Compendium of Measures (CoM)

Last Updated: September 2018

HSAG Health Services Advisory Group & Hospital Quality Institute
Leadership in quality and patient safety

Version History		
Date	**Version Number**	**Update History**
January 2017	Version 1.0	• Initial release
February 2017	Version 2.0	• Removed outcome measures for adverse drug events (ADE) and all-cause harm to further refine measure specifications. • Refined measure description for National Healthcare Safety Network (NHSN) central line-associated blood stream infection (CLABSI) standardized infection ratio (SIR) intensive care units (ICUs) + Other Units. • Added Strata A and Strata B numerator descriptions to 30-Day All-Cause Readmissions. • Refined numerator and denominator descriptions for Overall Sepsis Rate. • Changed measure name of Overall Sepsis Mortality Rate to 30-Day Sepsis Mortality Rate. • Refined numerator, denominator, and rate calculation descriptions for 30-Day Sepsis Mortality Rate.
April 2017	Version 3.0	• Modified Table 1 to include the process measures, updates to outcomes measures, and legend for measure designation. • Refined outcome measures for ADEs. • Added process measures for each adverse event area (AEA). • Added the Person and Family Engagement (PFE) measures. • Refined measure name description for NHSN Facility-Wide *Clostridium difficile* (*C. difficile)* Rate. • Refined measure name and denominator descriptions for NHSN Facility-Wide *C. difficile* SIR and NHSN Facility-wide *C. difficile* Rate. • Refined numerator and denominator descriptions for 30-Day All-Cause Readmissions. • Refined denominator description for NHSN Facility-Wide Methicillin-Resistant *Staphylococcus Aureus* (MRSA) SIR and NHSN Facility-Wide MRSA Rate. • Modified data source(s) description for all sepsis measures and Pressure Ulcer Stage 3+. • Refined rate calculation for 30-Day Sepsis Mortality Rate.

Version History		
July 2017	Version 4.0	• Removed Percentage of Antibiotic Stewardship Programs Implements as the MDRO process measure. • Removed Prophylactic Antibiotic Selection for Surgical Patients (NQF 0528) as the SSI process measure. • Added Days of Therapy for Fluoroquinolones per 1,000 patient days as the MDRO process measure. • Added Discontinuation of Prophylactic Parenteral Antibiotics (NQF 0271) as the SSI process measure.
October 2017	Version 5.0	• Updated Baseline Period for the Agency for Healthcare Research and Quality's (AHRQ's) Patient Safety Indicator (PSI) measures: Pressure Ulcer Stage 3+ (PSI-03), Postoperative Sepsis Rate (PSI-13), and Postoperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) (PSI-12) from calendar year 2014 to Q4 2015 to Q3 2016. • Updated Data Submission Time Period for Patient and Family Engagement (PFE) metrics from semi-annually to quarterly.
November 2017	Version 6.0	• Updated Measure Intent, Response Indications, and Measure Definition for PFE metrics. • Updated Data Submission Time for PFE metrics from quarterly to update(s) as necessary.
September 2018	Version 7.0	• Added measure specifications for: Inpatient Fall-Related Injuries per 1,000 Admissions, Possible Ventilator Associated Pneumonia (PVAP), Anticoagulant Related Adverse Drug Events per 1,000 Acute Inpatient Admissions, Opioid Related Adverse Drug Events per 1,000 Acute Inpatient Admissions, and Glycemic Related Adverse Drug Events per 1,000 Acute Inpatient Admissions

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Introduction

Background

As part of the Partnership for Patients (PfP) campaign, the Health Services Advisory Group Hospital Improvement Innovation Network (HSAG HIIN) will work with hospitals to reduce all-cause harm by 20 percent and preventable readmissions by 12 percent from a 2014 baseline. The HSAG HIIN is tasked with collecting operational and quality improvement metrics from participating hospitals by engaging hospitals, providers, patient and families, and broader caregiver communities to quickly implement well-tested and measured best practices. PfP will focus on the following patient safety areas to reduce harm:

- Adverse Drug Events (ADE)
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Central Line-Associated Bloodstream Infection (CLABSI)
- *Clostridium difficile* (C. *difficile*) Infection
- Falls
- Multi-Drug Resistant Organisms (MDRO) Infection
- Pressure Ulcers
- Readmissions
- Sepsis
- Surgical Site Infection (SSI)
- Venous Thromboembolism (VTE)
- Ventilator-Associated Event (VAE)

The Centers for Medicare & Medicaid Services (CMS) has selected commonly-reported, nationally-standardized measures for HIINs to report on. As part of participating with the HSAG HIIN, hospitals will be obligated to submit CMS-selected nationally-standardized measures. In addition to the required set of standardized measures, the HSAG HIIN may address several additional metrics related to all-cause harm. By participating with the HSAG HIIN, your hospital will be requested to submit the following measures identified in Table 1.

Icon Legend

The HSAG HIIN has provided easy-to-identify icons located at the top of each measure page. Each measure will display two icons designating if the measure is an outcome or process measure, as well as if the measure has been calculated by the HSAG HIIN or the measure needs to be self-reported. Table 1 provides details on which measure applies the icon combination.

 Outcome Measure

 Process Measure

 HSAG HIIN Calculated Measure

 Self-Reported Measure

Table 1—HSAG HIIN Measures				
AEA	**Outcome/HSAG HIIN Calculated Measures**	**Outcome/Self-Reported Measures**	**Process/HSAG HIIN Calculated Measures**	**Process/Self-Reported Measures**
ADE	• Anticoagulant Related Adverse Drug Events per 1,000 Acute Inpatient Admissions • Opioid Related Adverse Drug Events per 1,000 Acute Inpatient Admissions • Glycemic Related Adverse Drug Events per 1,000 Acute Inpatient Admissions	• International Normalized Ratio (INR) > 5 per 1,000 Patient Days • Blood Glucose < 50 per 1,000 Patient Days • Naloxone Use for Reversal of Opioid Over Sedation per 1,000 Patient Days		• Percentage of Daily INR on Patients Receiving Warfarin • Percentage of Use of Basal-Bolus Insulin for Glycemic Control • Percentage of Opioid Risk Assessment in Patients on an Opioid Agent
CAUTI	• National Healthcare Safety Network (NHSN) CAUTI (NQF 0138) Standardized Infection Ratio (SIR) Intensive Care Units (ICUs) + Other Units • NHSN CAUTI (NQF 0138) SIR ICUs Excluding Neonatal Intensive Care Units (NICUs) • NHSN CAUTI Rate ICUs + Other Units • NHSN CAUTI Rate ICUs Excluding NICUs		• Catheter Utilization Ratio (Catheter Days per 10,000 Patient Days) ICUs + Other Units • Catheter Utilization Ratio (Catheter Days per 10,000 Patient Days) ICUs Excluding NICUs	

