and proceed to recheck Tobacco Use Status. 19. Recheck Tobacco Use Status a. If Tobacco Use Status equals 2, 3, 4 or 11, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-2a. Stop processing. b. If Tobacco Use Status equals 1, 5, 9, 10, 12, 13 or 14, continue processing and proceed to recheck Tobacco Use Treatment FDA Approved Cessation Medication. 20. Recheck Tobacco Use Treatment FDA Approved Cessation Medication a. If Tobacco Use Treatment FDA Approved Cessation Medication equals 2, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for sub-measure TOB-2a. Stop processing.

	b. If Tobacco Use Treatment FDA Approved Cessation Medication equals 1, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-2a. Stop processing. c. If Tobacco Use Treatment FDA Approved Cessation Medication equals 3, continue processing and proceed to recheck Reason for No Tobacco Cessation Medication During Hospital Stay. 21. Recheck Reason for No Tobacco Cessation Medication During Hospital Stay a. If Reason for No Tobacco Cessation Medication During Hospital Stay equals 2, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for sub-measure TOB-2a. Stop processing. b. If Reason for No Tobacco Cessation Medication During Hospital Stay equals 1, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-2a. Stop processing. Attachment TOB2.docx
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	1656 TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge
Status	New Submission
Steward	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. Refer to section 2a1.10 Stratification Details/Variables for the rationale for the addition of the subset measure. These measures are intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB 2 Tobacco Use Treatment Provided or Offered During the Hospital Stay; TOB-4 Tobacco Use: Assessing Status After Discharge).
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The Joint Commission developed a web-based data collection tool that was used by hospitals 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. The contracted vendor cannot offer the measure set to hospitals until verification for the measure set has been passed. Attachment Tobacco Treatment Data Dictionary-634455630255330878.doc
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	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	Time Window: Episode of care which is the entire hospitalization from admission to discharge. There are six data elements that are used to calculate the numerator. 1. ICD-9-CM Other Diagnosis Codes - this data element identifies pregnant smokers who are not required to receive FDA-approved cessation medications, however they must still receive the referral to outpatient counseling. 2. ICD-9-CM Principal Diagnosis Code - as above 3. Prescription for Tobacco Cessation Medication - this data element 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. 4. Reason for No Tobacco Cessation Medication at Discharge - this data element allows for documentation by the practitioner of a reason for not giving a prescription for tobacco cessation medication at discharge. It is a yes/no data element and if answered in the affirmative, the case will be in the numerator if the referral for outpatient counseling is made. 5. Referral for Outpatient Tobacco Cessation Counseling - There are 5 allowable values for this data element so as to distinguish 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. 6. Tobacco Use Status - This data element is primarily responsible for identifying denominator cases, however allowable value 2 identifies light smokers and value 4 identifies patients using smokeless tobacco products, who are not required to receive a prescription for one of the FDA-approved medications although they must receive the referral to outpatient counseling to satisfy the numerator. Full specifications can be viewed on the Joint Commission web site at the following link: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/
Denominator Statement	The number of hospitalized inpatients 18 years of age and older identified as current tobacco users
Denominator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. There are six data elements that are used to calculate the denominator. 1. Admission Date - this is used to define the length of stay and to calculate the patient age. 2. Birthdate - this data element calculates the patient age by subtracting the birthdate from the admission date. Patients less than 18 are excluded from the population 3. Cognitive Impairment - a yes/no data element that excludes those who could not be screened for tobacco use. Temporary cognitive impairment due to acute substance use does not meet the definition for cognitive impairment. 4. Discharge Date - This data element is used to calculate the hospital length of stay (LOS) and exclude patients with a LOS of less than or equal to one day and those with LOS greater than 120 days. 5. Discharge disposition is used to exclude patients who are discharged to a setting where outpatient referral would not be possible or appropriate. 6. Tobacco Use Status - this data element identifies those patients who use tobacco products and are appropriate for tobacco cessation treatment and follow-up.
Exclusions	The exclusions to this measure are as follows: 1. Patients less than 18 years of age 2. Patients who are cognitively impaired 3. Patients who are not current tobacco users 4. Patients who refused or were not screened for tobacco use status during the hospital stay (as tobacco status cannot be known) 5. Patients who have a length of stay less than or equal to one day or greater than 120 days 6. Patients who expired during the hospital stay 7. Patients who left against medical advice 8. Patients discharged/transferred to another hospital for inpatient care 9. Patients discharged/transferred to a federal health care facility 10. Patients discharged/transferred to hospice 11. Patients who do not reside in the United States
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 determined to be cognitively impaired and cannot be screened and answer reliably regarding tobacco use and the data element is answered with a “yes” value, the patient will not be in the population. The data element Tobacco Use Status is used to exclude patients who do not use tobacco

	products (allowable value 6: The patient has not used any forms of tobacco in the past 30 days). This data element also excludes patients who refused the tobacco use screen by virtue of allowable value 7 (the patient refused the tobacco use screen). 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 Not Applicable
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 indicate
Type Score	Rate/proportion better quality = higher score
Algorithm	TOB-3: Tobacco Use Treatment Provided or Offered at Discharge Numerator: The number of patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge. Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users. Variable key: Patient Age Length of Stay 1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Calculate Patient Age. Patient Age, in years, is equal to the Admission Date minus the Birthdate. Use the month and day portion of admission date and Birthdate to yield the most accurate age. Only cases with valid Admission Date and Birthdate will pass the front end edits into the measure specific algorithms. 3. Check Patient Age a. If Patient Age is less than 18 years, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If Patient Age is equal to or older than 18 years, continue processing and proceed to calculate Length of Stay. 4. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date. 5. Check Length of Stay a. If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If Length of Stay is more than 1 day, continue processing and proceed to check Cognitive Impairment status. 6. Check Cognitive Impairment a. If Cognitive Impairment is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If Cognitive Impairment equals Yes, the case will proceed to a Measure Category

	Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. c. If Cognitive Impairment equals No, continue processing and proceed to check Discharge Disposition. 7. Check Discharge Disposition a. If Discharge Disposition is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If Discharge Disposition equals 2, 3, 4, 5, 6 or 7, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 3a. c. If Discharge Disposition equals 1 or 8, continue processing and proceed to check Tobacco Use Status. 8. Check Tobacco Use Status a. If Tobacco Use Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If Tobacco Use Status equals 6, 7 or 8, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 3a. c. If Tobacco Use Status equals 1, 2, 3, 4, 5, 9, 10, 11, 12, 13 or 14, continue processing and proceed to check Referral for Outpatient Tobacco Cessation Counseling. 9. Check Referral for Outpatient Tobacco Cessation Counseling a. If Referral for Outpatient Tobacco Cessation Counseling is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 3a. b. If Referral for Outpatient Tobacco Cessation Counseling equals 4, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. c. If Referral for Outpatient Tobacco Cessation Counseling equals 1, 2, 3 or 5, continue processing and proceed to recheck Referral for Outpatient Tobacco Cessation Counseling. 10. Recheck Referral for Outpatient Tobacco Cessation Counseling a. If Referral for Outpatient Tobacco Cessation Counseling equals 2 or 5, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If Referral for Outpatient Tobacco Cessation Counseling equals 1 or 3, continue processing and proceed to ICD-9-CM Principal Diagnosis Code. 11. Check ICD-9-CM Principal Diagnosis Code a. If ICD-9-CM Principal Diagnosis Code is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If ICD-9-CM Principal Diagnosis Code is not on Table 12.3, continue processing and proceed to ICD-9-CM Other Diagnosis Code.

	12. Check ICD-9-CM Other Diagnosis Code a. If at least one of the ICD 9 CM Other Diagnosis Code is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If all ICD-9-CM Other Diagnosis Code are missing or none is on Table 12.3, continue processing and proceed to recheck Tobacco Use Status. 13. Recheck Tobacco Use Status a. If Tobacco Use Status equals 2, 3, 4 or 11, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 3a. b. If Tobacco Use Status equals 1, 5, 9, 10, 12, 13 or 14, continue processing and proceed to check Prescription for Tobacco Cessation Medication. 14. Check Prescription for Tobacco Cessation Medication a. If Prescription for Tobacco Cessation Medication is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If Prescription for Tobacco Cessation Medication equals 3, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. c. If Prescription for Tobacco Cessation Medication equals 1, 2 or 4, continue processing and proceed to recheck Prescription for Tobacco Cessation Medication. 15. Recheck Prescription for Tobacco Cessation Medication a. If Prescription for Tobacco Cessation Medication equals 1 or 2, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB 3a. b. If Prescription for Tobacco Cessation Medication equals 4, continue processing and proceed to check Reason for No Tobacco Cessation Medication at Discharge. 16. Check Reason for No Tobacco Cessation Medication at Discharge a. If Reason for No Tobacco Cessation Medication at Discharge is missing, the case will proceed to a Measure Category Assignment of X and will be rejected for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. b. If Reason for No Tobacco Cessation Medication at Discharge equals 2, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. c. If Reason for No Tobacco Cessation Medication at Discharge equals 1, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (TOB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure TOB-3a. TOB-3a: Tobacco Use Treatment at Discharge Numerator The number of patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA- approved cessation medication at discharge. Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.

	17. Initialize Measure Category Assignment for sub-measure TOB-3a to Measure Category Assignment of B. Do not change the Measure Category Assignment that was already calculated for the overall measure (TOB-3). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall measure's (TOB-3) Measure Category Assignment. 18. Check Overall Rate Category Assignment a. If the Overall Rate Category Assignment equals B or X, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for the sub-measure TOB-3a. Stop processing. b. If Overall Rate Category Assignment equals D or E, continue processing and proceed to recheck Referral for Outpatient Tobacco Cessation Counseling. 19. Recheck Referral for Outpatient Tobacco Cessation Counseling a. If Referral for Outpatient Tobacco Cessation Counseling equals 3, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for sub-measure TOB-3a. Stop processing. b. If Referral for Outpatient Tobacco Cessation Counseling equals 1 or 2, continue processing and proceed to recheck ICD-9-CM Principal Diagnosis Code. 20. Recheck ICD-9-CM Principal Diagnosis Code a. If ICD-9-CM Principal Diagnosis Code is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-3a. Stop processing. b. If ICD-9-CM Principal Diagnosis Code is not on Table 12.3, continue processing and proceed to recheck ICD-9-CM Other Diagnosis Code. 21. Recheck ICD-9-CM Other Diagnosis Code a. If at least one of the ICD 9 CM Other Diagnosis Code is on Table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-3a. Stop processing. b. If all ICD-9-CM Other Diagnosis Code are missing or none is on Table 12.3, continue processing and proceed to recheck Tobacco Use Status. 22. Recheck Tobacco Use Status a. If Tobacco Use Status equals 2, 3, 4 or 11, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-3a. Stop processing. b. If Tobacco Use Status equals 1, 5, 9, 10, 12, 13 or 14, continue processing and proceed to recheck Prescription for Tobacco Cessation Medication. 23. Recheck Prescription for Tobacco Cessation Medication a. If Prescription for Tobacco Cessation Medication equals 2, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for sub-measure TOB-3a. Stop processing. b. If Prescription for Tobacco Cessation Medication equals 1, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure TOB-3a. Stop processing. c. If Prescription for Tobacco Cessation Medication equals 4, continue processing and proceed to recheck Reason for No Tobacco Cessation Medication at Discharge. 24. Recheck Reason for No Tobacco Cessation Medication at Discharge a. If Reason for No Tobacco Cessation Medication at Discharge equals 2, the case will proceed to Measure Category Assignment of D and will be in the Measure Population for sub-measure TOB-3a. Stop processing. b. If Reason for No Tobacco Cessation Medication at Discharge equals 1, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-

	measure TOB-3a. Stop processing. Attachment TOB3.docx
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	1661 SUB-1 Alcohol Use Screening
Status	New Submission
Steward	The Joint Commission
Description	Hospitalized patients 18 years of age and older who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records 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. Attachment Substance Use Data Dictionary.doc
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking
Numerator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. 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. There is one data element, Alcohol Use Status, that is used to calculate the numerator. There are six allowable values addressing: 1. A validated tool identifying no risk 2. A validated tool identifying moderate risk benefiting from brief intervention 3. A non validated tool resulting in no risk 4. A non validated tool identifying moderate risk benefiting from brief intervention 5. Patient refusal 6. Patient not screened. 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 will be added to the publicly available specifications for data collection beginning with 7/1/2012 discharges. The list will not be all inclusive, but will serve as a reference and will include tools such as the AUDIT, AUDIT-C, AUDIT-PC, ASSIST, TWEAK, CAGE, CRAFFT, MAST, G-MAST. A note for abstraction indicates that if there is a blood alcohol test 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 on thttp://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/he Joint Commission website at www.jointcommission.org at the following link:
Denominator	The number of hospitalized inpatients 18 years of age and older

