Hospital Workgroup Meeting

1030 15th Street NW
Washington, DC

NATIONAL QUALITY FORUM

Measure Applications Partnership

CONVENED BY THE NATIONAL QUALITY FORUM

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Measures under Consideration

Hospital Inpatient Quality Reporting (IQR) Program:

Measures under Consideration

NQF Measure # and Status
0077 Endorsed

Measure Title
Heart failure: Symptom and Activity Assessment

National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Heart Failure	Process

Description
Percentage of patient visits for those patients aged 18 years and older with a diagnosis of heart failure with quantitative results of an evaluation of both current level of activity and clinical symptoms documented

Numerator
Patient visits with quantitative results of an evaluation of both current level of activity and clinical symptoms documented**Evaluation and quantitative results documented should include: - documentation of New York Heart Association (NYHA) Class OR - documentation of completion of a valid, reliable, disease-specific instrument (eg, Kansas City Cardiomyopathy Questionnaire, Minnesota Living with Heart Failure Questionnaire, Chronic Heart Failure Questionnaire)

Denominator
All patient visits for those patients aged 18 years and older with a diagnosis of heart failure

Exclusions
Documentation of medical reason(s) for not evaluating both current level of activity and clinical symptoms (eg, severe cognitive or functional impairment)

Risk Adjustment
no risk adjustment necessary

Data Source
Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records, Electronic Clinical Data : Registry, Electronic Clinical Data : Electronic Clinical Data

Steward
American Medical Association-Physician Consortium for Performance Improvement

Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
0083 Endorsed

Measure Title
Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction

National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Heart Failure	Process

Description
Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge

Numerator
Patients who were prescribed* beta-blocker therapy** either within a 12 month period when seen in the outpatient setting or at hospital discharge *Prescribed may include prescription given to the patient for beta-blocker therapy at one or more visits in the measurement period OR patient already taking beta-blocker therapy as documented in current medication list**Beta-blocker therapy should include bisoprolol, carvedilol, or sustained release metoprolol succinate.

Denominator
All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction

Exclusions
Documentation of medical reason(s) for not prescribing beta-blocker therapyDocumentation of patient reason(s) for not prescribing beta-blocker therapyDocumentation of system reason(s) for not prescribing beta-blocker therapy

Risk Adjustment
no risk adjustment necessary

Data Source
Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

Steward
AMA

Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 3

NQF Measure # and Status
0228 Endorsed

Measure Title
3-Item Care Transition Measure (CTM-3)

National Quality Strategy Priority
Effective Communication and Care Coordination, Person- and Family-Centered Care,

Condition/Topic Area	Measure Type
Care Coordination	Patient Engagement/Experience

Description
Uni-dimensional self-reported survey that measure the quality of preparation for care transitions.

Numerator
The 15-item and the 3-item CTM share the same set of response patterns: Strongly Disagree; Disagree; Agree; Strongly Agree (there is also a response for Don't Know; Don't Remember; Not Applicable). Based on a subject's response, a score can be assigned to each item as follows: •Strongly Disagree = 1•Disagree = 2•Agree = 3•Strongly Agree = 4Next, the scores can be aggregated across either the 15 or 3 items, and then transformed to a scale ranging from 0 to 100. Thus the denominator is 100 and the numerator can range from 0 to 100. Time Window = recommended within 30 days of event

Denominator

Exclusions
The CTM has application to all hospitalized adults. Testing has not included children, but the measure may have potential application to this population as well. Persons with cognitive impairment have been included in prior testing, provided they are able to identify a willing and able proxy. The CTM has been tested in English- and Spanish-speaking (using an available Spanish version of the CTM) populations.

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Survey : Patient

Steward
University of Colorado Health Sciences Center

Contribution to the Program Set
MAP Duals Core Measure

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
0698 Endorsed

Measure Title
AMI 30-day Post Discharge Transition Composite Measure

National Quality Strategy Priority
Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Care Coordination	Composite

Description
This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.

Numerator
The numerator is the weighted sum of the three deviations from their expected values for the individual measures comprising the component measure. The question of appropriate weights on the deviations is difficult and would probably lead to a wide variation in opinion. The weights of -4, -2, and 1 are selected to represent order of magnitude differences in seriousness of the three outcomes, which most would agree to (that is to say: readmission is more important than ED which is more important in a negative way than E & M service is in a positive way). The idea of not using weights was also considered, but this was noted to be itself a de facto weight scheme (with all weights the same), and as such, a weight scheme that was less appropriate than the one chosen.

Denominator
The composite measure is the weighted sum of three individual measures. Thus, the denominator is one.

Exclusions
N/A

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Paper Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Electronic Clinical Data : Electronic Clinical Data, Management Data

Steward
CMS

Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
No	Under Consideration-Priority 2

NQF Measure # and Status
0699 Endorsed

Measure Title
HF 30-day Post Discharge Transition Composite Measure

National Quality Strategy Priority
Effective Communication and Care Coordination, Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Care Coordination	Composite

Description
This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.

Numerator
The numerator is the weighted sum of the three deviations from their expected values for the individual measures comprising the component measure. The question of appropriate weights on the deviations is difficult and would probably lead to a wide variation in opinion. The weights of -4, -2, and 1 are selected to represent order of magnitude differences in seriousness of the three outcomes, which most would agree to (that is to say: readmission is more important than ED which is more important in a negative way than E & M service is in a positive way). The idea of not using weights was also considered, but this was noted to be itself a de facto weight scheme (with all weights the same), and as such, a weight scheme that was less appropriate than the one chosen.

Denominator
The composite measure is the weighted sum of three individual measures. Thus, the denominator is one.

Exclusions
N/A

Risk Adjustment
No risk adjustment or risk stratification

Data Source

Steward
CMS

Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
No	Under Consideration-Priority 2

NQF Measure # and Status
0707 Endorsed

Measure Title
Pneumonia 30-day Post Discharge Transition Composite Measure

National Quality Strategy Priority
Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Pneumonia	Composite

Description
This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of PNA for three types of events: readmissions, ED visits, and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated witheffective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient OutcomesMeasures Phase II project's Call for Measures. Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weightedaverage of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompaniedby a percentile ranking to help with its interpretation.