Table 1—HSAG HIIN Measures				
AEA	**Outcome/HSAG HIIN Calculated Measures**	**Outcome/Self-Reported Measures**	**Process/HSAG HIIN Calculated Measures**	**Process/Self-Reported Measures**
CLABSI	• NHSN CLABSI (NQF 0139) SIR ICUs + Other Units • NHSN CLABSI (NQF 0139) SIR ICUs Including NICUs • NHSN CLABSI Rate ICUs + Other Units • NHSN CLABSI Rate ICUs Including NICUs		• Central Line Utilization Ratio (Catheter Days per 10,000 Patient Days) ICUs + Other Units • Central Line Utilization Ratio (Catheter Days per 10,000 Patient Days) ICUs Including NICUs	
C. difficile	• NHSN Facility-Wide *C. difficile* (NQF 1717) SIR • NHSN Facility-Wide *C. difficile* Rate			• Hand Hygiene Adherence Rate (*C. difficile*)
Falls	• Inpatient Fall-Related Injuries per 1,000 Admissions	• Falls with Injury (NQF 0202) All Acute Care Units		• Assessment of Fall Risk
MDRO	• NHSN Facility-Wide Methicillin-Resistant *Staphylococcus Aureus* (MRSA) SIR • NHSN Facility-Wide MRSA Rate			• Days of Therapy for Fluoroquinolones per 1,000 Patient Days
Pressure Ulcers	• Pressure Ulcer Rate Stage 3+ (Agency for Healthcare Research and Quality [AHRQ] Patient Safety Indicator [PSI]-03)	• Pressure Ulcer Prevalence Hospital-Acquired (NQF 0201) Stage 2+		• Pressure Ulcer Risk Assessment Completed Within 24 Hours of Admission

Table 1—HSAG HIIN Measures				
AEA	**Outcome/HSAG HIIN Calculated Measures**	**Outcome/Self-Reported Measures**	**Process/HSAG HIIN Calculated Measures**	**Process/Self-Reported Measures**
Readmissions	• 30-Day All-Cause Readmissions			• Patients Receiving Complete Discharge Education Verified by Teach-Back or Other Means (Project Re-Engineered Discharge [RED]/Better Outcomes by Optimizing Safer Transitions [BOOST])
Sepsis	• Postoperative Sepsis Rate (AHRQ PSI-13) • Overall Sepsis Rate • 30-Day Sepsis Mortality Rate			• Three-Hour Sepsis Bundle Compliance

Table 1—HSAG HIIN Measures				
AEA	**Outcome/HSAG HIIN Calculated Measures**	**Outcome/Self-Reported Measures**	**Process/HSAG HIIN Calculated Measures**	**Process/Self-Reported Measures**
SSI	• NHSN SSI Procedure-Specific (NQF 0753) SIR—Colon Surgeries • NHSN SSI Procedure-Specific (NQF 0753) SIR—Abdominal Hysterectomy • NHSN SSI Procedure-Specific (NQF 0753) SIR—Total Hip Replacements • NHSN SSI Procedure-Specific (NQF 0753) SIR—Total Knee Replacements • NHSN SSI Procedure-Specific Rate—Colon Surgeries • NHSN SSI Procedure-Specific Rate—Abdominal Hysterectomy • NHSN SSI Procedure-Specific Rate—Total Hip Replacements • NHSN SSI Procedure-Specific Rate—Total Knee Replacements			• Peri-Operative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures) (NQF 0271)

Table 1—HSAG HIIN Measures				
AEA	**Outcome/HSAG HIIN Calculated Measures**	**Outcome/Self-Reported Measures**	**Process/HSAG HIIN Calculated Measures**	**Process/Self-Reported Measures**
VAE	• Ventilator-Associated Condition (VAC) • Infection-related Ventilator-Associated Complication (IVAC) • Possible Ventilator Associated Pneumonia (PVAP)			• ABCDEF Bundle Compliance
VTE	• Postoperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate (AHRQ PSI-12)			• Venous Thromboembolism Prophylaxis (NQF 0371)

Adverse Drug Events (ADE)

Anticoagulant Related Adverse Drug Events per 1,000 Acute Inpatient Admissions

Anticoagulant Related Adverse Drug Events per 1,000 Acute Inpatient Admissions	
Numerator	Number of anticoagulant related adverse drug events, with a primary or secondary ICD-10-CM diagnosis as defined in anticoagulant ADE code list, not present on admission (POA)*
Denominator	All acute inpatient admissions (including transfers and left against medical advice [LAMA]) in the measurement timeframe
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Data Source(s)	Medicare Fee-For-Service (FFS) Claims
Baseline Period	Q4 2015 – Q3 2016

* For an ICD-10-CM diagnosis code to be considered not present on admission (POA), the POA flag must indicate "No" or "Unknown" (often notated as "N" or "U") – qualifying a patient for the measure numerator. ICD-10-CM codes that are designated as exempt from POA reporting and missing a POA indicator shall not be considered. Include all codes that begin with the included ICD code characters. (Example: T45.9 would imply inclusion of all "sub-codes" such as T45.91XA)

Additional Resources

- The Institute for Healthcare Improvement (IHI): http://ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html

Anticoagulant ADE Code List	
ICD Code	**Description**
T45.5	Poisoning by, adverse effect of and underdosing of anticoagulants and antithrombotic drugs
T45.6	Poisoning by, adverse effect of and underdosing of fibrinolysis-affecting drugs
T45.7	Poisoning by, adverse effect of and underdosing of anticoagulant antagonists, vitamin K and other coagulants
T45.8	Poisoning by, adverse effect of and underdosing of other primarily systemic and hematological agents
T45.9	Poisoning by, adverse effect of and underdosing of unspecified primarily systemic and hematological agent
D68.32	Hemorrhagic disorder due to extrinsic circulating anticoagulants
Y44.2	Drugs, medicaments and biological substances causing adverse effects in therapeutic use - Agents primarily affecting blood constituents, Anticoagulants
Q86.2	Dysmorphism due to warfarin

Opioid Related Adverse Drug Events per 1,000 Acute Inpatient Admissions

Opioid Related Adverse Drug Events per 1,000 Acute Inpatient Admissions	
Numerator	Number of opioid related adverse drug events, with a primary or secondary ICD-10-CM diagnosis as defined in opioid ADE code list, not present on admission (POA)*
Denominator	All acute inpatient admissions (including transfers and left against medical advice [LAMA]) in the measurement timeframe
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Data Source(s)	Medicare FFS Claims
Baseline Period	Q4 2015 – Q3 2016

* For an ICD-10-CM diagnosis code to be considered not present on admission (POA), the POA flag must indicate "No" or "Unknown" (often notated as "N" or "U") – qualifying a patient for the measure numerator. ICD-10-CM codes that are designated as exempt from POA reporting and missing a POA indicator shall not be considered. Include all codes that begin with the included ICD code characters. (Example: T45.9 would imply inclusion of all "sub-codes" such as T45.91XA)

Additional Resources

- The Institute for Healthcare Improvement (IHI): http://ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html

Opioid ADE Code List	
ICD Code	**Description**
T40.0	Poisoning by, adverse effect of and underdosing of opium
T40.1	Poisoning by and adverse effect of heroin
T40.2	Poisoning by, adverse effect of and underdosing of other opioids
T40.3	Poisoning by, adverse effect of and underdosing of methadone
T40.4	Poisoning by, adverse effect of and underdosing of other synthetic narcotics
T40.6	Poisoning by, adverse effect of and underdosing of other and unspecified narcotics
F11	Opioid related disorders

Glycemic Related Adverse Drug Events per 1,000 Acute Inpatient Admissions

Glycemic Related Adverse Drug Events per 1,000 Acute Inpatient Admissions	
Numerator	Number of glycemic related adverse drug events, with a primary or secondary ICD-10-CM diagnosis as defined in glycemic ADE code list, not present on admission (POA)*
Denominator	All acute inpatient admissions (including transfers and left against medical advice [LAMA]) in the measurement timeframe
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Data Source(s)	Medicare FFS Claims
Baseline Period	Q4 2015 – Q3 2016

