Influenza vaccination coverage among healthcare personnel

Percentage of healthcare personnel (HCP) who receive the influenza vaccination

Nominated by Dana Safran, BCBSMA

Priority Area: Appropriateness of hospital-based care
Steward: CDC
NOF Endorsed: (0431)

Summary

<table>
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<tr>
<th>Addresses SQAC Priority Area</th>
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<th>Minimum Scores</th>
<th>Overall Score</th>
<th>Rating</th>
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<td>14 (Average 3.5)</td>
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</table>

RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity
Minimum Score: 2

3 Overall, the measure tested well on validity and reliability, but there remain some questions about how HCP who declined vaccination were handled by different sites. Also, not every health care worker will have a medical record or chart to audit, so there is no gold standard for identifying those who have received vaccination.

Amenability to Targeted Improvement
No Minimum Score

3 Vaccination of health care workers has been associated with reduced work absenteeism and with fewer deaths among nursing home patients and elderly hospitalized patients. However, because workers can voluntarily decline vaccination, there are limits on how much improvement is reasonable.

Ease of Measurement
Minimum Score: 1

4 Already publicly reported by CMS.

Field Implementation
Minimum Score: 1

4 Already used and publicly reported by CMS on a facility level.

References

- NQF Measure Submission Forms:
HBIPS-1: Admission screening for violence risk, substance use, psychological trauma history and patient strengths completed

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.

Nominated by Dana Safran, BCBSMA

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Steward</th>
<th>NQF Endorsed (1922)</th>
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Summary

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RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity
Minimum Score: 2
3 All of the HBIPS measures have undergone a rigorous process of public comment, alpha testing and broad-scale pilot testing and are recognized by the field as important indicators of hospital-based inpatient psychiatric care.

Amenability to Targeted Improvement
No Minimum Score
3 There is strong evidence to support the efficacy and effectiveness of integrating traditional mental health treatment and addiction treatment. Improving on this measure requires better efforts to detect addiction in mental health patients. However, evidence that improving scores on this measure leads to more people receiving integrated treatment is limited.

Ease of Measurement
Minimum Score: 1
4 Already used and publicly reported by TJC on a facility level, but not available on Hospital Compare.

Field Implementation
Minimum Score: 1
4 Already used and publicly reported by TJC on a facility level.

References

- National Association of State Mental Health Program Directors (NASMHPD). Position statement on services and supports to trauma survivors. Alexandria (VA): NASMHPD; 2005
- Ziedonis DM. Integrated treatment of co-occurring mental illness and addiction: clinical intervention, program, and system perspectives. CNS Spectr. 2004 Dec;9(12):892-904, 925
HBIPS-2: Hours of physical constraint

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

Nominated by Dana Safran, BCBSMA

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Steward</th>
<th>NQF</th>
</tr>
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RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity

Minimum Score: 2

3  All of the HBIPS measures have undergone a rigorous process of public comment, alpha testing and broad-scale pilot testing and are recognized by the field as important indicators of hospital-based inpatient psychiatric care.

Amenability to Targeted Improvement

No Minimum Score

4  There are documented interventions that facilities can take to reduce use of physical constraints.

Ease of Measurement

Minimum Score: 1

4  Requires chart review, but is already publicly reported by CMS.

Field Implementation

Minimum Score: 1

4  Already used and publicly reported by CMS on a facility level.

References

- Donat DC. An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. Psychiatr Serv. 2003 Aug;54(8):1119-23
HBIPS-3: Hours of seclusion use

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.

Nominated by Dana Safran, BCBSMA

<table>
<thead>
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<th>Steward</th>
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<tr>
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RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity

Minimum Score: 2

| 3 | All of the HBIPS measures have undergone a rigorous process of public comment, alpha testing and broad-scale pilot testing and are recognized by the field as important indicators of hospital-based inpatient psychiatric care. |

Amenability to Targeted Improvement

No Minimum Score

| 4 | There are documented interventions that facilities can take to reduce use of seclusion. |

Ease of Measurement

Minimum Score: 1

| 4 | Requires chart review, but is already publicly reported by CMS |

Field Implementation

Minimum Score: 1

| 4 | Already used and publicly reported by CMS on a facility level. |

References

- Donat DC. An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. Psychiatr Serv. 2003 Aug;54(8):1119-23
SUB-1: Alcohol use screening

Hospitalized patients 18 years of age and older who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use.