Numerator
The numerator is the weighted sum of the three deviations from their expected values for the individual measures comprising the component measure. The question of appropriate weights on the deviations is difficult and would probably lead to a wide variation in opinion. The weights of –4, –2, and 1 are selected to represent order of magnitude differences in seriousness of the three outcomes, which most would agree to (that is to say: readmission is more important than ED, which is more important in a negative way than E & M service is in a positive way). The idea on not using weights was also considered, but this was noted to be itself a de facto weight scheme (with all weights the same), and as such, a weight scheme that was less appropriate than the one chosen.

Denominator
N/A The composite measure is the weighted of three individual measures. Thus, the denominator is one.

Exclusions
N/A

Risk Adjustment

Data Source
Electronic adminstrative data/claims

Steward
CMS

Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
1651 Submiited

Measure Title
TAM-1 Tobacco Use Screening

National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality, Health and Well-Being,

Condition/Topic Area	Measure Type
Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Process

Description
Hospitalized patients age 18 years and older who are screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days. This measure is intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-2 Tobacco Use Treatment Provided or Offered (during the hospital stay); TOB-3 Tobacco Use Treatment Provided or offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)

Numerator
The number of patients who were screened for tobacco use status

Denominator
The number of hospitalized inpatients 18 years of age and older

Exclusions
The denominator has three exclusions:• Patients less than 18 years of age• Patients who are cognitively impaired• Patients who a have a length of stay less than or equal to one day or greater than 120 days

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Administrative claims, Paper Records

Steward
The Joint Commission

Contribution to the Program Set
#1651 under consideration in Pop Health Prevention project; not yet reviewed

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
1654 Submitted

Measure Title
TAM-2 Tobacco Use Treatment Provided or Offered

National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Process

Description
The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom tobacco use treatment was provided during the hospital stay, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment during the hospital stay. Refer to section 2a1.10 Stratification Details/Variables for the rationale for the addition of the subset measure. These measures are intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB-3 Tobacco Use Treatment Provided or Offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)

Numerator
TOB-2: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications.TOB-2a: The number of patients who received practical counseling to quit AND received FDA-approved cessation medications.

Denominator
The number of hospitalized inpatients 18 years of age and older identified as current tobacco users

Exclusions
The following are excluded from the measure denominator.1. Patients less than 18 years of age2. Patients who are cognitively impaired3. Patients who are not current tobacco users4. Patients who refused or were not screened for tobacco use during the hospital stay.5. Patients who have a duration of stay less than or equal to one day or greater than 120 days

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Administrative claims, Paper Records

Steward
The Joint Commission

Contribution to the Program Set
#1654 under consideration in Pop Health Prevention project; not yet reviewed

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
1656 Submitted

Measure Title
TAM-3 Tobacco Use Treatment Management at Discharge

National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Process

Description
The measure is reported as an overall rate which includes all hospitalized patients 18 years of age an older to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment at discharge. Treatment at discharge includes a referral to outpatient counseling and a prescription for one of the FDA-approved tobacco cessation medications. Refer to section 2a1.10 Stratification Details/Variables for the rationale for the addition of the subset measure. These measures are intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB 2 Tobacco Use Treatment Provided or Offered During the Hospital Stay; TOB-4 Tobacco Use: Assessing Status After Discharge).

Numerator
TOB-3: The number of patients who received or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at dischargeTOB-3a: The number of patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication at discharge.

Denominator
The number of hospitalized inpatients 18 years of age and older identified as current tobacco users

Exclusions
The exclusions to this measure are as follows:1. Patients less than 18 years of age 2. Patients who are cognitively impaired3. Patients who are not current tobacco users4. Patients who refused or were not screened for tobacco use status during the hospital stay (as tobacco status cannot be known)5. Patients who have a length of stay less than or equal to one day or greater than 120 days6. Patients who expired during the hospital stay7. Patients who left against medical advice8. Patients discharged/transferred to another hospital for inpatient care9. Patients discharged/transferred to a federal health care facility10. Patients discharged/transferred to hospice11. Patients who do not reside in the United States

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Administrative claims, Paper Records

Steward
The Joint Commission

Contribution to the Program Set
#1656 under consideration in Pop Health Prevention project; not yet reviewed

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
1657 Submitted

Measure Title
TAM-4 Tobacco Use: Assessing Status after Discharge

National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Process

Description
Hospitalized patients 18 years of age and older who are identified through the screening process as having used tobacco products (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days who are contacted within 30 days after hospital discharge and follow-up information regarding tobacco use status is collected. This measure is intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB-2 Tobacco Use Treatment Provided or Offered (during hospital stay); TOB-3 Tobacco Use Treatment Provided or Offered at Discharge.

Numerator
The number of discharged patients who are contacted within 30 days after hospital discharge and follow-up information regarding tobacco use status is collected.

Denominator
The number of discharged patients 18 years of age and older identified as current tobacco users.

Exclusions
There are 12 exclusions from the denominator as follows:1. Patients less than 18 years of age2. Patients who are not current tobacco users3. Patients who expired during the hospital stay - identified by Discharge Disposition4. Patients who have a length of stay less than or equal to one day5. Patients with a length of stay greater than 120 days6. Patients discharged/transferred to another hospital for inpatient care7. Patients who left against medical advice8. Patients discharged/transferred to a federal health care facility9. Patients discharged/transferred to hospice10. Patients who do not reside in the United States11. Patients who do not have a phone or cannot provide contact information12. Patients discharged to a detention facility, jail or prison

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Administrative claims, Paper Records

Steward
The Joint Commission

Contribution to the Program Set
#1657 under consideration in Pop Health Prevention project; not yet reviewed

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
1661 Submitted

Measure Title
TAM-5 Alcohol Use Screening

National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Process

Description
Hospitalized patients 18 years of age and older who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).

