Louisiana Hospital Association Foundation (LHA-F) Encyclopedia of Measures (EOM)

Version #2025: 11/01/2024

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Version History

Version Number	Date Modified	Modified By	Description
2021.1	7/15/2021	M. Smith	Initial LHAREF EOM.
2021.2	8/23/2021	M. Smith	• Updated the reporting frequency for CDIFF_SIR and MRSA_SIR. • Added CAUTI and CLABSI SUR measures (all units) for reporting.
2024	2/20/2024	M. Smith	2024.1-Annual Updates, refer to the Summary of Changes for details.
2024.2	6/7/24	M. Smith	Added a clarification to the "Minor" definition for Falls with injury.
2025	11/01/2024	M. Smith	2025 Annual Update. Added 5 new measures and retired 7 measures.

Summary of Changes

Version #2021.1:

- Initial Release

Version #2021.2:

- Revised the reporting frequency for CDIFF_SIR to reflect quarterly reporting instead of monthly reporting.
- Revised the reporting frequency for MRSA_SIR to reflect quarterly reporting instead of monthly reporting.
- Added CAUTI Standard Utilization Ratio – All units, measure ID CAUTI_SUR_All, for reporting.
- Added CLABSI Standard Utilization Ratio – All units, measure ID CLABSI_SUR_All for reporting.

Version #2024.1:

- **Measure List**: Deleted "and reporting to NHSN" under Reporting Hospitals column from SSI SIR – Colon Surgeries and SSI SIR – Abdominal Hysterectomies.
- **ADE: Anticoagulation Safety**: Corrected Denominator Exclusion to reflect "greater than, present on admission" instead of "less than or present on admission."
- **ADE: Glycemic Management:** Corrected typographical error in the Numerator: "hypoglycemia defined as plasma glucose concentration ~~of~~ determined by the …"
- **CAUTI: Standardized Infection Ratio (SIR) – Two Measures**: Replaced Data Source reference "hospitals reporting to NHSN should confer rights and hospitals not reporting to NHSN should self-report" with "These measures are NOT applicable for hospitals that do not report into NHSN." Deleted NQF0138 reference in Specifications/Definitions/Recommendations.
- **CAUTI: Urinary Catheter Standard Utilization Ratio (SUR)**: Added "urinary" to clarify catheter type in Measure Description. Replaced Data Source reference "hospitals reporting to NHSN should confer rights and hospitals not reporting to NHSN should self-report" with "This measure is NOT applicable for hospitals that do not report into NHSN."
- **CLABSI: Standardized Infection Ratio (SIR) – Two Measures**: Replaced Data Source reference "hospitals reporting to NHSN should confer rights and hospitals not reporting to NHSN should self-report" with "These measures are NOT applicable for hospitals that do not report into NHSN." Deleted NQF0139 reference in Specifications/Definitions/Recommendations.
- **CLABSI: Central Line Standard Utilization Ratio (SUR):** Replaced Data Source "that hospitals reporting to NHSN should confer rights and hospitals not reporting to NHSN should self-report" with "This measure is NOT applicable for hospitals that do not report into NHSN."
- **CDI Standard Infection Ratio (SIR)**: Replaced Data Source reference "hospitals reporting to NHSN should confer rights and hospitals not reporting to NHSN should self-report" with "This measure is NOT applicable for hospitals that do not report into NHSN."

- **MRSA Bacteremia Standard Infection Ratio (SIR)**: Replaced Data Source reference "hospitals reporting to NHSN should confer rights and hospitals not reporting to NHSN should self-report" with "This measure is NOT applicable for hospitals that do not report into NHSN."

- **Medicare Fee-for-Service Measures**: Added ADE_HYPOGLYCEMIA, ADE_ANTICOAG, CIN_FFS_Medicare, Z_Codes, 90_MME_Discharge_FFS_Medicare_Proc, and 12_Pill_Discharge_FFS_Medicare to the list of HQIC measures where CMS is providing data. No action is required by hospitals.
- **Opioid Stewardship: Surgical Discharges with 12 or Fewer Opioid Pills**: Added Rate Mulitplier of 100. Corrected typographical error in Specifications/Definitions/Recommendations to reflect "the problem list should **not** include a diagnosis of cancer or sickle cell disease."
- **Opioid Stewardship: Opioids Use in the ED**: Added Rate Mulitplier of 100. Added clarifying statement "Please convert each opioid administered to MMEs using the conversion factors in the table below" before the MME Conversion Table in Specifications/Definitions/Recommendations.
- **Opioid Stewardship: Concurrent Opioids**: New measure added.
- **Overall Harm Measure – All Facilities**: Title changed from "Overall Harm" to "Preventable Harm." Modified Denominator to reflect patient days from submitted falls data will be used. Added "All included measures must be current in data submission to calculate Preventable Harm" to Data Source(s). Added Denominator Exclusions of "device utilization, opioid stewardship, readmissions, sepsis, SSIs, and worker safety." Expanded measure list in Specifications/ Definitions/Recommendations to include Falls_injury, Glycemic Management (HYPO40, HYPO50, or HYPO70), Anticoagulation (INR3.4, INR4, INR5, or INR6), and Naloxone. Readmissions and Sepsis Mortality are not included in the measure.
- **Pressure Injury, Hospital-Acquired (HAPI) Rate, Stage 3+ (PSI-03)**: Updated resource in Specifications/Definitions/Recommendations to reflect PSI Specification v2023.
- **Readmissions: Hospital-Wide, All-Cause, 30-Day**: Added "patients under the age of 18 years of age" as a Denominator Exclusion. Updated resource links in Specifications/Definitions/Recommendations.
- **Sepsis: Overall Mortality Rate**: Replaced references to Table 4.01 with a link to the Hospital Inpatient Specification Manual and listed the appropriate reference documents in the Manual.
- **Sepsis: Postoperative Rate**: Updated resource in Specifications/Definitions/Recommendations to reflect PSI Specification v2023. Updated Denominator Exclusions to "Refer to the current AHRQ PSI 13 denominator exclusions."
- **Sepsis: SEP-1**: New Measure added.
- **Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)-Two Measures**: Added Denominator Exclusion of outpatient procedures; Replaced Data Source reference "hospitals reporting to NHSN should confer rights and hospitals not reporting to NHSN should self-report" with "These measures are NOT applicable for hospitals that do not report into NHSN."
- **Surgical Site Infection (SSI) Rate-Two Measures**: Added Denominator Exclusion of Outpatient procedures.
- **Appendix D: Medicare Fee-for-Service (FFS) Measure Specifications**: Added ADE_HYPOGLYCEMIA, ADE_ANTICOAG, CIN_FFS_Medicare, Z_Codes, 90_MME_Discharge_FFS_Medicare_Proc, and 12_Pill_Discharge_FFS_Medicare descriptors.