* For an ICD-10-CM diagnosis code to be considered not present on admission (POA), the POA flag must indicate "No" or "Unknown" (often notated as "N" or "U") – qualifying a patient for the measure numerator. ICD-10-CM codes that are designated as exempt from POA reporting and missing a POA indicator shall not be considered. Include all codes that begin with the included ICD code characters. (Example: T45.9 would imply inclusion of all "sub-codes" such as T45.91XA)

Additional Resources

- The Institute for Healthcare Improvement (IHI): http://ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html

Glycemic ADE Code List	
ICD Code	**Description**
T38.3	Poisoning by, adverse effect of and underdosing of insulin and oral hypoglycemic [antidiabetic] drugs
E15	Nondiabetic hypoglycaemic coma
E16.0	Drug-induced hypoglycaemia without coma

INR > 5 per 1,000 Patient Days

INR > 5 per 1,000 Patient Days	
Numerator	Number of patient days with at least one INR reading > 5 for adult patients on Warfarin
Denominator	Number of patient days for adult (18 years of age or older) patients on Warfarin, excluding the emergency department*
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Data Source(s)	Electronic health record (EHR)
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	ANTICOAG_INR

*If a hospital is unable to limit the denominator to patients on Warfarin, then submit patient day counts as a proxy.

INR: International Normalized Ratio

Additional Resources

- The Institute for Healthcare Improvement (IHI): http://ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html

Blood Glucose < 50 per 1,000 Patient Days

Blood Glucose < 50 per 1,000 Patient Days	
Numerator	Number of patient days with at least one glucose reading < 50 mg/dL for adult patients on insulin
Denominator	Number of patient days for adult (18 years of age or older) patients on insulin, excluding the emergency department*
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Data Source(s)	EHR
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	DIABETIC_BG

*If a hospital is unable to limit the denominator to patients on insulin, then submit patient day counts as a proxy.

Additional Resources

- The Institute for Healthcare Improvement (IHI): http://ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html

Naloxone Use for Reversal of Opioid Over Sedation per 1,000 Patient Days

Naloxone Use for Reversal of Opioid Over Sedation per 1,000, Patient Days	
Numerator	Number of patient days where Naloxone administration was required for adult patients on an opioid agent
Denominator	Number of patient days for adult (18 years of age or older) patients on an opioid agent, excluding the emergency department and operating room*
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Data Source(s)	EHR
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	OPIOID_NARCAN

*If a hospital is unable to limit the denominator to patients on an opioid agent, then submit patient day counts as a proxy.

Additional Resources

- The Institute for Healthcare Improvement (IHI): http://ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html

Percentage of Daily INR on Patients Receiving Warfarin

Percentage of Daily INR on Patients Receiving Warfarin	
Numerator	Number of patient days with INR lab result for adult patients on Warfarin
Denominator	Number of patient days for adult patients (18 years of age or older) on Warfarin, excluding the emergency department*
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	EHR
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	ANTICOAG_DAILY_INR

*If a hospital is unable to limit the denominator to patients on Warfarin, then submit patient day counts as a proxy.

Additional Resources

- The Institute for Healthcare Improvement (IHI): http://ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html

Percentage of Use of Basal-Bolus Insulin for Glycemic Control

Percentage of Use of Basal-Bolus Insulin for Glycemic Control	
Numerator	Number of patient days with basal-bolus insulin given for adult patients on any insulin
Denominator	Number of patient days for adult (18 years of age or older) patients on any insulin, excluding the emergency department*
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	EHR
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	DIABETIC_INSULIN

*If a hospital is unable to limit the denominator to patients on any insulin, then submit patient day counts as a proxy.

Additional Resources

- The Institute for Healthcare Improvement (IHI): http://ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html

Percentage of Opioid Risk Assessment in Patients on an Opioid Agent

Percentage of Opioid Risk Assessment in Patients on an Opioid Agent	
Numerator	Number of patient days where an opioid risk assessment (e.g., Pasero Opioid-Induced Sedation Scale [POSS] or Richmond Agitation Sedation Scale [RASS]) was used for adult patients on an opioid agent
Denominator	Number of patient days for adult (18 years of age or older) patients on an opioid agent, excluding emergency department and operating room*
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	EHR
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	OPIOID_RISK

*If a hospital is unable to limit the denominator to patients on an opioid agent, then submit patient day counts as a proxy.

Additional Resources

- The Institute for Healthcare Improvement (IHI): http://ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html

Catheter-Associated Urinary Tract Infection (CAUTI)

NHSN CAUTI (NQF 0138) SIR ICUs + Other Units

NHSN CAUTI (NQF 0138) SIR ICUs + Other Units	
Numerator	Total number of observed infections
Denominator	Total number of predicted infections
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC CAUTI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CAUTI_ICU_P

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals are required to confer rights to all inpatient locations excluding NICUs. Hospitals not reporting to NHSN are required to report data for ICUs excluding NICUs and, also for ICUs excluding NICUs + Other Units, separately.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheter-associatedurinarytractinfectionscauti.html

NHSN CAUTI (NQF 0138) SIR ICUs Excluding NICUs

NHSN CAUTI (NQF 0138) SIR ICUs Excluding NICUs	
Numerator	Total number of observed infections
Denominator	Total number of predicted infections
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC CAUTI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CAUTI_ICU_I

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals are required to confer rights to all inpatient locations excluding NICUs. Hospitals not reporting to NHSN are required to report CAUTIs, patient days, and urinary catheter days, for ICUs excluding NICUs and, also for ICUs excluding NICUs + Other Units, separately.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheter-associatedurinarytractinfectionscauti.html

NHSN CAUTI Rate ICUs + Other Units

NHSN CAUTI Rate ICUs + Other Units	
Numerator	Total number of observed healthcare-associated CAUTI among patients in bedded inpatient care locations
Denominator	Total number of indwelling urinary catheter days for each location under surveillance for CAUTI during the data collection period
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	CDC CAUTI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CAUTI_RATE_ICU_P

These data elements shall be submitted by all hospitals which have not conferred rights to NHSN data. Hospitals must report the numerator and denominator for ICUs excluding NICUs and, also for ICUs excluding NICUs + Other Units, separately. For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate these rates shall be extracted and rates calculated.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheter-associatedurinarytractinfectionscauti.html

NHSN CAUTI Rate ICUs Excluding NICUs

NHSN CAUTI Rate ICUs Excluding NICUs	
Numerator	Total number of observed healthcare-associated CAUTI among patients in bedded inpatient care locations
Denominator	Total number of indwelling urinary catheter days for each location under surveillance for CAUTI during the data collection period
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	CDC CAUTI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes – for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CAUTI_RATE_ICU_I

These data elements shall be submitted by all hospitals which have not conferred rights to NHSN data. Hospitals must report the numerator and denominator for ICUs excluding NICUs and, also for ICUs excluding NICUs + Other Units, separately. For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate these rates shall be extracted and rates calculated.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheter-associatedurinarytractinfectionscauti.html

Catheter Utilization Ratio (Catheter Days per 10,000 Patient Days) ICUs + Other Units

Catheter Utilization Ratio (Catheter Days per 10,000 Patient Days) ICUs + Other Units	
Numerator	Total number of indwelling urinary catheter days for bedded inpatient care locations under surveillance (excluding patients in Level II or III NICUs)
Denominator	Total number of patient days for bedded inpatient care locations under surveillance (excluding patients in Level II or III NICUs)
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 10{,}000$
Measure Definition/Specifications	CDC CAUTI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CAUTI_DU_P