Numerator
The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking

Denominator
The number of hospitalized inpatients 18 years of age and older

Exclusions
The denominator has three exclusions:• Patients less than 18 years of age• Patients who are cognitively impaired• Patients who a have a duration of stay less than or equal to one day or greater than 120 days

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Paper Records

Steward
The Joint Commission

Contribution to the Program Set
#1661 under consideration in Behavioral Health project; not yet reviewed

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
1663 Submited

Measure Title
TAM-6 Alcohol Use Brief Intervention Provided or Offered

National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Process

Description
The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included.These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).

Numerator
SUB-2 The number of patients who received or refused a brief intervention.SUB-2a The number of patients who received a brief intervention.

Denominator
The number of hospitalized inpatients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence).

Exclusions
The denominator has 4 exclusions as follows:• Patients less than 18 years of age• Patient who are cognitively impaired• Patients who refused or were not screened for alcohol use during the hospital stay• Patients who have a length of stay less than or equal to one day and greater than 120 days

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Paper Records

Steward
The Joint Commission

Contribution to the Program Set
#1663 under consideration in Behavioral Health project; not yet reviewed

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
1664 Submitted

Measure Title
TAM-7 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge

National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Process

Description
The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).

Numerator
SUB-3: The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder OR received or refused a referral for addictions treatment.SUB-3a: The number of patients who received a prescription at discharge for medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment.

Denominator
The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder

Exclusions
There are 10 exclusions to the denominator as follows:• Patients less than 18 years of age• Patient drinking at unhealthy levels who do not meet criteria for an alcohol use disorder• Patients who are cognitively impaired• Patients who expire • Patients discharged to another hospital • Patients who left against medical advice• Patients discharged to another healthcare facility• Patients discharged to home for hospice care• Patients who have a length of stay less than or equal to one day or greater than 120 days• Patients who do not reside in the United States

Risk Adjustment
No risk adjustment or risk stratification 2a1.12. DescribeOther Risk Adjustment Type*

Data Source
Paper Records

Steward
The Joint Commission

Contribution to the Program Set
#1664 under consideration in Behavioral Health project; not yet reviewed

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
1665 Submitted

Measure Title
TAM-8 Alcohol and Drug Use: Assessing Status After Discharge

National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Process

Description
Hospitalized patients age 18 years and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted within 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected.This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).

Numerator
The number of discharged patients that are contacted within 30 days after hospital discharge and follow-up information regarding alcohol or drug use status is collected.

Denominator
The number of discharged patients 18 years of age and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug use disorder during their hospital stay.

Exclusions
The following are the exclusions from the denominator for this measure• Patients less than 18 years of age• Patient who expired • Patients who have a length of stay less than or equal to one day or greater than 120 days• Patients who do not screen positive for unhealthy alcohol use• Patients discharged to another hospital • Patients who left against medical advice• Patients discharged to another health care facility• Patients discharged to home for hospice care• Patients who do not reside in the United States• Patients who do not have a phone or cannot provide any contact information• Patients discharged to a detention facility, jail, or prison

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Paper Records

Steward
The Joint Commission

Contribution to the Program Set
#1665 under consideration in Behavioral Health project; not yet reviewed

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Hospital-wide Readmission
National Quality Strategy Priority

Condition/Topic Area	Measure Type
Care Coordination	Outcome

Description
Hospital-wide, all-cause, risk standardized readmission rate (RSRR) following hospitalization for all conditions and procedures (except those excluded)
Numerator
TBD
Denominator
TBD
Exclusions
TBD
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 1

NQF Measure # and Status
Not NQF Endorsed

Measure Title
Heart failure: Symptom Management

National Quality Strategy Priority

Condition/Topic Area	Measure Type
Heart Failure	

Description
TBD

Numerator
TBD

Denominator
TBD

Exclusions
TBD

Risk Adjustment

Data Source

Steward

Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
Not NQF Endorsed

Measure Title
Heart Failure: Counseling Regarding ICD for Patients with LVSD

National Quality Strategy Priority

Condition/Topic Area	Measure Type
Heart Failure	Process

Description
TBD

Numerator
TBD

Denominator
TBD

Exclusions
TBD

Risk Adjustment

Data Source

Steward

Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
Not NQF Endorsed

Measure Title
Heart Failure: Combination Medical Therapy for LVSD

National Quality Strategy Priority

Condition/Topic Area	Measure Type
Heart Failure	Process

Description
TBD

Numerator
TBD

Denominator
TBD

Exclusions
TBD

Risk Adjustment

Data Source

Steward

Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 2

NQF Measure # and Status
Not NQF Endorsed

Measure Title
Hip/Knee Complication

National Quality Strategy Priority

Condition/Topic Area	Measure Type
Hip/Knee	Outcome

Description
Hospital-specific, risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)

Numerator
TBD

Denominator
TBD

Exclusions
TBD

Risk Adjustment

Data Source

Steward

Contribution to the Program Set
#1550 currently recommended in NQF CDP project

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 1

NQF Measure # and Status
Not NQF Endorsed

Measure Title
Hip/Knee Readmission: 30-day all-cause readmission measure.

National Quality Strategy Priority

Condition/Topic Area	Measure Type
Hip/Knee	Outcome

Description
Hospital-specific, risk-standardized, all-cause, 30-day readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)

Numerator
TBD

Denominator
TBD

Exclusions
TBD

Risk Adjustment

Data Source

Steward

Contribution to the Program Set
#1551 currently recommended in NQF CDP project

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 1

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Safe Surgery Checklist
National Quality Strategy Priority

Condition/Topic Area	Measure Type
Safety	Process

Description
TBD
Numerator
TBD
Denominator
TBD
Exclusions
TBD
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Inpatient Quality Reporting
	Under Consideration-Priority 1

Hospital Value-based Purchasing (VBP) Program:

Measures under Consideration

NQF Measure # and Status
0139 Endorsed
Measure Title
Central line associated bloodstream infection
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
Percentage of ICU and high-risk nursery patients, who over a certain amount of days acquired a central line catheter-associated blood stream infections over a specified amount of line-days
Numerator
Number of central line-associated blood stream infections (laboratory-confirmed bloodstream infection or clinical sepsis) x 1,000Number of umbilical and central line-associated blood stream infections (laboratory-confirmed bloodstream infection or clinical sepsis) x 1,000
Denominator
Number of central line-days for ICU patients. Reported by type of ICU (coronary, cardiothoracic, medical, medical-surgical (major teaching and all others), neurosurgical, pediatric, surgical, trauma, burn, and respiratory)Number of central-line days for HRN patients?Reported for HRNs by birth weight category (<1,000, 1,001-1,500, 1,501-2,500, and >2,500g)
Exclusions
Risk Adjustment
Stratification by risk category/subgroup
Data Source
Electronic Clinical Data
Steward
Centers for Disease Control and Prevention
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
Yes	Under Consideration-Priority 3

NQF Measure # and Status
0439 Endorsed
Measure Title
AMI-10 Statin Prescribed at Discharge
National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Acute Myocardial Infarction	Process

Description
Ischemic stroke patients with LDL >/= 100 mg/dL, or LDL not measured, or, who were on cholesterol reducing therapy prior to hospitalization are discharged on a statin medication.
Numerator
Patients who were prescribed a statin medication at hospital discharge.
Denominator
All Ischemic stroke patients with an LDL³100 mg/dL, OR LDL not measured, OR who were on cholesterol reducing therapy prior to hospitalization.
Exclusions
• Patients discharged/transferred to another short term general hospital for inpatient care• Patients who expired• Patients who left against medical advice• Patients discharged to hospice• Patients receiving comfort measures only• Patients admitted for the performance of elective carotid endarterectomy
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Electronic Clinical Data, Electronic Health/Medical Record, Lab data, Paper medical record/flow-sheet, Pharmacy data, Registry data
Steward
The Joint Commission
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
Yes	Under Consideration-Priority 3

NQF Measure # and Status
0452 Endorsed
Measure Title
SCIP INF–10: Surgery patients with perioperative temperature management
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Process

Description
Surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at least one body temperature equal to or greater than 96.8° F/36° C recorded within the 30 minutes immediately prior to or the 15 minutes immediately after Anesthesia End Time.
Numerator
Surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at least one body temperature equal to or greater than 96.8° F/36° C recorded within the 30 minutes immediately prior to or the fifteen minutes immediately after Anesthesia End Time.
Denominator
All patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of 60 minutes duration
Exclusions
• Patients who have a length of stay >120 days (all CMS quality measures have this exclusion- has to do with quarterly reporting)• Patients whose ICD-9-CM principal procedure occurred prior to the date of admission• Patients whose length of anesthesia was less than 60 minutes• Patients who did not have general or neuraxial anesthesia • Patients with physician/APN/PA documentation of intentional hypothermia for the procedure performed.
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
Yes	Under Consideration-Priority 3

NQF Measure # and Status
0530 Endorsed
Measure Title
Mortality for selected medical conditions (composite)
National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
A composite measure of in-hospital mortality indicators for selected conditions.
Numerator
Number of in-hospital deaths
Denominator
Number of eligible discharges (all indicators are limited to the adult population)
Exclusions
Indicator specific
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims
Steward
AHRQ
Contribution to the Program Set
Aligns with core measuresSome mortality rates overlap with existing mortality measures already being reported

HQA approved	CMS Status Value Based Purchasing
No	Under Consideration-Priority 3

NQF Measure # and Status
0531 Endorsed
Measure Title
Complication/patient safety for selected indicators (composite)
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Composite

Description
A composite measure of potentially preventable adverse events for selected indicators
Numerator
Number of potentially preventable adverse events
Denominator
Number of eligible discharges (all indicators limited to the adult population)
Exclusions
Indicator specific
Risk Adjustment
Data Source
Electronic administrative data/claims
Steward
AHRQ
Contribution to the Program Set
Aligns with core measuresSome components overlap with exsisting HAC policy & AHRQ measures reported on Hospital Compare

HQA approved	CMS Status Value Based Purchasing
No	Under Consideration-Priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Medicare Spending per Beneficiary.
National Quality Strategy Priority
Affordable Care,

Condition/Topic Area	Measure Type
Cost	Cost

Description
Sum of all adjusted Medicare Part A and Part B payments divided by the total number of Medicare Spending per Beneficiary episodes for a hospital.
Numerator
Sum of all adjusted Medicare Part A and Part B payments during the Medicare Beneficiary Spending episode
Denominator
Total number of Medicare Spending per Beneficiary episodes
Exclusions
Beneficiaries not enrolled in both Medicare Part A and Medicare Part B, for the 90 days prior to the episodeGeographic payment rate differencesDifferential additional spending that results from the use of the Hospital-Specific Rates.exclude cases involving acute to acute transfers from being counted as index admissions.
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
	Under Consideration-Priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Vascular-Catheter Associated Infection
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
None listed. See numerator and denominator description
Numerator
Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U':• 999.31
Denominator
Number of acute inpatient FFS discharges during time period.
Exclusions
• Non-FFS discharges (MCOPDSW=-1-)• Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of -X-)• Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9).• Discharges that failed internal consistency checks specific to the SAF data sets.
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
	Under Consideration-Priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Pressure Ulcer Stages III and IV
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
None listed. See numerator and denominator description
Numerator
Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U':• 707.23• 707.24
Denominator
Number of acute inpatient FFS discharges during time period.
Exclusions
-The following exclusions were applied:• Non-FFS discharges (MCOPDSW=--1--)• Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of --X--)• Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9).• Discharges that failed internal consistency checks specific to the SAF data sets.-
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
	Under Consideration-Priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Manifestations of Poor Glycemic Control
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
None listed. See numerator and denominator description
Numerator
Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U':• 249.10–249.11• 249.20–249.21• 250.10–250.13• 250.20–250.23• 251.0
Denominator
Number of acute inpatient FFS discharges during time period.
Exclusions
• Non-FFS discharges (MCOPDSW=-1-)• Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of -X-)• Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9).• Discharges that failed internal consistency checks specific to the SAF data sets.
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
	Under Consideration-Priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Falls and Trauma
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
All documented patient falls with an injury level of minor (2) or greater.
Numerator
Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim), with a POA code of 'N' or 'U', and designated as a 2010 Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC):• Fracture 800–829 (CC/MCC)• Dislocation 830–839 (CC/MCC)• Intracranial injury 850–854 (CC/MCC)• Crushing injury 925–929 (CC/MCC)• Burn 940–949 (CC/MCC)• Electric shock 991–994 (CC/MCC)
Denominator
Number of acute inpatient FFS discharges during time period.
Exclusions
• Non-FFS discharges (MCOPDSW=--1--)• Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of --X--)• Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9).• Discharges that failed internal consistency checks specific to the SAF data sets.
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
	Under Consideration-Priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Catheter-Associated Urinary Tract Infection
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
None listed. See numerator and denominator description
Numerator
Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 996.64
Denominator
Number of acute inpatient FFS discharges during time period.
Exclusions
• Non-FFS discharges (MCOPDSW=-1-)• Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of -X-)• Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9).• Discharges that failed internal consistency checks specific to the SAF data sets.
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
	Under Consideration-Priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Blood Incompatibility
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible flood or blood products. Worded in proposed rule as -Blood Incompatibility
Numerator
Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 999.65
Denominator
Number of acute inpatient FFS discharges during time period.
Exclusions
• Non-FFS discharges (MCOPDSW=-1-)• Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of -X-)• Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9).• Discharges that failed internal consistency checks specific to the SAF data sets.
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
	Under Consideration-Priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
Air Embolism
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
Numerator
Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 998.4 • 998.7
Denominator
Number of acute inpatient FFS discharges during time period.
Exclusions
Hospital Inclusion/Exclusions: CMS is calculating and publicly reporting HAC Measures for hospitals that are paid under the IPPS only because these measures rely on Present on Admission (POA) coding, which is only required of IPPS hospitals. Non-IPPS hospitals are excluded from the measure calculation
Risk Adjustment
Data Source
Steward
Contribution to the Program Set

