



## Measure Information

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

### Brief Measure Information

**NQF #:** 1651

**Corresponding Measures:**

**De.2. Measure Title:** TOB-1 Tobacco Use Screening

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

**De.3. Brief Description of Measure:** Hospitalized patients age 18 years and older who are screened within the first day of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days.

**1b.1. Developer Rationale:** It was the expert opinion of our advisory panel that implementation of this measure would lead to increased rates of tobacco use cessation.

Routine screening of hospitalized patients will identify those patients who use tobacco products and would benefit from cessation interventions. Hospitalization is an ideal time to encourage smokers to quit. During hospitalization, smokers are not allowed to smoke, are in contact with many health professionals, and may be more willing to accept assistance in quitting. (1) Many smokers quit, unaided, following hospitalization. (2) A meta-analysis found that those who receive intensive treatment during hospitalization and outpatient follow-up treatment for at least one month are more likely to quit than smokers receiving no treatment.(1,3)

**S.4. Numerator Statement:** The number of patients who were screened for tobacco use status within the first day of admission.

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

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

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who have a length of stay less than or equal to one day or greater than 120 days
- Patients who are receiving comfort measures only

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

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

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

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

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

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

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

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

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

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

1651\_Evidence\_MSF5.0\_Data.doc

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

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

**1b. Performance Gap**

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

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

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

*If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.*

It was the expert opinion of our advisory panel that implementation of this measure would lead to increased rates of tobacco use cessation.

Routine screening of hospitalized patients will identify those patients who use tobacco products and would benefit from cessation interventions. Hospitalization is an ideal time to encourage smokers to quit. During hospitalization, smokers are not allowed to smoke, are in contact with many health professionals, and may be more willing to accept assistance in quitting. (1) Many smokers quit, unaided, following hospitalization. (2) A meta-analysis found that those who receive intensive treatment during hospitalization and outpatient follow-up treatment for at least one month are more likely to quit than smokers receiving no treatment.(1,3)

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

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

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

1. Rigotti N, Munafo M, Stead L. Interventions for smoking cessation in hospitalised patients. Cochrane Database Syst Rev. 2007;CD001837.[PubMed]
2. McBride CM, Emmons KM, Lipkus IM. Understanding the potential of teachable moments: The case of smoking cessation. Health Educ Res. 2003 Apr;18:156–170.[PubMed]
3. Rigotti NA, Munafo MR, Stead LF. Smoking cessation interventions for hospitalized smokers: A systematic review. Arch Intern Med. 2008 Oct 13;168:1950–1960.[PubMed]
4. Freund M, et al. Smoking care provision in hospitals: A review of prevalence. Nicotine Tob Res. 2008;10:757–774.[PubMed]
5. Koplan KE, et al. A computerized aid to support smoking cessation treatment for hospital patients. J Gen Intern Med. 2008 Aug;23:1214–1217. Epub May 9, 2008. [PMC free article][PubMed]
6. The Joint Commission. A Comprehensive Review of Development and Testing for National Implementation of Hospital Core Measures. 2002. [last accessed Sep. 16, 2009]. <http://www.jointcommission.org/NR/rdonlyres/48DFC95A-9C05-4A44-AB05-1769D5253014/0/AComprehensiveReviewofDevelopmentforCoreMeasures.pdf>.

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** *(This is required for maintenance of endorsement. Describe*

the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

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

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

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

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

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

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

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

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

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

Primary Prevention

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

Elderly

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

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

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

This is not an eMeasure Attachment:

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

**No data dictionary Attachment:**

**S.2c.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

**Attachment:**

**S.2d.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

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

Yes

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

Updates were made to the data element: Tobacco Use Status

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

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

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

The number of patients who were screened for tobacco use status within the first day of admission.

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

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

There is one data element used to calculate the numerator:

**Tobacco Use Status:**

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

There are 6 allowable values:

1 The patient has during the past 30 days:

- smoked, on average, 5 or more cigarettes ( $\geq \frac{1}{4}$  pack) daily, and/or
- smoked cigars and/or pipes daily.

2 The patient has during the past 30 days:

- smoked, on average, 4 or less cigarettes ( $< \frac{1}{4}$  pack) daily, and/or
- smoked cigarettes, cigars and/or pipes, but not daily, and/or
- used smokeless tobacco, regardless of frequency.

3 The patient has not used any forms of tobacco in the past 30 days.

4 The patient refused the tobacco use screen.

5 The patient was not screened for tobacco use during this hospitalization or unable to determine the patient's tobacco use status from medical record documentation.

