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CHI Franciscan Health Quality Indicators

A guide to Centers for Medicare & Medicaid Services/The Joint Commission quality measures including Value-Based Purchasing

Version 8.0 (Revised April 2018)

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How to Use This Guide

This guide is a reference for providing care to patients who are being treated for the conditions indicated.

The Centers for Medicare & Medicaid Services (CMS), The Joint Commission (TJC) and public and private health care stakeholders, are working to streamline and standardize hospital quality and safety performance and reporting. This trend presents a valuable opportunity for CHI Franciscan Health hospitals to refocus our efforts to provide the best quality, best practices, and best care to our patients. Quality of care typically is determined through a set of uniform, national hospital quality measures which focus on a limited number of high-volume conditions. The standard measures are summarized inside this guide.

Excellent performance in these measures has been shown to produce the greatest impact on quality improvement.

Quality indicators are reassessed and revised frequently; visit For Medical Staff SharePoint-Quality Indicators Guide for the latest information.

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ELECTRONIC QUALITY MEASURES

Electronic Clinical Quality Measure eCQMs

An electronic clinical quality measure (eCQM) is a measure that is specified in a standard electronic format and is designed to use structured, encoded data present in the electronic health record.

CMS Electronic Health Record (EHR) Incentive Program was implemented for calendar year 2016. CMS anticipates that most, if not all, quality measures will be based on data derived from the EHRs in the next few years. Once capture is possible within the EHR, electronic reporting will decrease burden to hospital's time and resources needed to manually abstract data and submit quality measures.

For more information, please visit:

https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html

https://ecqi.healthit.gov/eligible-hospital-critical-access-hospital-ecqms

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INPATIENT QUALITY INDICATORS OVERVIEW

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018)

(CMS Specifications Manual 5.3a—Discharges between 1-1-2018 and 06-30-2018)

(Electronic Clinical Quality Measures (eCQMS) Reporting Specifications)

IMMUNIZATIONS	• IMM-2 Influenza Immunization
EMERGENCY DEPARTMENT	• ED-1 Median time from ED arrival to ED departure for admitted patients eCQM • ED-2 Admit decision time to ED departure time for admitted patients eCQM
HOSPITAL BASED INPATIENT PSYCHIATRIC SERVICES (HBIPS)	• HBIPS-1 Admission screening for violence risk, substance use, psychological trauma history and patient strengths completed • HBIPS-2 Hours of physical restraint use • HBIPS-3 Hours of seclusion use • HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Quality indicators are reassessed and revised on a continual basis

For the most current information, please visit the Specifications Manual website:

http://www.qualitynet.org/dcs/ContentServer?cid=1141662756099&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page

https://manual.jointcommission.org/releases/TJC2017B2/

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(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018, and the American Heart Association)

(CMS Specifications Manual 5.3a—Discharges between 1-1-2018 and 06-30-2018)

(Electronic Clinical Quality Measures (eCQMS) Reporting Specifications)

VENOUS THROMBOEMBOLISM (VTE)	• VTE-1 Venous Thromboembolism Prophylaxis eCQM • VTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis eCQM • VTE-6 Hospital Acquired Potentially-Preventable Venous Thromboembolism
STROKE	• STK-1 VTE Prophylaxis • STK-2 Discharged on Antithrombotic Therapy • STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter • STK-4 Thrombolytic Therapy • STK-5 Antithrombotic Therapy by End of Hospital Day 2 • STK-6 Discharged on Statin Medication • STK-8 Stroke Education • STK-10 Assessed for Rehabilitation • STK-11 Smoking Cessation • STK-12 LDL Documentation • STK-14 Intensive Statin Therapy • STK-15 Dysphagia Screening • STK-16 Time to IV Thrombolytic Therapy • STK-17 IV RT-PA • STK-18 NIHSS Reported
PERINATAL	• PC-01 Elective Deliveries VBP • PC-02 Cesarean Section • PC-03 Antenatal Steroids • PC-04 Healthcare-Acquired Bloodstream Infections in Newborns • PC-05 Exclusive Breast Milk Feeding

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For the most current information, please visit the Specifications Manual website:

http://www.qualitynet.org/dcs/ContentServer?cid=1141662756099&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page

https://manual.jointcommission.org/releases/TJC2017B2/

http://www.heart.org/HEARTORG/Professional/GetWithTheGuidelines/Get-With-The-Guidelines-Stroke_UCM_306098_SubHomePage.jsp

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(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018, and the American Heart Association)

(CMS Specifications Manual 5.3a—Discharges between 1-1-2018 and 06-30-2018)

SEPSIS	• SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock
HEART FAILURE	• Ace Inhibitor (ACEI)/Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor/Neprilysn Inhibitor (ARNI) at discharge for patients with EF <40% • Evidence-based specific Beta-Blockers for patients with EF <40% • Measure left ventricular (LV) function • Post discharge appointment for heart failure patients • Anticoagulation for atrial fibrillation or atrial flutter • Aldosterone Antagonist at discharge • Hydralazine Nitrate at discharge • DVT prophylaxis • CRT-D or CRT-P placed or prescribed at discharge • ICD counseling or ICD placed or prescribed at discharge • Influenza vaccination during flu season – October through March • Pneumococcal vaccination • Follow-up visit within 7 days or less from date of discharge