HQA approved	CMS Status Value Based Purchasing
	Under Consideration-Priority 3

Inpatient Psychiatric Facility Quality Reporting Program: Measures under Consideration

NQF Measure # and Status
0552 Endorsed

Measure Title
HBIPS-4: Patients discharged on multiple antipsychotic medications.

National Quality Strategy Priority
Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Patients Discharged on Multiple Antipsychotic Medications	Process

Description
Patients discharged on mulitple antipsychotic medications.

Numerator
Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medicationsData Element: (note see Joint Commission data dictionary for detailed data element definition) Number of antipsychotic medications prescribed at discharge.

Denominator
Psychiatric inpatient dischargesIncluded Population:Patients with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders (Note, refer to Appendix A, Table 10.1) discharged on one or more routinely scheduled antipsychotic medications (Note, refer to Appendix B, Table 10.0))Data Elements: (Note, see Joint Commission data dictionary for detailed data element definition)ICD-9-CM Other Diagnosis Codes•ICD-9-CM Principal Diagnosis Code•Number of Antipsychotic Medications Prescribed at Discharge•Psychiatric Care Setting

Exclusions
Patients who expiredPatients with an unplanned departure resulting in discharge due to elopementPatients with an unplanned departure resulting in discharge due to failing to return from leave

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
The Joint Commission

Contribution to the Program Set

HQA approved	CMS Status Inpatient Psychiatric Quality Reporting
Yes	Under Consideration- Priority 1

NQF Measure # and Status
0557 Endorsed

Measure Title
HBIPS-6 Post discharge continuing care plan created

National Quality Strategy Priority
Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Post Discharge Continuing Care Plan	Process

Description
Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created

Numerator
Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendationsData Elements: (Note, see data dictionary for detailed data element definition)•Continuing Care Plan-Discharge Medications•Continuing Care Plan-Next Level of Care•Continuing Care Plan –Principal Discharge Diagnosis•Continuing Care Plan -Reason for Hospitalization

Denominator
Psychiatric inpatient dischargesIncluded Population:Patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders (Note, refer to Appendix A, Table 10.1) Data Elements: (Note, see Joint Commission data dictionary for detailed data element definition)•ICD-9-CM Other Diagnosis Codes•ICD-9-CM Principal Diagnosis Code•Patient Referral to Next Level of Care Provider

Exclusions
Patients who expiredPatients with an unplanned departure resulting in discharge due to elopementPatients or their guardians who refused aftercarePatients or guardians who refused to sign authorization to release informationPatients with an unplanned departure resulting in discharge due to failing to return from leave

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
The Joint Commission

Contribution to the Program Set

HQA approved	CMS Status Inpatient Psychiatric Quality Reporting
Yes	Under Consideration- Priority 1

NQF Measure # and Status
0558 Endorsed

Measure Title
HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge

National Quality Strategy Priority
Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Post Discharge Continuing Care Plan	Process

Description
Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity.

Numerator
Psychiatric inpatients for whom the post discharge continuing care plan was transmitted to the next level of careData Elements: (Note, see data dictionary for detailed data element definition)•Continuing Care Plan-Discharge Medications•Continuing Care Plan-Next Level of Care•Continuing Care Plan –Principal Discharge Diagnosis•Continuing Care Plan -Reason for Hospitalization

Denominator
Psychiatric inpatient dischargesIncluded Population:Patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders (Note, refer to Appendix A, Table 10.1) Data Elements: (Note, see data dictionary for detailed data element definition)•ICD-9-CM Other Diagnosis Codes•ICD-9-CM Principal Diagnosis Code•Patient Referral to Next Level of Care Provider •Psychiatric Care Setting

Exclusions
Patients who expiredPatients with an unplanned departure resulting in discharge due to elopementPatients or their guardians who refused aftercarePatients or guardians who refused to sign authorization to release informationPatients with an unplanned departure resulting in discharge due to failing to return from leave

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
The Joint Commission

Contribution to the Program Set
MAP Duals Core Measure

HQA approved	CMS Status Inpatient Psychiatric Quality Reporting
Yes	Under Consideration- Priority 1