2024.2

- **Falls with Injury:** Modified the definition of "Minor" to reflect the administration of a pain medication (instead of just pain), or the appearance of a bruise or abrasion meets the definition of minor. Our original verbiage was from NQF0202's Measure Logic document but these specs are no longer updated by NQF.

2025

- Measure List: Updated with measure retirements and additions.
- **ADE: Anticoagulation Safety**: RETIRED effective 12/31/24 and deleted corresponding Appendix.
- **ADE: Glycemic Management**: Hypoglycemic appendix is now Appendix A. Removed the Baseline Period dates.
- **ADE: Hospital Harm - Severe Hyperglycemia**: ADDED HH_HYPER_eCQM.
- **ADE: Hospital Harm - Severe Hypoglycemia**: ADDED HH_HYPO_eCQM.
- **ADE: Naloxone Administration**: Naloxone appendix is now Appendix B. Removed the Baseline Period dates.
- **CAUTI: Standardized Infection Ratio (SIR), Rate, and Utilization**: RETIRED the ICU measures effective 12/31/24. Removed the Baseline Period dates.
- **CAUTI: Urinary Catheter Standard Utilization Ratio (SUR)**: Removed the Baseline Period dates.
- **CLABSI: Standardized Infection Ratio (SIR), Rate, and Utilization**: RETIRED the ICU effective 12/31/24. Removed the Baseline Period dates.
- **CLABSI: Central Line Standard Utilization Ratio (SUR)**: Removed the Baseline Period dates.
- **CDI: Standardized Infection Ratio (SIR) and Rate**: Removed the Baseline Period dates.
- **Falls with Injury**: Removed the Baseline Period dates.
- **Hospital Harm - Falls with Injury**: ADDED eCQM HH_FI_eCQM.
- **MRSA Bacteremia: Standardized Infection Ratio (SIR) and Rate**: Removed the Baseline Period dates.
- **Medicare Fee-for-Service (FFS) Measures**: DELETED all FFS measures.
- **Opioid Stewardship: Opioid Use in the ED**: RETIRED effective 12/31/2024.
- **Opioid Stewardship: Concurrent Opioids**: Added QDM reference to Specification list. Removed the Baseline Period dates.
- **Hospital Harm - Opioid Related Adverse Events**: ADDED eCQM measure HH_ORAE_eCQM.
- **Pressure Injury, Hospital-Acquired (HAPI) Rate, Stage 3+ (PSI-03)**: Updated AHRQ PSI reference link to 2024. Removed the Baseline Period dates.
- **Hospital Harm - Pressure Injury**: ADDED eCQM HH_PI_eCQM.
- **Preventable Harm**: RETIRED effective 12/31/2024.
- **Readmissions: Hospital-Wide, All-Cause, 30-Day**: Moved "Patients admitted to a different level of care…" from Numerator definition to Denominator Exclusion list. Updated reference links in "Specifications/ Definitions/Recommendations." Removed the Baseline Period dates.
- **Sepsis: Overall Mortality Rate**: Removed the specific version reference in the Specifications and added note to refer to applicable version for the timeframe. Removed the Baseline Period dates.
- **Sepsis: Post-operative Rate**: RETIRED effective 12/31/2024.
- **Sepsis: SEP-1**: Removed the specific version reference in the Specifications and added note to refer to applicable version for the timeframe. Removed the Baseline Period dates.
- **Surgical Site Infection (SSI): Standardized Infection Ratio (SIR) and Rate**: Removed the Baseline Period dates.
- **Worker Safety: Violence**: RETIRED effective 12/31/2024.
- **Appendixes**: Removed Anticoagulation appendix and renumbered hypoglycemia and naloxone appendixes. Deleted Appendix D for the Medicare FFS measures.

Measure List

MEASURE NAME	DATA SOURCE	REPORTING HOSPITALS
Adverse Drug Events (ADE)		
ADE: Glycemic Management	Self-Report	All Hospitals
ADE: Hospital Harm – Severe Hyperglycemia	Self-Report	All Hospitals
ADE: Hospital Harm – Severe Hypoglycemia	Self-Report	All Hospitals
ADE: Naloxone Administration	Self-Report	All Hospitals
Catheter-Associated Urinary Tract Infection (CAUTI)		
CAUTI SIR – All Units Excluding NICUs	NHSN	All Hospitals
CAUTI Rate – All Units Excluding NICUs	NHSN or Self-Report	All Hospitals
CAUTI Utilization – All Units Excluding NICUs	NHSN or Self-Report	All Hospitals
CAUTI SUR – All Units Excluding NICUs	NHSN	All Hospitals
Central Line-Associated Bloodstream Infections (CLABSI)		
CLABSI SIR – All Units	NHSN	All Hospitals
CLABSI Rate – All Units	NHSN or Self-Report	All Hospitals
CLABSI Utilization – All Units	NHSN or Self-Report	All Hospitals
CLABSI SUR – All Units	NHSN	All Hospitals
Clostridioides Difficile (CDI)		
CDI SIR – All Units	NHSN	All Hospitals
CDI Rate – All Units	NHSN or Self-Report	All Hospitals
Falls		
Falls With Injury	Self-Report	All Hospitals
Hospital Harm – Falls with Injury	Self-Report	All Hospitals
Methicillin-Resistant Staphylococcus Aureus (MRSA)		
MRSA Bacteremia SIR	NHSN	All Hospitals
MRSA Bacteremia Rate	NHSN or Self-Report	All Hospitals
Opioid Stewardship		
Opioid: Concurrent Opioids	Self-Report	All Hospitals
Hospital Harm: Opioid-Related Adverse Events	Self-Report	All Hospitals
Hospital-Acquired Pressure Injury (HAPI)		
HAPI (PSI-03) Rate	Self-Report	All Hospitals
Hospital Harm: Pressure Injury	Self-Report	All Hospitals
Readmissions		
Readmissions, All-cause, 30-day	Self-Report	All Hospitals
Sepsis		
Sepsis: Overall Mortality Rate	Self-Report	All Hospitals
Sepsis: Postoperative (PSI-13) Rate	Self-Report	All Hospitals that perform surgery

MEASURE NAME	DATA SOURCE	REPORTING HOSPITALS
Surgical Site Infections (SSI)		
SSI SIR – Colon Surgeries	NHSN	All Hospitals performing colon surgeries
SSI SIR – Abdominal Hysterectomies	NHSN	All Hospitals performing abdominal hysterectomies
SSI Rate – Colon Surgeries	NHSN or Self-Report	All Hospitals performing colon surgeries
SSI Rate – Abdominal Hysterectomies	NHSN or Self-Report	All Hospitals performing abdominal hysterectomies

Category: Adverse Drug Events (ADE)