Quality indicators are reassessed and revised on a continual basis

For the most current information, please visit the Specifications Manual website:

http://www.qualitynet.org/dcs/ContentServer?cid=1141662756099&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page

https://manual.jointcommission.org/releases/TJC2017B1/

http://www.heart.org/HEARTORG/Professional/GetWithTheGuidelines/GetWithTheGuidelines-HF/Get-With-The-Guidelines-HF-Clinical-Tools-Library_UCM_305817_Article.jsp#.WrliYWdlC71

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OUTPATIENT QUALITY INDICATORS OVERVIEW

(CMS Specifications Manual 11.0a—Discharges between 1-1-2018 and 12-31-2018)

Acute Myocardial Infarction (AMI)

- OP-1 Median time to fibrinolysis
- OP-2 Fibrinolytic therapy received within 30 minutes of ED arrival
- OP-3 Median time to transfer to another facility for acute coronary intervention
- OP-4 Aspirin to Arrival
- OP-5 Median time to ECG

Chest Pain (CP)

- OP-4 Aspirin at arrival
- OP-5 Median time to ECG

ED Throughput

- OP-18 Median time from ED arrival to ED departure for discharged ED patients
- OP-22 Left without being seen

Pain Management

- OP-23 Head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke patient who rec'd head CT or MRI scan interpretation within 45 minutes of ED arrival

Imaging Efficiency

- OP-8 MRI lumbar spine for low back pain
- OP-9 Mammography follow-up rates
- OP-10 Abdomen CT- use of contrast material
- Op-11 Thorax CT- use of contrast material
- OP-13 Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery
- OP-14 Simultaneous use of brain computed tomography (CT) and sinus computed tomography (CT)

Measures submitted to CMS via a web-based tool

- OP-12 The ability for providers with HIT to receive laboratory data electronically directly into their ONC-Certified EHR system as discrete searchable data
- OP-17 Tracking clinical results between visits
- OP-25 Safe surgery checklist use
- OP-26 Hospital outpatient volume on selected outpatient surgical procedures
- OP-27 Influenza vaccination coverage among healthcare personnel
- OP-29 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patient
- OP-30 Colonoscopy interval for patient with a history of adenomatous polyps- avoidance of inappropriate use
- OP-31 Cataracts- Improvement in patient's visual function within 90 days following cataract surgery
- OP-33 External Beam Radiotherapy for Bone Metastases

OUTPATIENT QUALITY INDICATORS OVERVIEW CONTINUE

(CMS Specifications Manual 11.0a—Discharges between 1-1-2018 and 12-31-2018)

Outcome

- OP-32 Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy
- OP-35 Admissions and ED visits for patient receiving outpatient chemotherapy ***NEW 2018***
- OP-36 Hospital visits after hospital outpatient surgery ***NEW 2018***

Quality indicators are reassessed and revised on a continual basis

For the most current information, please visit:

http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244

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PAYMENT REDUCTION PROGRAMS

The Centers for Medicare & Medicaid Services (CMS) has in place one payment incentive program (Value Based Purchasing) and two payment reduction programs (Readmission Reduction Program & Hospital Acquired Condition) for hospitals. These programs are intended to encourage hospitals to follow identified national standards by linking reimbursement to quality performance. Excellent performance in these measures has been shown to produce the greatest impact on quality improvement.

In this guide you will see symbols next to the quality measures that are currently included in the various CMS payment programs.

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1. VALUE-BASED PURCHASING VBP

This program was established as part of the 2010 Affordable Care Act. It is a national Pay-for-Performance incentive program that promotes higher quality of care for patients.

Measures are based on a progression of 4 Domains: clinical care process, person and community engagement, safety, and efficiency/cost instead of volume of services.

There is a percentage reduction in Medicare payments kept in reserve for the incentive program. Reimbursement is dependent on meeting the measure benchmarks in order to earn back the reduction in payment. Exceeding the benchmarks is an incentive that can result in even higher reimbursement.

To learn more about the Value-Based Purchasing Program:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937

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2. HOSPITAL READMISSION REDUCTION PROGRAM

This program was established as part of the 2010 Affordable Care Act. It addresses excessive hospital readmissions for specific conditions.

The measures selected are either National Quality Forum (NQF)-endorsed or identified by the Medicare Payment Advisory Commission for inclusion in this program. These measures represent conditions or procedures that involve high volumes of patients or that have a high cost.

Medicare payments may be reduced depending on the hospital's performance.

To learn more about the Hospital Readmission Reduction Program:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458

— Acute Myocardial Infarction 30-Day Readmission Rate
— Heart Failure 30-Day Readmission Rate
— Pneumonia 30-Day Readmission Rate
— Coronary Artery Bypass Graft 30-Day Readmission Rate
— Chronic Obstructive Pulmonary Disease 30-Day Readmission Rate
— Stroke 30-Day Readmission Rate
— Hip/Knee Replacement 30-Day Readmission Rate

— Hospital-Wide All-Cause Unplanned Readmission Rate

PAYMENT REDUCTION PROGRAMS (PAGE 2)

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3. HOSPITAL-ACQUIRED CONDITION (HAC) AND INFECTIONS (HAI)

CMS developed this program to promote higher quality of care and to improve patient outcomes for Medicare beneficiaries by reducing the number of hospital-acquired conditions. According to CMS it is believed that these conditions could reasonably have been prevented through the application of evidence-based practice guidelines.

Through payment adjustment to the Medicare base-operating DRG payments, CMS is attempting to encourage hospitals to utilize evidence-based practice guidelines to eliminate the incidence of HACs. This payment reduction will be made **after** the Hospital Value-Based Purchasing Program and Hospital Readmission Reduction Program adjustments have been applied.