NQF Measure # and Status
0560 Endorsed

Measure Title
HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

National Quality Strategy Priority
Patient Safety, Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Patients Discharged on Multiple Antipsychotic Medications	Process

Description
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification

Numerator
Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justificationData Element: (Note, see Joint Commission data dictionary for detailed data element definition)•Appropriate Justification for Multiple Antipsychotic Medications

Denominator
Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medicationsData Elements: (Note, see Joint Commission data dictionary for detailed data element definition)•ICD-9-CM Other Diagnosis Codes•ICD-9-CM Principal Diagnosis Code•Number of Antipsychotic Medications Prescribed at Discharge•Patient Referral to Next Level of Care Provider•Psychiatric Care Setting

Exclusions
Patients who expiredPatients with an unplanned departure resulting in discharge due to elopementPatients with an unplanned departure resulting in discharge due to failing to return from leavePatients with a length of stay less than and equal to 3 days

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
The Joint Commission

Contribution to the Program Set

HQA approved	CMS Status Inpatient Psychiatric Quality Reporting
Yes	Under Consideration- Priority 1

NQF Measure # and Status
0640 Endorsed

Measure Title
HBIPS-2 Hours of physical restraint use

National Quality Strategy Priority
Patient Safety, Person- and Family-Centered Care,

Condition/Topic Area	Measure Type
Use of Restraint and Seclusion	Process

Description
The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age group

Numerator
The number of hours that all psychiatric inpatients were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age group

Denominator
Number of psychiatric inpatient hoursOverall and stratified by age group: children (age 1 through 12 years), adolescents (age 13 through 17), adults (age 18 through 64), older adults (age > 65 years)

Exclusions
Total leave days

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
The Joint Commission

Contribution to the Program Set

HQA approved	CMS Status Inpatient Psychiatric Quality Reporting
	Under Consideration- Priority 1

NQF Measure # and Status
0641 Endorsed

Measure Title
HBIPS-3 Hours of seclusion use

National Quality Strategy Priority

Condition/Topic Area	Measure Type
Use of Restraint and Seclusion	Process

Description
The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion per 1000 psychiatric inpatient hours, overall and stratified by age group

Numerator
The number of hours that all psychiatric inpatients were held in seclusion per 1000 psychiatric inpatient hours, overall and stratified by age group

Denominator
Number of psychiatric inpatient hoursstratified by age group: children (age 1 through 12 years), adolescents (age 13 through 17), adults (age 18 through 64), older adults (age > 65 years)

Exclusions
Total leave days

Risk Adjustment
No risk adjustment or risk stratification

Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
The Joint Commission

Contribution to the Program Set

HQA approved	CMS Status Inpatient Psychiatric Quality Reporting
	Under Consideration- Priority 1

Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs (Meaningful Use):

Measures under Consideration

NQF Measure # and Status
0132 Endorsed

Measure Title
Aspirin at arrival for acute myocardial infarction (AMI)

National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Acute Myocardial Infarction	Process

Description
Percentage of acute myocardial infarction (AMI) patients who received aspirin within 24 hours before or after hospital arrival

Numerator
AMI patients who received aspirin within 24 hours before or after hospital arrival

Denominator
AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal diagnosis code of AMI: 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91)

Exclusions
Exclusions: •<18 years of age•Patients who have a length of stay greater than 120 days•Patients enrolled in clinical trials •Discharged to another hospital on day of or day after arrival•Discharged on day of arrival•Expired on day of or day after arrival•Left against medical advice on day of or day after arrival•Patients with comfort measures only documented on day of or day after arrival•Patients with a documented reason for no aspirin on arrival

Risk Adjustment
no risk adjustment necessary

Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
CMS

Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0136 Endorsed
Measure Title
HF-1 Discharge instructions
National Quality Strategy Priority
Patient Safety, Effective Communication and Care Coordination, Prevention and Treatment of Leading Causes of Mortality, Person- and Family-Centered Care, He

Condition/Topic Area	Measure Type
Heart Failure	Process

Description
Percentage of heart failure patients discharged home with written instructions or educational material given to patient or caregiver at discharge or during the hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.

Numerator
HF patients with documentation that they or their caregivers were given written discharge instructions or other educational material addressing all of the following:1.activity level2.diet3.discharge medications4.follow-up appointment5.weight monitoring6.what to do if symptoms worsen

Denominator
HF patients discharged home (ICD-9-CM principal diagnosis of HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9); and a discharge to home, home care, or court/law enforcement

Exclusions
Exclusions:•<18 years of age•Patients who have a length of stay greater than 120 days•Patients enrolled in clinical trials•Patients with comfort measures only documented •Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-9-CM procedure code of LVAD and Heart Transplant: 33.6, 37.51, 37.52, 37.53, 37.54, 37.60, 37.62, 37.63, 37.65, 37.66, 37.68)

Risk Adjustment
no risk adjustment necessary
Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
CMS
Contribution to the Program Set
Not recommended

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0137 Endorsed
Measure Title
ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients
National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Acute Myocardial Infarction	Process

Description
Percentage of acute myocardial infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.
Numerator
AMI patients who are prescribed an ACEI or ARB at hospital discharge
Denominator
AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal diagnosis code of AMI: 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91); with chart documentation of a left ventricular ejection fraction (LVEF) < 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction
Exclusions
Exclusions:•<18 years of age•Patients who have a length of stay greater than 120 days•Discharged to another hospital •Expired •Left against medical advice •Discharged to home for hospice care•Discharged to a health care facility for hospice care•Patients with comfort measures only documented •Patients enrolled in clinical trials•Patients with a documented reason for no ACEI and no ARB at discharge
Risk Adjustment
no risk adjustment necessary
Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0142 Endorsed
Measure Title
AMI–2 Aspirin prescribed at discharge
National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Acute Myocardial Infarction	Process

Description
Percentage of acute myocardial infarction (AMI) patients who are prescribed aspirin at hospital discharge

Numerator
AMI patients who are prescribed aspirin at hospital discharge

Denominator
AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal diagnosis code of AMI: 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91)