Nominated by Dana Safran, BCBSMA

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Steward</th>
<th>NQF</th>
</tr>
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<tr>
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Summary

Addresses SQAC Priority Area

NQF-Endorsed or in a National Set

Minimum Scores

Overall Score: 10 (Average 2.5)

Rating: Good

RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity

Minimum Score: 2

3

The measure tested well, but there are some concerns over meaningful numbers of exclusions due to cognitive impairment and LOS <1 day.

Amenability to Targeted Improvement

No Minimum Score

2

There is evidence to support screening patients for alcohol use, but we were unable to find evidence for the exact population targeted by this measure. Also, the large number of exclusions may impact how improvements in screening are reflected by measure scores.

Ease of Measurement

Minimum Score: 1

2

There is public reporting on 3 VA hospitals in Massachusetts, but data for other facilities would need to come from administrative data and medical records.

Field Implementation

Minimum Score: 1

3

The measure is collected by TJC, but results are only available for a few hospitals in MA. Nationally, measure scores are available for VA hospitals but few others nationwide, as the measure may not have sufficient volume for many providers.

References

Median time to transfer to another facility for acute coronary intervention

The median time from emergency department (ED) arrival to time of transfer to another facility for acute coronary intervention (ACI) for ST-segment myocardial infarction (STEMI) patients that require a percutaneous coronary intervention (PCI).

Nominated by Dana Safran, BCBSMA

<table>
<thead>
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RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity
Minimum Score: 2

| 3 | NQF found the measure to be reliable but had limited concerns about validity due to large numbers of exclusions for one of the data elements. NQF also recommended that this measure be composited with other related measures. |

Amenability to Targeted Improvement
No Minimum Score

| 3 | There is evidence to support reducing time-to-treatment for patients with AMI. However, we were unable to find evidence that specifically reducing time-to-transfer improves outcomes. |

Ease of Measurement
Minimum Score: 1

| 3 | Requires chart abstracted data, but already used and publicly reported by CMS on a facility level. However, CMS does not report scores for most hospitals |

Field Implementation
Minimum Score: 1

| 4 | Already used and publicly reported by CMS on a facility level. |

References

- NQF Measure Submission Forms:
Aspirin at arrival

Percentage of emergency department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) without aspirin contraindications who received aspirin within 24 hours before ED arrival or prior to transfer.

Nominated by Dana Safran, BCBSMA

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Steward</th>
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<td>Appropriateness of hospital-based care</td>
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Summary

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</table>

No Alternative

RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity
Minimum Score: 2
3
There are no reliability results at the measure level, but the underlying claims data used for public reporting by CMS is extensively validated and considered the gold standard. Validity testing was strong.

Amenability to Targeted Improvement
No Minimum Score
3
NQF removed endorsement because this measure was “topped out”. However, scores voluntarily reported by MA hospitals do show some performance gap. There is evidence of a correlation between improved outcomes and immediate use of aspirin, but evidence supporting aspirin use any time within the first 24 hours is less clear.

Ease of Measurement
Minimum Score: 1
4
Requires chart review, but is already publicly reported by CMS.

Field Implementation
Minimum Score: 1
4
Already used and publicly reported by CMS on a facility level.

References

- Measure Submission and Testing Form:
- A Comprehensive Review of Development and Testing for National Implementation of Hospital Core Measures:
Median time to ECG

Median time from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with Probable Cardiac Chest Pain).