To learn more about the Hospital-Acquired Condition (HAC) Reduction Program:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html

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HOSPITAL-ACQUIRED CONDITIONS (HACS)

- Agency for Healthcare Research & Quality (AHRQ) Patient Safety Indicators (PSI-90 Composite)
    - Pressure Ulcer Rate
    - Iatrogenic Pneumothorax Rate
    - Central Venous Catheter-Related Blood Stream Infection Rate
    - Postoperative Hip Fracture Rate
    - Postoperative PE/DVT Rate
    - Postoperative Sepsis Rate
    - Postoperative Wound Dehiscence Rate
    - Accidental Puncture/Laceration Rate

HOSPITAL-ACQUIRED INFECTIONS (HAI)

- Central Line-Associated Bloodstream Infection (CLABSI)
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Surgical Site Infection following Colon Procedures
- Surgical Site Infection following Hysterectomy Procedures
- Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia
- Clostridium Difficile (CDI)

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CLAIMS-BASED QUALITY INDICATORS OVERVIEW

READMISSIONS	• Acute Myocardial Infarction (AMI) 30-day risk standardized readmission (Medicare patients) RRP • Heart Failure (HF) 30-day risk standardized readmission (Medicare patients) RRP • Pneumonia (PN) 30-day risk standardized readmission (Medicare patients) RRP • Hospital-wide, all cause unplanned readmission (HWR) • 30-day risk standardized readmission following Total Hip/Total Knee Arthroplasty RRP • Stroke 30-day risk standardized readmission • COPD 30-day risk standardized readmission RRP • CABG 30-day risk standardized readmission RRP
MORTALITY	• AMI 30-day mortality rate VBP • HF 30-day mortality rate VBP • PN 30-day mortality rate VBP • Stroke 30-day mortality rate • COPD 30-day mortality rate VBP • CABG 30-day mortality rate
PATIENT SAFETY	• PC-01 Elective Deliveries VBP • PSI-4 Death among surgical inpatients with serious treatable complications • PSI-90 Patient Safety and Adverse Events (Composite Measure) ○ Pressure ulcer rate ○ Iatrogenic pneumothorax ○ Central vein catheter infection ○ Postop hip fracture ○ Postop PE/VTE ○ Postop sepsis ○ Wound dehiscence ○ Accidental puncture/laceration)
SURGICAL COMPLICATIONS	• Hip/Knee Complication: Hospital-level risk standardized complication rate following elective primary Total Hip Arthroplasty VBP
COST EFFICIENCY	• Medicare spending per beneficiary (MSPB) VBP • AMI payment per episode of care • HF payment per episode of care • PN payment per episode of care • THA/TKA payment per episode of care

To learn more about the Claims-Based Quality Indicators:
http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228763452133

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HOSPITAL-ACQUIRED CONDITIONS (HACS) AND PRESENT ON ADMISSION (POA) INDICATOR REPORTING

For discharges occurring on or after October 1, 2008, Inpatient Prospective Payment System (IPPS) hospitals will not receive additional payment for cases when one of the selected complicating conditions is acquired during hospitalization (i.e. was not present on admission).

Present on Admission (POA) is defined as present at the time the order for inpatient admission occurs—conditions that develop during an outpatient encounter, including ED, observation, or outpatient surgery, are considered POA.

If at discharge there is a selected complicating condition that was not identified as POA, it is considered a hospital-acquired condition.

The healthcare provider who is legally accountable for the patient must document POA before discharge.
The importance of consistent, complete documentation in the medical record cannot be overemphasized.

HOSPITAL-ACQUIRED CONDITIONS (HACS) AND HOSPTIAL-ACQUIRED INFECTIONS (HAI)

- Deep Vein Thrombosis and Pulmonary Embolism
- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma
- Fracture
- Dislocation
- Intracranial Injury
- Crushing Injury
- Burn
- Other Injuries
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Vascular Catheter-Associated Infection
- Iatrogenic Pneumothorax with Venous Catheterization
- Manifestations of Poor Glycemic Control
- Diabetic Ketoacidosis
- Nonketotic Hyperosmolar Coma
- Hypoglycemic Coma
- Secondary Diabetes with Ketoacidosis
- Secondary Diabetes with Hyperosmolarity
- Surgical Site Infection, Mediastinitis, following Coronary Artery Bypass Graft (CABG)
- Surgical Site Infection following Cardiac Implantable Electronic Device (CIED)
- Surgical Site Infection following Certain Orthopedic Procedures
- Spine
- Neck
- Shoulder
- Elbow
- Surgical Site Infection following Bariatric Surgery for Obesity
- Laparoscopic Gastric Bypass
- Gastroenterostomy
- Laparopscopic Gastric Restrictive Surgery
- Surgical Site Infection following Colon and Abdominal Hysterectomy

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** As specified as statue, CMS may revise the list of conditions from time to time, as long as it contains at least two conditions*

HCAHPS ("H-CAPS")

HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS

The HCAHPS survey is a standardized national survey implemented by CMS. The survey asks about the aspects of the patient experience that, based on research, are directly connected with health outcomes. The survey is administered by phone to a random sample of adult, discharged patients who had been treated for a range of medical conditions, including maternity services. The 8 composite scores are currently included in the CMS Value-Based Purchasing (VBP) program.

The inpatient survey sets a high bar for responses, with only the highest or "top box" responses counted in the VBP scoring algorithm. The "top box" score is the best score on the scale (i.e., always, yes, 9 or 10, definitely yes). For an example, the top box composite score for "Nurse Communication" domain, reports the weighted average of the individual questions top box score. The Nurse Communication domain and its included questions is shown below.