Exclusions
Exclusions:•<18 years of age•Patients who have a length of stay greater than 120 days•Patients enrolled in clinical trials •Discharged to another hospital•Expired •Left against medical advice •Discharged to home for hospice care•Discharged to a health care facility for hospice care•Patients with comfort measures only documented • Patients with a documented reason for no aspirin at discharge

Risk Adjustment
no risk adjustment necessary
Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0143 Endorsed
Measure Title
Use of relievers for inpatient asthma
National Quality Strategy Priority

Condition/Topic Area	Measure Type
Child Health	Process

Description
Percentage of pediatric asthma inpatients, age 2-17, who were discharged with a principal diagnosis of asthma who received relievers for inpatient asthma

Numerator
Pediatric asthma inpatients who received relievers during hospitalization

Denominator
Pediatric asthma inpatients (age 2 – 17 years) who were discharged with a principal diagnosis of asthma (ICD-9-CM principal diagnosis code of 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.90, 493.91, 493.92)Stratified as follows:•age 2 years through 17 years - Overall Rate•age 2 years through 4 years•age 5 years through 12 years•age 13 years through 17 years

Exclusions
•Age < 2 years of age•Age >17 years of age •Pediatric patients for whom use of relievers is contraindicated

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Paper medical record/flow-sheet
Steward
The Joint Commission
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 2

NQF Measure # and Status
0144 Endorsed
Measure Title
Use of systemic corticosteroids for inpatient asthma
National Quality Strategy Priority

Condition/Topic Area	Measure Type
Child Health	Process

Description
Percentage of pediatric asthma inpatients (age 2 – 17 years) who were discharged with principal diagnosis of asthma who received systemic corticosteroids for inpatient asthma

Numerator
Pediatric asthma inpatients who received systemic corticosteroids during hospitalization

Denominator
Pediatric asthma inpatients (age 2 – 17 years) who were discharged with principal diagnosis of asthma (ICD-9-CM principal diagnosis code of 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.90, 493.91, 493.92)Stratified as follows:•age 2 years through 17 years - Overall Rate•age 2 years through 4 years•age 5 years through 12 years•age 13 years through 17 years

Exclusions

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Paper medical record/flow-sheet

Steward
The Joint Commission
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 2

NQF Measure # and Status
0147 Endorsed
Measure Title
PN–6 Appropriate initial antibiotic selection
National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Pneumonia	Process

Description
Percentage of pneumonia patients 18 years of age or older selected for initial receipts of antibiotics for community-acquired pneumonia (CAP)
Numerator
Pneumonia patients who received an initial antibiotic regimen consistent with current guidelines during the first 24 hours of hospitalization
Denominator
Pneumonia patients 18 years of age or older (ICD-9-CM principal diagnosis code of 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 [pneumonia]; or ICD-9-CM principal diagnosis code of 038.0, 038.10, 038.11, 038.19, 038.2, 038.3, 038.40, 038.41, 038.42, 038.43, 038.44, 038.49, 038.8, 038.9 [septicemia] or 518.81, 518.84 [acute or chronic respiratory failure], and a secondary diagnosis code of pneumonia)
Exclusions
•Received in transfer from another acute care or critical access hospital, including another emergency department•No working diagnosis of pneumonia at the time of admission•Receiving comfort measures only4•Do not receive antibioticsduring the hospitalization or within 36 hours (2160 minutes)after arrival at the hospital•Compromised as defined in data dictionary (i.e., documentation that the patient had (1) any of the following compromising conditions: HIV positive, AIDS, cystic fibrosis, systemic chemotherapy within last three months, systemic immunosuppressive therapy within the past three months, leukemia documented in the past three months, lymphoma documented in the past three months, radiation therapy in the past three months; (2) a prior hospitalization within 14 days [the patient was discharged from an acute care facility for inpatient care to a non-acute setting—home, SNF, ICF, or rehabilitation hospital—before the second admission to the same or different acute care facility]) and abstraction guidelines•With healthcare associated pneumonia as defined in data dictionary (i.e., presence of at least one of the following: (1) hospitalization for 2 days within the last 90 calendar days; (2) residence in a nursing home or extended care facility for any amount of time within the last 90 days; (3) chronic dialysis within the last 30 days; (4) wound care provided by a health care professional within the last 30 days) and abstraction guidelines•Involved in protocols or clinical trials•No chest x-ray or CT scan that indicated positive infiltrate within 24 hours prior to hospital arrival or anytime during this hospitalization
Risk Adjustment
Data Source
Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0148 Endorsed
Measure Title
PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital
National Quality Strategy Priority
Effective Communication and Care Coordination, Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Pneumonia	Process

Description
Percentage of pneumonia patients 18 years of age and older who have had blood cultures performed in the emergency department prior to initial antibiotic received in hospital
Numerator
Number of pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics
Denominator
Pneumonia patients 18 years of age and older who have an initial blood culture collected in the emergency department (ICD-9-CM principal diagnosis code of 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 [pneumonia]; or ICD-9-CM principal diagnosis code of 038.0, 038.10, 038.11, 038.19, 038.2, 038.3, 038.40, 038.41, 038.42, 038.43, 038.44, 038.49, 038.8, 038.9 [septicemia] or 518.81, 518.84 [acute or chronic respiratory failure], and a secondary diagnosis code of pneumonia)
Exclusions
•Received in transfer from another acute care or critical access hospital, including another emergency department•No working diagnosis of pneumonia at the time of admission•Receiving comfort measures only4•<18 years of age•Do not receive antibiotics or a blood culture•No chest x-ray or CT scan that indicated positive infiltrate within 24 hours prior to hospital arrival or anytime during this hospitalization
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set
Aligns with core measures

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0160 Endorsed
Measure Title
Beta-blocker prescribed at discharge for AMI
National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality, Health and Well-Being,

Condition/Topic Area	Measure Type
Acute Myocardial Infarction	Process

Description
Percentage of acute myocardial infarction (AMI) patients who are prescribed a beta-blocker at hospital discharge

Numerator
AMI patients who are prescribed a beta-blocker at hospital discharge

Denominator
AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal diagnosis code of AMI: 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91)

Exclusions
Exclusions•<18 years of age•Patients who have a length of stay greater than 120 days•Patients enrolled in clinical trials •Discharged to another hospital•Expired •Left against medical advice •Discharged to home for hospice care•Discharged to a health care facility for hospice care•Patients with comfort measures only documented •Patients with a documented reason for no beta-blocker at discharge

Risk Adjustment
no risk adjustment necessary
Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0163 Endorsed
Measure Title
AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)
National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Acute Myocardial Infarction	Process

Description
Percentage of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary percutaneous coronary intervention (PCI) during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.