ADE: Glycemic Management	
Measure Name Detail	Hypoglycemia in Inpatients Receiving Insulin: Select one applicable measure based on the hospital's critical value: • ADE: Glycemic Management for glucose <40 • ADE: Glycemic Management for glucose <50 • ADE: Glycemic Management for glucose <70
Measure ID	Select one applicable measure ID based on the hospital's critical value: • HYPO40 • HYPO50 • HYPO70
Measure Type	Outcome
Measure Description	Adverse Drug Events (ADE) related to glycemic management: Hypoglycemia in inpatients receiving insulin
Numerator	Number of patients receiving insulin who experience a hypoglycemic event (hypoglycemia defined as plasma glucose concentration determined by the hospital critical value <40, <50 or <70)
Denominator	Number of inpatients receiving insulin
Denominator Exclusions	• Patients with hypoglycemia present on admission • Non-insulin receiving patients
Rate Multiplier	100
Data Source(s)	• Self-report measure that aligns with the hospital's critical value. • Numerator: incident reporting systems, trigger tools, pharmacists' intervention systems, medical record review, laboratory systems or administrative data. • Denominator: billing systems • For glucose values outside of the specific critical values listed, please either round up to the next glucose value or submit under HYPO50 as this will be the default submission.
Specifications/Definitions/ Recommendations	• Patients that experience more than one event at the determined value or greater during a hospital stay are only counted once. • An adverse event determination is related to the facility's administration of insulin. • See Appendix A
Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: ADE-1b (Oct. 2016 – March 2020) HEN2: ADE-1b (July 2015 – Sept. 2016)

Category: Adverse Drug Events (ADE)

ADE: Hospital Harm - Severe Hyperglycemia	
Measure Name Detail	Hospital Harm - Severe Hyperglycemia
Measure ID	HH_HYPER_eCQM
Measure Type	Outcome
Measure Description	Measure assesses the number of inpatient hospital days for patients age 18 and older with a hyperglycemic event (harm) per the total qualifying inpatient hospital days for that encounter.
Numerator	Inpatient hospitalizations with a hyperglycemic event within the first 10 days of the encounter minus the first 24 hours, and minus the last period before discharge from the hospital if less than 24 hours.
Denominator	Inpatient hospitalizations for patients age 18 and older that end during the measurement period, as well as either: A diagnosis of diabetes that starts before the end of the encounter; **OR** Administration of at least one dose of insulin or any hypoglycemic medication that starts during the encounter; **OR** Presence of at least one glucose value >=200 mg/dL at any time during the encounter.
Exclusions	• Inpatient hospitalizations for patients with a glucose result of >=1000 mg/dL anytime between 1 hour prior to the start of the encounter to 6 hours after the start of the encounter. • Inpatient hospitalizations for patients who have comfort care measures ordered or provided during the encounter. • Inpatient hospitalizations for patients who have a discharge disposition to home or to a health care facility for hospice care.
Rate Multiplier	n/a (Numerator minus exclusions/Denominator minus exclusions)
Data Source(s)	• Self-report the numerator as the number of inpatients that met criteria minus exclusions. Report the denominator as the initial population minus exclusions. • 2025 eCQM Flow – CM871v4: Hospital Harm - Severe Hyperglycemia • Hospital Harm - Severe Hyperglycemia (eCQI Resource Center)
Specifications/Definitions/ Recommendations	• A hyperglycemic event is defined as either: 1) A day with at least one glucose value >300 mg/dL OR 2) A day where a glucose test and result was not found, and it was immediately preceded by two contiguous, consecutive days where at least one glucose value during each of the two days was >=200 mg/dL. • Inpatient hospitalizations include time in the emergency department and observation when the transition between these encounters (if they exist) and the inpatient encounter are within an hour or less of each other. • Hospital days are not defined as midnight-to-midnight but are full 24-hour periods that start at the time of admission to the hospital (including emergency department and observation), excluding the last period before discharge from hospital inpatient if it is less than 24 hours. • This version of the eCQM uses QDM version 5.6. Please refer to eCQI's QDM page for more information on the QDM.
Baseline Period	January – December 2024
Reporting Timeline	Monthly Data, Submitted Quarterly
Measure Reporting History:	n/a

Category: Adverse Drug Events (ADE)

ADE: Hospital Harm - Severe Hypoglycemia	
Measure Name Detail	Hospital Harm - Severe Hypoglycemia
Measure ID	HH_HYPO_eCQM
Measure Type	Outcome
Measure Description	Measure assesses the number of inpatient hospitalizations for patients age 18 and older who were administered at least one hypoglycemic medication during the encounter and who suffer the harm of a severe hypoglycemic event during the encounter.
Numerator	Inpatient hospitalizations where a severe hypoglycemic event occurred during the encounter.
Denominator	Inpatient hospitalizations that end during the measurement period for patients age 18 and older and at least one hypoglycemic medication administration starts during the encounter.
Exclusions	None
Rate Multiplier	n/a
Data Source(s)	• Self-report the numerator as the number of inpatients that met criteria. Report the denominator as the initial population. • 2025 eCQM Flow – CM816v4: Hospital Harm - Severe Hypoglycemia • Hospital Harm - Severe Hypoglycemia (eCQI Resource Center)
Specifications/Definitions/ Recommendations	• A severe hypoglycemic event is: A glucose test with a result less than 40 mg/dL **AND** a hypoglycemic medication was administered within 24 hours before the start of the severe hypoglycemic event (i.e., the glucose test with a result less than 40 mg/dL) **AND** there was no subsequent repeat test for glucose with a result greater than 80 mg/dL within five minutes or less from the start of the initial glucose test with a result less than 40 mg/dL. The 24-hour and 5-minute timeframes are based on the time the glucose was drawn, as this reflects the time the patient was experiencing that specific glucose level. • Only one qualifying severe hypoglycemic event is counted in the numerator, and only one severe hypoglycemic event is counted per encounter. • Note the measure is currently confined to using mg/dL as the unit of measurement for glucose results. Glucose levels are determined by laboratory or point-of-care (POC) tests, including capillary/glucometer blood glucose tests, and by interstitial fluid specimens from continuous glucose monitors. Glucose test results from urine specimens are not considered. • This version of the eCQM uses QDM version 5.6. Please refer to eCQI's QDM page for more information on the QDM.
Baseline Period	January – December 2024
Reporting Timeline	Monthly Data, Submitted Quarterly
Measure Reporting History:	n/a

Category: Adverse Drug Events (ADE)

ADE: Naloxone Administration	
Measure Name Detail	Adverse Drug Event due to Opioids: Rate of Naloxone Administration in Patients
Measure ID	NALOXONE
Measure Type	Outcome
Measure Description	Adverse Drug Events (ADE) related to opioids: patients administered naloxone after onsite treatment with opioids (any route)
Numerator	Number of patients where an opioid was administered onsite (any route) and was subsequently administered a reversal agent
Denominator	Number of patients administered an opioid onsite (any route) (See example medications in Appendix B.)
Denominator Exclusions	• Obstetric patients • Emergency department • Free-standing/independent surgery centers • Hospice/respite care patients
Rate Multiplier	100
Data Source(s)	• Self-reported by all hospitals • Numerator: incident reporting systems, trigger tools, pharmacists' intervention systems, medical record review • Denominator: billing systems