Nominated by Dana Safran, BCBSMA

Priority Area
Appropriateness of hospital-based care

Steward
CMS

NQF
Endorsement Removed (0289)

Summary

Addresses SQAC
Priority Area

NQF-Endorsed or in a National Set

Minimum Scores

Overall Score

Rating

✔

No Alternative

✔

11 (Average 2.75)

Good

RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity
Minimum Score: 2

2 Variation may exist in the assignment of ICD-10-CM codes; therefore, coding practices may require evaluation to ensure consistency. There may be additional variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Amenability to Targeted Improvement
No Minimum Score

1 NQF removed endorsement in 2014 for lack of evidence indicating that knowing the door to ECG time improves outcomes, particularly given that door to balloon time for STEMI patients is already measured. This measure is more distal to the outcome of treatment for STEMI patients; as such, the Committee did not find it to be necessary to endorse this measure, and consequently devote resources to calculating this measure, when the outcome measure is already available and in use.

Ease of Measurement
Minimum Score: 1

4 Requires chart review, but is already publicly reported by CMS.

Field Implementation
Minimum Score: 1

4 Already used and publicly reported by CMS on a facility level.

References

Acute stroke mortality rate

In-hospital deaths per 1,000 hospital discharges with acute stroke as a principal diagnosis for patients ages 18 years and older. Includes metrics for discharges grouped by type of stroke. Excludes obstetric discharges and transfers to another hospital.

Nominated by Dana Safran, BCBSMA

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Steward</th>
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</table>

RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity

Minimum Score: 2

2 There were some validity concerns about using in-hospital deaths because hospitals may be able to artificially lower their scores by moving stroke patients to other care settings. Evidence suggests that the measure shows meaningful variation between providers, and it is risk-adjusted.

Amenability to Targeted Improvement

No Minimum Score

2 During NQF measure testing, expert panels gave the measure a mean rating of 6.1 on a scale of 1-10 for overall usefulness for quality improvement within a hospital. For comparative reporting, the mean score was 4.8.

Ease of Measurement

Minimum Score: 1

3 Measure scores are not currently reported, but the software to calculate the measure is maintained by AHRQ and facility-level scores should be possible to calculate from CHIA Case Mix data.

Field Implementation

Minimum Score: 1

2 The software to calculate the measure is publicly available, but measure scores are not widely reported or consistently used in performance programs.

References

Thorax CT – Use of contrast material
This measure calculates the percentage of thorax computed tomography (CT) studies that are performed with and without contrast out of all thorax CT studies performed (those with contrast, those without contrast and those with both) at each facility. The measure is calculated based on a one-year window of Medicare claims data.

Nominated by Dana Safran, BCBSMA

<table>
<thead>
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<th>Priority Area</th>
<th>Steward</th>
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Summary

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</table>

RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity
Minimum Score: 2
4 Measure testing indicates strong measure reliability. The results of testing indicate that the measure is able to identify true differences in performance between individual facilities. Additionally, the Medicare claims data used to calculate the measure is extensively validated for payment purposes. The measure was also rated to have high face validity by experts.

Amenability to Targeted Improvement
No Minimum Score
3 The process of identifying thorax CT studies performed concurrently (with a non-contrast study performed first, followed by a study using contrast) is related to improved outcomes, including reduced exposure to radiation, reduced exposure to contrast agents, and more efficient use of imaging resources.

Ease of Measurement
Minimum Score: 1
4 Claims-based and already publicly reported by CMS.

Field Implementation
Minimum Score: 1
4 Already used and publicly reported by CMS on a facility level.

References

- Measure Submission Form:  
Cardiac imaging for preoperative risk assessment for non-cardiac, low-risk surgery (OP-13)

This measure calculates the percentage of stress echocardiography, single photon emission computed tomography myocardial perfusion imaging (SPECT MPI), cardiac computed tomography angiography (CCTA), or stress magnetic resonance (MR) imaging studies performed at each facility in the 30 days prior to an ambulatory non-cardiac, low-risk surgery performed at any location. The measure is calculated based on a one-year window of Medicare claims data.

Nominated by Dana Safran, BCBSMA

Priority Area: Appropriateness of hospital-based care

Steward: CMS

NQF Endorsed (0669)

Summary

Addresses SQAC Priority Area: Yes

NQF-Endorsed or in a National Set: Yes

Minimum Scores: Yes

Overall Score: 12 (Average 3)

Rating: Good

RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity

Minimum Score: 2

Measure testing indicates that it can reliably identify outliers, but it is not a "gold standard" measurement. The claims data for calculating the measure is extensively validated for payment purposes. Though the exclusions of the measure are supported by literature reviews, experts consulted during measure development were unable to reach consensus about their appropriateness.

