OHA Hospital Improvement and Innovation Network

Data Dictionary

Version 1.1

Last Updated: April 20, 2017

Summary of 4/20/2017 Updates

- Based on NHSN Corrections for NHSN COLO & HYST Operative Procedure Codes for procedures performed on or after January 1, 2017:

  ICD-10 COLO: 0DB80ZX – Remove from COLO and ADD to SB

  ICD-10 COLO: 0DTQ0ZZ – Remove from COLO

  ICD-10 COLO: 0W3P0ZZ – Remove from COLO and ADD to XLAP

  CPT HYST: 58570- ADD to HYST

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Catheter-Associated Urinary Tract Infections (CAUTI) Standardized Infection Ratio (SIR)
National Health Safety Network (NHSN) Reporting Facilities Only

CAUTI: CMS HIIN Evaluation Measure – NHSN Reporting Facilities ONLY – NQF 0138	
Catheter-associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio (SIR) • *ICUs, excluding NICU* • *ICUs + Other Inpatient Units (House-wide)*	
Measure Type	Outcome
Numerator	Number of Observed Infections
Denominator	Number of Expected Infections
Calculation	Numerator / Denominator
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN Available from National Quality Forum (NQF 0138)
Data Source	NHSN (all inpatient locations)
NHSN data transfer	Yes for all hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	SIR 0.63
Notes	

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to OHA HIIN. Hospitals are required to confer rights to all inpatient locations excluding Neonatal Intensive Care Units (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 Inpatient Units (House-wide), separately.

Additional References:

The Centers for Disease Control and Prevention (CDC) has developed numerous resources for CAUTI surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/CAUTI/index.html

The Partnership for Patients has also gathered many resources for CAUTI prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheterassociatedurinarytractinfectionscauti.html

Catheter-Associated Urinary Tract Infections (CAUTI) Rate

All Facilities

CAUTI: CMS HIIN Evaluation Measure – All Facilities	
Catheter-associated Urinary Tract Infection (CAUTI) rates • *ICUs, excluding NICU* • *ICUs + Other Inpatient Units (House-wide)*	
Measure Type	Outcome
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 period
Calculation	(Numerator / Denominator) * 1,000
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN Available from National Quality Forum (NQF 0138)
Data Source	Infection surveillance systems
NHSN data transfer	Yes for all hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	ICU 0.6; House-wide 0.48
Notes	

These data elements shall be submitted by all hospitals which have NOT conferred rights to NHSN data as described above. Hospitals must report the numerator and denominators for ICUs excluding NICUs and also for ICUs excluding NICUs + Other Inpatient Units (House-wide), separately. For hospitals reporting to NHSN and conferring rights to OHA, the numerators and denominators to calculate these rates shall be extracted and rates calculated.

Additional References:

The Centers for Disease Control and Prevention (CDC) has developed numerous resources for CAUTI surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/CAUTI/index.html

The Partnership for Patients has also gathered many resources for CAUTI prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheterassociatedurinarytractinfectionscauti.html

Urinary Catheter Utilization Ratio

All Facilities

CAUTI: CMS HIIN Evaluation Measure	
Urinary Catheter Utilization Ratio • *ICUs, excluding NICU* • *ICUs + Other Inpatient Units (House-wide)*	
Measure Type	Process
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)
Calculation	(Numerator / Denominator) * 100
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN Available from National Quality Forum (NQF 0138)
Data Source	NHSN (all inpatient locations) OR In-hospital infection prevention surveillance systems & billing systems
NHSN data transfer	Yes for all hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	

For hospitals reporting to NHSN and conferring rights to OHA, 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 Inpatient Units (House-wide), separately.

Additional References:

The Centers for Disease Control and Prevention (CDC) has developed numerous resources for CAUTI surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/CAUTI/index.html

The Partnership for Patients has also gathered many resources for CAUTI prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheterassociatedurinarytractinfectionscauti.html

Central Line-Associated Blood Stream Infection (CLABSI) Standardized Infection Ratio (SIR) National Health Safety Network (NHSN) Reporting Facilities Only

CLABSI: CMS HIIN Evaluation Measure– NHSN Reporting Facilities ONLY – NQF 0139	
Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio (SIR) • *ICUs, including NICU* • *ICUs + Other Inpatient Units (House-wide)*	
Measure Type	Outcome
Numerator	Number of Observed Infections
Denominator	Number of Expected Infections
Calculation	Numerator / Denominator
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN Available from National Quality Forum (NQF 0139)
Data Source	NHSN (all inpatient locations)
NHSN data transfer	Yes for all hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	ICU 0.32
Notes	

Data elements to calculate this ratio will be extracted from NHSN for hospitals which confer rights to OHA HIIN. Hospitals are required to confer rights to all inpatient locations excluding Neonatal Intensive Care Units (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 excluding NICUs + Other Inpatient Units (House-wide), separately.