Specifications/Definitions/ Recommendations	• Measure includes:
	  ○ Observation beds
	  ○ Outpatient procedure services (exclusions noted above)
	• **Multiple doses of naloxone to the same patient during a hospital stay count as one event.**
	• Appendix B

Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: ADE-1c (Oct. 2016 – March 2020) HEN2: ADE-1c (July 2015 – Sept. 2016)

Category: Catheter-Associated Urinary Tract Infection (CAUTI)

CAUTI: Standardized Infection Ratio (SIR)	
Measure Name Detail	CAUTI SIR: All Units including ICU(s), excluding NICU(s)
Measure ID	CAUTI_SIR_All
Measure Type	Outcome
Measure Description	Number of observed CAUTIs per number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	All NICU locations
Rate Multiplier	n/a
Data Source(s)	• NHSN • These measures are NOT applicable for hospitals that do not report into NHSN.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • CDC Urinary Tract Infection (UTI) Events
Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CAUTI-1a & CAUTI-1b (Oct. 2016 – March 2020) HEN2: CAUTI-1a & CAUTI-1b (July 2015 – Sept. 2016)

Category: Catheter-Associated Urinary Tract Infection (CAUTI)

CAUTI Rate	
Measure Name Detail	CAUTI Rate – All Units including ICU(s), excluding NICU(s)
Measure IDs	CAUTI_RATE_All
Measure Type	Outcome
Measure Description	Number of healthcare associated CAUTIs per 1,000 catheter days
Numerator	Number of healthcare associated CAUTIs among patients in bedded inpatient care locations during the calendar month
Denominator	Number of indwelling urinary catheter days for bedded inpatient care locations during the calendar month
Denominator Exclusions	All NICU locations
Rate Multiplier	1,000
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do NOT report to NHSN or do NOT confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • CDC Urinary Tract Infection (UTI) Events • Rate denominator reported = utilization measure numerator reported
Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CAUTI-2a & CAUTI-2b (Oct. 2016 – March 2020) HEN2: CAUTI-2a & CAUTI-2b (July 2015 – Sept. 2016)

Category: Catheter-Associated Urinary Tract Infection (CAUTI)

CAUTI: Urinary Catheter Device Utilization	
Measure Name Detail	CAUTI: Urinary Catheter Device Utilization – All units including ICU(s), excluding NICU(s)
Measure IDs	CAUTI_Util_All
Measure Type	Process
Measure Description	Device utilization is the number of urinary catheter days per 100 patient days
Numerator	Number of indwelling urinary catheter days for bedded inpatient care locations during the calendar month
Denominator	Number of patient days for bedded inpatient care locations during the calendar month
Denominator Exclusions	All NICU locations
Rate Multiplier	100
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do NOT report to NHSN or do NOT confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • CDC Urinary Tract Infection (UTI) Events • **Utilization measure numerator reported = rate denominator reported**
Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CAUTI-3a & CAUTI-3b (Oct. 2016 – March 2020) HEN2: CAUTI-3a & CAUTI-3b (July 2015 – Sept. 2016) (Re-baselined in 2015)

Category: Catheter-Associated Urinary Tract Infection (CAUTI)

CAUTI: Urinary Catheter Standard Utilization Ratio (SUR)	
Measure Name Detail	CAUTI Urinary Catheter SUR – All units including ICU(s), excluding NICU(s)
Measure IDs	CAUTI_SUR_All
Measure Type	Outcome
Measure Description	Number of observed urinary catheter device days per number of predicted urinary catheter device days
Numerator	Number of Observed Device Days
Denominator	Number of Predicted Device Days
Denominator Exclusions	All NICU locations
Rate Multiplier	n/a
Data Source(s)	• NHSN • This measure is NOT applicable for hospitals that do not report into NHSN.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • CDC Urinary Tract Infection (UTI) Events • NHSN SUR Guide
Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	n/a

Category: Central Line-Associated Blood Stream Infection (CLABSI)

CLABSI: Standardized Infection Ratio (SIR)	
Measure Name Detail	CLABSI SIR – All Units including ICU(s)
Measure IDs	CLABSI_SIR_All
Measure Type	Outcome
Measure Description	Number of observed CLABSIs per number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	None
Rate Multiplier	n/a
Data Source(s)	• NHSN • These measures are NOT applicable for hospitals that do not report into NHSN.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • Bloodstream Infection (BSI) Events
Baseline Period	n/a
Reporting Period	Monthly
Measure Reporting History:	HIIN: CLABSI-1a & CLABSI-1a (Oct. 2016 – March 2020) HEN2: CLABSI-1a & CLABSI-1b (July 2015 – Sept. 2016) (Re-baselined in 2015)

Category: Central Line-Associated Blood Stream Infection (CLABSI)

CLABSI Rate	
Measure Name Detail	CLABSI Rate: All Units including ICU(s)
Measure ID	CLABSI_Rate_All
Measure Type	Outcome
Measure Description	Number of healthcare associated CLABSIs per 1,000 central line days
Numerator	Number of healthcare associated CLABSI among patients in bedded inpatient care locations during the calendar month
Denominator	Number of central line days in bedded inpatient care locations during the calendar month
Denominator Exclusions	None
Rate Multiplier	1,000
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do NOT report to NHSN or do NOT confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• Includes NICUs • Available from CDC NHSN • Bloodstream Infection (BSI) Events • **Rate denominator reported = utilization measure numerator reported**
Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CLABSI-2a & CLABSI-2a (Oct. 2016 – March 2020) HEN2: CLABSI-2a & CLABSI-2b (July 2015 – Sept. 2016) (Re-baselined in 2015)

Category: Central Line-Associated Blood Stream Infection (CLABSI)

CLABSI: Central Line Utilization	
Measure Name Detail	CLABSI Central Line Utilization – All Units including ICU(s)
Measure IDs	CLABSI_Util_All
Measure Type	Process
Measure Description	Number of central line days per 100 patient days
Numerator	Number of central line days in bedded inpatient care locations during the calendar month
Denominator	Number of patient days for bedded inpatient care locations during the calendar month
Denominator Exclusions	None
Rate Multiplier	100
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do NOT report to NHSN or do NOT confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • Bloodstream Infection (BSI) Events • **Utilization measure numerator reported = rate denominator reported**
Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CLABSI-3a & CLABSI-3a (Oct. 2016 – March 2020) HEN2: CLABSI-3a & CLABSI-3b (July 2015 – Sept. 2016) (Re-baselined in 2015)