Statement	
Denominator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Four data elements are used to calculate the denominator: Admission Date, Birth date, Discharge Date and Cognitive Impairment. Admission Date and Birthdate are used to calculate age. Admission Date and Discharge Date calculate the length of stay. 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 thus would not qualify as cognitive impairment. This is a yes/no data element
Exclusions	The denominator has three 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
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 determined to be cognitively impaired and cannot be screened and answer reliably for alcohol use and the data element is answered with a “yes” value, the patient will not be in the population.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
Stratification	Not Applicable, the measure is not stratified
Type Score	Rate/proportion better quality = higher score
Algorithm	SUB-1: Alcohol Use Screening Numerator: The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking. Denominator: The number of hospitalized inpatients 18 years of age and older. Variable key: Patient Age Length of Stay 1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Calculate Patient Age. Patient Age, in years, is equal to the Admission Date minus the Birthdate. Use the month and day portion of Admission Date and Birthdate to yield the most accurate age. Only cases with valid Admission Date and Birthdate will pass the front end edits into the measure specific algorithms. 3. Check Patient Age a. If Patient Age is less than 18 years, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. b. If Patient Age is equal to or greater than 18 years, continue processing and proceed to calculate Length of Stay. 4. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.

	5. Check Length of Stay a. If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. b. If Length of Stay is greater than 1 day, continue processing and proceed to check Cognitive Impairment. 6. Check Cognitive Impairment a. If Cognitive Impairment is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b. If Cognitive Impairment equals Yes, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. c. If Cognitive Impairment equals No, continue processing and proceed to check 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 1, 2, or 5 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing. c. 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. Attachment SUB1.docx
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	1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
Status	New Submission
Steward	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. These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records The Joint Commission developed a web-based data collection tool that was used by hospitals and for reliability testing during the pilot test. When the measures are made part of The Joint Commission's ORYX data collection and reporting program, the data will be collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy of the data collection tool with the specifications. Vendors may not offer a measure set to hospitals until they have passed the verification process. Attachment Substance Use Data Dictionary-634455691920643378.doc
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	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	Time Window: Episode of care which is the entire hospitalization from admission to discharge. One data element (Brief Intervention) is used to determine the numerator. In order to receive credit for the brief intervention there must be a bedside discussion with the patient focusing 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 intervention should 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 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. Full specifications can be viewed on the Joint Commission web site at www.jointcommission.org at the following link: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/
Denominator Statement	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	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Five data elements are used to calculate the denominator: Admission Date, Birthdate, Discharge Date, Cognitive Impairment, and Alcohol Use Status. Admission date and Birthdate are used to calculate age; Admission date and Discharge date

	calculate the length of stay. Patients who are cognitively impaired will be excluded from the measure population. 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. This is a yes/no data element. The six allowable values for the data element Alcohol Use Status will determine if the patient has unhealthy alcohol use and would benefit from a brief intervention. The values address the score from the screening from a validated tool. The data element contains a definition of a validated tool (an instrument that has been psychometrically tested for reliability, validity, sensitivity and specificity).
Exclusions	The denominator has 4 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
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. If the patient is found to be cognitively impaired and cannot be screened and answer reliably for alcohol use and the data element is answered with a “yes” value, the patient will not be in the population. Patients who refused or were not screened for alcohol use during the hospital stay (value 5 or value 6 for the data element Alcohol Use Status) will not be included in the measure population because the use status is unknown.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
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 wher
Type Score	Rate/proportion better quality = higher score
Algorithm	SUB-2: Alcohol Use Brief Intervention Provided or Offered Numerator: The number of patients who received or refused a brief intervention. 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). Variable key: Patient Age Length of Stay 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 for overall rate (SUB-2) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-2a. b. If Patient Age is equal to or greater than 18 years, continue processing and proceed to calculate Length of Stay. 4. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date. 5. Check Length of Stay a. If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B for overall rate (SUB-2) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-2a. b. If Length of Stay is greater than 1 day, continue processing and proceed to check Cognitive Impairment. 6. Check Cognitive Impairment a. If Cognitive Impairment is missing, the case will proceed to a Measure Category Assignment of X for overall rate (SUB-2) and will be rejected. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-2a. b. If Cognitive Impairment equals Yes, the case will proceed to a Measure Category Assignment of B for overall rate (SUB-2) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-2a. c. If Cognitive Impairment equals No, 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 for overall rate (SUB-2) and will be rejected. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-2a. b. If Alcohol Use Status equals 1, 3, 5, 6 the case will proceed to a Measure Category Assignment of B for overall rate (SUB-2) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-2a. c. If Alcohol Use Status equals 2 or 4 continue processing and proceed to check Brief Intervention. 8. Check Brief Intervention a. If Brief Intervention is missing, the case will proceed to a Measure Category Assignment of X for overall rate (SUB-2) and will be rejected. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-2a. b. If Brief Intervention equals 3 the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-2a. c. If Brief Intervention equals 1 or 2 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-2a. SUB-2a: Alcohol Use Brief Intervention Numerator: The number of patients who received a brief intervention. 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). 9. Initialize the Measure Category Assignment for sub-measure SUB-2a to Measure Category Assignment B.

	Do not change the Measure Category Assignment that was already calculated for the overall measure (SUB-2).The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall measure's (SUB-2) Measure Category Assignment. 10. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals B or X, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population for sub-measure SUB-2a. Stop Processing. b. If Overall Rate Category Assignment equals D or E, continue processing and proceed to check Brief Intervention. 11. Check Brief Intervention a. If Brief Intervention equals 2, 3 the case will proceed to a Measure Category Assignment of D and will be in the Measure Population for sub-measure SUB-2a. Stop Processing. b. If Brief Intervention equals 1 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure SUB-2a. Stop Processing. Attachment SUB2.docx
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	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
Status	New Submission
Steward	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. These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records 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 the 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. The vendor may not offer a measure set to hospitals until the verification for the measure set has been passed. Attachment Tobacco Treatment Data Dictionary-634455474540798928.doc
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	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	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Two data elements are used to calculate the numerator 1. Referral for Addiction Treatment and 2. Prescription for Alcohol or Drug Disorder Medication. A referral to addiction treatment may be given at discharge or the referral can take place prior to discharge and the healthcare professional referred to can provide treatment during the hospitalization. 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. Full specifications can be viewed on the Joint Commission web site at www.jointcommission.org at the following link: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/ 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.

Denominator Statement	The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder
Denominator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. There are 10 data elements used to identify and calcualte the denominator: Admission Date, Alcohol Or Drug Disorder, Birthdate, Cognitive Impairment, Discharge Date, Discharge Disposition, ICD-9-CM Other Diagnosis Codes, ICD-9-CM Other Procedure Codes, ICD-9-CM Principal Diagnosis Code, ICD-9-CM Principal Procedure Code. The Admission date and birthdate are used to calculate the patient age. Admission date and discharge date calculate the length of stay and month for data transmission. The ICD-9-CM diagnosis codes and procedure codes are used to identify those who have an alcohol or drug use disorder. The data element Alcohol or Drug Disorder is used to to identify the patients with Alcohol or Drug Disorder if no ICD-9-CM code is used. Discharge Disposition is used to remove patients from the population who are discharged to another hospital, leave AMA, expire or are discharged to hospice.
Exclusions	There are 10 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 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
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 cognitive impariment (a yes/no data element). 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 or who do not have narrative documentation of dependence or alcohol or drug use disorder would not be included in the measure population.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
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 a
Type Score	Rate/proportion better quality = higher score
Algorithm	SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge

	Numerator: The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder or dependence at discharge OR received or refused a referral for addictions treatment. Denominator: The number of hospitalized inpatients 18 years of age and older identified with alcohol or drug disorder. Variable key: Patient Age Length of Stay 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 for overall rate (SUB-3) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. b. If Patient Age is equal to or greater than 18 years, continue processing and proceed to calculate of 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 for overall rate (SUB-3) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. b. If Length of Stay is greater than 1 day, continue processing and proceed to check Cognitive Impairment. 6. Check Cognitive Impairment a. If Cognitive Impairment is missing, the case will proceed to a Measure Category Assignment of X for overall rate (SUB-3) and will be rejected. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. b. If Cognitive Impairment equals Yes, the case will proceed to a Measure Category Assignment of B for overall rate (SUB-3) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. c. If Cognitive Impairment equals No, continue processing and proceed to check Discharge Disposition. 7. Check Discharge Disposition a. If Discharge Disposition is missing, the case will proceed to a Measure Category Assignment of X for overall rate (SUB-3) and will be rejected. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. b. If Discharge Disposition equals 2, 3, 4, 5, 6 or 7, the case will proceed to a Measure Category Assignment of B for overall rate (SUB-3) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. c. If Discharge Disposition equals 1 or 8, continue processing and proceed to check ICD-9-CM Principal Diagnosis Code. 8. Check ICD-9-CM Principal Diagnosis Code a. If ICD-9-CM Principal Diagnosis Code is not on Table 13.1 or 13.2, continue processing and proceed to check ICD-9-CM Other Diagnosis Code.