	Adjusted N	Correlation	Your Top Box	HSTM DB Top Box	HSTM DB Top Box Percentile Rank
Nurse Communication	**317**	**0.51**	**83.9%**	**81.8%**	**60**
H2C Courtesy/respect of nurses	106	0.50	91.5%	87.7%	76
H2O Nurses listening carefully to patients	105	0.54	81.9%	79.8%	58
H2J Clear communication by nurses	106	0.50	78.3%	77.8%	46

The survey is designed to produce comparable data to allow for objective and meaningful comparisons among hospitals and to create incentives for hospitals to improve quality of care. The aim is to consistently score top-box rating in each major composite, and thus improving rank when compared to our peers. (CMS states that HCAHPS is designed and intended for inter-hospital (hospital-to-hospital) comparisons. CMS does not review, endorse, or recommend the user of HCAHPS scores for intra-hospital comparisons. E.g. comparing unit, floor or staff to others.)

CHI Franciscan Health has adopted AIDET, an evidence-based practice, as a means to convey our RICE values. Establishing trust and rapport improves patient perception of care when used appropriately with every patient every time. AIDET means Acknowledging the patient and loved ones with eye contact and a smile, Introducing yourself and your colleagues, providing information about the Duration of wait times and procedures, providing Explanations why and Thanking patients and family members at the end of each encounter. CHI has mandated a companywide patient experience playbook which outlines strategies for improved goals and specific facility action plans. You can find links to the CHI playbook and site-specific action plans at https://chifh.catholichealth.net/Comm/px .

2018 HCAHP Changes:

- FHS returned to surveying by units when and where possible.
- Press Ganey purchased CHI's survey vendor HealthStream. Although HCAHPS questions will stay the same, significant changes will be implemented this year as we switch platforms.
- Reporting for HCAHPS by Unit is currently problematic. This supposedly is being fixed by our vendor and CHI BI.
- E-Surveys were implemented this year for EDCAHPS, OAS, and IP. (E-Surveys are text / email based surveying for all.)
- IP Express began. It is a new pilot project intended to survey all eligible patients who are not selected for the HCAHPS phone survey. Current results are useless so we expect this survey solution to be discontinued in the near future.

The latest updates and resources are available on the FHS Patient Experience SharePoint site: https://chifh.catholichealth.net/Comm/px.

Local FHS Contact: PXSupport@chifranciscan.org

HCAHPS (PAGE 2)

INPATIENT HCAHPS SURVEY QUESTIONS

Nurse Communication VBP	During this hospital stay, how often did nurses treat you with courtesy and respect? During this hospital stay, how often did nurses listen carefully to you? During this hospital stay, how often did nurses explain things in a way you could understand?	***TOP BOX SCORE** *4=Always, 3=Usually, 2=Sometimes, 1=Never
Doctor Communication VBP	During this hospital stay, how often did nurses treat you with courtesy and respect? During this hospital stay, how often did nurses listen carefully to you? During this hospital stay, how often did nurses explain things in a way you could understand?	*4=Always, 3=Usually, 2=Sometimes, 1=Never
Responsiveness of staff VBP	During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? During this hospital stay, how often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?	***TOP BOX SCORE** *4=Always, 3=Usually, 2=Sometimes, 1=Never
Hospital Cleanliness and Quietness VBP	During this hospital stay, how often were your room and bathroom kept clean? During this hospital stay, how often was the area around your room quiet at night?	*4=Always, 3=Usually, 2=Sometimes, 1=Never
Communication about Pain VBP	During this hospital stay did you have any pain? During this hospital stay, how often did the hospital staff talk with you about how much pain you had? During this hospital stay, how often did the hospital staff talk with you about how to treat your pain?	*4=Always, 3=Usually, 2=Sometimes, 1=Never
Communication about Medications VBP	Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?	*4=Always, 3=Usually, 2=Sometimes, 1=Never

HCAHPS (PAGE 3)

INPATIENT HCAHPS SURVEY QUESTIONS

Category	Question	Response
Discharge Instructions VBP	During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?	*1=Yes, 2=No
Overall Rating of Hospital VBP	Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital? Would you recommend this hospital to your friends and family? During this hospital stay, how often did the staff treat you as a whole person, not just a medical condition? How often did the staff meet your expectations regarding your family's involvement in your care?	*10=Best hospital possible, 0=Worst hospital possible
	Did a nurse leader visit you during your hospital say? A Hospitalist is a hospital-based doctor who cares for hospitalized patients in the place of a patient's personal healthcare provider. Did you receive care from a Hospitalist? Using any number from 0 to 10, where 0 is the worst possible care and 10 is the best possible care, what number would you use to rate the care received from the hospitalist who treated you? Thinking of your hospital stay, what one thing could the hospital have done better? Is there a specific person you would like to see complimented or thanked for the care they provided?	***TOP BOX SCORE** Yes/No *10=Best hospital possible, 0=Worst hospital possible
Care Transition VBP	During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.	1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree
	When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.	1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree
	When I left the hospital, I clearly understood the purpose for taking each of my medications.	1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree 5=I was not given any medication when I left the hospital

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EDUCATION FORM

INPATIENT IMMUNIZATIONS

(CMS Specifications Manual 5.3a—Discharges between 1-1-2018 and 06-30-2018)

(CMS Specifications Manual 5.4-Discharges between 7-1-2018-12-31-2018)