For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate this ratio shall be extracted, and the ratio calculated. Hospitals not reporting to NHSN are required to report urinary catheter days and patient days, for ICUs excluding NICUs and, also for ICUs excluding NICUs + Other Units, separately.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheter-associatedurinarytractinfectionscauti.html

Catheter Utilization Ratio (Catheter Days per 10,000 Patient Days) ICUs Excluding NICUs

Catheter Utilization Ratio (Catheter Days per 10,000 Patient Days) ICUs Excluding NICUs	
Numerator	Total number of indwelling urinary catheter days for bedded inpatient care locations under surveillance (excluding patients in Level II or III NICUs)
Denominator	Total number of patient days for bedded inpatient care locations under surveillance (excluding patients in Level II or III NICUs)
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 10{,}000$
Measure Definition/Specifications	CDC CAUTI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CAUTI_DU_I

For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate this ratio shall be extracted, and the ratio calculated. Hospitals not reporting to NHSN are required to report urinary catheter days and patient days, for ICUs excluding NICUs and, also for ICUs excluding NICUs + Other Units, separately.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheter-associatedurinarytractinfectionscauti.html

Central Line-Associated Blood Stream Infection (CLABSI)

NHSN CLABSI (NQF 0139) SIR ICUs + Other Units

NHSN CLABSI (NQF 0139) SIR ICUs + Other Units	
Numerator	Total number of observed infections
Denominator	Total number of predicted infections
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC CLABSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CLABSI_ICU_P

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals are required to confer rights to all inpatient locations including NICUs. Hospitals not reporting to NHSN are required to report CLABSIs, patient days, and central line days, for ICUs including NICUs and, also for ICUs including NICUs + Other Units, separately.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-centralline-associatedbloodstreaminfections/toolcentralline-associatedbloodstreaminfectionsclabsi.html

NHSN CLABSI (NQF 0139) SIR ICUs Including NICUs

NHSN CLABSI (NQF 0139) SIR ICUs Including NICUs	
Numerator	Total number of observed infections
Denominator	Total number of predicted infections
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC CLABSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CLABSI_ICU_I

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals are required to confer rights to all inpatient locations including NICUs. Hospitals not reporting to NHSN are required to report CLABSIs, patient days, and central line days, for ICUs including NICUs and, also for ICUs including NICUs + Other Units, separately.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-centralline-associatedbloodstreaminfections/toolcentralline-associatedbloodstreaminfectionsclabsi.html

NHSN CLABSI Rate ICUs + Other Units

NHSN CLABSI Rate ICUs + Other Units	
Numerator	Total number of observed healthcare-associated CLABSI among patients in bedded inpatient care locations
Denominator	Total number of central line days for each location under surveillance for CLABSI during the data collection period
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	CDC CLABSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CLABSI_RATE_ICU_P

These data elements shall be submitted by all hospitals which have not conferred rights to NHSN data. Hospitals must report the numerator and denominator for ICUs including NICUs and, also for ICUs including NICUs + Other Units, separately. For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate these rates shall be extracted and rates calculated.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-centralline-associatedbloodstreaminfections/toolcentralline-associatedbloodstreaminfectionsclabsi.html

NHSN CLABSI Rate ICUs Including NICUs

NHSN CLABSI Rate ICUs Including NICUs	
Numerator	Total number of observed healthcare-associated CLABSI among patients in bedded inpatient care locations
Denominator	Total number of central line days for each location under surveillance for CLABSI during the data collection period
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	CDC CLABSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CLABSI_RATE_ICU_I

These data elements shall be submitted by all hospitals which have not conferred rights to NHSN data. Hospitals must report the numerator and denominator for ICUs including NICUs and, also for ICUs including NICUs + Other Units, separately. For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate these rates shall be extracted and rates calculated.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-centralline-associatedbloodstreaminfections/toolcentralline-associatedbloodstreaminfectionsclabsi.html

Central Line Utilization Ratio (Central Line Days per 10,000 Patient Days) ICUs + Other Units

Central Line Utilization Ratio (Central Line Days per 10,000 Patient Days) ICUs + Other Units	
Numerator	Total number of central line days for bedded inpatient care locations under surveillance
Denominator	Total number of patient days for bedded inpatient care locations under surveillance
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 10{,}000$
Measure Definition/Specifications	CDC CLABSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CLABSI_UR_P

For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate this ratio shall be extracted, and the ratio calculated. Hospitals not reporting to NHSN are required to report central line days and patient days, for ICUs including NICUs and, also for ICUs including NICUs + Other Units, separately.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-centralline-associatedbloodstreaminfections/toolcentralline-associatedbloodstreaminfectionsclabsi.html

Central Line Utilization Ratio (Central Line Days per 10,000 Patient Days) ICUs Including NICUs

Central Line Utilization Ratio (Central Line Days per 10,000 Patient Days) ICUs Including NICUs	
Numerator	Total number of central line days for bedded inpatient care locations under surveillance
Denominator	Total number of patient days for bedded inpatient care locations under surveillance
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 10{,}000$
Measure Definition/Specifications	CDC CLABSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDC_CLABSI_UR_I

For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate this ratio shall be extracted, and the ratio calculated. Hospitals not reporting to NHSN are required to report central line days and patient days, for ICUs including NICUs and, also for ICUs including NICUs + Other Units, separately.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  https://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-centralline-associatedbloodstreaminfections/toolcentralline-associatedbloodstreaminfectionsclabsi.html

Clostridium difficile (*C. difficile*) Infection

NHSN Facility-Wide *C. difficile* (NQF 1717) SIR

NHSN Facility-Wide *C. difficile* (NQF 1717) SIR	
Numerator	Total number of observed hospital-onset *C. difficile* lab identified events among all inpatients in the facility, excluding well-baby nurseries and NICUs
Denominator	Predicted cases of patients with *C. difficile* (facility-wide)
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC CDIFF NHSN NQF 1717
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDIFF_SIR

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/hai/organisms/cdiff/Cdiff_settings.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

NHSN Facility-Wide *C. difficile* Rate

Facility-Wide *C. difficile* Rate	
Numerator	Total number of observed hospital-onset *C. difficile* lab identified events among all inpatients in the facility, excluding well-baby nurseries and NICUs
Denominator	Patient days (facility-wide)
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 10{,}000$
Measure Definition/Specifications	CDC CDIFF NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDIFF_RATE

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/hai/organisms/cdiff/Cdiff_settings.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

Hand Hygiene Adherence Rate (*C. difficile*)

Hand Hygiene Adherence Rate (*C. difficile*)	
Numerator	Hand hygiene performed consistent with guidelines
Denominator	Total number of hand-hygiene observation opportunities
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	Chart review
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	CDIFF_HAND

Additional Resources

- The Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/hai/organisms/cdiff/cdiff_clinicians.html
- Rationale for Hand Hygiene Recommendations after Caring for a Patient with *C. difficile* Infection https://www.shea-online.org/images/patients/CDI-hand-hygiene-Update.pdf

Falls

Inpatient Fall-Related Injuries per 1,000 Admissions

Inpatient Fall-Related Injuries per 1,000 Admissions	
Numerator	Number of Medicare beneficiaries with a diagnosis of a fall or fall-related injury (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock) indicated as not present on admission
Denominator	Number of Medicare beneficiaries who were admitted to a hospital with any diagnosis
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Data Source(s)	Medicare FFS Claims
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2014
Measure ID	FALL_RATE

Additional Resources

- The Agency for Healthcare Research & Quality (AHRQ): http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html
- The Partnership for Patients (PfP): https://partnershipforpatients.cms.gov/p4p_resources/tsp-injuriesandfallsfromimmobility/toolinjuriesandfallsfromimmobility.html