	b. If ICD-9-CM Principal Diagnosis Code is on Table 13.1 or 13.2, continue processing and proceed to check Referral for Addictions Treatment. 9. Check ICD-9-CM Other Diagnosis Code a. If none of the ICD 9 CM Other Diagnosis Code(s) are on Table 13.1 or 13.2, continue processing and proceed to check ICD-9-CM Principal or Other Procedure Code. b. If at least one of the ICD-9-CM Other Diagnosis Code(s) is on Table 13.1 or 13.2, continue processing and proceed to check Referral for Addictions Treatment. 10. Check ICD-9-CM Principal or Other Procedure Code a. If none of the ICD-9-CM Principal or Other Procedure Code is on Table 13.3 continue processing and proceed to check Alcohol or Drug Disorder. b. If any of the ICD-9-CM Principal or Other Procedure Code is on Table 13.3, continue processing and proceed to check Referral for Addictions Treatment. 11. Check Alcohol or Drug Disorder a. If Alcohol or Drug Disorder is missing, the case will proceed to a Measure Category Assignment of X for overall rate (SUB-3) and will be rejected. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. b. If Alcohol or Drug Disorder equals No, the case will proceed to a Measure Category Assignment of B for overall rate (SUB-3) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. c. If Alcohol or Drug Disorder equals Yes, continue processing and proceed to check Referral for Addictions Treatment. 12. Check Referral for Addictions Treatment a. If Referral for Addictions Treatment is missing, the case will proceed to a Measure Category Assignment of X for overall rate (SUB-3) and will be rejected. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. b. If Referral for Addictions Treatment equals 4, the case will proceed to a Measure Category Assignment of B for overall rate (SUB-3) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. c. If Referral for Addictions Treatment equals 1, 2, 3 or 5, continue processing and proceed to recheck Referral for Addictions Treatment. 13. Recheck Referral for Addictions Treatment a. If Referral for Addictions Treatment equals 1 or 3, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (SUB-3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. b. If Referral for Addictions Treatment equals 2 or 5, continue processing and proceed to check Prescription for Alcohol or Drug Disorder Medication. 14. Check Prescription for Alcohol or Drug Disorder Medication a. If Prescription for Alcohol or Drug Disorder Medication is missing, the case will proceed to a Measure Category Assignment of X for overall rate (SUB-3) and will be rejected. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. b. If Prescription for Alcohol or Drug Disorder Medication equals 3, the case will proceed to a Measure Category Assignment of B for overall rate (SUB-3) and will not be in the Measure Population. Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. c. If Prescription for Alcohol or Drug Disorder Medication equals 1, 2 or 4, continue processing and proceed to recheck Prescription for Alcohol or Drug Disorder Medication. 15. Recheck Prescription for Alcohol or Drug Disorder Medication a. If Prescription for Alcohol or Drug Disorder Medication equals 4, the case will proceed to

	Measure Category Assignment of D and will be in the Measure Population for the overall measure rate (SUB 3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. b. If Prescription for Alcohol or Drug Disorder Medication equals 1 or 2, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for the overall measure rate (SUB 3). Continue processing and proceed to Initialize Measure Category Assignment for sub-measure SUB-3a. c. SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge Numerator: The number of patients who received a prescription for medication for treatment of alcohol or drug use disorder or dependence at discharge or a referral for addictions treatment. Denominator: The number of hospitalized inpatients 18 years of age and older identified with alcohol or drug disorder. 16. Initialize the Measure Category Assignment for the sub-measure SUB-3a to Measure Category Assignment B. Do not change the Measure Category Assignment that was already calculated for the overall measure (SUB-3). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall measure's (SUB-3) Measure Category Assignment. 17. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals B or X, the case will proceed to a Measure Category Assignment of B for sub-measure SUB-3a and will not be in the Measure Population. Stop processing. b. If Overall Rate Category Assignment equals D or E, continue processing and proceed to recheck Referral for Addictions Treatment. 18. Recheck Referral for Addictions Treatment a. If Referral for Addictions Treatment equals 1, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure SUB-3a. Stop processing. b. If Referral for Addictions Treatment equals 2, 3, 4 or 5, continue processing and proceed to recheck Prescription for Alcohol or Drug Dependence Medication. 19. Recheck Prescription for Alcohol or Drug Dependence Medication a. If Prescription for Alcohol or Drug Dependence Medication equals 2 or 3, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population for sub-measure SUB-3a. Stop processing. b. If Prescription for Alcohol or Drug Dependence Medication equals 1, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population for sub-measure SUB-3a. Stop processing. Attachment SUB3.docx
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	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
Status	New Submission
Steward	Centers for Medicare & Medicaid Services
Description	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with bipolar I disorder who are prescribed a mood stabilizer medication, with adherence to the mood stabilizer medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).
Type	Process
Data Source	Administrative claims, Other, Electronic Clinical Data : Pharmacy For measure calculation, the following Medicare files were required: • Denominator tables • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME • Prescription drug benefit (Part D) claims For ACO attribution, the following were required: • Denominator tables for Parts A and B enrollment • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME • Prescription drug benefit (Part D) claims For physician group attribution, the following were required: • Non-institutional claims (Part B)—physician carrier/non-DME • Denominator tables to determine individual enrollment • Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payor status • CMS physician and physician specialty tables • National Plan & Provider Enumeration System (NPPES) database Attachment NQF_-1880_Codes_Table-634902104096034295.xls
Level	Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : State
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Numerator Statement	Individuals with bipolar I disorder who filled at least two prescriptions for any mood stabilizer medication and have a Proportion of Days Covered (PDC) for mood stabilizer medications of at least 0.8.
Numerator Details	Time Window: We define this as any time during the measurement period (12 consecutive months). The numerator is defined as individuals with a PDC of 0.8 or greater. The PDC is calculated as follows: PDC NUMERATOR: The PDC numerator is the sum of the days covered by the days' supply of all mood stabilizer prescriptions. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the

	measurement period. If there are prescriptions for the same drug (generic name or 10-digit generic product identifier [GPI]) on the same date of service, keep the prescription with the largest days' supply. If prescriptions for the same drug (generic name or GPI) overlap, then adjust the prescription start date to be the day after the previous fill has ended. PDC DENOMINATOR: The PDC denominator is the number of days from the first prescription date through the end of the measurement period, or death date, whichever comes first.
Denominator Statement	Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder with at least two claims for any mood stabilizer medication during the measurement period (12 consecutive months).
Denominator Details	Time Window: We define this as any time during the measurement period (12 consecutive months). IDENTIFICATION OF BIPOLAR I DISORDER Individuals with bipolar I disorder are identified by having a diagnosis of bipolar I disorder within the inpatient or outpatient claims data. Individuals must have: At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or nonacute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period. CODES USED TO IDENTIFY BIPOLAR I DISORDER DIAGNOSIS: ICD-9-CM: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7 ICD-10-CM: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.89, F31.9 CODES USED TO IDENTIFY ENCOUNTER TYPE: OUTPATIENT SETTING Current Procedural Terminology (CPT):* 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983, 077x, 090x, 091x, 0961 OR CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 Emergency Department setting CPT: 99281-99285 UB-92 revenue: 045x, 0981, 0961 OR CPT: 90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291 WITH

	POS: 23 Nonacute Inpatient setting CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 HCPCS: H0017-H0019, T2048 UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x, 1000, 1001, 1003-1005, 0961 OR CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291 WITH POS: 31, 32, 56 Acute Inpatient setting UB-92 revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987, 080x, 0961 OR CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH POS: 21, 51 *CPT Copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. The following are the mood stabilizer medications by Class for the denominator. The route of administration includes all oral formulations of the medications and depot formulations (where they are available) listed below. MOOD STABILIZER MEDICATIONS: ANTICONVULSANTS: valproic acid divalproex sodium carbamazepine lamotrigine TYPICAL ANTIPSYCHOTIC MEDICATIONS**: chlorpromazine thioridazine fluphenazine thiothixene haloperidol trifluoperazine loxapine succinate molindone perphenazine pimozide prochlorperazine perphenazine-amitriptyline ATYPICAL ANTIPSYCHOTIC MEDICATIONS: aripiprazole asenapine

	clozapine iloperidone lurasidone olanzapine paliperidone quetiapine risperidone ziprasidone olanzapine-fluoxetine ANTIMANIC MEDICATIONS: lithium carbonate lithium citrate **During the CMS public comment period, several commenters recommended including the antipsychotics in the list of mood stabilizers. The public comments agreed with the measure specifications. Note: Active ingredients listed above are limited to oral, buccal, sublingual, and translingual formulations only. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than 3 years prior to the beginning of the measurement period or look-back period, if applicable. The following are the long-acting (depot) injectable antipsychotic medications by Class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below. TYPICAL ANTIPSYCHOTIC MEDICATIONS: fluphenazine decanoate (J2680) haloperidol decanoate (J1631) ATYPICAL ANTIPSYCHOTIC MEDICATIONS: olanzapine pamoate (J2358) paliperidone palmitate (J2426) risperidone microspheres (J2794) Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Part D and Part B: fluphenazine decanoate (J2680) – 28 days' supply haloperidol decanoate (J1631) – 28 days' supply olanzapine pamoate (J2358) – 28 days' supply paliperidone palmitate (J2426) – 28 days' supply risperidone microspheres (J2794) – 14 days' supply
Exclusions	Not Applicable
Exclusion Details	Not Applicable
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
Stratification	Depending on the operational use of the measure, measure results may be stratified by: • State • Accountable Care Organizations (ACOs)* • Plan • Physician Group**

	• Age- Divided into 6 categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years • Race/E
Type Score	Rate/proportion better quality = higher score
Algorithm	Adherence to mood stabilizers for individuals with bipolar I disorder is calculated as follows: Obtain Medicare administrative claims data and related files as described in detail in Section 2a1.26. Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two claims for a mood stabilizer during the measurement period. Create Denominator: 1. Pull beneficiaries who are 18 or older as of January 1 of the measurement period.* *During the CMS public comment period, a commenter recommended that the age requirement should be met by the beginning of the measurement period, not the end of the period. In response to this comment, the measure developer revised the specifications in accordance with the comment. 2. Include beneficiaries who were continuously enrolled in Part D coverage during the measurement year and the previous year, with no more than a one-month gap in enrollment during the measurement year. 3. Include individuals who had no more than a 1-month gap in Part A enrollment, no more than a 1-month gap in Part B enrollment, and no more than 1 month of HMO [Health Maintenance Organization] enrollment during the current measurement year (fee-for-service [FFS] individuals only). 4. Of those beneficiaries identified in Step 3, keep individuals who had at least 2 encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or nonacute inpatient setting during the measurement period; OR Individuals who had at least 1 encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period. 5. For the individuals identified in Step 4, extract Part D claims for a mood stabilizer during the measurement year. 6. For the individuals identified in Step 5, exclude those who did not have at least 2 claims for a mood stabilizer on different dates of service (identified by having at least 2 Part D claims with the specific codes) during the measurement period. Numerator: Individuals with bipolar I disorder who fill at least two prescriptions for a mood stabilizer and have a Proportion of Days Covered (PDC) for mood stabilizer medication of at least 0.8. Of the individuals in the denominator, calculate the PDC for each individual according to the following methods: 1. Determine the individual's measurement period, defined as the number of days from the index date through the end of the measurement period, or death, whichever comes first. The index date is the date of the first prescription in the measurement period. 2. Within the measurement period, count the days the individual was covered by at least one mood stabilizer drug based on the prescription fill date and days of supply. a. Pull Part D mood stabilizer claims for individuals in the denominator. Attach the drug ID and the generic name to the dataset. b. Sort and de-duplicate claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name or 10-digit generic product identifier [GPI]) are dispensed on the same date of service for an individual, keep the dispensing

	with the largest days' supply. c. Calculate the number of days covered by mood stabilizer drug therapy per individual. i. For prescriptions with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. ii. If prescriptions for the same drug (generic name or GPI) overlap, then adjust the latest prescription start date to be the day after the previous fill has ended. iii. If prescriptions for different drugs (different generic names or GPIs) overlap, do not adjust the prescription start date. 3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's measurement period found in Step 1. An example of SAS code for Steps 1-3 was adapted from PQA and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf The algorithm regarding the Part D plan and physician group attribution is provided in the attachment below in Section 2a1.21. Attachment NQF_-1880_-_Part_D_Plan_and_Physician_Group_Attribution.doc
Copyright/ Disclaimer	Not Applicable Not Applicable