IMMUNIZATION QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
INFLUENZA VACCINATION— must be assessed and administered when applicable to all patients 6 months of age and older, regardless of diagnosis, hospitalized (discharged) during the months of September through March	Reasons for not administering include: • Influenza vaccine was received in the past (during this flu season) and is documented in the medical record for the present episode of care • Documentation of patient or caregiver's refusal of influenza vaccine • Documented allergy/sensitivity to influenza vaccine • Documented anaphylactic egg allergy • Documented anaphylactic latex allergy • Documented bone marrow transplant within the past 6 months • Documented history of Guillian-Barré syndrome within 6 weeks after a previous influenza vaccination

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EDUCATION FORM

INPATIENT VENOUS THROMBOEMBOLISM (VTE)

(CMS Specifications Manual 5.3a—Discharges between 1-1-2018 and 06-30-2018)

(CMS Specifications Manual 5.4-Discharges between 7-1-2018-12-31-2018)

(Electronic Clinical Quality Measures (eCQMS) Reporting Specifications)

VTE QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
VTE RISK ASSESSMENT AND APPROPRIATE PROPHYLAXIS BEGUN eCQM	• Applies to Medical and surgical patients upon hospital admission and ALL patients up on admission / transfer to ICU • Documentation must be completed within 1 day of admission, surgery, or transfer to ICU • Both pharmacologic and mechanical prophylaxis must be addressed. If one type of prophylaxis is contraindicated (with reason documented), the other type of prophylaxis must be used unless a contraindication is explicitly documented as well. (e.g. 'Active GI bleeding-LMWH contraindicated'. The patient would still require mechanical prophylaxis.) • Only acceptable reasons for not administering any pharmacologic or mechanical prophylaxis: • Patient at low risk for VTE • Explicit documentation that patient doesn't need VTE prophylaxis • Patient/family refusal • Documentation that patient is already adequately anticoagulated • Warfarin is listed as a home medication • Only Acceptable Indications for Oral Factor Xa Inhibitor: • History of hip replacement surgery (not fracture) • History of knee replacement surgery • History of/current finding of Atrial Fibrillation or Atrial Flutter (except when terminated within 8 weeks following CABG) • History of treatment for VTE

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EDUCATION FORM

INPATIENT STROKE

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018, and the American Heart Association)

STROKE QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
VTE PROPHYLAXIS GIVEN THE DAY OF OR THE DAY AFTER HOSPTIAL ADMISSION (ISCHEMIC AND HEMORRAHGIC)	• **Both** pharmacologic and mechanical prophylaxis must be addressed • Reasons for not administering pharmacologic prophylaxis must be explicitly documented such as “Active GI bleed – LMWH contraindicated” • Stroke patient require a documented reason for not administering another form of prophylaxis when graduated compression stockings or aspirin are the ONLY form of BTE prophylaxis administered • Documentation that patient is ambulating without mention of VTE prophylaxis is insufficient to pass measure.
ANTITHROMBOTIC THERAPY PRESCRIBED AT HOSPITAL DISCHARGE – ANTICOAGULANT AND ANTIPLATELET DRUGS (ISCHEMIC)	• All discharge medication documentation available in the chart will be taken into account unless the documentation is contradictory • If documentation is contradictory, it will be considered “unable to determine” which will result in a variance • The antithrombotic must be listed by name and not by medication class. Contraindication to antithrombotic therapy must be documented during hospitalization or at discharge. • Patients discharging to SJMC Inpatient Rehab should have discharge medications listed in the DC Summary. Discharge Medications written after discharge from an acute care setting will not be considered
ANTICOAGULATION THERAPY FOR ATRIAL FIBRILLATION/FLUTTER PRESCRIBED AT HOSPITAL DISCHARGE (ISCHEMIC)	• All discharge medication documentation available in the chart will be taken into account unless the documentation is contradictory • If documentation is contradictory, it will be considered “unable to determine” which will result in a variance • ANY mention of history of Afib/flutter requires either prescribing anticoagulation therapy at discharge, or documentation of a reason for not prescribing anticoagulation therapy at discharge. • Patients discharging to SJMC Inpatient Rehab should have discharge medications listed in the DC Summary. Discharge Medications written after discharge from an acute care setting will not be considered.

EDUCATION FORM

INPATIENT STROKE (PAGE 2)

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018, and the American Heart Association)

STROKE QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
THROMBOLYTIC THERAPY FOR ACUTE ISCHEMIC STROKE PATIENTS WHO ARRIVE WITHIN 2 HOURS OF TIME LAST KNOWN WELL AND IV TPA INITIATED WITHIN 3 HOURS	• **Last Known Well (LKW) is abstracted first from Code Stroke form/template, then from other sources, including ambulance records** • Reasons for not initiating IV thrombolytic therapy must be explicitly documented by a Physician/APN/PA or Pharmacist • Nursing may document patient/family refusal, NIHSS score of zero or initiation of IV thrombolytic at a transferring hospital • If administered between 3-4/5 hours from LKW, must document a Reason for Extending the Initiation of IV Thrombolytic
ANTITHROMBOTIC THERAPY BY END OF HOSPITAL DAY 2 (ISCHEMIC)	• Reason for not administering antitrhobotic therapy must be dated/timed prior to end of hospital day 2 and explicitly documented by a Physician/PAN/PA or Pharmacist • Nursing may document patient/family refusal but is must be documented in the timeframe of arrival to end of hospital day 2
DISCHARGE ON STATIN MEDICATION (ISCHEMIC)	• All discharge medication documentation available in the chart will be taken into account unless the documentation is contradictory • If documentation is contradictory, it will be considered “unable to determine” which will result in a variance • The statin must be listed by name and not by medication class • If not prescribing a statin for an ischemic stroke patient with an LDL≥70, specifically document the reason why • Patients discharging to SJMC Inpatient Rehab should have discharge medications listed in the DC Summary. Discharge Medications written after discharge from an acute care setting will not be considered
STROKE EDUCATION (ISCHEMIC AND HEMORRHAGIC)	Documentation that the patient or caregiver was given written educational materials during the hospital stay addressing all of the following: • Activation of emergency medical system • Follow up after discharge • Medications prescribed at discharge (AVS-Home Medication List must match with Discharge orders and Discharge Summary) • Risk factors for stroke • Warning signs and symptoms of stroke