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

Tobacco Use Status is used to screen or examine methodologically in order to make a separation into different groups that address

the various tobacco products or combinations thereof and the volume and frequency of use as well as the timeframe of use. Notes for abstraction are included along with suggested data sources. Full specifications for version 5.2a of the Specifications Manual for National Hospital Inpatient Quality Measures Discharges 01-01-17 through 12-31-17 can be viewed on the Joint Commission web site at the following link:

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

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

The number of hospitalized inpatients 18 years of age and older

**S.7. Denominator Details** *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

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

Five data elements are used to calculate the denominator:

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

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

There are 6 allowable values:

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

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

The denominator has four exclusions:

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who have a length of stay less than or equal to one day or greater than 120 days
- Patients who are receiving comfort measures only

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

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

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

Not Applicable, the measure is not stratified.

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

No risk adjustment or risk stratification

If other:

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

Rate/proportion

If other:

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

Better quality = Higher score

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

1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.
2. Calculate Patient Age. Patient Age, in years, is equal to the Admission Date minus the Birthdate. Use the month and day portion of Admission Date and Birthdate to yield the most accurate age. Only cases with valid Admission Date and Birthdate will pass the front end edits into the measure specific algorithms.
3. Check Patient Age
  - a. If Patient Age is less than 18 years, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
  - b. If Patient Age is equal to or greater than 18 years, continue processing and proceed to calculate Length of Stay.
4. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.
5. Check Length of Stay
  - a. If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
  - b. If Length of Stay is greater than 1 day, continue processing and proceed to check Comfort Measures Only.
6. Check Comfort Measures Only
  - a. If Comfort Measures Only is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
  - b. If Comfort Measures Only is equal to 1, 2, or 3, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
  - c. If Comfort Measures Only is equal to 4, continue processing and proceed to check Tobacco Use Status.

<p>7. Check Tobacco Use Status</p> <p>a. If Tobacco Use Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.</p> <p>b. If Tobacco Use Status equals 6, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.</p> <p>c. If Tobacco Use Status equals 1, 2, 3, 4, or 5, continue processing and proceed to re-check Tobacco Use Status.</p> <p>8. Recheck Tobacco Use Status</p> <p>a. If Tobacco Use Status equals 1, 2, 3, or 4, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.</p> <p>b. If Tobacco Use Status equals 5, the case will proceed to Measure Category Assignment of D and will be in the Measure Population. Stop processing.</p>
<p><b>S.15. Sampling</b> (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)</p> <p>IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed. The global Initial Patient Population is defined and identified by two data elements (Admission Date and Discharge Date). All patients discharged from acute inpatient care with Length of Stay (Discharge Date minus Admission Date less than or equal to 120 days) are included in the Global Initial Population and are eligible for sampling. Hospitals that choose to sample have the option of sampling quarterly or monthly. The sample is taken randomly as follows for a monthly sample.</p> <ul style="list-style-type: none"> <li>• Average monthly Initial Patient Population &gt; or = 510 results in a minimum random sample size of 102</li> <li>• Average monthly Initial Patient Population &gt; or = 255 – 509 results in a random sample of 20% of the population size</li> <li>• Average monthly Initial Patient Population &gt; or = 51 – 254 results in a random sample of 51</li> <li>• Average monthly Initial Patient Population &lt; 51: No sampling, 100% population required.</li> </ul> <p><b>S.16. Survey/Patient-reported data</b> (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)</p> <p>Specify calculation of response rates to be reported with performance measure results.</p>
<p><b>S.17. Data Source</b> (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).</p> <p>If other, please describe in S.18.</p> <p>Electronic Health Records, Paper Medical Records</p> <p><b>S.18. Data Source or Collection Instrument</b> (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)</p> <p>IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration. Each data element in the data dictionary includes suggested data sources.</p> <p>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.</p> <p><b>S.19. Data Source or Collection Instrument</b> (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</p> <p><b>S.20. Level of Analysis</b> (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)</p> <p>Facility, Other</p> <p><b>S.21. Care Setting</b> (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)</p> <p>Inpatient/Hospital</p> <p>If other:</p>
<p><b>S.22. COMPOSITE Performance Measure</b> - Additional Specifications (Use this section as needed for aggregation and weighting rules,</p>

or calculation of individual performance measures if not individually endorsed.)