	1884 Depression Response at Six Months- Progress Towards Remission
Status	New Submission
Steward	MN Community Measurement
Description	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at six months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Registry The data source is the medical group's/ clinic's medical record information, most frequently from am EMR. A CSV file is created by each medical group and uploaded to a password protected, HIPAA secure data portal which performs rate calculation. Selected Patient Reported Data, not because it is necessarily a separate data source, but because this measure is based on a patient reported outcome tool, a PRO-PM measure. Frequently this PRO tool, the PHQ-9, is housed within a clinic's EMR, or in paper charts is a part of the patient's medical record. Attachment Depression_Template_Formatted_Updated_2012.xlsx URL http://mncm.org/site/upload/files/Depression_Care_Measures_2012_DDS_12.21.2011.pdf
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Numerator Statement	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.
Numerator Details	Time Window: PHQ-9 scores are collected for each patient from the time they meet the inclusion criteria of diagnosis ICD-9 codes and PHQ-9 score greater than nine (this is the index or anchor date) until seven months have elapsed. This allows for calculation of a response rate +/- 30 days from the index date. The numerator is defined as those patients who achieve a response to treatment at six months (+/- 30 days). Response is defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. The numerator rate is calculated as follows: # adult pts with major depression or dysthymia (296.2x, 296.3x or 300.4) with a PHQ-9 score reduced by 50% or greater from the initial PHQ-9 score at 6 months(+/- 30 days)/ # adult pts with major depression or dysthymia (296.2x, 296.3x or 300.4)with index contact PHQ-9 > 9 Patients who do not have a six month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure.
Denominator Statement	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.
Denominator Details	Time Window: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine. The measurement time frame is determined by the inclusion of patients who have their index contact date within the defined measurement period and then allowing for a seven month window of follow-up to obtain an assessment at six months plus or minus 30 days. Adults age 18 and older; no upper age limit Have the diagnosis of major depression or dysthymia defined by any of the following ICD-9* codes:

	296.2x Major depressive disorder, single episode 296.3x Major depressive disorder, recurrent episode 300.4 Dysthymic disorder AND PHQ-9 Score is greater than nine. * For primary care providers the diagnosis codes can be in any position (primary or secondary). For behavioral health providers the diagnosis codes need to be in the primary position. This is to more accurately define major depression and exclude patients who may have other more serious mental health diagnoses (e.g. schizophrenia, psychosis) with a secondary diagnosis of depression. Patients who do not have a six month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure. ICD-9 Code ICD-9 Description 296.2 Major depressive disorder single episode 296.20 Major depressive affective disorder single episode unspecified degree 296.21 Major depressive affective disorder single episode mild degree 296.22 Major depressive affective disorder single episode moderate degree 296.23 Major depressive affective disorder single episode severe degree without psychotic behavior 296.24 Major depressive affective disorder single episode severe degree specified as with psychotic behavior 296.25 Major depressive affective disorder single episode in partial or unspecified remission 296.26 Major depressive affective disorder single episode in full remission 296.3 Major depressive disorder recurrent episode 296.30 Major depressive affective disorder recurrent episode unspecified degree 296.31 Major depressive affective disorder recurrent episode mild degree 296.32 Major depressive affective disorder recurrent episode moderate degree 296.33 Major depressive affective disorder recurrent episode severe degree without psychotic behavior 296.34 Major depressive affective disorder recurrent episode severe degree specified as with psychotic behavior 296.35 Major depressive affective disorder recurrent episode in partial or unspecified remission 296.36 Major depressive affective disorder recurrent episode in full remission 300.4 Dysthymic disorder Plan for ICD-10 based on DRAFT ICD-10 2011; may change with FINAL ICD-10 manual in 2014 ICD-10 Code ICD-10 Description F32.0 Major depressive disorder, single episode, mild F32.1 Major depressive disorder, single episode, moderate F32.2 Major depressive disorder, single episode, severe without psychotic features F32.3 Major depressive disorder, single episode, severe with psychotic features F32.4 Major depressive disorder, single episode, in partial remission F32.5 Major depressive disorder, single episode, in full remission F32.9 Major depressive disorder, single episode, unspecified F33.0 Major depressive disorder, recurrent, mild F33.1 Major depressive disorder, recurrent, moderate F33.2 Major depressive disorder, recurrent severe without psychotic features

	F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms F33.40 Major depressive disorder, recurrent, in remission, unspecified F33.41 Major depressive disorder, recurrent, in partial remission F33.42 Major depressive disorder, recurrent, in full remission F33.9 Major depressive disorder, recurrent, unspecified F34.1 Dysthymic disorder
Exclusions	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.
Exclusion Details	•Patients who die during the measurement time frame •Patients who are a permanent nursing home resident > 1 year during the measurement time frame •Patients who are enrolled in hospice during the measurement time frame •Bipolar Disorder (in any position) See bipolar disorder codes below. •Personality Disorder (in any position). See personality disorder codes below. ICD-9 Bipolar Disorder Codes: 296.00 Bipolar I Disorder, Single Manic Episode, Unspecified 296.01 Bipolar I Disorder, Single Manic Episode, Mild 296.02 Bipolar I Disorder, Single Manic Episode, Moderate 296.03 Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features 296.04 Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features 296.05 Bipolar I Disorder, Single Manic Episode, In Partial Remission 296.06 Bipolar I Disorder, Single Manic Episode, In Full Remission 296.10 Manic disorder, recurrent episode; Unspecified 296.11 Manic disorder, recurrent episode; Mild 296.12 Manic disorder, recurrent episode; Moderate 296.13 Manic disorder, recurrent episode; Severe Without Psychotic Features 296.14 Manic disorder, recurrent episode; Severe With Psychotic Features 296.15 Manic disorder, recurrent episode; In Partial Remission 296.16 Manic disorder, recurrent episode; In Full Remission 296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified 296.41 Bipolar I Disorder, Most Recent Episode Manic, Mild 296.42 Bipolar I Disorder, Most Recent Episode Manic, Moderate 296.43 Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features 296.44 Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features 296.45 Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission 296.46 Bipolar I Disorder, Most Recent Episode Manic, In Full Remission 296.50 Bipolar I Disorder, Most Recent Episode Depressed, Unspecified 296.51 Bipolar I Disorder, Most Recent Episode Depressed, Mild 296.52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate 296.53 Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features 296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features 296.55 Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission 296.56 Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission 296.60 Bipolar I Disorder, Most Recent Episode Mixed, Unspecified 296.61 Bipolar I Disorder, Most Recent Episode Mixed, Mild

	296.62 Bipolar I Disorder, Most Recent Episode Mixed, Moderate 296.63 Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features 296.64 Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features 296.65 Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission 296.66 Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission 296.7 Bipolar I Disorder, Most Recent Episode Unspecified 296.80 Bipolar Disorder NOS 296.81 Atypical Manic Disorder 296.82 Atypical Depressive Disorder 296.89 Bipolar II Disorder ICD-9 Personality Disorder Codes: 301.0 Paranoid personality disorder 301.1 Affective personality disorder 301.10 Affective personality disorder unspecified 301.11 Chronic hypomanic personality disorder 301.12 Chronic depressive personality disorder 301.13 Cyclothymic disorder 301.2 Schizoid personality disorder 301.20 Schizoid personality disorder unspecified 301.21 Introverted personality 301.22 Schizotypal personality disorder 301.3 Explosive personality disorder 301.4 Obsessive-compulsive personality disorder 301.5 Histrionic personality disorder 301.50 Histrionic personality disorder unspecified 301.51 Chronic factitious illness with physical symptoms 301.59 Other histrionic personality disorder 301.6 Dependent personality disorder 301.7 Antisocial personality disorder 301.8 Other personality disorders 301.81 Narcissistic personality disorder 301.82 Avoidant personality disorder 301.83 Borderline personality disorder 301.84 Passive-aggressive personality 301.89 Other personality disorders 301.9 Unspecified personality disorder Plan for ICD-10 based on DRAFT ICD-10 2011; may change with FINAL ICD-10 manual in 2014 Exclusion ICD-10- Bipolar ICD-10 Code ICD-10 Description F30.10 Manic episode without psychotic symptoms, unspecified F30.11 Manic episode without psychotic symptoms, mild F30.12 Manic episode without psychotic symptoms, moderate F30.13 Manic episode, severe, without psychotic symptoms F30.2 Manic episode, severe with psychotic symptoms F30.3 Manic episode in partial remission F30.4 Manic episode in full remission

	F30.8 Other manic episodes F30.9 Manic episode, unspecified F31.0 Bipolar disorder, current episode hypomanic F31.10 Bipolar disorder, current episode manic without psychotic features, unspecified F31.11 Bipolar disorder, current episode manic without psychotic features, mild F31.12 Bipolar disorder, current episode manic without psychotic features, moderate F31.13 Bipolar disorder, current episode manic without psychotic features, severe F31.2 Bipolar disorder, current episode manic severe with psychotic features F31.30 Bipolar disorder, current episode depressed, mild or moderate severity, unspecified F31.31 Bipolar disorder, current episode depressed, mild F31.32 Bipolar disorder, current episode depressed, moderate F31.4 Bipolar disorder, current episode depressed, severe, without psychotic features F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features F31.60 Bipolar disorder, current episode mixed, unspecified F31.61 Bipolar disorder, current episode mixed, mild F31.62 Bipolar disorder, current episode mixed, moderate F31.63 Bipolar disorder, current episode mixed, severe, without psychotic features F31.64 Bipolar disorder, current episode mixed, severe, with psychotic features F31.70 Bipolar disorder, currently in remission, most recent episode unspecified F31.71 Bipolar disorder, in partial remission, most recent episode hypomanic F31.72 Bipolar disorder, in full remission, most recent episode hypomanic F31.73 Bipolar disorder, in partial remission, most recent episode manic F31.74 Bipolar disorder, in full remission, most recent episode manic F31.75 Bipolar disorder, in partial remission, most recent episode depressed F31.76 Bipolar disorder, in full remission, most recent episode depressed F31.77 Bipolar disorder, in partial remission, most recent episode mixed F31.78 Bipolar disorder, in full remission, most recent episode mixed F31.81 Bipolar II disorder F31.89 Other bipolar disorder F31.9 Bipolar disorder, unspecified Exclusion ICD-10- Personality Disorder ICD-10 Code ICD-10 Description F21 Schizotypal disorder F34.0 Cyclothymic disorder F60.0 Paranoid personality disorder F60.1 Schizoid personality disorder F60.2 Antisocial personality disorder F60.3 Borderline personality disorder F60.4 Histrionic personality disorder F60.5 Obsessive-compulsive personality disorder F60.6 Avoidant personality disorder F60.7 Dependent personality disorder F60.81 Narcissistic personality disorder F60.89 Other specific personality disorders F60.9 Personality disorder, unspecified F68.10 Factitious disorder, unspecified