Amenability to Targeted Improvement

No Minimum Score

2 Because the measure may include some appropriate use of imaging, it is unclear what a "target" score would be. As a measure of efficiency it may help to reduce overuse.

Ease of Measurement

Minimum Score: 1

4 Claims-based and already publicly reported by CMS.

Field Implementation

Minimum Score: 1

4 Already used and publicly reported by CMS on a facility level.

References

- NQF Submission Forms:
Child HCAHPS

The main purpose of the Child Hospital Survey is to address the need to assess and improve the experiences of pediatric inpatients and their parents. Like other CAHPS surveys, this questionnaire focuses on aspects of pediatric inpatient care that are important to patients and their parents, and for which patients and their parents are generally the best source of information.

Nominated by Matthew Westfall, Boston Children’s Hospital

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Steward Center for Quality Improvement and Patient Safety – AHRQ</th>
<th>NQF Endorsed (2548)</th>
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</table>

RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity

Minimum Score: 2

4  Testing indicates that composite Child HCAHPS scores have good reliability and validity.

Amenability to Targeted Improvement

No Minimum Score

4  Research shows that more patient-centered care is associated with positive outcomes.

Ease of Measurement

Minimum Score: 1

1  High resource cost: requires fielding of a patient survey. Some providers (e.g. children's hospitals) may currently administer this survey to patients, but it would be resource-intensive to implement at other facilities.

Field Implementation

Minimum Score: 1

2  It is used in certain applicable settings (e.g. children's hospitals) but is not currently used in any public reporting or accountability programs, and may not be applicable to many MA providers.

References

Pediatric all-condition readmission measure

Case-mix-adjusted readmission rates, defined as the percentage of admissions followed by 1 or more readmissions within 30 days, for patients less than 18 years old. The measure covers patients discharged from general acute care hospitals, including children’s hospitals.

Nominated by Matthew Westfall, Boston Children’s Hospital

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Steward Center for Excellence for Pediatric Quality Measurement</th>
<th>NQF Endorsed (2393)</th>
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**Summary**

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RECOMMENDED FOR INCLUSION

**Detailed Measure Evaluation**

1. **Reliability and Validity**
   - Minimum Score: 2
   - The measure reliability was generally good. Measures of validity were similar to the adult all-payer readmissions measure that is currently in the SQMS. However, there are some concerns broadly about the appropriateness of all-cause readmissions measures.

2. **Amenability to Targeted Improvement**
   - No Minimum Score
   - Adult-focused studies have demonstrated that quality improvement interventions focused on improving the discharge process, the transition from hospital to ambulatory care, and the provision of timely followup care have been associated with reduced hospital readmission rates. However, there has been little evaluation of pediatric interventions to reduce readmissions because this measure fills a significant gap in readmissions measurement.

3. **Ease of Measurement**
   - Minimum Score: 1
   - Data elements for the measure are captured in CHIA Case Mix data, but the measure is not currently calculated or publicly reported.

4. **Field Implementation**
   - Minimum Score: 1
   - The measure is used by some providers (e.g. Boston Children's Hospital), but it is not widely implemented.

**References**

Prescriber prescription drug monitoring compliance

Numerator: Quantity of RXs for schedule II and III where prescription drug monitoring program was checked by prescriber prior to prescribing.

Denominator: Quantity of RXs for schedule II and III opioids written by independent provider.

Nominated by Kate Fillo, MA DPH

Summary

<table>
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<td>12 (Average 3)</td>
<td>Good</td>
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</table>

RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity
Minimum Score: 2
2 The metric directly measures compliance based on whether providers log in and use the PDMP. It relies on data that is entered independently by both the prescriber and the pharmacy which should improve reliability. However, there is no evidence specifically on the reliability or validity of these exact specifications.