Inpatient Fall-Related ICD 10 Code List	
ICD Code	**Description**
R296	Repeated falls
V00811A	Fall from moving wheelchair (powered), initial encounter
V00811S	Fall from moving wheelchair (powered), sequela
V00831A	Fall from motorized mobility scooter, initial encounter
W010XXA	Fall on same level from slipping, tripping and stumbling without subsequent striking against object, initial encounter
W010XXD	Fall on same level from slipping, tripping and stumbling without subsequent striking against object, subsequent encounter

Inpatient Fall-Related ICD 10 Code List	
ICD Code	**Description**
W010XXS	Fall on same level from slipping, tripping and stumbling without subsequent striking against object, sequela
W0110XA	Fall on same level from slipping, tripping and stumbling with subsequent striking against unspecified object, initial encounter
W0110XS	Fall on same level from slipping, tripping and stumbling with subsequent striking against unspecified object, sequela
W01110A	Fall on same level from slipping, tripping and stumbling with subsequent striking against sharp glass, initial encounter
W01190A	Fall on same level from slipping, tripping and stumbling with subsequent striking against furniture, initial encounter
W01198A	Fall on same level from slipping, tripping and stumbling with subsequent striking against other object, initial encounter
W01198D	Fall on same level from slipping, tripping and stumbling with subsequent striking against other object, subsequent encounter
W03XXXA	Other fall on same level due to collision with another person, initial encounter
W03XXXD	Other fall on same level due to collision with another person, subsequent encounter
W04XXXA	Fall while being carried or supported by other persons, initial encounter
W04XXXD	Fall while being carried or supported by other persons, subsequent encounter
W050XXA	Fall from non-moving wheelchair, initial encounter
W050XXD	Fall from non-moving wheelchair, subsequent encounter
W052XXA	Fall from non-moving motorized mobility scooter, initial encounter
W06XXXA	Fall from bed, initial encounter
W06XXXD	Fall from bed, subsequent encounter
W06XXXS	Fall from bed, sequela
W07XXXA	Fall from chair, initial encounter
W08XXXA	Fall from other furniture, initial encounter
W102XXA	Fall (on)(from) incline, initial encounter
W108XXA	Fall (on) (from) other stairs and steps, initial encounter
W109XXA	Fall (on) (from) unspecified stairs and steps, initial encounter
W1789XA	Other fall from one level to another, initial encounter
W1789XD	Other fall from one level to another, subsequent encounter
W1789XS	Other fall from one level to another, sequela
W1800XA	Striking against unspecified object with subsequent fall, initial encounter
W1809XA	Striking against other object with subsequent fall, initial encounter
W1811XA	Fall from or off toilet without subsequent striking against object, initial encounter
W1811XD	Fall from or off toilet without subsequent striking against object, subsequent encounter
W1812XA	Fall from or off toilet with subsequent striking against object, initial encounter
W182XXA	Fall in (into) shower or empty bathtub, initial encounter
W182XXS	Fall in (into) shower or empty bathtub, sequela
W1830XA	Fall on same level, unspecified, initial encounter
W1830XD	Fall on same level, unspecified, subsequent encounter

Inpatient Fall-Related ICD 10 Code List	
ICD Code	**Description**
W1830XS	Fall on same level, unspecified, sequela
W1831XA	Fall on same level due to stepping on an object, initial encounter
W1839XA	Other fall on same level, initial encounter
W1839XD	Other fall on same level, subsequent encounter
W1839XS	Other fall on same level, sequela
W19XXXA	Unspecified fall, initial encounter
W19XXXD	Unspecified fall, subsequent encounter
W19XXXS	Unspecified fall, sequela

Inpatient Fall-Related Injuries ICD 10 Code List		
Injury Type	**ICD Code**	**Description**
Burn	T20 - T25	Burns and corrosions of external body surface, specified by site
	T26 - T28	Burns and corrosions confined to eye and internal organs
	T30 -T32	Burns and corrosions of multiple and unspecified body regions
Crushing Injury	S07	Crushing injury of head
	S28	Crushed chest
	S38	Crushing injury of abdomen, lower back, and pelvis
	S77	Crushing injury of thigh
	S87	Crushing injury of lower leg
Dislocation	S01	Unspecified open wound of unspecified cheek and temporomandibular area, initial encounter
	S03	Dislocation of jaw, initial encounter
	S11	Unspecified open wound of unspecified part of neck, initial encounter
	S13	Dislocation and sprain of joints and ligaments at neck level
	S21	Open wound of thorax
	S31	Open wound of lower back and pelvis
	S33	Dislocation and sprain of joints and ligaments of lumbar spine and pelvis
	S41	Open wound of shoulder and upper arm
	S43	Dislocation and sprain of joints and ligaments of shoulder girdle
	S51	Open wound of elbow and forearm
	S53	Dislocation and sprain of joints and ligaments of elbow
	S61	Open wound of wrist, hand and fingers
	S63	Dislocation and sprain of joints and ligaments at wrist and hand level
	S71	Open wound of hip and thigh
	S73	Dislocation and sprain of joint and ligaments of hip
	S81	Open wound of knee and lower leg
	S83	Dislocation and sprain of joints and ligaments of knee
	S91	Open wound of ankle, foot and toes
	S93	Dislocation and sprain of joints and ligaments at ankle, foot and toe level
	T14	Injury of unspecified body region
Electric Shock	T34	Frostbite with tissue necrosis
	T67	Effects of heat and light

Inpatient Fall-Related Injuries ICD 10 Code List		
Injury Type	**ICD Code**	**Description**
	T68	Hypothermia
	T69	Other effects of reduced temperature
	T70	Effects of air pressure and water pressure
	T71	Asphyxiation
	T73	Effects of other deprivation
	T75	Other and unspecified effects of other external causes
Fracture	S02	Fracture of skull and facial bones
	S06	Intracranial injury
	S12	Fracture of cervical vertebra and other parts of neck
	S14	Injury of nerves and spinal cord at neck level
	S22	Fracture of rib(s), sternum and thoracic spine
	S24	Injury of nerves and spinal cord at thorax level
	S32	Fracture of lumbar spine and pelvis
	S34	Injury of lumbar and sacral spinal cord and nerves at abdomen, lower back and pelvis level
	S42	Fracture of shoulder and upper arm
	S52	Fracture of forearm
	S62	Fracture at wrist and hand level
	S72	Fracture of femur
	S82	Fracture of lower leg, including ankle
	S92	Fracture of foot and toe, except ankle
	T07	Unspecified multiple injuries
	T14	Injury of unspecified body region
Intracranial Injury	S01	Open wound of head
	S06	Intracranial injury

Falls with Injury (NQF 0202) All Acute Care Units

Falls with Injury (NQF 0202) All Acute Care Units	
Numerator	Total number of patient falls of injury level minor or greater (whether or not assisted by staff member) by eligible hospital unit during the measurement period
Denominator	Patient days by eligible units during the measurement period
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	NQF 0202
Data Source(s)	Numerator—incident reporting systems, chart review Denominator—billing systems
CALNOC Reporters	Hospitals conferring rights to HSAG HIIN do not self-report
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2014
Measure ID	FALL_INJURY

Additional Resources

- The Agency for Healthcare Research & Quality (AHRQ): http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-injuriesandfallsfromimmobility/toolinjuriesandfallsfromimmobility.html
- The American Nurses Association (ANA) has published an article about measuring fall-program outcomes: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No2May07/ArticlePreviousTopic/MeasuringFallProgramOutcomes.html