	F68.11 Factitious disorder with predominantly psychological signs and symptoms F68.12 Factitious disorder with predominantly physical signs and symptoms F68.13 Factitious disorder with combined psychological and physical signs and symptoms F68.8 Other specified disorders of adult personality and behavior F69 Unspecified disorder of adult personality and behavior
Risk Adjustment	Stratification by risk category/subgroup Risk adjustment to the statewide average severity mix based on a patient's initial PHQ-9 score. This measure is risk adjusted based on severity band of the PHQ-9 which is based on the initial PHQ-9 score. Severity bands are defined as 10 to 14- moderate Attachment Depression_Report_2013-03-03.pdf
Stratification	This measure is currently not stratified. We are contemplating stratification functionality on our consumer facing public website, MN HealthScores at www.mnhealthscores.org that would allow results to be displayed in total or by practice specialty of beha
Type Score	Rate/proportion better quality = higher score
Algorithm	This measure is calculated by submitting a visit level file for the eligible patients, each record in the file represents a contact with the patient and PHQ-9 score associated with this contact. Data file is submitted to a HIPAA secure data portal. Programming within the data portal determines the starting point (index visit) and then calculates based on dates if a six month +/- 30 days PHQ-9 was obtained and the resulting score. Calculation logic: Is patient eligible for inclusion with diagnosis codes of either 296.2x, 296.3x or 300.4 and PHQ-9 > 9? If yes, mark the visit as index (anchor) and include this patient in the denominator. Does patient have a PHQ-9 score completed with a contact date that is six months +/- 30 days from the index date? If yes, include this score to calculate rate. Programming logic includes the most recent score within the +/- 30 day window. If no, patient is included in the denominator only. Not having a PHQ-9 score within the +/- 30 day window is considered a numerator miss. If the patient does have a six month +/- 30 day PHQ-9 score, is it reduced from the initial PHQ-9 score by 50% or greater? If yes; patient is considered a numerator case for rate calculation. Attachment Measure Algorithm for Six Month Response 2012.pdf
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	1885 Depression Response at Twelve Months- Progress Towards Remission
Status	New Submission
Steward	MN Community Measurement
Description	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Registry The data source is the medical group's/ clinic's medical record information, most frequently from am EMR. A CSV file is created by each medical group and uploaded to a password protected, HIPAA secure data portal which performs rate calculation. Selected Patient Reported Data, not because it is necessarily a separate data source, but because this measure is based on a patient reported outcome tool, a PRO-PM measure. Frequently this PRO tool, the PHQ-9, is housed within a clinic's EMR, or in paper charts is a part of the patient's medical record. Attachment Depression_Template_Formatted_Updated_2012-634646558483558922.xlsx URL http://mncm.org/site/upload/files/Depression_Care_Measures_2012_DDS_12.21.2011.pdf
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Numerator Statement	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.
Numerator Details	Time Window: PHQ-9 scores are collected for each patient from the time they meet the inclusion criteria of diagnosis ICD-9 codes and PHQ-9 score greater than nine (this is the index or anchor date) until thirteen months have elapsed. This allows for calculation of a response rate +/- 30 days from the index date. The numerator is defined as those patients who achieve a response to treatment at twelve months (+/- 30 days). Response is defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. The numerator rate is calculated as follows: # adult pts with major depression or dysthymia (296.2x, 296.3x or 300.4) with a PHQ-9 score reduced by 50% or greater from the initial PHQ-9 score at 12 months(+/- 30 days)/ # adult pts with major depression or dysthymia (296.2x, 296.3x or 300.4)with index contact PHQ-9 > 9 Patients who do not have a twelve month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure.
Denominator Statement	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.
Denominator Details	Time Window: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine. The measurement time frame is determined by the inclusion of patients who have their index contact date within the defined measurement period and then allowing for a thirteen month window of follow-up to obtain an assessment at twelve months plus or minus 30 days. Adults age 18 and older; no upper age limit Have the diagnosis of major depression or dysthymia defined by any of the following ICD-9* codes:

	296.2x Major depressive disorder, single episode 296.3x Major depressive disorder, recurrent episode 300.4 Dysthymic disorder AND PHQ-9 Score is greater than nine. * For primary care providers the diagnosis codes can be in any position (primary or secondary). For behavioral health providers the diagnosis codes need to be in the primary position. This is to more accurately define major depression and exclude patients who may have other more serious mental health diagnoses (e.g. schizophrenia, psychosis) with a secondary diagnosis of depression. Patients who do not have a twelve month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure. ICD-9 Code ICD-9 Description 296.2 Major depressive disorder single episode 296.20 Major depressive affective disorder single episode unspecified degree 296.21 Major depressive affective disorder single episode mild degree 296.22 Major depressive affective disorder single episode moderate degree 296.23 Major depressive affective disorder single episode severe degree without psychotic behavior 296.24 Major depressive affective disorder single episode severe degree specified as with psychotic behavior 296.25 Major depressive affective disorder single episode in partial or unspecified remission 296.26 Major depressive affective disorder single episode in full remission 296.3 Major depressive disorder recurrent episode 296.30 Major depressive affective disorder recurrent episode unspecified degree 296.31 Major depressive affective disorder recurrent episode mild degree 296.32 Major depressive affective disorder recurrent episode moderate degree 296.33 Major depressive affective disorder recurrent episode severe degree without psychotic behavior 296.34 Major depressive affective disorder recurrent episode severe degree specified as with psychotic behavior 296.35 Major depressive affective disorder recurrent episode in partial or unspecified remission 296.36 Major depressive affective disorder recurrent episode in full remission 300.4 Dysthymic disorder Plan for ICD-10 based on DRAFT ICD-10 2011; may change with FINAL ICD-10 manual in 2014 ICD-10 Code ICD-10 Description F32.0 Major depressive disorder, single episode, mild F32.1 Major depressive disorder, single episode, moderate F32.2 Major depressive disorder, single episode, severe without psychotic features F32.3 Major depressive disorder, single episode, severe with psychotic features F32.4 Major depressive disorder, single episode, in partial remission F32.5 Major depressive disorder, single episode, in full remission F32.9 Major depressive disorder, single episode, unspecified F33.0 Major depressive disorder, recurrent, mild F33.1 Major depressive disorder, recurrent, moderate F33.2 Major depressive disorder, recurrent severe without psychotic features

	F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms F33.40 Major depressive disorder, recurrent, in remission, unspecified F33.41 Major depressive disorder, recurrent, in partial remission F33.42 Major depressive disorder, recurrent, in full remission F33.9 Major depressive disorder, recurrent, unspecified F34.1 Dysthymic disorder
Exclusions	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.
Exclusion Details	•Patients who die during the measurement time frame •Patients who are a permanent nursing home resident > 1 year during the measurement time frame •Patients who are enrolled in hospice during the measurement time frame •Bipolar Disorder (in any position) See bipolar disorder codes below. •Personality Disorder (in any position). See personality disorder codes below. ICD-9 Bipolar Disorder Codes: 296.00 Bipolar I Disorder, Single Manic Episode, Unspecified 296.01 Bipolar I Disorder, Single Manic Episode, Mild 296.02 Bipolar I Disorder, Single Manic Episode, Moderate 296.03 Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features 296.04 Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features 296.05 Bipolar I Disorder, Single Manic Episode, In Partial Remission 296.06 Bipolar I Disorder, Single Manic Episode, In Full Remission 296.10 Manic disorder, recurrent episode; Unspecified 296.11 Manic disorder, recurrent episode; Mild 296.12 Manic disorder, recurrent episode; Moderate 296.13 Manic disorder, recurrent episode; Severe Without Psychotic Features 296.14 Manic disorder, recurrent episode; Severe With Psychotic Features 296.15 Manic disorder, recurrent episode; In Partial Remission 296.16 Manic disorder, recurrent episode; In Full Remission 296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified 296.41 Bipolar I Disorder, Most Recent Episode Manic, Mild 296.42 Bipolar I Disorder, Most Recent Episode Manic, Moderate 296.43 Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features 296.44 Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features 296.45 Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission 296.46 Bipolar I Disorder, Most Recent Episode Manic, In Full Remission 296.50 Bipolar I Disorder, Most Recent Episode Depressed, Unspecified 296.51 Bipolar I Disorder, Most Recent Episode Depressed, Mild 296.52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate 296.53 Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features 296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features 296.55 Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission 296.56 Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission 296.60 Bipolar I Disorder, Most Recent Episode Mixed, Unspecified 296.61 Bipolar I Disorder, Most Recent Episode Mixed, Mild

	296.62 Bipolar I Disorder, Most Recent Episode Mixed, Moderate 296.63 Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features 296.64 Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features 296.65 Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission 296.66 Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission 296.7 Bipolar I Disorder, Most Recent Episode Unspecified 296.80 Bipolar Disorder NOS 296.81 Atypical Manic Disorder 296.82 Atypical Depressive Disorder 296.89 Bipolar II Disorder ICD-9 Personality Disorder Codes: 301.0 Paranoid personality disorder 301.1 Affective personality disorder 301.10 Affective personality disorder unspecified 301.11 Chronic hypomanic personality disorder 301.12 Chronic depressive personality disorder 301.13 Cyclothymic disorder 301.2 Schizoid personality disorder 301.20 Schizoid personality disorder unspecified 301.21 Introverted personality 301.22 Schizotypal personality disorder 301.3 Explosive personality disorder 301.4 Obsessive-compulsive personality disorder 301.5 Histrionic personality disorder 301.50 Histrionic personality disorder unspecified 301.51 Chronic factitious illness with physical symptoms 301.59 Other histrionic personality disorder 301.6 Dependent personality disorder 301.7 Antisocial personality disorder 301.8 Other personality disorders 301.81 Narcissistic personality disorder 301.82 Avoidant personality disorder 301.83 Borderline personality disorder 301.84 Passive-aggressive personality 301.89 Other personality disorders 301.9 Unspecified personality disorder Plan for ICD-10 based on DRAFT ICD-10 2011; may change with FINAL ICD-10 manual in 2014 Exclusion ICD-10- Bipolar ICD-10 Code ICD-10 Description F30.10 Manic episode without psychotic symptoms, unspecified F30.11 Manic episode without psychotic symptoms, mild F30.12 Manic episode without psychotic symptoms, moderate F30.13 Manic episode, severe, without psychotic symptoms F30.2 Manic episode, severe with psychotic symptoms F30.3 Manic episode in partial remission F30.4 Manic episode in full remission

	F30.8 Other manic episodes F30.9 Manic episode, unspecified F31.0 Bipolar disorder, current episode hypomanic F31.10 Bipolar disorder, current episode manic without psychotic features, unspecified F31.11 Bipolar disorder, current episode manic without psychotic features, mild F31.12 Bipolar disorder, current episode manic without psychotic features, moderate F31.13 Bipolar disorder, current episode manic without psychotic features, severe F31.2 Bipolar disorder, current episode manic severe with psychotic features F31.30 Bipolar disorder, current episode depressed, mild or moderate severity, unspecified F31.31 Bipolar disorder, current episode depressed, mild F31.32 Bipolar disorder, current episode depressed, moderate F31.4 Bipolar disorder, current episode depressed, severe, without psychotic features F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features F31.60 Bipolar disorder, current episode mixed, unspecified F31.61 Bipolar disorder, current episode mixed, mild F31.62 Bipolar disorder, current episode mixed, moderate F31.63 Bipolar disorder, current episode mixed, severe, without psychotic features F31.64 Bipolar disorder, current episode mixed, severe, with psychotic features F31.70 Bipolar disorder, currently in remission, most recent episode unspecified F31.71 Bipolar disorder, in partial remission, most recent episode hypomanic F31.72 Bipolar disorder, in full remission, most recent episode hypomanic F31.73 Bipolar disorder, in partial remission, most recent episode manic F31.74 Bipolar disorder, in full remission, most recent episode manic F31.75 Bipolar disorder, in partial remission, most recent episode depressed F31.76 Bipolar disorder, in full remission, most recent episode depressed F31.77 Bipolar disorder, in partial remission, most recent episode mixed F31.78 Bipolar disorder, in full remission, most recent episode mixed F31.81 Bipolar II disorder F31.89 Other bipolar disorder F31.9 Bipolar disorder, unspecified Exclusion ICD-10- Personality Disorder ICD-10 Code ICD-10 Description F21 Schizotypal disorder F34.0 Cyclothymic disorder F60.0 Paranoid personality disorder F60.1 Schizoid personality disorder F60.2 Antisocial personality disorder F60.3 Borderline personality disorder F60.4 Histrionic personality disorder F60.5 Obsessive-compulsive personality disorder F60.6 Avoidant personality disorder F60.7 Dependent personality disorder F60.81 Narcissistic personality disorder F60.89 Other specific personality disorders F60.9 Personality disorder, unspecified F68.10 Factitious disorder, unspecified