Additional References:

The Centers for Disease Control and Prevention (CDC) has developed numerous resources for CAUTI surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/CLABSI/index.html

The Partnership for Patients has also gathered many resources for CAUTI prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-centralline-associatedbloodstreaminfections/toolcentralline-associatedbloodstreaminfectionsclabsi.html

Central Line-Associated Blood Stream Infection (CLABSI) Rate

All Facilities

CLABSI: CMS HIIN Evaluation Measure– NHSN Reporting Facilities ONLY – NQF 0139	
Central Line-Associated Bloodstream Infection (CLABSI) Rates • *ICUs, including NICU* • *ICUs + Other Inpatient Units (House-wide)*	
Measure Type	Outcome
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 period
Calculation	(Numerator / Denominator) * 1,000
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN Available from National Quality Forum (NQF 0139)
Data Source	NHSN (all inpatient locations)
NHSN data transfer	Yes for all hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	ICU 0.40; House-wide 0.18
Notes	

These data elements shall be submitted by all hospitals which have not conferred rights to NHSN data as described above. Hospitals must report the numerator and denominators for ICUs including NICUs **and** also for ICUs including NICUs + Other Inpatient Units (House-wide), separately. For hospitals reporting to NHSN and conferring rights to OHA, the numerators and denominators to calculate these rates shall be extracted and rates calculated.

Additional References:

The Centers for Disease Control and Prevention (CDC) has developed numerous resources for CAUTI surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/CLABSI/index.html

The Partnership for Patients has also gathered many resources for CAUTI prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tspcatheterassociatedurinarytractinfections/toolcentralline-associatedbloodstreaminfectionsclabsi.html

Central Line Utilization Rate

All Facilities

CLABSI: CMS HIIN Evaluation Measure– NHSN Reporting Facilities ONLY – NQF 0139	
Central Line-Associated Bloodstream Infection (CLABSI) Rates • *ICUs, including NICU* • *ICUs + Other Inpatient Units (House-wide)*	
Measure Type	Process
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
Calculation	(Numerator / Denominator) * 100
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN Available from National Quality Forum (NQF 0139)
Data Source	NHSN (all inpatient locations) OR In-hospital infection prevention surveillance systems & billing systems
NHSN data transfer	Yes for all hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	

For hospitals reporting to NHSN and conferring rights to OHA, 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 Inpatient Units (House-wide), separately.

Additional References:

The Centers for Disease Control and Prevention (CDC) has developed numerous resources for CAUTI surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/CLABSI/index.html

The Partnership for Patients has also gathered many resources for CAUTI prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tspcatheterassociatedurinarytractinfections/toolcentralline-associatedbloodstreaminfectionsclabsi.html

Falls with Injury

Falls: CMS HIIN Evaluation Measure (NQF 0202)	
All documented Patient Falls with an Injury Level of Minor or Greater	
Measure Type	Outcome
Numerator	Total number of patient falls with injury level minor or greater (whether or not assisted by a staff member) by eligible hospital unit during the measurement period
Denominator	Patient days in eligible units during measurement period
Calculation	(Numerator / Denominator) * 1,000
Specifications/Definitions/Sources/ Recommendations	Available from National Quality Forum (NQF 0202) NDNQI definitions for injury level noted below in Notes section
Data Source	NDNQI (all inpatient locations)
NHSN data transfer	N/A
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	0.5
Notes	• None—patient had no injuries (no signs or symptoms) resulting from the fall, if an x-ray, CT scan or other post fall evaluation results in a finding of no injury. • Minor—resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise or abrasion. • Moderate—resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain. • Major—resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of the fall. • Death—the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall).

These data elements shall be submitted by all hospitals. The total patient days can be collected from billing systems. The number of patient falls could be collected from electronic clinical data or medical records, fall surveillance systems, injury reports, event tracking systems or other similar sources.