Amenability to Targeted Improvement
No Minimum Score
4 Evidence suggests that PDMPs are effective in combating prescription drug abuse.

Ease of Measurement
Minimum Score: 1
3 Data is collected by MA DPH but not publicly reported. Data reported back to prescribers is used for monitoring, but not for accountability or performance programs.

Field Implementation
Minimum Score: 1
3 Data is collected by MA DPH and reported back to providers at the prescriber level. However, data is not publicly reported at the prescriber level.

References

Substance use disorder evaluation in the ED following naloxone administration and suspected substance use disorder

Numerator: Presence of clinical procedural terminology (CPT) codes 99408, 99409, Medicare codes G0396 or G0397, or Medicaid codes H0049 or H0050 in the administrative chart for the emergency department.

Denominator: Corresponds to ICD-10 :T40.0-4 (x1-x4) as a diagnosis. Note that some individuals may be represented more than once if there were multiple ED visits in the reporting year.

Nominated by Kate Fillo, MA DPH

Priority Area: Opioid Use

Steward: MDPH

NQF: Not Endorsed

Summary

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NOT RECOMMENDED FOR INCLUSION

Detailed Measure Evaluation

Reliability and Validity
Minimum Score: 2

There is currently little evidence that submissions to MA DPH align with other data sources. MA DPH is planning to validate submissions against MA APCD and Case Mix data, but this validation has not yet been completed.

Amenability to Targeted Improvement
No Minimum Score

The measure does not specify a particular substance abuse screening tool; as such the evidence is limited. However, literature supports that substance abuse screening tools may be useful in driving patient outcomes.

Ease of Measurement
Minimum Score: 1

MA DPH collects this data directly from providers. Similar data is collected in MA APCD, Case Mix, and EMS submissions. However, these sources may frequently conflict with each other making accurate measurement difficult.

Field Implementation
Minimum Score: 1

DPH collects this data and reports some pieces to providers.

References

- Section 51½ of chapter 111 of the General Laws, added by section 32 of chapter 52 of the acts of 2016, An Act Relative to Substance Abuse, Treatment, Education and Prevention, and amended by section 138 of chapter 133 of the acts of 2016
**SCARED: Screen for child anxiety related disorders**

The Screen for Child Anxiety Related Disorders (SCARED) is a 41-item inventory rated on a 3 point Likert-type scale. It comes in two versions; one asks questions to parents about their child and the other asks these same questions to the child directly. The purpose of the instrument is to screen for signs of anxiety disorders in children.

Nominated by Julianne Walsh, Bridgewater Pediatric

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Steward</th>
<th>NQF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration of behavioral health and primary care</td>
<td>N/A</td>
<td>Not Endorsed</td>
</tr>
</tbody>
</table>

**Summary**

<table>
<thead>
<tr>
<th>Addresses SQAC Priority Area</th>
<th>NQF-Endorsed or in a National Set</th>
<th>Minimum Scores</th>
<th>Overall Score</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>✗</td>
<td>✗</td>
<td>4 (Average 1)</td>
<td>Weak</td>
</tr>
</tbody>
</table>

**NOT RECOMMENDED FOR INCLUSION**

**Detailed Measure Evaluation**

**Reliability and Validity**

- Minimum Score: 2
- Several reviews have concluded that the tool successfully identifies depressive and disruptive disorders.

**Amenability to Targeted Improvement**

- No Minimum Score
- The tool is used clinically to identify anxiety issues. However, the tool itself is not a quality measure. There are no metrics about use of the tool, success in reducing anxiety, or appropriate treatment of children who screen as having potential anxiety-related disorders.

**Ease of Measurement**

- Minimum Score: 1
- Extreme resource cost: survey must be administered and scored individually. Administration can be done online or in writing, but data from the survey is not otherwise available using medical records, claims, or other available data sets.

**Field Implementation**

- Minimum Score: 1
- Results are not publicly reported anywhere, though they may be used in individual facilities for identifying anxiety and planning clinical interventions.

**References**

- California Evidence Based Clearinghouse for Child Welfare Evaluation of SCARED.