	F68.11 Factitious disorder with predominantly psychological signs and symptoms F68.12 Factitious disorder with predominantly physical signs and symptoms F68.13 Factitious disorder with combined psychological and physical signs and symptoms F68.8 Other specified disorders of adult personality and behavior F69 Unspecified disorder of adult personality and behavior
Risk Adjustment	Stratification by risk category/subgroup Risk adjustment to the statewide average severity mix based on a patient's initial PHQ-9 score. This measure is risk adjusted based on severity band of the PHQ-9 which is based on the initial PHQ-9 score. Severity bands are defined as 10 to 14- moderate Attachment Depression_Report_2013-03-03-634982930516453636.pdf
Stratification	This measure is currently not stratified. We are contemplating stratification functionality on our consumer facing public website, MN HealthScores at www.mnhealthscores.org that would allow results to be displayed in total or by practice specialty of beha
Type Score	Rate/proportion better quality = higher score
Algorithm	This measure is calculated by submitting a visit level file for the eligible patients, each record in the file represents a contact with the patient and PHQ-9 score associated with this contact. Data file is submitted to a HIPAA secure data portal. Programming within the data portal determines the starting point (index visit) and then calculates based on dates if a twelve month +/- 30 days PHQ-9 was obtained and the resulting score. Calculation logic: Is patient eligible for inclusion with diagnosis codes of either 296.2x, 296.3x or 300.4 and PHQ-9 > 9? If yes, mark the visit as index (anchor) and include this patient in the denominator. Does patient have a PHQ-9 score completed with a contact date that is twelve months +/- 30 days from the index date? If yes, include this score to calculate rate. Programming logic includes the most recent score within the +/- 30 day window. If no, patient is included in the denominator only. Not having a PHQ-9 score within the +/- 30 day window is considered a numerator miss. If the patient does have a twelve month +/- 30 day PHQ-9 score, is it reduced from the initial PHQ-9 score by 50% or greater? If yes; patient is considered a numerator case for rate calculation. Attachment Measure Algorithm for Twelve Month Response 2012.pdf
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	1922 HBIPS-1 Admission Screening
Status	New Submission
Steward	The Joint Commission Other organizations: The hospital-based, inpatient psychiatric services measure set was developed in collaboration with the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Mental Health Program Directors Research Institute (NRI Inc.). Input was also provided by the American Psychiatric Association (APA).
Description	The proportion of patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are 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 and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed. URL http://manual.jointcommission.org/releases/TJC2013A/DataDictionaryIntroductionTJC.html#AlphaDataElementList
Level	Facility, Population : National
Setting	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient
Numerator Statement	Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths
Numerator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Five data elements are used to calculate the numerator: 1. Patient Strengths - Documentation in the medical record that an admission screening for a minimum of two patient strengths was performed within the first three days of admission. Allowable values: Yes, No/UTD or unable to complete admission screening. 2. Psychological Trauma History - Documentation in the medical record that an admission screening for a psychological trauma history was performed within the first three days of admission. Allowable values: Yes, No/UTD or unable to complete admission screening. 3. Substance Use - Documentation in the medical record that an admission screening for alcohol and substance use which occurred over the past twelve (12) months was performed within the first three days of admission. Allowable values: Yes, No/UTD or unable to complete admission screening. 4. Violence Risk to Others - Documentation in the medical record that an admission screening for violence risk to others over the past six months was performed within the first three days of admission. Allowable values: Yes, No/UTD or unable to complete admission screening. 5. Violence Risk to Self - Documentation in the medical record that an admission screening for violence risk to self over the past six months was performed within the first three days of

	admission. Allowable values: Yes, No/UTD or unable to complete admission screening. Patients are eligible for the numerator population when the allowable value equals "yes" for all five data elements: Patient Strengths, Psychological Trauma History, Substance Use, Violence Risk to Others and Violence Risk to Self as defined above.
Denominator Statement	Psychiatric inpatient discharges
Denominator Details	Time Window: Episode of care which is the entire hospitalization from admission to discharge. Six 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. ICD-9-CM Other Diagnosis Codes - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the secondary diagnoses for this hospitalization. 5. ICD-9-CM Principal Diagnosis Code - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization. 6. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No. Populations: Discharges with Table 10.01 Mental Disorders in the Psychiatric Care Setting.
Exclusions	• Patients for whom there is an inability to complete admission screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths within the first three days of admission due to the patient's inability or unwillingness to answer screening questions • Patients with a Length of Stay = or less than 3 days or = or greater than 365 days
Exclusion Details	• Patients for whom screening cannot be completed due to the patient's inability or unwillingness to answer assessment questions within the first three days of admission OR patients with a previous admission to the psychiatric unit during a single hospitalization. • Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is less than 3 days or greater than 365 days, the patient is excluded.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
Stratification	The measure is stratified by the following age groups: • Children (1 through 12 years) • Adolescent (13 through 17 years) • Adult (18 through 64 years) • Older Adult (=65 years)
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Run all cases that are included in the Initial Patient Population for HBIPS-1,4,5,6,7 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure 2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date. 3. Check Length of Stay a. If Length of Stay is less than or equal to 3 days or greater than or equal to 365 days, 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 3 days and less than 365 days, continue processing and

	proceed to Psychiatric Care Setting. 4. Check Psychiatric Care Setting a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing. b. If Psychiatric Care Setting equals Yes, continue processing. 5. Initialize Missing Counter to equal zero. Initialize No Screening Counter to equal zero, Initialize Incomplete Screening Counter to equal zero. Continue processing and proceed to Patient Strengths. 6. Check Patient Strengths a. If Patient Strengths equals No, add one to No Screening Counter. Continue processing and proceed to Psychological Trauma History. b. If Patient Strengths is missing, add one to Missing Counter. Continue processing and proceed to Psychological Trauma History. c. If Patient Strengths equals Yes or X, Continue processing and proceed to check Patient Strengths. 7. Check Patient Strengths a. If Patient Strengths equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Psychological Trauma History. b. If Patient Strengths equals Yes, Continue processing and proceed to Psychological Trauma History. 8. Check Psychological Trauma History a. If Psychological Trauma History equals No, add one to No Screening Counter. Continue processing and proceed to Substance Use. b. If Psychological Trauma History is missing, add one to Missing Counter. Continue processing and proceed to Substance Use. c. If Psychological Trauma History equals Yes or X, Continue processing and proceed to check Psychological Trauma History. 9. Check Psychological Trauma History a. If Psychological Trauma History equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Substance Use. b. If Psychological Trauma History equal Yes, Continue processing and proceed to Substance Use. 10. Check Substance Use a. If Substance Use equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Others. b. If Substance Use is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Others. c. If Substance Use equals Yes or X, Continue processing and proceed to check Substance Use. 11. Check Substance Use a. If Substance Use equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Others. b. If Substance Use equal Yes, Continue processing and proceed to Violence Risk to Others. 12. Check Violence Risk to Others a. If Violence Risk to Others equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Self. b. If Violence Risk to Others is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Self. c. If Violence Risk to Others equals Yes or X, Continue processing and proceed to check

	Violence Risk to Others. 13. Check Violence Risk to Others a. If Violence Risk to Others equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Self. b. If Violence Risk to Others equal Yes, Continue processing and proceed to Violence Risk to Self. 14. Check Violence Risk to Self a. If Violence Risk to Self equals No, add one to No Screening Counter. Continue processing and proceed to Incomplete Screening Counter. b. If Violence Risk to Self is missing, add one to Missing Counter. Continue processing and proceed to Incomplete Screening Counter. c. If Violence Risk to Self equals Yes or X, Continue processing and proceed to check Violence Self. 15. Check Violence Risk to Self a. If Violence Risk to Self equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Incomplete Screening Counter. b. If Violence Risk to Self equal Yes, Continue processing and proceed to Incomplete Screening Counter. 16. Check Incomplete Screening Counter a. If Incomplete Screening Counter equals 5, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Continue processing and proceed to initialize the Measure Category Assignment for each strata measure. b. If Incomplete Screening Counter is less than five, continue processing and proceed to Missing Counter. 17. Check Missing Counter a. If Missing Counter is more than zero, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-1a) and will be rejected. Proceed to step initialize the Measure Category Assignment for each strata measure. b. If Missing Counter equals zero, continue processing and proceed to No Screening Counter. 18. Check No Screening Counter a. If No Screening Counter is greater than zero, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-1a) and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure. b. If No Screening Counter equals zero, the case will proceed to a Measure Category Assignment of E and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure. 19. Initialize the Measure Category Assignment for each strata measure (b-e) equal 'B'. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-1a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-1a) Measure Category Assignment. Continue processing and proceed to Overall Rate Category Assignment. 20. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals B or X, retain the Measure Category Assignment for the strata measures (HBIPS-1b through HBIPS-1e) equals B. Stop processing. b. If Overall Rate Category Assignment equals D or E, continue processing and proceed to Patient Age at Discharge. 21. Check Patient Age at Discharge

	a. If Patient Age at Discharge is greater than or equal to 1 year and less than 13 years, set the Measure Category Assignment for the measure HBIP-1b equal to Measure Category Assignment for measure HBIP-1a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 13 years, continue processing and proceed to Patient Age at Discharge. 22. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 13 years and less than 18 years, set the Measure Category Assignment for the measure HBIP-1c equal to Measure Category Assignment for measure HBIP-1a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 18 years, continue processing and proceed to Patient Age at Discharge. 23. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 18 years and less than 65 years, set the Measure Category Assignment for the measure HBIP-1d equal to Measure Category Assignment for measure HBIP-1a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 65 years, set the Measure Category Assignment for the measure HBIP-1e equal to Measure Category Assignment for measure HBIP-1a. Stop processing. URL http://manual.jointcommission.org/releases/TJC2013A/MIF0116.html
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	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
Status	New Submission
Steward	American Medical Association - convened Physician Consortium for Performance Improvement (AMA-convened PCPI) Other organizations: The measure was developed by a multi-disciplinary, cross-speciality work group representing all key stakeholders and including representation from the following specialties, most of whom were sponsored by their medical specialty society: family medicine, internal medicine, geriatric medicine, gastroenterology, general surgery, colon & rectal surgery, infectious disease, radiology, cardiology, obstetrics & gynecology, emergency medicine, preventive medicine, occupational medicine, nursing, psychology, occupational therapy, chiropractics, dietetics, optometry.
Description	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Type	Process
Data Source	Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry Not applicable. Attachment AMA-PCPI_eSpec_PCS-UnhealthyAlcohol_Mar_2013.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic, Other, Behavioral Health/Psychiatric : Outpatient Occupational Therapy
Numerator Statement	Patients who were screened for unhealthy alcohol use* at least once during the two-year measurement period using a systematic screening method** AND who received brief counseling*** if identified as an unhealthy alcohol user *Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men <=65 years of age. **A systematic method of assessing for unhealthy alcohol use should be utilized. Systemic screening methods include but are not limited to: AUDIT Screening Instrument CAGE Screening Instrument AUDIT-C Screening Instrument Single Item Screening Instrument Alternative approaches may also include questions regarding quantity/frequency of consumption (ie, drinks per week or drinks per occasion). ***Brief counseling refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking5.
Numerator Details	Time Window: Once during the 24 month measurement period For EHR Specifications:

	eSpecifications attached
Denominator Statement	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two-year measurement period
Denominator Details	Time Window: 24 consecutive months Note: for certain implementation programs that cannot support a 2 year measurement period, the measure can be reported within a 12 month period with a 24 month look back for the numerator details. For EHR Specifications: eSpecifications attached
Exclusions	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)
Exclusion Details	The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (eg, limited life expectancy, other medical reasons) not screening for unhealthy alcohol use. Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Additional details by data source are as follows: For EHR Specifications: eSpecifications attached
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for exception when exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with

	valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in eSpecification attachment (see 2a1.30).
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Appendix B: Project Steering Committee and NQF Staff