Additional References:

The Agency for Healthcare Research & Quality (AHRQ) has developed a comprehensive resource for measuring fall rates and fall prevention practices. The resource is available online at the following link: http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html

The American Nurses Association (ANA) has published an article about measuring fall program outcomes. The article is available online at the following link: http://www.nursingworld.org/MainMenuCategories/ANAMarketpace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No2May07/ArticlePreviousTopic/MeasuringFallProgramOutcomes.html

The Partnership for Patients has also gathered many resources for injuries from falls and immobility. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-injuriesandfallsfromimmobility/toolinjuriesandfallsfromimmobility.html

Fall Risk Assessment

Falls: HIIN Process Measure	
Percentage of patients for which a fall assessment is completed upon admission.	
Measure Type	Process
Numerator	Total number of fall risk assessments done on admission
Denominator	Number of charts reviewed
Calculation	(Numerator / Denominator) * 100
Specifications/Definitions/Sources/ Recommendations	Available from National Committee for Quality Assurance
Data Source	Patient charts
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	100%
Notes	

Additional References:

The Agency for Healthcare Research & Quality (AHRQ) has developed a comprehensive resource for measuring fall rates and fall prevention practices. The resource is available online at the following link: http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html

The American Nurses Association (ANA) has published an article about measuring fall program outcomes. The article is available online at the following link: http://www.nursingworld.org/MainMenuCategories/ANAMarketpace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No2May07/ArticlePreviousTopic/MeasuringFallProgramOutcomes.html

Pressure Ulcer Rate, Stage 3+

Pressure Ulcer: CMS HIIN Evaluation Measure (AHRQ PSI-03)	
Pressure Ulcer, Rate, Stages 3+	
Measure Type	Outcome
Numerator	Discharges, among cases meeting inclusion and exclusion rules for the denominator, with any secondary diagnosis codes for pressure ulcer and 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 or medical discharges are defined by specific DRG or MS-DRG codes
Calculation	(Numerator / Denominator) * 1,000
Specifications/Definitions/Sources/ Recommendations	Available from AHRQ
Data Source	Administrative data
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	All Payer 0.246; Medicare 0.328
Notes	

These data elements shall be submitted by all hospitals. Data can be collected through incident reporting, hospital discharge or administrative data.

Additional References:

The AHRQ has developed several resources for the patient safety indicators. These resources are available online at the following links:
http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx

http://qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10.aspx

The Partnership for Patients has also gathered many resources for pressure ulcer prevention and measurement. These resources are catalogued online at the following link:
http://partnershipforpatients.cms.gov/p4p_resources/tsp-pressureulcers/toolpressureulcers.html

The AHRQ has developed a comprehensive resource for measuring pressure ulcer rates and prevention practices. The resource is available online at the following link:
http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool5.html

Pressure Ulcer Rate, Stage 2+

Pressure Ulcer: CMS HIIN Evaluation Measure (NQF 0201)	
Pressure Ulcer Prevalence, Hospital-Acquired Stage 2+	
Measure Type	Outcome
Numerator	Patients that have at least one category/stage II or greater hospital-acquired pressure ulcer on the day of the prevalence measurement episode
Denominator	All patients, 18 years of age or greater, surveyed for the measurement period
Calculation	(Numerator / Denominator) * 100
Specifications/Definitions/Sources/ Recommendations	Available from NQF 0201 NDNQI
Data Source	Surveillance systems
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	1.487
Notes	

These data elements shall be submitted by all hospitals. Data can be collected through incident reporting, hospital discharge or administrative data.

Additional References:

The Partnership for Patients has also gathered many resources for pressure ulcer prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-pressureulcers/toolpressureulcers.html

The AHRQ has developed a comprehensive resource for measuring pressure ulcer rates and prevention practices. The resource is available online at the following link: http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool5.html

Patients with Pressure Ulcer Risk Assessment Completed within 24 hours of Admission

Pressure Ulcer: HIIN Process Measure	
The percentage of patients that have a pressure ulcer assessment completed within 24 hours of admission	
Measure Type	Process
Numerator	Number of inpatients with documentation in medical record of a complete pressure ulcer risk assessment
Denominator	All inpatients admitted to hospital or unit under surveillance
Calculation	(Numerator / Denominator) * 100
Specifications/Definitions/Sources/ Recommendations	Available from AHRQ
Data Source	Charts, unit logs
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	100%
Notes	

Additional References:

- The Partnership for Patients has also gathered many resources for pressure ulcer prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-pressureulcers/toolpressureulcers.html
- The AHRQ has developed a comprehensive resource for measuring pressure ulcer rates and prevention practices. The resource is available online at the following link: http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool5.html

Post-Operative Pulmonary Embolism or Deep Vein Thrombosis Rate

VTE: CMS HIIN Evaluation Measure (AHRQ PSI 12)	
Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate	
Measure Type	Outcome
Numerator	Number of surgical patients that develop a post-operative PE or DVT
Denominator	All surgical discharges age 18 or older defined by specific DRGs or MS-DRGs and a procedure code for an operating room procedure
Calculation	(Numerator / Denominator) * 1,000
Specifications/Definitions/Sources/ Recommendations	Available from AHRQ
Data Source	Administrative data
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	0.369
Notes	

These data elements shall be submitted by all hospitals. Data can be collected through incident reporting, hospital discharge or administrative data.

Additional References:

- The Partnership for Patients has also gathered many resources for venous thromboembolism (VTE) prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-venousthromboembolism/toolvenousthromboembolismvte.html
- The AHRQ has developed a comprehensive resource for the patient safety indicators. The resource is available online at the following links:
  http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx
  http://qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10.aspx

Incidence of Potentially Preventable Hospital-Acquired Venous Thromboembolism (VTE)

VTE: VTE-6	
Incidence of Potentially Preventable Hospital-Acquired VTE	
Measure Type	Outcome
Numerator	Number of patients that receive no VTE prophylaxis prior to the VTE diagnostic test order date
Denominator	Total number of patients who developed confirmed VTE during hospitalization
Calculation	(Numerator / Denominator) * 100
Specifications/Definitions/Sources/ Recommendations	Available from AHRQ/Joint Commission
Data Source	Chart Review
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	
Notes	

These data elements shall be submitted by all hospitals. Data can be collected through incident reporting, hospital discharge or administrative data.

Additional References:

- The Partnership for Patients has also gathered many resources for venous thromboembolism (VTE) prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-venousthromboembolism/toolvenousthromboembolismvte.html
- The AHRQ has developed a comprehensive resource for the patient safety indicators. The resource is available online at the following links:
  http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx
  http://qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10.aspx

Venous Thromboembolism (VTE) Warfarin Therapy Discharge Instructions

VTE: VTE-5 (NQF 0375)	
Percentage of patients diagnosed with confirmed VTE who are discharged (to home, home care, home hospice care, or court/law enforcement) on warfarin with written discharge instructions	
Measure Type	Process
Numerator	Patients with documentation that they or their caregivers were given written discharge instructions or other educational material about warfarin that addressed all CMS-designated issues
Denominator	All patients
Calculation	(Numerator / Denominator) * 100
Specifications/Definitions/Sources/ Recommendations	Available from CMS, NQF 0375
Data Source	Chart
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	
Notes	

These data elements shall be submitted by all hospitals. Data can be collected through incident reporting, hospital discharge or administrative data.

Additional References:

- The Partnership for Patients has also gathered many resources for venous thromboembolism (VTE) prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-venousthromboembolism/toolvenousthromboembolismvte.html
- The AHRQ has developed a comprehensive resource for the patient safety indicators. The resource is available online at the following links:
  http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx
  http://qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10.aspx

Ventilator-Associated Condition (VAC)
All Facilities

VAE: CMS HIIN Evaluation Measure	
Ventilator-Associated Condition (VAC)	
Measure Type	Outcome
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	Number of ventilator days
Calculation	(Numerator/Denominator) x 1,000
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN
Data Source	Infection surveillance systems
NHSN data transfer	Yes – for hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	2.845
Notes	

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

Additional References:

- The CDC has developed numerous resources for ventilator-associated event (VAE) surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/VAE/index.html
- The Partnership for Patients has also gathered many resources for VAE prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-ventilator-associatedpneumonia/toolventilator-associatedpneumoniavap.html

Infection-Related Ventilator-Associated Complication (IVAC)
All Facilities

VAE: CMS HIIN Evaluation Measure	
Infection-Related Ventilator-Associated Complication (IVAC)	
Measure Type	Outcome
Numerator	Number of events that meet the criteria of infection-related ventilator-associated complication (IVAC), including those that meet the criteria for possible/probable ventilator-associated pneumonia (VAP)
Denominator	Number of ventilator days
Calculation	(Numerator/Denominator) x 1,000
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN
Data Source	Infection surveillance systems
NHSN data transfer	Yes – for hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	

Data elements to calculate this rate will be extracted from NHSN for hospital which confer rights to the OHA HIIN group. **Hospitals not reporting to NHSN** shall be required to report the number of observed compliances and number of observation for each standard.