EDUCATION FORM

INPATIENT STROKE (PAGE 3)

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018, and the American Heart Association)

STROKE QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
ASSESSED FOR REHABILITATION SERVICES (ISCHEMIC AND HEMORRHAGIC)	• Assessment for rehabilitation services must be completed by a qualified provider (excluding nursing) • Reason for not assessing for rehab services must be stated in the context of rehabilitation services such as "Patient returned to prior level of function, rehabilitation not indicated at this time" or "Symptoms resolved – no rehab needed"
SMOKING CESSATION	• Applies to patients that have smoked at least one cigarette within the past year • Documentation that the patient received counseling to stop smoking or smoking cessation advice during the hospitalization is accepted • Smoking cessation therapies such as patch, gum are also equivalent to counseling
LDL DOCUMENTED	• Lipid measurements within the first 48 hours of hospital arrival are abstracted, values after 48 hours are not accepted
INTENSIVE STATIN THERAPY	• Patients with LDL >=70 should be prescribed intensive statin therapy at discharge • Reasons for not prescribing intensive statin therapy at discharge must be documented by a physician, PA or APN

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INPATIENT STROKE (PAGE 4)

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018, and the American Heart Association)

STROKE QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
DYSPHAGIA SCREENING	• Hemorrhagic and ischemic stroke patients must have an assessment of their swallowing ability prior to oral intake of food, fluid or medications • Reasons for not performing a swallow assessment must be explicitly documented by a physician, PA or APN • The swallow evaluation should be a standardized method of swallowing assessment
TIME TO IV THROMBOLYTIC THERAPY-60 MINUTES	• Reasons for not initiating IV thrombolytic therapy within 60 minutes of hospital arrival must be explicitly documented by a physician/PA /APN or pharmacist • Reasons must be mentioned in the context of IV thrombolytics
IV RT-PA ARRIVE BY 3.5 HOUR, TREAT BY 4.5 HOUR	• Last Known Well (LKW) is abstracted primarily from the Code Neuro Flow Sheet/template, then subsequently from a hierarchy of resources • Reasons for not initiating IV thrombolytic therapy by the 4.5 hour from LKW must be explicitly documented by the physician/PA/APN or pharmacist • Nursing may document refusal, NIHSS of zero or the initiation of therapy at a transferring facility
NIHSS REPORTED	• The first NIHSS documented based on the first arrival notes or in the first neurology exam is abstracted, if completed after 48 hours of arrival it is not accepted • The NIHSS must be completed prior to the administration of t-PA or the initiation of an acute endovascular procedure, if completed after these treatments are begun it is not accepted • Patients that transfer from another facility must have an initial NIHSS completed within 48 hours of arrival • Patients that transfer from another facility must have an initial NIHSS completed prior to the initiation of an endovascular procedure • NIHSS score must be **totaled**. Do not leave blank.

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INPATIENT PERINATAL

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018)

PERINATAL QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
MEASURE ID: PC-01 VBP **MEASURE NAME:** Elective Delivery PATIENTS WITH ELECTIVE VAGINAL DELIVERIES OR ELECTIVE CESAREAN BIRTHS AT ≥ 37 AND <39 WEEKS OF GESTATION COMPLETED	• Document any prior uterine surgery • Document history of previous stillbirth or intrauterine fetal demise > 20 weeks • Clearly document if patient is in labor, do not use prodromal to describe labor • Document if the patient is in labor prior to augmentation • Admission with ruptured membranes, clearly document if PROM or labor based on clinical presentation

MEASURE ID: PC-02
MEASURE NAME: Cesarean Birth
NULLIPAROUS WOMEN WITH A TERM, SINGLETON BABY IN A VERTEX POSITION DELIVERED BY CESAREAN BIRTH
	• Document number of live births experienced prior to this hospitalization
	• Document gestational age
	• Document diagnosis for contraindication to vaginal delivery; per TJC, acceptable contraindications are limited to:
	  ○ Breech or other malposition
	  ○ Early onset delivery
	  ○ Fetal demise
	  ○ Multiples

MEASURE ID: PC-03 **MEASURE NAME:** Antenatal Steroids PATIENTS AT RISK OF PRETERM DELIVERY AT ≥24 AND <34 WEEKS GESTATION RECEIVING ANTENATAL STEROIDS PRIOR TO DELIVERING PRETERM NEWBORNS	• Any reason for not initiating antenatal steroid therapy before delivery must be explicitly documented or clearly implied • Reasons may include fetal anomalies not expected to survive, imminent delivery (occurring within two hours of arrival to hospital), or other reasons documented by physician/APN/PA/CNM

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INPATIENT PERINATAL (PAGE 2)

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018)