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Appendix C: Measures Endorsed in Behavioral Health

NQF Number	Title	Steward
0003	Bipolar Disorder: Assessment for diabetes	Center for Quality Assessment and Improvement in Mental Health
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	National Committee for Quality Assurance
0008	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	Agency for Healthcare Research and Quality
0011	Promoting Healthy Development Survey (PHDS)	Oregon Health & Science University
0027	Medical Assistance with Smoking and Tobacco Use Cessation	National Committee for Quality Assurance
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	American Medical Association-Physician Consortium for Performance Improvement
0103	Major Depressive Disorder: Diagnostic Evaluation	American Medical Association - Physician Consortium for Performance Improvement
0104	Major Depressive Disorder: Suicide Risk Assessment	American Medical Association - Physician Consortium for Performance Improvement
0105	Antidepressant Medication Management (AMM)	National Committee for Quality Assurance
0106	Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents	Institute for Clinical Improvement
0107	Management of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents	Institute for Clinical Improvement
0108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication.	National Committee for Quality Assurance
0109	Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors	Center for Quality Assessment and Improvement in Mental Health
0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Center for Quality Assessment and Improvement in Mental Health
0111	Bipolar Disorder: Appraisal for risk	Center for Quality Assessment and

	of suicide	Improvement in Mental Health
0112	Bipolar Disorder: Level-of-function evaluation	Center for Quality Assessment and Improvement in Mental Health
0260	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	RAND Corporation
0316	Back Pain: Mental Health Assessment	National Committee for Quality Assurance
0418	Screening for Clinical Depression	Center for Medicare and Medicaid Services
0518	Depression Assessment Conducted	Center for Medicare and Medicaid Services
0552	HBIPS-4: Patients discharged on multiple antipsychotic medications.	The Joint Commission
0557	HBIPS-6 Post discharge continuing care plan created	The Joint Commission
0558	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	The Joint Commission
0560	HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	The Joint Commission
0576	Follow-Up Hospitalization for Mental Illness	National Committee for Quality Assurance
0580	Bipolar antimanic agent	Resolution Health
0595	Lithium Annual Lithium Test in ambulatory setting	Resolution Health
0596	Lithium Annual Thyroid Test in ambulatory setting	Resolution Health
0609	Lithium Annual Creatinine Test in ambulatory setting	Resolution Health
0629	Male Smokers or Family History of Abdominal Aortic Aneurysm (AAA) - Consider Screening for AAA	ActiveHealth Management
0640	HBIPS-2 Hours of physical restraint use	The Joint Commission
0641	HBIPS-3 Hours of seclusion use	The Joint Commission
0690	Percent of Residents Who Have Depressive Symptoms (Long-Stay)	Center for Medicare and Medicaid Services
0710	Depression Remission at Twelve Months	Minnesota Community Measurement
0711	Depression Remission at Six Months	Minnesota Community Measurement
0712	Depression Utilization of the PHQ-9 Tool	Minnesota Community Measurement
0722	Pediatric Symptom Checklist	Massachusetts General Hospital
0726	Inpatient Consumer Survey (ICS)	National Association of State Mental

	consumer evaluation of inpatient behavioral health services	Health Program Directors Research, Instit., Inc. (NRI)
1341	Autism Screening	National Committee for Quality Assurance
1346	Children Who Are Exposed To Secondhand Smoke Inside Home	Maternal and Child Health Bureau, HRSA
1364	Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation	American Medical Association - Physician Consortium for Performance Improvement
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	American Medical Association - Physician Consortium for Performance Improvement
1385	Developmental screening using a parent completed screening tool (Parent report, Children 0-5)	Maternal and Child Health Bureau, HRSA
1394	Depression Screening By 13 years of age	National Committee for Quality Assurance
1399	Developmental Screening by 2 Years of Age	National Committee for Quality Assurance
1401	Maternal Depression Screening	National Committee for Quality Assurance
1406	Risky Behavioral Assessment or Counseling by Age 13 Years	National Committee for Quality Assurance
1448	Developmental Screening in the First Three Years of Life	National Committee for Quality Assurance and the Child and Adolescent Health measurement Initiative
1507	Risky Behavior Assessment or Counseling by Age 18 Years	National Committee for Quality Assurance
1515	Depression Screening By 18 years of age	National Committee for Quality Assurance
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Florida Medical Quality Assurance, Inc.
1927	Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications	National Committee for Quality Assurance
1932	Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)	National Committee for Quality Assurance
1933	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)	National Committee for Quality Assurance
1934	Diabetes monitoring for people with diabetes and schizophrenia (SMD)	National Committee for Quality Assurance
1937	Follow-Up After Hospitalization for	National Committee for Quality

	Schizophrenia (7- and 30-day)	Assurance
2020	Adult Current Smoking Prevalence	Legacy
2111	Antipsychotic Use in Persons with Dementia	Pharmacy Quality Alliance

Appendix D: Measure Developer Responses to NQF Notice of Related and Competing Measures

Alcohol Use: Developer Responses

Measure Number	Title	Steward
1661	SUB-1 Alcohol Use Screening	The Joint Commission
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	The Joint Commission
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
1665	SUB-4 Alcohol & Drug Use: Assessing Status After Discharge	The Joint Commission
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI

Response from PCPI:

For the upcoming review of AMA PCPI measures in the behavioral health projects, we offer the following information for consideration by the steering committee.

Substance Use Related Measures – PCPI Measure (NQF#2152) Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Among the many measures included in this category, two measures developed by The Joint Commission (TJC) appear to related to 2152 - 1661: SUB-1 Alcohol Use Screening and 1663: SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention. We have discussed the measures and their various elements in detail with our colleagues at TJC. In doing so, we believe that, for the most part, our measures are well aligned. The measures call for screening using a validated instrument but are not prescriptive as to what that may be, the measures allow for the exclusion of patients to whom the measure may not be appropriate (TJC includes both limited life expectancy and cognitive impairment whereas we include limited life expectancy as an example and allow for other medical reasons), the measures call for a brief intervention for patients identified as unhealthy alcohol users which focuses largely on increasing the patient's understanding of alcohol use and harms and motivating the patient to change risky behaviors. Should the steering committee identify additional possibilities for alignment, we are open to exploring modifications with our colleagues at TJC and our expert work group.

Response from The Joint Commission:

The four Joint Commission Substance Use (SUB) measures comprise the SUB core measure set. The measures are complementary to each other and are meant to be used as an entire set by hospitals to evaluate four key processes related to substance use. Measure 1661 SUB-1: Alcohol Use Screening evaluates the patient's alcohol use status. If a patient screens positive for unhealthy alcohol use, he or she is then eligible to be evaluated in the remaining three measures comprising the set. Measure 1663 SUB-2: Alcohol Use Brief Intervention Provided or Offered evaluates the patient receiving or refusing a brief intervention during the hospitalization. The sub-measure SUB-2a: Alcohol Use Brief Intervention

evaluates only the patients receiving a brief intervention during the hospitalization (i.e., those patients who refuse are not included in the measure). Measure 1664 SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge evaluates the patient receiving or refusing a prescription for medication for alcohol or drug use or a referral for addictions treatment at the time of discharge. The sub-measure SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge evaluates only the patients receiving a prescription for medication for alcohol or drug use or a referral for addictions treatment at the time of discharge (i.e., those patients who refuse are not included in the measure.) Measure 1665 SUB-4: Alcohol and Drug Use: Assessing Status after Discharge evaluates the patients receiving a follow up call to assess alcohol or drug use status, addictions treatment status or alcohol or drug use medication status.

All four Joint Commission measures evaluate patients 18 years of age or older who were hospitalized. Data is reported at an aggregate level for each hospital. The AMA-PCPI measure 2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling evaluates patients 18 years of age or older who were seen twice for any visits or had at least one preventive care visit during a 24 month period in an ambulatory care setting. Data is reported at the individual provider level. Measure 2152 only evaluates screening for unhealthy alcohol use and brief counseling if indicated. The Joint Commission measure set provides a comprehensive approach to identify unhealthy alcohol use, a brief intervention received or refused if indicated, a prescription for alcohol or drug use received or refused or a referral to addictions treatment received or refused at discharge and follow-up post discharge to determine alcohol or drug use status, alcohol or drug use medication status or addictions treatment status.

Based on the NQF decision logic SUB-1 and SUB-2 are related measures to measure 2152 with different target populations. Measure 2152 evaluates patients in an ambulatory setting of care and the level of analysis is performed at a provider level. SUB-1 and SUB-2 evaluate patients in a hospital setting and the level of analysis is performed at a facility level. All three measures evaluate patients 18 years of age or older.

Areas for Potential Harmonization:

SUB-1 determines unhealthy alcohol use with a validated screening tool, i.e., AUDIT, AUDIT-C, ASSIST, TWEAK, CRAFFT, MAST or G-MAST. In addition, patients with a blood alcohol test indicative of acute intoxication are considered to have unhealthy alcohol use. Measure 2152 determines unhealthy alcohol use with a validated screening tool, i.e., AUDIT CAGE or AUDIT-C. The SUB-1 measure specifications do not consider the CAGE tool to be appropriate for screening general populations, as it aims to identify only severely dependent patients. Additionally, SUB-1 excludes patients who are cognitively impaired, and the measure specifications have been revised to exclude patients receiving comfort measures only in the next version of the specifications manual. Measure 2152 excludes patients with a documented medical reason for not screening for unhealthy alcohol use, e.g., limited life expectancy; other medical reasons which may potentially include cognitive impairment. These measures could potentially be harmonized by expanding the list of the different types of validated tools and excluding the use of the CAGE tool and clarifying “other medical reasons” for measure 2152.

SUB-2 measure specifications describe a brief intervention as a qualified health care professional engaging the patient in a joint decision-making process regarding alcohol use and plans for follow-up that are discussed and agreed to which directly corresponds to the 5 A’s: Ask, Advise, Assess, Assist and

Arrange. The brief intervention is based on the VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders (SUD) page 21. Measure 2152 does not describe the methodology used for brief counseling. These measures could potentially be harmonized by describing the methodology used for brief counseling based on the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders for measure 2152.

Depression Diagnosis and Screening: Developer Responses

Measure Number	Title	Steward
0103	Major Depressive Disorder (MDD): Diagnostic Evaluation	PCPI
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	CMS / Quality Insights of PA
0518	Depression Assessment Conducted	CMS/Acumen/Oasis

Response from PCPI:

For the upcoming review of AMA PCPI measures in the behavioral health projects, we offer the following information for consideration by the steering committee.

Depression Screening & Diagnosis Related Measures – PCPI Measure (NQF#0103) Major Depressive Disorder (MDD): Diagnostic Evaluation

Among the many measures included in this category, we do not believe that any of the measures can be categorized as related or competing. Measure 0103 is focused on patients with a diagnosis of MDD and is designed to ensure that such patients receive a thorough diagnostic assessment and an evaluation of the degree of severity of the disorder. A diagnostic assessment can help clinicians tailor a patient's treatment to their needs and rule out general medical conditions or other psychiatric conditions which may be contributing to depressive symptomology. The other measures in this category are focused on screening undiagnosed patients for depression. The manner in which screening is defined for the general population is and should be very different than a diagnostic assessment for a diagnosed patient.