Category: Central Line-Associated Blood Stream Infection (CLABSI)

CLABSI: Central Line Standard Utilization Ratio (SUR)	
Measure Name Detail	CLABSI Central Line SUR– All Units including ICU(s)
Measure IDs	CLABSI_SUR_All
Measure Type	Outcome
Measure Description	Number of observed central line device days per number of predicted central line device days
Numerator	Number of Observed Device Days
Denominator	Number of Predicted Device Days
Denominator Exclusions	None
Rate Multiplier	n/a
Data Source(s)	• NHSN • This measure is NOT applicable for hospitals that do not report into NHSN.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • Bloodstream Infection (BSI) Events • NHSN SUR Guide
Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	n/a

Category: Clostridioides Difficile (CDI)

CDI Standardized Infection Ratio (SIR)	
Measure Name Detail	CDI SIR – All Units
Measure ID	CDI_SIR
Measure Type	Outcome
Measure Description	The number of hospital-onset CDI observed infections divided by the number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	• Predicted infection count less than one • No data reported during baseline period
Rate Multiplier	n/a
Data Source(s)	• NHSN • This measure is NOT applicable for hospitals that do not report into NHSN.
Specifications/Definitions/ Recommendations	Available from CDC NHSN
Baseline Period	n/a
Reporting Timeline	Quarterly
Measure Reporting History:	HIIN: CDI-1a (Oct. 2016 – March 2020) HEN2: CDI-1a (July 2015 – Sept. 2016)

Category: Clostridioides Difficile (CDI)

CDI Rate, Hospital Onset LabID Events	
Measure Name Detail	CDI Rate – All Units
Measure ID	CDI_LabID
Measure Type	Outcome
Measure Description	The number of hospital-onset CDI per 10,000 patient days
Numerator	Number of hospital-onset LabID CDI events
Denominator	Number of patient days
Denominator Exclusions	• Inpatient rehab facilities or inpatient psychiatric facilities with separate CCN • All NICU locations
Rate Multiplier	10,000
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do NOT report to NHSN or do NOT confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	Available from CDC NHSN
Baseline Period	n/a
Reporting Period	Monthly
Measure Reporting History:	HIIN: CDI-1b (Oct. 2016 – March 2020) HEN2: CDI-1b (July 2015 – Sept. 2016)

Category: Falls

Falls with Injury	
Measure Name Detail	Patient falls with an injury level of minor or greater
Measure ID	Falls_Injury
Measure Type	Outcome
Measure Description	All documented patient falls with an injury level of minor or greater
Numerator	Total number of patient falls with injury level minor or greater (including those assisted by a staff member) on eligible hospital units during the calendar month
Denominator	Patient days in eligible units during the calendar month
Denominator Exclusions	Other unit types (e.g., pediatric, psychiatric, obstetrical, etc.)
Rate Multiplier	1,000
Data Source(s)	Self-reported using billing systems, medical records, or surveillance systems. 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, surveillance systems, injury reports, event tracking systems, etc.

Specifications/Definitions/ Recommendations	• NQF-0202
	• Definition of Minor or Greater: When the initial fall report is written by the nursing staff, the extent of injury may not yet be known. Hospitals have 24 hours to determine the injury level, e.g., when you are awaiting diagnostic test results or consultation reports.
	  ○ None: no signs or symptoms of injuries 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/administration of a dressing, ice, wound cleaning, limb elevation, topical medication, pain medication, or the appearance of a bruise or abrasion;
	  ○ **Moderate:** resulted in suturing, application of steri-strips or glue, splinting, or muscle/joint strain;
	  ○ **Major:** resulted in surgery, casting, traction, neurological consult, internal injury, or patients with coagulopathy who receive blood products as a result;
	  ○ **Death:** died of injuries sustained from the fall (not from physiologic events causing the fall).
	• Eligible populations: Target population is adult, acute care inpatient, short stay, observation, and rehabilitation patients.
	• **Eligible units:** adult critical care, step-down, medical, surgical, medical-surgical combined, critical access, adult rehabilitation in-patient.
	• Recommendations: The Agency for Healthcare Research & Quality (AHRQ) resource for measuring fall rates and fall prevention practices.

Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: Falls-1 (Oct. 2016 – March 2020) HEN2: Falls-1 (July 2015 – Sept. 2016)

Category: Falls

Hospital Harm - Falls with Injury	
Measure Name Detail	Hospital Harm – Falls with Injury
Measure ID	HH_FI_eCQM
Measure Type	Outcome
Measure Description	This ratio measure assesses the number of inpatient hospitalizations where at least one fall with a major or moderate injury occurs among the total qualifying inpatient hospital days for patients age 18 years and older
Numerator	Inpatient hospitalizations where the patient has a fall that results in a major or moderate injury during the encounter. The diagnosis of a major or moderate injury must not be present on admission.
Denominator	Inpatient hospitalizations for patients age 18 and older with a length of stay less than or equal to 120 days that ends during the measurement period.
Exclusions	Inpatient hospitalizations where the patient has a fall diagnosis present on admission. The diagnosis of a major or moderate injury must not be present on admission.
Rate Multiplier	1000 ([Total number of encounters with falls with moderate or major injury / Total number of eligible hospital days] x 1000)
Data Source(s)	• Self-report the numerator as the number of inpatients that met criteria minus exclusions. Report the denominator as the initial population minus exclusions. • Hospital Harm - Falls with Injury (eCQI Resource Center)
Specifications/Definitions/ Recommendations	• Hospital days are measured in 24-hour periods starting from the time of arrival at the hospital (including time in the Emergency Department and or Observation.) The number of days will be counted as whole numbers; any fractional periods are dropped. For example, an eligible encounter with a length of stay of 75 hours will be measured as 3 days (72 hours). • Reported as the number of inpatient hospitalizations with falls with moderate or major injury per 1000 patient days. • This eCQM is an episode-based measure. An episode is defined as each inpatient hospitalization or encounter that ends during the measurement period. • This version of the eCQM uses QDM version 5.6. Please refer to eCQI's QDM page for more information on the QDM.
Baseline Period	January – December 2024
Reporting Timeline	Monthly Data, Submitted Quarterly
Measure Reporting History:	n/a

Category: Methicillin-Resistant Staphylococcus Aureus (MRSA)

MRSA Bacteremia Standardized Infection Ratio (SIR)	
Measure Name Detail	MRSA Bacteremia SIR
Measure ID	MRSA_SIR
Measure Type	Outcome
Measure Description	Number of observed MRSA per number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	• Inpatient rehab facilities or inpatient psychiatric facilities with a separate CCN • All NICU locations • Predicted infection count less than one • No data reported during baseline period
Rate Multiplier	n/a
Data Source(s)	• NHSN • This measure is NOT applicable for hospitals that do not report into NHSN.
Specifications/Definitions/ Recommendations	Available from CDC NHSN
Baseline Period	n/a
Reporting Timeline	Quarterly
Measure Reporting History:	HIIN: MRSA-1 (Oct. 2016 – March 2020) HEN2: MRSA-1 (July 2015 – Sept. 2016)