MEASURE ID: PC-04 **MEASURE NAME:** Health Care-Associated Bloodstream Infections in Newborns STAPHYLOCOCCAL AND GRAM NEGATIVE SEPTICEMIAS OR BACTEREMIAS IN HIGH-RISK NEWBORNS	• Document within the first 48 hours of admission if patient has a blood stream infection or a suspected bloodstream infection is being treated • Clinician must specifically document newborn appears septic or document signs and symptoms of sepsis. (Rule/out sepsis or work up for sepsis is not sufficient documentation of infection present on admission) • Must document that sepsis was ruled out, or case will be coded for septicemia and fail the measure
MEASURE ID: PC-05 **MEASURE NAME:** Exclusive Breast Milk Feeding EXCLUSIVE BREAST MILK FEEDING DURING THE NEWBORN'S ENTIRE HOSPITALIZATION	• Document if the newborn is fed only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals or medicines. • Sweet ease or similar 24% sucrose and water solution used for the purpose of reducing discomfort during a procedure is classified as a medication

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EDUCATION FORM

HOSPITAL BASED INPATIENT PSYCHIATRIC SERVICES (HBIPS)

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018)

HBIPS QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
ADMISSION SCREENING FOR RISK OF VIOLENCE TO SELF OR OTHERS, SUBSTANCE USE, PSYCHOLOGICAL TRAUMA HISTORY AND PATIENT STRENGTHS COMPLETED	• Completion of **all five** initial assessment categories: Risk of violence to self in past six months, risk of violence to others in past six months and lifetime, alcohol and substance use in past twelve months (including type, amount, frequency of use and problems due to use), psychological trauma history and minimum of two patient strengths • Documentation in the medical record that an admission screening for violence risk to self over the past six months was performed within the first three days of admission. Violence Risk to Self includes: ideation, plans/preparation and/or intent to act if ideation present, past suicidal behavior and risk/protective factors within the 6 months prior to admission • Documented within the first three days of admission • Each substance abuse must be assessed completely. Quit time-frame must be documented (i.e. Patient quit smoking 2 years ago) • If unable to assess then must be documented as such
HOURS OF PHYSICAL RESTRAINT USE HOURS OF SECLUSION USE	• Document type and time of restraint or seclusion initiated and discontinued within the flowsheet
PATIENTS DISCHARGED ON MULTIPLE ANTIPSYCHOTIC MEDICATIONS WITH APPROPRIATE JUSTIFICATION	• Documented justification for patients discharged on two or more antipsychotic medications • Only acceptable justifications: History of 3 or more failed monotherapy trials with names of previously failed medications, plan to taper to monotherapy or cross-taper in progress at discharge with names of medications intended to be tapered and/or increased, OR augmentation of Clozapine

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EDUCATION FORM

INPATIENT SEPSIS

(CMS Specifications Manual 5.3a—Discharges between 1-1-2018 and 06-30-2018)

SEPSIS QUALITY INDICATOR	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
MEASURE ID: SEP-1 **MEASURE NAME:** Early Management Bundle, Severe Sepsis/Septic Shock THIS MEASURE FOCUSES ON ADULTS 18 YEARS AND OLDER WITH A DIAGNOSIS OF SEVERE SEPSIS OR SEPTIC SHOCK. IT ASSESSES MEASUREMENT OF INTERVENTIONS THAT SHOULD OCCUR WITHIN 3 HOURS OF PRESENTATION OF SEVERE SEPSIS AND INTERVENTIONS THAT SHOULD OCCUR WITHIN 6 HOURS OF PRESENTATION OF SEPTIC SHOCK.	**SEVERE SEPSIS Definition:** Two or more of SIRS Criteria + Infection + Organ Dysfunction **SEPTIC SHOCK Definition:** Severe Sepsis + Initial Lactate ≥ 4 ***OR*** Severe Sepsis + Persistent Hypotension **SIRS Criteria:** • Temp > 38.3C (100.9F) or <36.0C (96.8F) • HR > 90 • RR > 20 • WBC > 12 or < 4 or 10% bands **Organ Dysfunction:** • SBP <90 or MAP <65 or SBP decrease of >40pts • Cr > 2.0 or UP <0.5ml/kg/hr for 2hr • Total bilirubin > 2mg/dL (34.2 mmol/L) • Platelet count <100,000 • INR > 1.5 or aPTT >60 sec • Lactate > 2 mmol/L (18.0mg/dL) • Acute Respiratory Failure with new need for Mechanical Ventilation Measure **NUMERATOR:** Patients who received ALL of the interventions below. Measure **DENOMINATOR:** Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis, or Septic Shock. **Time "0" =** Earliest time of Inclusion Terms (provider documentation of Severe Sepsis and/or Septic Shock) and/or time last clinical criterion met.

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INPATIENT SEPSIS (PAGE 2)

(CMS Specifications Manual 5.3a—Discharges between 1-1-2018 and 06-30-2018)

SEPSIS QUALITY INDICATOR	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
EARLY MANAGEMENT BUNDLE, SEVERE SEPSIS/SEPTIC SHOCK	**Interventions expected to be completed within <u>3 hours</u> of presentation of Severe Sepsis:** • Initial lactate • Blood cultures • Broad spectrum antibiotic administration **Interventions expected to be completed within <u>6 hours</u> of presentation of Septic Shock:** • Fluid resuscitation • Vasopressor administration • Reassessment of volume status and tissue perfusion • Repeat lactate **Crystalloid Fluid Resuscitation- 30ml/kg** Required for: • Initial Hypotension (2 values of SBP <90 or MAP <65) OR… • Initial Lactate (lactate level closest to time “0”) ≥ 4 OR… • Provider inclusion terms of Septic Shock **Antibiotic Therapy-** • Required within 3hrs of Severe Sepsis or Septic Shock • Clinicians must rapidly treat • Initial therapy should be broad spectrum to cover all likely pathogens • As soon as the causative organism is identified, immediately deescalate to the most appropriate microbial therapy to cover the identified pathogen, safely and cost effectively • Use order set to guide therapy selection • If infection is NOT PRESENT, de-escalation of antibiotic use is imperative