Additional References:

- The CDC has developed numerous resources for ventilator-associated event (VAE) surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/VAE/index.html
- The Partnership for Patients has also gathered many resources for VAE prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-ventilator-associatedpneumonia/toolventilator-associatedpneumoniavap.html

Possible/Probable Ventilator-Associated Pneumonia
All Facilities

VAE: CMS HIIN Evaluation Measure	
Possible/Probable Ventilator-Associated Pneumonia (PVAP)	
Measure Type	Outcome
Numerator	Number of events that meet the criteria of possible/probable ventilator-associated pneumonia (VAP)
Denominator	Number of ventilator days
Calculation	(Numerator/Denominator) x 1,000
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN
Data Source	Infection surveillance systems
NHSN data transfer	Yes – for hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	0.66; VAP SIR 0.6
Notes	

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

Additional References:

- The CDC has developed numerous resources for ventilator-associated event (VAE) surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/VAE/index.html
- The Partnership for Patients has also gathered many resources for VAE prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-ventilator-associatedpneumonia/toolventilator-associatedpneumoniavap.html

Surgical Site Infection (SSI) Standardized Infection Rate (SIR)

SSI: CMS HIIN Evaluation Measure – NHSN Reporting Facilities ONLY (NQF 0753)	
Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) – separately for each procedure • *Colon Surgeries; Abdominal Hysterectomies; Total Knee Arthroplasty; Total Hip Arthroplasty*	
Measure Type	Outcome
Numerator	Number of observed infections
Denominator	Number of predicted infections
Calculation	(Numerator/Denominator)
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN
Data Source	• NHSN (all inpatient locations) OR • In-hospital infection prevention surveillance systems and billing systems
NHSN data transfer	Yes – for hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Colon 0.59; Hyster 0.6; THA 0.605; TKA 0.414
Notes	See NHSN Changes for COLO & HYST for procedures on or after January 1, 2017 listed below.

Data elements to calculate this ratio will be extracted from NHSN for hospital which confer rights to the OHA HIIN group. **Hospitals not reporting to NHSN** shall be required to report SSIs and number of operative procedures.

Additional References:

- The CDC has developed numerous resources for SSI surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
- The Partnership for Patients has also gathered many resources for VAE prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html
- NHSN ICD-10 Procedure Code changes for operative procedures performed on or after January 1, 2017
    - COLO ICD-10-PCS codes:
        - If procedures using procedure code 0DB80ZX have been identified as COLO, the events should be edited and **reassigned to the SB category** – if the facility is following SB in the Monthly Reporting Plan.
        - If procedures using procedure code 0DTQ0ZZ have been identified as COLO, the events **should be deleted** from the COLO category.
        - If procedures using procedure code 0W3P0ZZ have been identified as COLO, the events should be edited and **reassigned to the XLAP category –** if the facility is following XLAP in the Monthly Reporting Plan.

        - After all edits/deletions have been made the facility should generate a new dataset to ensure that any analysis performed reflects the facility's current dataset.
    - HYST CPT code:
        - All HYST procedures with **CPT code 58570 should be included in HYST** reporting for the facility
        - After HYST procedures using CPT code 58570 have been added the facility should generate a new dataset to ensure that any analysis performed reflects the facility's current dataset

Surgical Site Infection (SSI) Rate

SSI: CMS HIIN Evaluation Measure – All Facilities	
Surgical Site Infection (SSI) Rate – separately for each procedure • *Colon Surgeries; Abdominal Hysterectomies; Total Knee Arthroplasty; Total Hip Arthroplasty*	
Measure Type	Outcome
Numerator	Total number of surgical site infections based on CDC NHSN definition
Denominator	All patients having any of the procedures included in the selected NHSN operative procedure category(s)
Calculation	(Numerator/Denominator) x 100
Specifications/Definitions/Sources/ Recommendations	Available from CDC NHSN
Data Source	Infection surveillance systems
NHSN data transfer	Yes – for hospitals conferring rights to OHA
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	

Data elements shall be submitted by all hospitals which have NOT conferred rights to NHSN data as described above. 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 OHA, the numerators and denominators to calculate these rates shall be extracted, and rates calculated.