Category: Methicillin-Resistant Staphylococcus Aureus (MRSA)

MRSA Bacteremia Rate Hospital-Onset Events	
Measure Name Detail	MRSA Bacteremia Rate (Hospital-Onset Events)
Measure ID	MRSA_Rate
Measure Type	Outcome
Measure Description	Number of hospital-onset MRSA bacteremia events
Numerator	MRSA bacteremia events
Denominator	Patient days
Denominator Exclusions	None
Rate Multiplier	1,000
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do NOT report to NHSN or do NOT confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	Available from CDC NHSN
Baseline Period	n/a
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: MRSA-2 (Oct. 2016 – March 2020) HEN2: MRSA-2 (July 2015 – Sept. 2016)

Category: Opioid Stewardship

Opioid Stewardship: Concurrent Opioids	
Measure Name Detail	Safe Use of Opioids – Concurrent Prescribing
Measure ID	Opioid_Concurrent_eCQM
Measure Type	Process
Measure Description	Proportion of inpatient hospitalizations for patients age 18 years and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge
Numerator	Inpatients prescribed or continuing to take two or more opioids OR an opioid AND a benzodiazepine at discharge.
Denominator	Inpatients, 18 years or older, with a length of stay less than or equal to 120 days, that are prescribed one or more new or continuing opioids or benzodiazepine at discharge
Denominator Exclusions	Inpatient hospitalizations where the patient has any of the following: • Patients under 18 years of age. • Patients with inpatient stays greater than 120 days. • Cancer that begins prior to or during the encounter. • Ordered or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the hospitalization or in an emergency department encounter or observation stay immediately prior to hospitalization. • Discharged to another inpatient care facility. • Expires during the inpatient stay.
Rate Multiplier	100
Data Source(s)	• Self-report the numerator as the number of inpatients that met criteria. Report the denominator as the initial population minus exclusions and exceptions. Please note that reporting system verbiage may differ. • 2024 eCQM Flow – CMS506.v6: Safe Use of Opioids – Concurrent Prescribing • Safe Use of Opioids – Concurrent Prescribing (eCQI Resource Center)
Specifications/Definitions/ Recommendations	• For the purpose of this measure, the following are defined as: ○ Opioid: Any Schedule II or III opioid medication ○ Benzodiazepine: Any Schedule IV benzodiazepine medication ○ Prescribed: The intent of the measure is to capture opioid and/or benzodiazepine medications continued or ordered at discharge ○ Numerator criteria: Two or more unique orders for opioids, or an opioid and benzodiazepine at discharge • Clinician judgement, clinical appropriateness, or both may indicate concurrent prescribing of two unique opioids or an opioid and benzodiazepine is medically necessary, thus the measure is not expected to have a zero rate. • Inpatient hospitalizations with discharge medications of a new or continuing opioid or a new or continuing benzodiazepine prescription should be included in the initial population. • Inpatient hospitalizations with discharge medications of two or more new or continuing opioids or new or continuing opioid and benzodiazepine resulting in concurrent therapy at discharge should be included in the numerator. Each

	benzodiazepine and opioid included on the medication discharge list is considered a unique prescription. • This eCQM is an episode-based measure. An episode is defined as each inpatient hospitalization or encounter that ends during the measurement period. • Submit overall numerator and denominator to CDS for the LHA Foundation. • This version of the eCQM uses QDM version 5.6. Please refer to eCQI's QDM page for more information on the QDM.
Baseline Period	n/a
Reporting Period	Monthly Data, Submitted Quarterly
Measure Reporting History:	n/a

Category: Opioid Stewardship

Hospital Harm - Opioid-Related Adverse Events	
Measure Name Detail	Hospital Harm - Opioid-Related Adverse Events
Measure ID	**(**HH_ORAE_eCQM**)**
Measure Type	Outcome
Measure Description	This measure assesses the number of inpatient hospitalizations for patients age 18 and older who have been administered an opioid medication outside of the operating room and are subsequently administered a non-enteral opioid antagonist outside of the operating room within 12 hours, an indication of an opioid-related adverse event.
Numerator	Inpatient hospitalizations where a non-enteral opioid antagonist administration starts during the hospitalization outside of the operating room and 12 hours or less following an opioid medication administered outside of the operating room.
Denominator	Inpatient hospitalizations for patients age 18 and older during which at least one opioid medication was administered outside of the operating room.
Exclusions	None
Rate Multiplier	n/a
Data Source(s)	• Self-report the numerator as the number of inpatients that met criteria. Report the denominator as the initial population. • 2025 eCQM Flow – CMS819v3: Opioid-Related Adverse Events • Hospital Harm - Opioid-Related Adverse Events (eCQI Resource Center)
Specifications/Definitions/ Recommendations	• The route of administration of the opioid antagonist must be by intranasal spray, inhalation, intramuscular, subcutaneous, or intravenous injection. Only one numerator event is counted per encounter. • Qualifying encounters (denominator) include all patients 18 years of age or older with at least one opioid medication administered outside of the operating room. To create the numerator: 1. First, start with those encounters meeting denominator criteria. 2. Next, remove all events where an opioid or opioid antagonist was administered in the operating room. Opioid antagonist administrations in the operating room are excluded because they could be part of the sedation plan as administered by an anesthesiologist. Encounters that include use of opioid antagonists for procedures and recovery outside of the operating room (e.g., bone marrow biopsy and PACU) are included in the numerator, as it would indicate the patient was over-sedated. Note that should a facility not utilize temporary patient locations, alternative times may be used to determine whether a patient is in the operating room during opioid antagonist administration. Since anesthesia end time could represent the time the anesthesiologist signed off, and thus may include the patient's time in the PACU, this should be avoided. 3. Next, remove all events where the opioid antagonist was administered via an enteral route. Only opioid antagonists given by a non-enteral (i.e., intravenous, intramuscular, subcutaneous, intranasal, inhalation) route are considered. 4. Finally, remove all administrations of opioid antagonist that were given greater than 12 hours following hospital administration of an opioid medication.