Response from Oasis QM team @ Abt Associates:

Relationship of measure #0518 to other NQF-endorsed Depression Diagnosis/Screening Measures

The OASIS QM team reviewed and compared #0518 with the other NQF-endorsed depression diagnosis and screening measures. We found differences in the focus, target population and care setting:

- Focus: the HH measure focus is the same as #1394, #1515, #1401 (depression screening), and partially the same as measures #0418, (i.e. #0418 includes documentation of a follow-up plan whereas #0518 does not);
- Target Population: the HH measure has a different target population than all other measures (i.e., #0518 includes only homebound adult, non-maternity Medicare and Medicaid patients receiving skilled services in the home);
- Care Setting: the HH measure was developed to be used in the HH setting only. It is calculated based on responses to the OASIS data set which is collected only in the HH setting. None of the other related measures were developed to be used in the HH setting.

Based on NQF's "Decision Logic to Identify Related and Competing Measures", measure #0518 would therefore be classified as a "related" rather than a "competing" measure with other depression screening measures on the NQF BH list.

Opportunities for Harmonization

We did find that there are opportunities for harmonization with NQF #0418, a CMS measure which is calculated based on HCPCS Clinical Quality Codes derived from claims. Both measures address screening for depression using a standardized depression screening tool. However there are differences between the numerators, denominators and exclusions

- Numerator:
  - #0518 – The numerator is screening done with a standardized depression screening tool
  - #0418 – The numerator is screening done with a standardized depression screening tool and if positive, a follow-up plan is documented
- Denominator:
  - #0518 – The denominator is an episode of care in the Home Health Care setting to be reported for each episode of care.
  - #0418 – The denominator is reported once [per patient] for various identified encounters to be reported once per measurement period. This denominator could be expanded to include the home health setting but there is a difference between the reporting requirements
- Exclusions:
  - #0518 – excludes only episodes in which the patient was nonresponsive at the time of assessment,
  - #0418 – the patient is defined as not eligible for the screening and excluded from the denominator for additional reasons including patient refusal, patient having a previous diagnosis of depression and several other reasons (discussed below in more detail).

Issues regarding potential harmonization of these two measures:

Numerator
In a previous communication, we provided NQF with the rationale for the differences between the HH measure #0518 and measure #0418 related to incorporation of a follow-up plan. When the Home Health Process Measures were first submitted to NQF in 2008, CMS proposed that measurement include a requirement that a follow-up plan be documented in the physician-ordered plan of care for patients that screened positive for depression, and also documentation that the follow-up plan was implemented by the time of discharge. NQF reviewers felt that these requirements presented too much of a challenge for providers in the home health setting, noting the lack of control that home health providers had in implementing interventions that might require action by the patient's physician, and the lack of mental health providers in some areas of the country.

The measure developer is open to revisiting these issues. The addition of a requirement for follow-up is feasible since the OASIS dataset now collects information on documentation and implementation of follow-up plans, and CMS calculates two separate measures based on those data and makes them available to agencies for use in their quality improvement efforts.

The definition of follow-up plan in the OASIS currently is that the physician-ordered plan of care include "depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment". This is slightly different from how the follow-up plan is defined in #0418, but the OASIS could potentially be revised to include a definition similar to #0418 since the OASIS-C is also undergoing revision so that there is a unique, time-limited opportunity for incorporation of language in the OASIS data set to support a measure revision.

One is issue is that the definition of follow-up plan in measure #0418 appears to have two components: it "must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider". While a requirement for further evaluation is appropriate in a Clinician Office/Clinic, Hospital/Acute Care/Post Acute/Long Term Care Facility, it may not be realistic in a home health setting where the care home health clinician may not have the preparation/qualification to conduct further evaluation and must rely on the referring physician to write orders for consultations. Another consideration would be whether the follow-up plan must be in place at the time of the completion of the Start of Care assessment when the depression screening is conducted, or whether it must be in place at the time the episode of home health care ends. In the (non-endorsed) measures currently being reported to home health agencies, the plan must be in place at the time of the Start of Care assessment, and must have been implemented at the time of discharge.

Denominator
The data collection that supports #0518 "Depression Assessment Conducted" (and also the item that documents a follow-up plan) is conducted at the beginning of the home health episode and is reported once for each episode of HH care. A HH episode can last anywhere from a few days to multiple years. We will explore with the developers of measure #0418 whether there is a way that the denominator for their measure could be expanded to include the home health setting.

Exclusions
The home health measure excludes only "Episodes in which the patient was nonresponsive at the time of assessment," In #0418, the patient is defined as not eligible for the screening and excluded from the denominator if one or more of the following conditions exist:

1. Patient refuses to participate
2. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
3. Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
4. Patient was referred with a diagnosis of depression
5. Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period
6. Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

We believe there is an opportunity for harmonization of some of these exclusions:

- Exclusion 1 is open for discussion. The HH measure does not exclude patients who refuse, preferring that they be included in the measure as "not screened". The rationale is similar to a patient refusing an influenza or pneumonia immunization and being retained in the denominator. We believe that excluding those patients can provide an inaccurate perception of that percent of patients that actually received a screening. Also, depression screening can be a

challenge for some clinicians and how the clinician approaches the patient influences response rate. We are concerned about providing clinicians with a way to avoid screening as well as potentially distorting the rate of patient's being assessed for depression by leaving "refusals" out.

- Exclusions #2 and #3 do not seem relevant or appropriate to the HH setting.
- Exclusions #4 and #5 exclude patients who have been previously screened, have a diagnosis of depression or are currently in treatment for depression. The HH measure checks on depressive symptoms with the idea that there should be an "action plan" if the patient is having those depressive symptoms regardless of whether they have been previously diagnosed. Changes to this component require further discussion
- Exclusion #6 -the home health measure exclusions for " nonresponsive at the time of assessment," is generally aligned with this and the wording used in #6 could be substituted/incorporated into the OASIS item or guidance.

Next Steps

We have initiated discussions with the developers of #0418 to see gain further insight into the rationale for the exclusions for that measure, and look forward to NQF's insights into the best direction for us to proceed toward the goal of maximizing harmonization of the HH measure of depression screening.

Response from Quality Insights of PA:

Quality Insights of Pennsylvania has analyzed and compared the behavioral health measures NQF #0103 and NQF #0518 to CMS/QIP measure NQF #0418.

Quality Insights feels that NQF# 0103 addresses a different focus and population than NQF #0418 and hence these two measures cannot be harmonized.

- 0103 is addressing patients with a new diagnosis or recurrent episode of major depressive disorder.
- 0418 is targeting all patients aged 12 years and older and screening for depression or a depressive disorder thus excluding patients who already have an active diagnosis of depression or bipolar disorder.

Although both measures use standardized screening tools, the tools are addressing two very diverse populations. Additionally, NQF #0418 has a more robust numerator which includes not only a screening for depression but also a follow-up for a positive screen. NQF #0103 does not required a follow-up plan for a positive depression screen.

Quality Insights feels that NQF #0518 is partially related to NQF #0418 and there is a potential for harmonization. Both measures address screening for depression using a standardized depression screening tool. However there are differences between the denominators and numerators

- Denominators:
  - #0518 – The denominator is an episode of care in the just the Home Health Care setting, to be reported for each episode of care.

    - #0418 – The denominator is reported once office visit for various identified encounters with a scope much larger than NQF #0518. The frequency of reporting for this measure is once per measurement period.
    - NQF# 0418 could be expanded to include the home health setting encounters, but there is a difference between the reporting requirements which would need discussion
- Numerators:
    - #0518 – The numerator is screening done with a standardized depression screening tool
    - #0418 – The numerator is screening done with a standardized depression screening tool and if positive, a follow-up plan is documented.

Quality Insights is willing to work with the stewards of #0518 to attempt to harmonize their measure NQF #0518 into NQF #0418 if this is feasible due to the different reporting process (episode of care vs. visit).

Depression Screening and Follow-up: Developer Responses

Measure Number	Title	Steward
1884	Depression Response at Six Months	MN Community Measurement
1885	Depression Response at Twelve Months	MN Community Measurement

Response from MN Community Measurement:

These five measures are harmonized and they are related.

The remission measures are patient reported outcome measures, that each evaluate the patient's improvement in symptoms over time, first at six months than later at twelve months. The denominator include patients with major depression and dysthymia and an elevated PHQ-9 score, and it is at the date that the PHQ-9 score is elevated that starts the forward (prospective) count to determine if there is an improvement at the two follow-up points in time. This measure is considered our ultimate desired outcome because remission means that the patient has little or no symptoms of depression and this is demonstrated at a PHQ-9 score less than five.

The response measures are also patient reported outcome measures of the same population and same method, except it is an intermediate outcome. The numerator is looking for a PHQ-9 score that is reduced by 50% or more at the two follow-up points in time. This measure is viewed as progressing toward remission

The fifth measure, utilization of the PHQ-9, is a process measure that supports the four outcome measures above. Same diagnosis criteria is used, same exclusions. The only difference is that this measure is for all patients with depression and dysthymia, and does not have the additional criteria of an elevated PHQ-9 to be part of the denominator.

Both the remission and response measures are currently used for public reporting and pay for performance programs in Minnesota.

Medication Adherence: Developer Responses

Measure Number	Title	Steward
0105	Antidepressant Medication Management (AMM)	NCQA
1880	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	FMQAI

Response from NCQA:

After closely reviewing the measure comparisons, we determined that NCQA's *0105: Antidepressant Medication Management (AMM)* is not a related or competing measure to the Health Benchmarks-IMS Health and CMS measures. Using NQF's decision logic for related and competing measures, *Antidepressant Medication Management (AMM)'s* target population is specific to major depression which differs from the other measures' target populations (i.e. bipolar disorder, schizophrenia or schizoaffective disorder, individuals on chronic medications or statin therapy). The level of analysis for the NCQA measure is specific only to Health Plan and Integrated Delivery System. The other measures mainly focus on the Clinician Level.

Response from FMQAI:

The target population (bipolar versus major depression) and the underlying concept (chronic adherence versus persistent treatment in the acute and continuation phase) are very different. The data sources (administrative claims) and the age of the eligible population (18 and older) are similar. After a careful review of the specifications for both measures, we did not identify any opportunities for harmonization and have concluded that the measures are not closely related or competing.

Tobacco Use: Developer Responses

Measure Number	Title	Steward
1651	TOB-1 Tobacco Use Screening	The Joint Commission
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	The Joint Commission
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
1657	TOB-4 Tobacco Use: Assessing Status after Discharge	The Joint Commission

Response from The Joint Commission:

The four Joint Commission TOB measures comprise the TOB core measure set. The measure are complementary to each other and are meant to be used as an entire set by hospitals to evaluate four key processes related to tobacco treatment. TOB-1: Tobacco Use Screening evaluates the patient's tobacco use status. If a patient is identified as a current tobacco user, he or she is then eligible to be evaluated in the remaining three measures comprising the set. TOB-2: Tobacco Use Treatment Provided or Offered evaluates the patient receiving or refusing practical counseling and tobacco cessation medication if indicated during the hospitalization. The sub-measure TOB-2a: Tobacco Treatment evaluates only the patients receiving practical counseling and tobacco cessation medication if indicated during the hospitalization (i.e., those patients who refuse are not included in the measure). TOB-3: Tobacco Use Treatment Provided or Offered at Discharge evaluates the patient receiving or refusing a referral to outpatient counseling and a prescription for tobacco cessation medication if indicated at the time of discharge. The sub-measure TOB-3a: Tobacco Use Treatment at Discharge evaluates only the patients receiving a referral to outpatient counseling and a prescription for tobacco cessation medication if indicated at the time of discharge (i.e., those patients who refuse are not included in the measure.) TOB-4: Tobacco Use: Assessing Status after Discharge evaluates the patients receiving a follow up call to assess tobacco use status, outpatient counseling status and tobacco cessation medication status if indicated.