Additional References:

- The CDC has developed numerous resources for SSI surveillance, definitions, data collection and reporting. These resources are available online, at the following link: http://www.cdc.gov/nhsn/acute-care-hospital/SSI/index.html
- The Partnership for Patients has also gathered many resources for VAE prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-surgicalsiteinfections/toolsurgicalsiteinfections.html

Sepsis Three Hour Bundle Compliance
All Facilities

Sepsis Three Hour Bundle	
Sepsis Three Hour Bundle Compliance – Separately for • *Initial Lactate Level drawn within 3 hours; Number of blood cultures drawn within 3 hours; Number of broad spectrum antibiotics administered within 3 hours; Number of crystalloid fluids administered within 3 hours*	
Measure Type	Process
Numerator	Number of observed compliances to each standard
Denominator	Number of observations
Calculation	(Numerator/Denominator) x 100
Specifications/Definitions/Sources/ Recommendations	Available from CDC Sepsis Core Measure
Data Source	• NHSN (all inpatient locations) OR • In-hospital infection prevention surveillance systems and billing systems
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	

Data elements should be entered into the OHA Quality Institute Data Portal at www.qualityinstitute.org/cops/Login.aspx

Additional References:

- The Ohio Hospital Association has also gathered many resources at OHA SOS (Signs of Sepsis) for sepsis prevention and measurement. These resources are catalogued online at the following link: www.ohiohospitals.org/SOS

Sepsis: AHRQ Postoperative Sepsis (PSI 13)
All Facilities

Sepsis: AHRQ Postoperative Sepsis (PSI 13)	
Sepsis: Postoperative Sepsis (PSI 13)	
Measure Type	Outcome
Numerator	Discharges among cases meeting the inclusion and exclusion rules for the denominator. with ICD-10-CM code for sepsis in any secondary diagnosis field.
Denominator	All elective* surgical discharges age 18 and older defined by specific DRGs or MS-DRGs and an ICD-9- CM code for an operating room procedure.
Calculation	(Numerator/Denominator)
Specifications/Definitions/Sources/ Recommendations	AHRQ Quality Indicators Web Site: http://www.qualityindicators.ahrq.gov
Data Source	Administrative Date
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	
Notes	

Data elements will be extracted from OHA Claims data.

Additional References:

- The Ohio Hospital Association has also gathered many resources at OHA SOS (Signs of Sepsis) for sepsis prevention and measurement. These resources are catalogued online at the following link: www.ohiohospitals.org/SOS
- AHRQ Patient Quality Indicators: AHRQ Quality Indicators Web Site: http://www.qualityindicators.ahrq.gov

Sepsis: Overall Sepsis Mortality
All Facilities

Sepsis: Overall Mortality	
Sepsis Mortality	
Measure Type	Process
Numerator	Number of patients admitted to acute care setting with severe sepsis or septic shock who died (discharge code 20) during hospital stay
Denominator	Number of patients admitted to acute care setting with severe sepsis or septic shock
Calculation	(Numerator/Denominator)
Specifications/Definitions/Sources/ Recommendations	Available from CDC Sepsis Core Measure
Data Source	OHA Claims Data
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	ICD-10 Codes: Severe Sepsis without septic shock R65.20, Severe Sepsis with septic shock R65.21, SIRS of non-infectious origin without acute organ dysfunction R65.10; ICD-9 Severe Sepsis 995.92, Severe Sepsis with septic shock 785.52

Data elements will be extracted from OHA Claims data.

Additional References:

- The Ohio Hospital Association has also gathered many resources at OHA SOS (Signs of Sepsis) for sepsis prevention and measurement. These resources are catalogued online at the following link: www.ohiohospitals.org/SOS

Multi-Drug Resistant Organisms (MDRO): Hospital Onset MRSA (Bacteremia) Infections (SIR) All Facilities

Multi-Drug Resistant Organisms (MDRO): MRSA (Bacteremia) Infections	
MRSA SIR	
Measure Type	Outcome
Numerator	Number of Hospital Onset (HO) HAI (MRSA Bacteremia) observed
Denominator	Number of HAI expected
Calculation	(Numerator/Denominator)
Specifications/Definitions/Sources/ Recommendations	NHSN
Data Source	NHSN
NHSN data transfer	Yes
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	

Data elements will be extracted from NHSN. For hospitals not reporting to NHSN, numerator and denominator should be entered into OHA Quality Institute data portal (www.qualityinstitute/cops/Login.aspx)