EDUCATION FORM

INPATIENT SEPSIS (PAGE 3)

(CMS Specifications Manual 5.3a—Discharges between 1-1-2018 and 06-30-2018)

SEPSIS QUALITY INDICATOR	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
EARLY MANAGEMENT BUNDLE, SEVERE SEPSIS/SEPTIC SHOCK	**Additional Talking Points:** • SIRS or organ dysfunction criterion WILL NOT be considered IF there is physician/APN/PA documentation indicating criteria is NOT RELATED to infection (tip sheet with examples provided below) • VS taken while a patient is in the OR is not reviewed for Severe Sepsis and/or Septic Shock criterion • INR or aPTT levels are not considered IF a patient is on anticoag medications listed in Table 5.3 Appendix C • ADMISSION Time = Earliest admission time to observation/inpatient status • ARRRIVAL Time = Earliest documented date and time when patient arrived into hospital • "POA" is not recognized by CMS • Document all/any patient refused interventions • Two documented BP readings are required WITHIN 1hr post 30ml/kg • DO NOT DELAY antibiotic administration, document all unsuccessful attempts at collecting blood culture specimens

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INPATIENT HEART FAILURE

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018, and the American Heart Association)

HEART FAILURE QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
ACE INHIBITOR (ACEI)/ANGIOTENSIN RECEPTOR BLOCKER (ARB) OR ANGIOTENSIN RECEPTOR/NEPRILYSN INHIBITOR (ARNI) AT DISCHARGE – FOR PATIENTS WITH EF <40%	• Explanation and/or contraindications must be documented in the medical record for each episode of care • Allergy to one class does not exclude the other class • Documentation must be linked to the medication (e.g. no ACEI/ARB due to renal function
EVIDENCE-BASED SPECIFIC BETA-BLOCKERS – FOR PATIENTS WITH EF <40%	• There are only 3 beta blockers which meet criteria for this measure • Bisoprolol, Carvedilol, and sustained-release Metoprolol Succinate
MEASURE LEFT VENTRICULAR (LV) FUNCTION	• Result does not have to be from this admission but must be referenced in the medical record either by % or qualitative description – normal, moderate or severe dysfunction • **Must be referenced in each episode of care (i.e. Patient had an echo from previous admission that showed an LVF of 40%.)**
POST DISCHARGE APPOINTMENT FOR HEART FAILURE PATIENTS WITHIN 7 DAYS OF DISCHARGE	• Not required for patients discharging to a SNF, hospice, or transferring to another acute care facility • Required for patients discharging to assisted living facility • Appointment needs to be on the AVS and must include: date, time, and location for provider/home health appointments
ALDOSTERONE ANTAGONIST AT DISCHARGE	• Patients with a principle diagnosis of heart failure and a documented ejection fraction of <=35% or a qualitative ejection fraction of moderate/ severe dysfunction • **Specific** explanation and/or contraindications must be documented in the medical record

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INPATIENT HEART FAILURE (PAGE 2)

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018, and the American Heart Association)

HEART FAILURE QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
ANTICOAGULATION FOR ATRIAL FIBRILLATION OR ATRIAL FLUTTER	• Patients with a primary diagnosis of heart failure AND documented chronic or recurrent atrial fibrillation or atrial flutter and at high risk for thromboembolism, according to CHADS2 risk stratification • Explanation and/or contraindications must be documented in the medical record
HYDRALAZINE NITRATE AT DISCHARGE	• African American patients with a principle diagnosis of heart failure and a documented ejection fraction of <40% or a narrative description of LVF consistent with moderate or severe systolic dysfunction • Explanation and/or contraindications must be documented in the medical record
DVT PROPHYLAXIS	• Non-ambulatory heart failure patients receive DVT prophylaxis by end of hospital day two • Explanation and/or contraindications must be documented in the medical record
CRT-D OR CRT-P PLACED OR PRESCRIBED AT DISCHARGE	• Patients with left ventricular ejection fraction less than or equal to 35% with a QRS duration of 120 ms or above and Left Bundle Branch Block or QRS 150ms or above regardless of QRS morphology • Document contraindications, intolerance, or any other reason in the medical record
ICD COUNSELING OR ICD PLACED OR PRESCRIBED AT DISCHARGE	• Documented in the medical record for heart failure patients with left ventricular ejection fraction less than or equal to 35% • Was ICD counseling provided • Did patient have ICD prior to hospitalization • Did patient have ICD placed during hospitalization • Has patient been prescribed an ICD at discharge

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INPATIENT HEART FAILURE (PAGE 3)

(TJC Specifications Manual v2017B2-Discharges between 1-1-2018 and 06-30-2018, and the American Heart Association)

HEART FAILURE QUALITY INDICATORS	EXPLANATION AND/OR CONTRAINDICATIONS MUST BE DOCUMENTED IN THE MEDICAL RECORD
INFLUENZA VACCINATION DURING FLU SEASON – OCTOBER THROUGH MARCH	• Document refusal or contraindication
PNEUMOCOCCAL VACCINATION	• Document refusal or contraindication

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