	• This eCQM is an episode-based measure. An episode is defined as each inpatient hospitalization or encounter that ends during the measurement period. • This version of the eCQM uses QDM version 5.6. Please refer to eCQI's QDM page for more information on the QDM.
Baseline Period	January – December 2024
Reporting Period	Monthly Data, Submitted Quarterly
Measure Reporting History:	n/a

Category: Pressure Injury, Hospital-Acquired (HAPI)

Pressure Injury, Hospital-Acquired (HAPI) Rate, Stage 3+ (PSI-03)	
Measure Name Detail	Pressure Injury Rate, Stage 3+
Measure ID	HAPI_PSI03
Measure Type	Outcome
Measure Description	Rate of Stage III, Stage IV, unstageable pressure ulcers or unstageable (secondary diagnosis) among surgical or medical patients ages 18 years and older that are not present on admission
Numerator	Number of patients with Stage III, Stage IV, or Unstageable Pressure Ulcers
Denominator	Number of surgical or medical discharges, for patients ages 18 years and older
Denominator Exclusions	• Length of stay less than 3 days • Cases with a principal stage III or IV (or unstageable) or deep tissue injury pressure ulcer diagnosis • Cases with all secondary diagnosis of Stage III or IV pressure ulcer (or unstageable) or deep tissue injury that is present on admission. • Severe burns (>= 20% body surface area) • Exfoliative disorders of the skin (>=20% body surface area) • Obstetric cases
Rate Multiplier	1,000
Data Source(s)	Self-reported
Specifications/Definitions/ Recommendations	PSI 03 Pressure Ulcer Rate Specification v2024 (July 2024)
Baseline Period	n/a
Reporting Period	Monthly
Measure Reporting History:	HIIN: PrU-1 (Oct. 2016 – March 2020) HEN2: PrU-1 (July 2015 – Sept. 2016)

Category: Pressure Injury

Hospital Harm - Pressure Injury	
Measure Name Detail	Hospital Harm - Pressure Injury
Measure ID	HH_PI_eCQM
Measure Type	Outcome
Measure Description	The measure assesses the number of inpatient hospitalizations for patients aged 18 and older who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury.
Numerator	Inpatient hospitalizations for patients with a new deep tissue pressure injury (DTPI) or stage 2, 3, 4, or unstageable pressure injury, as evidenced by **any** of the following: • A diagnosis of DTPI with the DTPI not present on admission, i.e., the diagnosis of DTPI has a present on admission (POA) Indicator; or • A diagnosis of stage 2, 3, 4 or unstageable pressure injury with the pressure injury diagnosis not POA; or • A DTPI found on exam greater than 72 hours after the start of the encounter; or • A stage 2, 3, 4 or unstageable pressure injury found on exam greater than 24 hours after the start of the encounter.
Denominator	Inpatient hospitalizations for patients aged 18 and older.
Exclusions	Denominator - Inpatient hospitalizations for patients: • With a DTPI or stage 2, 3, 4 or unstageable pressure injury diagnosis POA, i.e., the diagnosis of pressure injury has a POA indicator = Y (yes-Diagnosis was present at time of inpatient admission) or W (clinically undetermined). • With a DTPI found on exam 72 hours or less after the start of the encounter. • With a stage 2, 3, 4, or unstageable pressure injury found on exam 24 hours or less after the start of the encounter. Inpatient hospitalizations for patients with diagnosis of a COVID-19 infection during the encounter.
Rate Multiplier	100
Data Source(s)	• Self-report the numerator as the number of inpatients that met criteria. Report the denominator as the initial population minus denominator exclusions. • 2025 eCQM Flow – CMS826v2: Hospital Harm - Pressure Injury • Hospital Harm - Pressure Injury (eCQI Resource Center)

Specifications/Definitions/ Recommendations	• The measure defines a new deep tissue pressure injury (DTPI) as found on exam greater than 72 hours after hospital arrival and was not POA, i.e., with POA indicators:
	  ○ N: Diagnosis was not present at time of inpatient admission; or
	  ○ U: Documentation insufficient to determine if the condition was present at the time of inpatient admission.
	• Inpatient hospitalizations: Includes time in the emergency department and observation when the transition between these encounters (if they exist) and the inpatient encounter are within an hour or less of each other.
	• The measure defines a new stage 2, stage 3, stage 4, or unstageable pressure injury as found on exam greater than 24 hours after hospital arrival and was not POA.

	• In addition to clinical electronic health record data, this measure uses POA indicators (e.g., POA = U) as found in billing/claims system within the measure criteria. • This measure excludes encounters for patients with a DTPI or stage 2, stage 3, stage 4, and unstageable pressure injuries that are POA, i.e., POA indicator = Y (Diagnosis was present at the time of inpatient admission) or W (clinically undetermined). The POA Indicator is intended to differentiate conditions present at the time of admission from those conditions that develop during the inpatient admission.- A POA Indicator of Y = yes (Diagnosis was present at time of inpatient admission).- A POA Indicator of N = no (Diagnosis was not present at time of inpatient admission).- A POA Indicator of W = clinically undetermined.- A POA Indicator of U = documentation insufficient to determine if the condition was present at the time of inpatient admission. Per CMS and the Agency for Healthcare Research and Quality (AHRQ) convention, POA indicators of Y and W are accepted indicators of a diagnosis POA. POA indicators of N and U are accepted indicators of a diagnosis that is not POA. • Only one harm (new qualifying pressure injury) is counted per encounter. This eCQM is an episode-based measure. An episode is defined as each inpatient hospitalization or encounter that ends during the measurement period. • This version of the eCQM uses QDM version 5.6. Please refer to eCQI's QDM page for more information on the QDM.
Baseline Period	January – December 2024
Reporting Period	Monthly Data, Submitted Quarterly
Measure Reporting History:	n/a

Category: Readmissions

Readmissions: Hospital-Wide, All-Cause, 30-Day	
Measure Name Detail	30-day All-Cause Readmission Rate per 100 Admissions
Measure ID	READ-1
Measure Type	Outcome
Measure Description	Rate of all-cause readmissions for all patients 18 years of age and older that arise from acute clinical events requiring urgent rehospitalization **to the same hospital** within 30 days of discharge.
Numerator	Number of inpatients returning as an acute care inpatient within 30 days of date of discharge.
Denominator	Patients discharged alive
Denominator Exclusions	• Patients that expired in the index stay. • Patients under the age of 18 years of age. • Patients admitted to a different level of care (e.g., rehabilitation facilities, hospice) are not counted as readmissions
Rate Multiplier	100
Data Source(s)	Numerators and denominators will be reported by hospitals and obtained either through administrative data, billing systems or other tracking systems.
Specifications/Definitions/ Recommendations	• Facilities should follow the CMS definition of a readmission explained in the Readmission Measures Methodology for measure updates or Frequently asked questions about readmissions (updated May 6, 2024). This is the same definition used for Medicare readmission measure but includes all payors. • Measure is not risk-adjusted.
Baseline Period	n/a
Reporting Period	Monthly
Measure Reporting History:	HIIN: Read-1 (Oct. 2016 – March 2020) HEN2: Read-1 (July 2015 – Sept. 2016)