Assessment of Fall Risk

Assessment of Fall Risk	
Numerator	Patients that were assessed using the Algorithm for Fall Risk Assessment & Interventions within 24 hours of admission
Denominator	All patients
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	Patients; chart review
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	FALL_RISK

Additional Resources

- The Agency for Healthcare Research & Quality (AHRQ): http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-injuriesandfallsfromimmobility/toolinjuriesandfallsfromimmobility.html
- The American Nurses Association (ANA) has published an article about measuring fall-program outcomes: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No2May07/ArticlePreviousTopic/MeasuringFallProgramOutcomes.html

Multi-Drug Resistant Organisms (MDRO) Infection

NHSN Facility-Wide Methicillin-Resistant *Staphylococcus Aureus* (MRSA) SIR

NHSN Facility-Wide Methicillin-Resistant *Staphylococcus Aureus* (MRSA) SIR	
Numerator	Observed number of nosocomial patients with laboratory identification of MRSA
Denominator	Predicted number of nosocomial patients with laboratory identification of MRSA (facility-wide)
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC MDRO NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	MRSA_SIR

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/PDFs/Overview_MRSA_Surveillance_Final12_08.pdf
  http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

NHSN Facility-Wide MRSA Rate

NHSN Facility-Wide MRSA Rate	
Numerator	Number of nosocomial patients with laboratory identification of MRSA
Denominator	Number of patient days (facility-wide)
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	CDC MDRO NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	MRSA_RATE

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/PDFs/Overview_MRSA_Surveillance_Final12_08.pdf
  http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

Days of Therapy for Fluoroquinolones per 1,000 Patient Days

Days of Therapy Fluoroquinolones per 1,000 Patient Days	
Numerator	Days of therapy for fluoroquinolones
Denominator	Total patient days
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Data Source(s)	Chart review, electronic health record (EHR)
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	MDRO_FLUORO

Additional Resources

- The Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html
- Antimicrobial Use and Resistance (AUR) Module for National Healthcare Safety Network (NHSN) reporting: https://www.cdc.gov/nhsn/pdfs/pscmanual/11pscaurcurrent.pdf

Pressure Ulcers

Pressure Ulcer Rate Stage 3+ (AHRQ PSI-03)

Pressure Ulcer Rate Stage 3+ (AHRQ PSI-03)	
Numerator	Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary diagnosis codes for pressure ulcer stage III or IV (or unstageable)
Denominator	Surgical or medical discharges, for patients ages 18 years and older. Surgical and medical discharges are defined by specific DRG or MSDRG codes
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	AHRQ PSI-03
Data Source(s)	Medicare FFS Claims
Data Submission Time Period	Monthly
Baseline Period	Q4 2015 – Q3 2016
Measure ID	PSI03

Additional Resources

- The Agency for Healthcare Research & Quality (AHRQ):
  http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool5.html
  https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD10/TechSpecs/PSI_03_Pressure_Ulcer_Rate.pdf
- The Partnership for Patients (PfP):
  https://partnershipforpatients.cms.gov/p4p_resources/tsp-pressureulcers/toolpressureulcers.html

Pressure Ulcer Prevalence Hospital-Acquired (NQF 0201) Stage 2+

Pressure Ulcer Prevalence Hospital-Acquired (NQF 0201) Stage 2+	
Numerator	Patients that have at least one category/stage II or greater hospital-acquired pressure ulcer on the day of the prevalence measurement period
Denominator	All patients, 18 years of age or greater, surveyed for the measurement period
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	NQF 0201
Data Source(s)	Numerator—incident reporting systems, chart review Denominator—billing systems
CALNOC Reporters	Hospitals conferring rights to HSAG HIIN do not self-report
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2014
Measure ID	NQF0201

Additional Resources

- The Agency for Healthcare Research & Quality (AHRQ): http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool5.html
- The Partnership for Patients (PfP): https://partnershipforpatients.cms.gov/p4p_resources/tsp-pressureulcers/toolpressureulcers.html

Pressure Ulcer Risk Assessment Completed Within 24 Hours of Admission

Pressure Ulcer Risk Assessment Completed Within 24 Hours of Admission	
Numerator	Number of inpatients with documentation in medical records of a complete pressure-ulcer risk assessment
Denominator	All inpatients admitted to hospital or unit under surveillance
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	Charts review; unit logs
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	PRU_RISK

Additional Resources

- The Agency for Healthcare Research & Quality (AHRQ): http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool5.html
- The Partnership for Patients (PfP): https://partnershipforpatients.cms.gov/p4p_resources/tsp-pressureulcers/toolpressureulcers.html

Readmissions

30-Day All-Cause Readmissions

30-Day All-Cause Readmissions	
Numerator	Inpatients returning as an acute care inpatient to any facility within 30 days of date of discharge Strata A: Inpatients returning as an acute care inpatient to the same facility within 30 days of date of discharge Strata B: Inpatient returning as an acute care inpatient to a different facility than that which the patient was first admitted to within 30 days of date of discharge
Denominator	Total inpatient discharges (excluding discharges due to death)
Rate Calculation	$\frac{Numerator}{Denominator}$
Data Source(s)	Medicare FFS Claims
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2014
Measure ID	READM_30DAY READM_30DAY_SAME (Strata A) READM_30DAY_OTHR (Strata B)

Additional Resources

- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-preventablereadmissions/toolpreventablereadmissions.html

Patients Receiving Complete Discharge Education Verified by Teach-Back or Other Means (Project RED/BOOST)

Percentage of Patients Receiving Complete Discharge Education Verified by Teach-Back or Other Means (Project RED/BOOST)	
Numerator	Patients receiving complete discharge education verified by teach-back or other means
Denominator	All eligible patients
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	Chart review
Data Submission Time Period	Monthly
Baseline Period	Calendar year (CY) 2015
Measure ID	READM_RED_BOOST

Additional Resources

- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-preventablereadmissions/toolpreventablereadmissions.html
- The Agency for Healthcare Research and Quality (AHRQ): https://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html
- The Society of Hospital Medicare (SHM): http://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality___Innovation/Implementation_Toolkit/Boost/BOOST_Intervention/BOOST_Tools.aspx

Sepsis

Postoperative Sepsis Rate (AHRQ PSI-13)

Postoperative Sepsis Rate (AHRQ PSI-13)	
Numerator	Discharges among cases meeting the inclusion and exclusion rules for the denominator, with any AHRQ designated secondary ICD-9-CM or ICD-10 diagnosis codes for sepsis
Denominator	Elective surgical discharges for patients ages 18 years and older
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	AHRQ PSI-13
Data Source(s)	Medicare FFS Claims
Data Submission Time Period	Monthly
Baseline Period	Q4 2015 – Q3 2016
Measure ID	PSI13

Additional Resources

- The Surviving Sepsis Campaign: http://www.survivingsepsis.org/Pages/default.aspx
- The Agency for Healthcare Research and Quality (AHRQ): https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD10/TechSpecs/PSI_13_Postoperative_Sepsis_Rate.pdf

Overall Sepsis Rate

Overall Sepsis Rate	
Numerator	Number of Medicare beneficiaries with a primary or secondary diagnosis of sepsis; excluding sepsis present on admission
Denominator	Number of Medicare beneficiaries who were admitted to a hospital with any diagnosis
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Data Source(s)	Medicare FFS Claims
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2014
Measure ID	SEPSIS_RATE