Additional References:

- https://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

Multi-Drug Resistant Organisms (MDRO): Hospital Onset MRSA (Bacteremia) Infections Rate All Facilities

Multi-Drug Resistant Organisms (MDRO): MRSA (Bacteremia) Infections	
MRSA Rate	
Measure Type	Outcome
Numerator	Number of Hospital Onset (HO) HAI (MRSA) infections
Denominator	Total number of patient days facility-wide
Calculation	(Numerator/Denominator) x 10,000
Specifications/Definitions/Sources/ Recommendations	NHSN
Data Source	NHSN
NHSN data transfer	Yes
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	0.745
Notes	

Data elements will be extracted from NHSN. For hospitals not reporting to NHSN, numerator and denominator should be entered into OHA Quality Institute data portal (www.qualityinstitute/cops/Login.aspx)

Additional References:

- https://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

C. difficile Inpatient Hospital-Onset CDI (NQF 1717) (SIR)
All Facilities

C. difficile Inpatient Hospital-Onset CDI (NQF 1717) SIR	
CDI Hospital-Onset SIR	
Measure Type	Outcome
Numerator	Number of Hospital Onset (HO) HAI (CDI) observed
Denominator	Number of HAI expected
Calculation	(Numerator/Denominator)
Specifications/Definitions/Sources/ Recommendations	NHSN
Data Source	NHSN
NHSN data transfer	Yes
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	0.745
Notes	

Data elements will be extracted from NHSN. For hospitals not reporting to NHSN, numerator and denominator should be entered into OHA Quality Institute data portal (www.qualityinstitute/cops/Login.aspx)

Additional References:

- https://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

C. difficile Inpatient Hospital-Onset CDI Rate
All Facilities

C. difficile Inpatient Hospital-Onset CDI Rate	
CDI Hospital-Onset Rate	
Measure Type	Outcome
Numerator	Number of Hospital Onset (HO) HAI (CDI)
Denominator	Total number of patient days (facility-wide)
Calculation	(Numerator/Denominator) x 10,000
Specifications/Definitions/Sources/ Recommendations	NHSN
Data Source	NHSN
NHSN data transfer	Yes
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	4.40
Notes	

Data elements will be extracted from NHSN. For hospitals not reporting to NHSN, numerator and denominator should be entered into OHA Quality Institute data portal (www.qualityinstitute/cops/Login.aspx)

Additional References:

- https://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

Iatrogenic Delirium Assessment in ICU
Work Group Only

Iatrogenic Delirium	
Iatrogenic Delirium Assessment in ICU	
Measure Type	Process
Numerator	Number patients assessed positive for delirium in ICU
Denominator	Total number of ICU patients
Calculation	(Numerator/Denominator) x 100
Specifications/Definitions/Sources/ Recommendations	OHA Claims Data
Data Source	Chart Review
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	Delirium ICD-10 Codes: F19.921, F05, G93.40, G93.41, G93.49, I67.83, G92

Additional References:

- **https://www.mnhospitals.org/Portals/0/Documents/ptsafety/LEAPT%20Delirium/Road%20map%20to%20a%20delerium%20detection%20prevention%20and%20management%20program%20-%20Final.pdf**

Iatrogenic Delirium Incidence
Work Group Only

Iatrogenic Delirium	
Iatrogenic Delirium Incidence	
Measure Type	Outcome
Numerator	Number of ICU non-POA delirium cases
Denominator	Total number of ICU discharges
Calculation	(Numerator/Denominator) x 100
Specifications/Definitions/Sources/ Recommendations	OHA Claims Data
Data Source	Chart Review
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	Delirium ICD-10 Codes: F19.921, F05, G93.40, G93.41, G93.49, I67.83, G92

Additional References:

- **https://www.mnhospitals.org/Portals/0/Documents/ptsafety/LEAPT%20Delirium/Road%20map%20to%20a%20delerium%20detection%20prevention%20and%20management%20program%20-%20Final.pdf**

Readmission: Follow-up Visit Scheduled
All Facilities

Readmission: Follow-up Visit	
Readmission: Follow-up Visit	
Measure Type	Process
Numerator	Number of patients discharged who had a follow up visit scheduled
Denominator	Total number of discharged charts reviewed
Calculation	(Numerator/Denominator) x 100
Specifications/Definitions/Sources/ Recommendations	Administrative Data
Data Source	Administrative Data
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	
Notes	30 charts reviewed whenever possible