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

[1651\\_MeasureTesting\\_MSF5.0\\_Data.zip](#)

### 2.1 For maintenance of endorsement

*Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.*

### 2.2 For maintenance of endorsement

*Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.*

### 2.3 For maintenance of endorsement

*Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.*

## 3. Feasibility

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

### 3a. Byproduct of Care Processes

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

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

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

### 3b. Electronic Sources

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

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

[Some data elements are in defined fields in electronic sources](#)

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

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

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

**Attachment:**

### **3c. Data Collection Strategy**

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

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

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

Notes for abstraction have been clarified as noted above to improve data element reliability. During the pilot test, it was noted that hospitals frequently did not have enough time to see or screen patients who had a short length of stay (LOS) of 1 day or less. As a result, patients who have a length of stay one day or less are excluded from the measure. A sampling strategy was not provided for the pilot test however, sampling will be available for hospitals when the measures are implemented for The Joint Commission in 1/1/2012.

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

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

## **4. Usability and Use**

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

### **4a. Accountability and Transparency**

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

#### **4.1. Current and Planned Use**

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

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

**4a.1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:**

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

- Level of measurement and setting

**4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

**4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

**4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

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

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

**4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

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

**4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

**Describe how feedback was obtained.**

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

**4a2.2.2. Summarize the feedback obtained from those being measured.**

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

**4a2.2.3. Summarize the feedback obtained from other users**

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

**4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

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

#### **Improvement**

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

**4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**

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

#### **4b2. Unintended Consequences**

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

evidence exists).

**4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.**

**4b2.2. Please explain any unexpected benefits from implementation of this measure.**

## 5. Comparison to Related or Competing Measures

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

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

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

Yes

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

0027 : Medical Assistance With Smoking and Tobacco Use Cessation

0028 : Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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

### 5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

No

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

A conference call was held with NCQA, TJC and University of Wisconsin to discuss the differences in the measures from the three organizations. While the TJC and University of Wisconsin measure are harmonized there are differences between the AMA and NCQA measures. Differences were discussed with NCQA. Attempts were made to contact the AMA and an e-mail was received at the University of Wisconsin regarding the potential of harmonization. The AMA suggested they would be open to discussions if our measures were endorsed. Measures 0027 and 0028 are to be used in the outpatient environment. As such, patients are screened only once per year when they visit their general practitioner. The screening questions related to tobacco use are also different relative to the length of time since use, our measure defines current user as anyone who has used in the past 30 days and these measures define a current user as anyone who has used in the past year. Our basis for screening comes from the US Public Health Service Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update. The measure specifications provide a standardized definition for the use of tobacco products and the definition of a current tobacco user as anyone who has used in the past 30 days, however the specifications are not prescriptive in the exact questions that are to be used for screening. Only the volume used and the type of product need to be identified so that the measures can capture screening and treatment according to the guidelines. The hospitals are given latitude in how they obtain that information through screening. One could define a current user as one who has used in the past day or the past week, but then a person who does not smoke every day could be missed. Using the 30 day time frame provides standardization and assures that the current user will be identified consistently on a national level. Reliability studies were conducted on the data element during the pilot test and are addressed in the section on Scientific Acceptability, 2a2.3. The agreement rate for the data element Tobacco Use Status was 80.5%

#### 5b. Competing Measures

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

**OR**

Multiple measures are justified.

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

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

[Not applicable as the measures have different target populations.](#)

## Appendix

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**Attachment:**

## Contact Information

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

**Co.2 Point of Contact:** [John Marc Alban, \[jalban@jointcommission.org\]\(mailto:jalban@jointcommission.org\), 630-792-5304-](#)

**Co.3 Measure Developer if different from Measure Steward:** [The Joint Commission](#)

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

## Additional Information

**Ad.1 Workgroup/Expert Panel involved in measure development**

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

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

**Measure Developer/Steward Updates and Ongoing Maintenance**

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

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

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

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

**Ad.6 Copyright statement:** [The Specifications Manual for National Hospital Inpatient Quality Measures \(Specifications Manual\) is the result of the collaborative efforts of the Centers for Medicare & Medicaid Services \(CMS\) and The Joint Commission to publish a uniform set of national hospital quality measures. A primary objective of this collaborative effort is to promote and enhance the utility of these measures for all hospitals.](#)

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[Example Acknowledgement: The Specifications Manual for National Hospital Inpatient Quality Measures \[Version xx, Month, Year\] is the collaborative work of the Centers for Medicare & Medicaid Services and The Joint Commission. The Specifications Manual is](#)

periodically updated by the Centers for Medicare & Medicaid Services and The Joint Commission. Users of the Specifications Manual for National Hospital Inpatient Quality Measures must update their software and associated documentation based on the published manual production timelines.

**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:**