Additional Resources

- The Surviving Sepsis Campaign: http://www.survivingsepsis.org/Pages/default.aspx

30-Day Sepsis Mortality Rate

30-Day Sepsis Mortality Rate	
Numerator	Number of Medicare beneficiaries who died within 30 days of being diagnosed with sepsis
Denominator	Number of Medicare beneficiaries who were admitted with a primary or secondary diagnosis of sepsis; including sepsis present on admission
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	Medicare FFS Claims
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2014
Measure ID	SEPSIS_MORTALITY

Additional Resources

- The Surviving Sepsis Campaign: http://www.survivingsepsis.org/Pages/default.aspx

Three-Hour Sepsis Bundle Compliance

Three-Hour Sepsis Bundle Compliance	
Numerator	Number of identified sepsis patients who receive all elements of the bundle
Denominator	Number of identified sepsis patients
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	Administrative claims
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	SEPSIS_BUNDLE

Additional Resources

- The Surviving Sepsis Campaign:
  http://www.survivingsepsis.org/Pages/default.aspx
  http://www.survivingsepsis.org/SiteCollectionDocuments/Bundle-Three-Hour-SSC.pdf

Surgical Site Infection (SSI)

NHSN SSI Procedure Specific (NQF 0753) SIR—Colon Surgeries

NHSN SSI Procedure Specific (NQF 0753) SIR—Colon Surgeries	
Numerator	Number of observed infections
Denominator	Number of predicted infections
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC SSI NHSN NQF 0753
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	SSI_COLO_SIR

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals not reporting to NHSN are required to report SSIs and number of operative procedures.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
  http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

NHSN SSI Procedure Specific (NQF 0753) SIR—Abdominal Hysterectomies

NHSN SSI Procedure Specific (NQF 0753) SIR—Abdominal Hysterectomies	
Numerator	Number of observed infections
Denominator	Number of predicted infections
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC SSI NHSN NQF 0753
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	SSI_HYST_SIR

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals not reporting to NHSN are required to report SSIs and number of operative procedures.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
  http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

NHSN SSI Procedure Specific (NQF 0753) SIR—Total Hip Replacements

NHSN SSI Procedure Specific (NQF 0753) SIR—Total Hip Replacements	
Numerator	Number of observed infections
Denominator	Number of predicted infections
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC SSI NHSN NQF 0753
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	SSI_HPRO_SIR

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals not reporting to NHSN are required to report SSIs and number of operative procedures.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
  http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

NHSN SSI Procedure Specific (NQF 0753) SIR—Total Knee Replacements

NHSN SSI Procedure Specific (NQF 0753) SIR – Total Knee Replacements	
Numerator	Number of observed infections
Denominator	Number of predicted infections
Rate Calculation	$\frac{Numerator}{Denominator}$
Measure Definition/Specifications	CDC SSI NHSN NQF 0753
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	SSI_KPRO_SIR

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals not reporting to NHSN are required to report SSIs and number of operative procedures.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
  http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

NHSN SSI Procedure Specific Rate—Colon Surgeries

NHSN SSI Procedure Specific Rate—Colon Surgeries	
Numerator	Total number of surgical site infections based on CDC's NHSN definition
Denominator	All patients having any of the procedures included in the selected NHSN operative procedure category
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Measure Definition/Specifications	CDC SSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	SSI_COLO_RATE

These data elements shall be submitted by all hospitals which have not conferred rights to NHSN data. Hospitals must report the numerator and denominators, for all inpatient locations, for these four specific surgeries separately. For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate these rates shall be extracted, and rates calculated.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
  http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

NHSN SSI Procedure Specific Rate—Abdominal Hysterectomies

NHSN SSI Procedure Specific Rate—Abdominal Hysterectomies	
Numerator	Total number of surgical site infections based on CDC's NHSN definition
Denominator	All patients having any of the procedures included in the selected NHSN operative procedure category
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Measure Definition/Specifications	CDC SSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to *Cal* HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	SSI_HYST_RATE

These data elements shall be submitted by all hospitals which have not conferred rights to NHSN data. Hospitals must report the numerator and denominators, for all inpatient locations, for these four specific surgeries separately. For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate these rates shall be extracted, and rates calculated.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
  http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

NHSN SSI Procedure Specific Rate—Total Hip Replacements

NHSN SSI Procedure Specific Rate—Total Hip Replacements	
Measure Type	Outcome
Numerator	Total number of surgical site infections based on CDC's NHSN definition
Denominator	All patients having any of the procedures included in the selected NHSN operative procedure category
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Measure Definition/Specifications	CDC SSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	SSI_HPRO_RATE

These data elements shall be submitted by all hospitals which have not conferred rights to NHSN data. Hospitals must report the numerator and denominators, for all inpatient locations, for these four specific surgeries separately. For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate these rates shall be extracted, and rates calculated.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
  http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

NHSN SSI Procedure Specific Rate—Total Knee Replacements

NHSN SSI Procedure Specific Rate – Total Knee Replacements	
Measure Type	Outcome
Numerator	Total number of surgical site infections based on CDC's NHSN definition
Denominator	All patients having any of the procedures included in the selected NHSN operative procedure category
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Measure Definition/Specifications	CDC SSI NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	SSI_KPRO_RATE

These data elements shall be submitted by all hospitals which have not conferred rights to NHSN data. Hospitals must report the numerator and denominators, for all inpatient locations, for these four specific surgeries separately. For hospitals reporting to NHSN and conferring rights to HSAG HIIN, the numerators and denominators to calculate these rates shall be extracted, and rates calculated.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
  http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

Peri-Operative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures) (NQF 0271)

Peri-Operative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures) (NQF 0271)	
Numerator	Non-cardiac surgical patients who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time
Denominator	All non-cardiac surgical patients aged 18 years or older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	Chart review, electronic health record (EHR)
Measure Definition/Specifications	NQF 0271
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	NQF0271

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
  http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

Venous Thromboembolism (VTE)

Postoperative PE or DVT Rate (AHRQ PSI-12)

Postoperative PE or DVT Rate (AHRQ PSI-12)	
Numerator	Number of surgical patients that develop a postoperative PE or DVT
Denominator	All surgical discharges age 18 and older defined by specific DRGs or MS-DRGs and a procedure code for an operating room procedure
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	AHRQ PSI-12
Data Source(s)	Medicare FFS Claims
Data Submission Time Period	Monthly
Baseline Period	Q4 2015 – Q3 2016
Measure ID	PSI12

PE: Pulmonary Embolism

Additional Resources

- The Partnership for Patients (PfP): https://partnershipforpatients.cms.gov/p4p_resources/tsp-venusthromboembolism/toolvenousthromboembolismvte.html
- The Agency for Healthcare Research and Quality (AHRQ): https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD10/TechSpecs/PSI_12_Perioperative_Pulmonary_Embolism_or_Deep_Vein_Thrombosis_Rate.pdf

Venous Thromboembolism Prophylaxis (NQF 0371)

Venous Thromboembolism Prophylaxis (NQF 0371)	
Numerator	Patients who received venous thromboembolism (VTE) prophylaxis (or have documentation for why no VTE prophylaxis was given): Surgery inpatients—the day of or the day after surgery (for surgeries that start the day of or the day after hospital admission) OR All other inpatients—the day of or day after hospital admission
Denominator	All patients
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Measure Definition/Specifications	NQF 0371
Data Source(s)	Chart review
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	NQF0371

Additional Resources

- The Partnership for Patients (PfP): https://partnershipforpatients.cms.gov/p4p_resources/tsp-venusthromboembolism/toolvenousthromboembolismvte.html