Category: Sepsis

Sepsis: Overall Mortality Rate	
Measure Name Detail	Sepsis Overall Mortality Rate
Measure ID	SEPSIS_MORTALITY
Measure Type	Outcome
Measure Description	Rate of patients with a principal or secondary diagnosis code from the SEP-1 inclusion criteria who have a discharge status of expired.
Numerator	Number of patients with sepsis diagnosis and discharge status of expired
Denominator	Number of patients with any principal or secondary diagnosis code from SEP-1 inclusion criteria (refer to Specifications/Definitions/Recommendations section below)
Denominator Exclusions	Patients with COVID ICD-10 Code U071
Rate Multiplier	1,000
Data Source(s)	Numerators and denominators will be reported by hospitals.
Specifications/Definitions/ Recommendations	Hospital Inpatient Specifications Manuals (Documents 2aSEP-List, 2b-SEP1, and Appendix A-1); refer to applicable version for the timeframe).
Baseline Period	n/a
Reporting Period	Monthly
Measure Reporting History:	HIIN: Sepsis-1d (Oct. 2016 – March 2020) HEN2: Sepsis-1d (July 2015 – Sept. 2016)

Category: Sepsis

Sepsis: SEP-1	
Measure Name Detail	Severe Sepsis and Septic Shock Management Bundle (Composite Measure)
Measure ID	SEP-1
Measure Type	Process
Measure Description	This measure focuses on adults 18 years and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, it assesses measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement.

Numerator	Patients who receive **ALL** the following:
	• Within three hours of presentation of severe sepsis:
	  ○ Initial lactate level measurement; and
	  ○ Broad spectrum or other antibiotics administered; and
	  ○ Blood cultures drawn prior to antibiotics;
	• **AND** received within six hours of presentation of severe sepsis ONLY if the initial lactate is elevated, a repeat lactate level measurement;
	• **AND** within three hours of initial hypotension, resuscitation with 30 mL/kg crystalloid fluids; **OR** within three hours of septic shock, resuscitation with 30 mL/kg crystalloid fluids;
	• **AND** within six hours of septic shock presentation, ONLY if hypotension persists after fluid administration, vasopressors are administered;
	• **AND** within six hours of septic shock presentation, if hypotension persists after fluid administration or initial lactate >= 4 mmol/L, repeat volume status and tissue perfusion assessment is performed.

Denominator	Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis, or septic shock and **not equal to U07.1 (COVID-19).**
Denominator Exclusions	• Patients under the age of 18 years • Patients with length of stay >120 days • Patients with an ICD-10-CM principal or other diagnosis code of U07.1 (COVID-19) • Patients with a directive for Comfort Care or Palliative Care within six hours of presentation of severe sepsis or septic shock • Patients that transfer in from another acute care facility • Patients enrolled in a clinical trial for sepsis, severe sepsis or septic shock treatment or intervention • Patients with severe sepsis or septic shock who are discharged within six hours of presentation • Patients receiving IV antibiotics for more than 24 hours prior to presentation of severe sepsis. • Patients with administrative contraindication to care within six hours of presentation of severe sepsis or septic shock
Rate Multiplier	100
Data Source(s)	Overall SEP-1 numerators and denominators will be self-reported by hospitals.

Specifications/Definitions/ Recommendations	Hospital Inpatient Specifications Manuals (Documents 2aSEP-List, 2b-SEP1, and Appendix A-1; refer to applicable version for the timeframe).
Baseline Period	n/a
Reporting Period	Monthly Data, Submitted Quarterly
Measure Reporting History:	n/a

Category: Surgical Site Infection (SSI)

Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) – Two Measures	
Measure Name Detail	(1) SSI SIR, Colon Surgeries (2) SSI SIR, Abdominal Hysterectomies
Measure ID	(1) SSI_Colon_SIR (2) SSI_AbHyst_SIR
Measure Type	Outcome
Measure Description	Number of observed SSIs per number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	Outpatient procedures
Rate Multiplier	n/a
Data Source(s)	• NHSN • These measures are NOT applicable for hospitals that do not report into NHSN.
Specifications/Definitions/ Recommendations	• CDC NHSN • Additional resources: CDC
Baseline Period	n/a
Reporting Period	Monthly
Measure Reporting History:	HIIN: SSI-1a and SSI-1b (Oct. 2016 – March 2020) HEN2: SSI-1a and SSI-1b (July 2015 – Sept. 2016)

Category: Surgical Site Infection (SSI)

Surgical Site Infection (SSI) Rate – Two Measures	
Measure Name Detail	(1) SSI Rate, Colon Surgeries (2) SSI Rate, Abdominal Hysterectomies
Measure ID	(1) SSI_Colon_Rate (2) SSI_AbHyst_Rate
Measure Type	Outcome
Measure Description	(1) Number of colon surgical site infections based on CDC NHSN definition (2) Number of abdominal hysterectomy surgical site infections based on CDC NHSN definition
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
Denominator Exclusions	Outpatient procedures
Rate Multiplier	100
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do NOT report to NHSN or do NOT confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• CDC NHSN • Additional resources: CDC
Baseline Period	n/a
Reporting Period	Monthly
Measure Reporting History:	HIIN: SSI-2a and SSI-2b (Oct. 2016 – March 2020) HEN2: SSI-2a and SSI-2b (July 2015 – Sept. 2016)

Appendix A:
Additional Information for Hypoglycemia in Inpatients Receiving Insulin

These data elements shall be submitted monthly by all hospitals. Data can be collected through laboratory systems, pharmacists' intervention data, medical records, or administrative data.

Data Collection Tips:

- Partner with pharmacy, laboratory staff and/or Information Technology.
- Connect with pharmacists or Endocrine service as they may already be collecting these data.
- Create/utilize laboratory/EHR hypoglycemia documentation reports for blood glucose levels at or below value set by the hospital.
- Implement a notification process: identifying paper/stickers attached to IV Dextrose 50% bags or Glucagon for periodic retrieval.
- If collecting house-wide data is not currently possible, focus on collecting data from just those units where insulin is most often administered, and then work towards collecting house-wide.

Link back to measure specifications.

Appendix B:
Additional Information for Opioids: Rate of Naloxone Administration in Patients

These data elements shall be submitted monthly by all hospitals. Data can be collected through laboratory systems, pharmacists' intervention data, medical records, or administrative data.

Opioids: (any form of, including combinations): codeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine sulfate, oxycodone, propoxyphene, tapentadol, tramadol, and ultram.

Data Collection Tips:

- Partner with pharmacy, procedural area staff and/or Information Technology.
- Connect with pharmacists as they may already be collecting these data.
- Implement a notification process: identifying paper/stickers attached to naloxone vials for periodic retrieval.
- Multiple doses of naloxone to the same patient during a hospital stay count as one event.
- Consider non-traditional data collection sources: rapid response team event reports, medication dispensing cabinet reports, RASS, or MOSS sedation assessment documentation.

Link back to measure specifications.