Additional References:

- The Partnership for Patients has also gathered many resources for readmissions prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-preventablereadmissions/toolpreventablereadmissions.html

Readmission: Hospital 7-Day and 30-Day All-Cause Risk-Standardized Readmission Rate (per 1,000 population adult and Medicare)
All Facilities

Readmission: All-Cause 7 and 30-Day Readmission Rate	
Readmission: All-Cause 7 and 30-Day Readmission Rate	
Measure Type	Outcome
Numerator	30 day Medicare FFS All-Cause readmission (per 100 discharges); 30 day All Payor All-Cause readmission (per 100 discharges)
Denominator	Total number of inpatient discharges (excluding discharges due to death)
Calculation	(Numerator/Denominator) x 100
Specifications/Definitions/Sources/ Recommendations	Facilities should follow the CMS definition of a readmission. This definition is explained in the "Frequently asked questions about readmissions" chapter, available on Quality Net. "Chapter 3 – Readmissions Measures," section "Defining Readmissions" beginning on page 7
Data Source	Administrative Data
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Medicare ≤ 15.26; All Payor – 12% from HIIN baseline 8.37
Notes	

Additional References:

- The Partnership for Patients has also gathered many resources for readmissions prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-preventablereadmissions/toolpreventablereadmissions.html

Adverse Drug Events (ADE): Anticoagulation Safety
All Facilities

Adverse Drug Events (ADE): Anticoagulation Safety	
Excessive Anticoagulation with Warfarin – Inpatients	
Measure Type	Outcome
Numerator	Number of Inpatients with INR>5
Denominator	Total number of Inpatients receiving Warfarin
Calculation	(Numerator/Denominator) x 100
Specifications/Definitions/Sources/ Recommendations	Numerator: Incident Reporting Systems, trigger tools, pharmacists' intervention systems, medical record review Denominator: billing systems
Data Source	Chart Review
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	2% of INR Readings > 5
Notes	ED patients excluded

Additional References:

- The Partnership for Patients has also gathered many resources for ADE prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html
- The Institute for Healthcare Improvement's (IHI) trigger tool includes a list of known ADE triggers and instructions for measuring the number and degree of harmful medication events. The tool is available online at the following link: http://www.ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx

Adverse Drug Events (ADE): Glycemic Management
All Facilities

Adverse Drug Events (ADE): Glycemic Management	
Hypoglycemia in Inpatients Receiving Insulin	
Measure Type	Outcome
Numerator	Number of blood glucose readings < 50 mg/dL
Denominator	Total number of inpatient blood glucose readings
Calculation	(Numerator/Denominator) x 100
Specifications/Definitions/Sources/ Recommendations	Numerator: Incident Reporting Systems, trigger tools, pharmacists' intervention systems, medical record review Denominator: billing systems
Data Source	Chart Review
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	3% of Blood Glucose readings
Notes	ED patients excluded

Additional References:

- The Partnership for Patients has also gathered many resources for ADE prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html
- The Institute for Healthcare Improvement's (IHI) trigger tool includes a list of known ADE triggers and instructions for measuring the number and degree of harmful medication events. The tool is available online at the following link: http://www.ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx

Adverse Drug Events (ADE): Opioid Safety (Inpatient Only)
All Facilities

Adverse Drug Events (ADE): Opioid Safety	
Naloxone reversals for Opioid Overdose	
Measure Type	Outcome
Numerator	Number of Naloxone doses given
Denominator	Total doses of opioids given
Calculation	(Numerator/Denominator) x 100
Specifications/Definitions/Sources/ Recommendations	Numerator: Incident Reporting Systems, trigger tools, pharmacists' intervention systems, medical record review Denominator: billing systems
Data Source	Chart Review
NHSN data transfer	No
Baseline Period	2014
Monitoring Period	Monthly, beginning October 2016
Benchmark	Not defined
Notes	Excludes operating rooms, procedure rooms or ED for patients age > 18 years old

Additional References:

- The Partnership for Patients has also gathered many resources for ADE prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-adversedrugevents/tooladversedrugeventsade.html
- The Institute for Healthcare Improvement's (IHI) trigger tool includes a list of known ADE triggers and instructions for measuring the number and degree of harmful medication events. The tool is available online at the following link: http://www.ihi.org/resources/Pages/Tools/TriggerToolforMeasuringAdverseDrugEvents.aspx