Ventilator Associated Event (VAE)

Ventilator Associated Condition (VAC)

Ventilator Associated Condition (VAC)	
Numerator	Number of events that meet the criteria of VAC; including those that meet the criteria for infection-related ventilator-associated complication (IVAC) and possible/probable ventilator-associated pneumonia (VAP)
Denominator	Total number of ventilator days for each location under surveillance during the data collection period
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	CDC VAE NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	VAC

Data elements to calculate this rate will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals not reporting to NHSN shall be required to report the number of VACs and number of ventilator days.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/vae/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/10-VAE_FINAL.pdf
- The Partnership for Patients (PfP):
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-ventilator-associatedpneumonia/toolventilator-associatedpneumoniavap.html

Infection-Related Ventilator Associated Complication (IVAC)

Infection-Related Ventilator-Associated Complication (IVAC)	
Numerator	Number of events that meet the criteria of infection-related ventilator-associated condition (IVAC); including those that meet the criteria for possible/probable VAP
Denominator	Total number of ventilator days for each location under surveillance during the data collection period
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	CDC VAE NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	IVAC

Data elements to calculate this rate will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals not reporting to NHSN shall be required to report the number of IVACs events and number of ventilator days.

Additional Resources

- The Centers for Disease Control and Prevention (CDC):
  http://www.cdc.gov/nhsn/acute-care-hospital/vae/index.html
  http://www.cdc.gov/nhsn/PDFs/pscManual/10-VAE_FINAL.pdf
- The Partnership for Patients (PfP):
  https://partnershipforpatients.cms.gov/p4p_resources/tsp-ventilator-associatedpneumonia/toolventilator-associatedpneumoniavap.html

Possible Ventilator-Associated Pneumonia (PVAP)

Possible Ventilator Associated Pneumonia (PVAP)	
Numerator	Number of events that meet the criteria for possible ventilator-associated pneumonia (PVAP)
Denominator	Total number of ventilator days for each location under surveillance during the data collection period
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 1{,}000$
Measure Definition/Specifications	CDC VAE NHSN
Data Source(s)	NHSN
NHSN Data Transfer	Yes—for hospitals conferring rights to HSAG HIIN
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	PVAP

Data elements to calculate this rate will be extracted from NHSN for hospitals which confer rights to HSAG HIIN. Hospitals not reporting to NHSN shall be required to report the number of PVAPs and number of ventilator days.

Additional Resources

- The Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/nhsn/acute-care-hospital/vae/index.html http://www.cdc.gov/nhsn/PDFs/pscManual/10-VAE_FINAL.pdf
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-ventilator-associatedpneumonia/toolventilator-associatedpneumoniavap.html

ABCDEF Bundle Compliance

ABCDEF Bundle Compliance	
Numerator	Number of patients on a ventilator who were assessed with the ABCDEF Bundle where all bundle elements were completed
Denominator	Total number of patients on a ventilator
Rate Calculation	$\left(\frac{Numerator}{Denominator}\right) x\ 100$
Data Source(s)	Chart review
Data Submission Time Period	Monthly
Baseline Period	Calendar year 2015
Measure ID	VAE_BUNDLE

Additional Resources

- The Society of Critical Care Medicine: http://www.sccm.org/ICULiberation/ABCDEF-Bundles
- The Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/nhsn/acute-care-hospital/vae/index.html http://www.cdc.gov/nhsn/PDFs/pscManual/10-VAE_FINAL.pdf
- The Partnership for Patients (PfP): http://partnershipforpatients.cms.gov/p4p_resources/tsp-ventilator-associatedpneumonia/toolventilator-associatedpneumoniavap.html

Person and Family Engagement (PFE)

Planning Checklist for Scheduled Admissions

Planning Checklist for Scheduled Admissions	
Response Choices	Yes—No (each hospital indicates a Yes or No response)
Measure Intent	For all scheduled admissions, hospital staff discuss a checklist of items to prepare patients and families for the hospital stay and invite them to be active partners in care.
"Yes" Response Indicates	• Hospital has a physical planning checklist for patients with scheduled admissions. • Hospital staff discuss the checklist with the patient and family prior to or at admission.
Measure Definition/Specifications	PfP Strategic Vision Roadmap for PFE
Data Submission Time Period	Update(s) as Necessary
Baseline Period	2017 Hospital Self-Assessment
Measure ID	PFE1

Shift Change Huddles or Bedside Reporting

Shift Change Huddles or Bedside Reporting	
Response Choices	Yes—No (each hospital indicates a Yes or No response)
Measure Intent	Include the patient and/or family caregiver in as many conversations about their care as possible throughout the hospital stay.
"Yes" Response Indicates	On at least one unit, nurse shift change huddles OR clinician reports/rounds occur at the bedside and involve the patient and/or family members in all feasible cases.
Measure Definition/Specifications	PfP Strategic Vision Roadmap for PFE
Data Submission Time Period	Update(s) as Necessary
Baseline Period	2017 Hospital Self-Assessment
Measure ID	PFE2

Designated PFE Leader

Designated PFE Leader	
Response Choices	Yes—No (each hospital indicates a Yes or No response)
Measure Intent	Hospital has a designated individual (or individuals) with leadership responsibility and accountability for PFE.
"Yes" Response Indicates	• There is a named hospital employee (or employees) responsible for PFE efforts. Such individual(s) can hold either a full-time position or a percentage of time within another position. • Appropriate hospital staff and clinicians are able to identify the person named as responsible for PFE.
Measure Definition/Specifications	PfP Strategic Vision Roadmap for PFE
Data Submission Time Period	Update(s) as Necessary
Baseline Period	2017 Hospital Self-Assessment
Measure ID	PFE3

Patient and Family Advisory Council (PFAC), or Patient/Family Representative(s) on Hospital Committee

PFAC, or Patient/Family Representative(s) on Hospital Committee	
Response Choices	Yes—No (each hospital indicates a Yes or No response)
Measure Intent	Ensure that a hospital has a formal relationship with patient and family advisors (PFAs) from the local community who provide input and guidance from the patient perspective on hospital operations, policies, procedures, and quality improvement efforts.
"Yes" Response Indicates	• Patient and/or family representatives from the community have been formally named as members of a PFAC or another hospital committee (at least one patient.). • Meetings of the PFAC or another committee with patient and family representatives have been scheduled and conducted.
Measure Definition/Specifications	PfP Strategic Vision Roadmap for PFE
Data Submission Time Period	Update(s) as Necessary
Baseline Period	2017 Hospital Self-Assessment
Measure ID	PFE4

Patient/Family Representative(s) on the Board of Directors

Patient/Family Representative(s) on the Board of Directors	
Response Choices	Yes—No (each hospital indicates a Yes or No response)
Measure Intent	Ensure that the board includes patient and family perspectives when making governance decisions at the hospital. Ensure that at least one board member with full voting rights and privileges provides the patient and family perspective on all matters before the Board.
"Yes" Response Indicates	• Hospital has at least one position on the board designated for a patient or family member who is appointed to represent that perspective. • If a formal position on the board is not possible, an alternative exists to incorporate the perspectives of patients and families when making governance decisions (e.g., requesting PFAC input on board matters; asking board members to attend PFAC meetings or visit care units in the hospital, etc.)
Measure Definition/Specifications	PfP Strategic Vision Roadmap for PFE
Data Submission Time Period	Update(s) as Necessary
Baseline Period	2017 Hospital Self-Assessment
Measure ID	PFE5