Numerator
AMI patients whose time from hospital arrival to primary Percutaneous Coronary Intervention (PCI) is 90 minutes or less.

Denominator
Principal diagnosis of AMI (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal diagnosis code of AMI: 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91); and PCI procedure (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal or other procedure code for PCI: 00.66); and ST-segment elevation or LBBB on the ECG performed closest to hospital arrival; and PCI performed within 24 hours after hospital arrival.

Exclusions
Exclusions: •<18 years of age•Patients who have a length of stay greater than 120 days•Patients enrolled in clinical trials •Patients received as a transfer from an inpatient or outpatient department of another hospital•Patients received as a transfer from the emergency/observation department of another hospital•Patients received as a transfer from an ambulatory surgery center•Patient administered fibrinolytic agent prior to PCI•PCI described as non-primary by physician, advanced practice nurse, or physician assistant•Patients who did not receive PCI within 90 minutes and had a reason for delay documented by a physician, advanced practice nurse, or physician assistant (e.g., social, religious, initial concern or refusal, cardiopulmonary arrest, balloon pump insertion, respiratory failure requiring intubation)

Risk Adjustment
no risk adjustment necessary
Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set
Aligns with core measures

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0164 Endorsed

Measure Title
AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival

National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Acute Myocardial Infarction	Process

Description
Percentage of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less.

Numerator
AMI patients whose time from hospital arrival to fibrinolysis is 30 minutes or less

Denominator
Principal diagnosis of AMI (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal diagnosis code of AMI: 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91); and ST-segment elevation or LBBB on the ECG performed closest to hospital arrival; and fibrinolytic therapy within 6 hours after hospital arrival; and fibrinolytic therapy is primary reperfusion therapy

Exclusions
Exclusions: •<18 years of age•Patients who have a length of stay greater than 120 days•Patients enrolled in clinical trials •Patients received as a transfer from an inpatient or outpatient department of another hospital•Patients received as a transfer from the emergency/observation department of another hospital•Patients received as a transfer from an ambulatory surgery center•Patients who did not receive fibrinolytic therapy within 30 minutes and had a reason for delay documented by a physician, advanced practice nurse, or physician assistant (e.g., social, religious, initial concern or refusal, cardiopulmonary arrest, balloon pump insertion, respiratory failure requiring intubation)

Risk Adjustment
no risk adjustment necessary

Data Source
Electronic Health/Medical Record, Paper medical record/flow-sheet

Steward
CMS

Contribution to the Program Set
Aligns with core measures

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0218 Endorsed
Measure Title
SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Process

Description
Percentage of surgery patients who received appropriate Venous Thromboembolism (VTE) Prophylaxis within 24 hours prior to surgery to 24 hours after surgery end time
Numerator
Surgery patients who received appropriate VTE prophylaxis within 24 hours prior to Surgical Incision Time to 24 hours after Surgery End TimeAppropriate prophylaxis according to Surgery Type: Intracranial NeurosurgeryAny of the following:•Intermittent pneumatic compression devices (IPC) with or without graduated compression stockings (GCS)•Low-dose unfractionated heparin (LDUH) Low molecular weight heparin (LMWH)2•LDUH or LMWH2 combined with IPC or GCSGeneral SurgeryAny of the following:•Low-dose unfractionated heparin (LDUH)•Low molecular weight heparin (LMWH)•Factor Xa Inhibitor (Fondaparinux)•LDUH or LMWH or Factor Xa Inhibitor (fondaparinux) combined with IPC or GCSGeneral Surgery with a reason for not administering pharmacological prophylaxisAny of the following:•Graduated Compression stockings (GCS)•Intermittent pneumatic compression devices (IPC)Gynecologic SurgeryAny of the following:•Low-dose unfractionated heparin (LDUH)•Low molecular weight heparin (LMWH)•Factor Xa Inhibitor (fondaparinux)•Intermittent pneumatic compression devices (IPC)•LDUH or LMWH or Factor Xa Inhibitor (fondaparinux) combined with IPC or GCSUrologic SurgeryAny of the following:•Low-dose unfractionated heparin (LDUH)•Low molecular weight heparin (LMWH)•Factor Xa Inhibitor (fondaparinux)•Intermittent pneumatic compression devices (IPC) •Graduated compression stockings (GCS)•LDUH or LMWH or Factor Xa Inhibitor
Denominator
All selected surgery patients
Exclusions
Data ElementsClinical TrialLaparoscopePerioperative DeathPreadmission WarfarinReason for Not Administering VTE Prophylaxis
Risk Adjustment
no risk adjustment necessary
Data Source
Electronic Clinical Data, Electronic Health/Medical Record, Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set
Aligns with core measures

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0284 Endorsed

Measure Title
SCIP Cardiovascular-2: Surgery Patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period

National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Safety	Process

Description
Percentage of patients on beta blocker therapy prior to admission who received a beta blocker during the perioperative period. To be in the denominator, the patient must be on a beta-blocker prior to arrival. The case is excluded if the patient is not on a beta-blocker prior to arrival, as described below in 2a4.

Numerator
Surgery patients on beta blocker therapy prior to admission who receive a beta blocker during the perioperative period

Denominator
All surgery patients on daily beta blocker therapy prior to arrivalData Element Data Collection Question: Is there documentation that the patient was on a daily beta-blocker therapy prior to arrival? Yes/NoNotes for Abstraction: • If there is documentation that the beta-blocker was taken daily at “home” or is a “current” medication, select “Yes”. • If a beta-blocker is listed as a home medication without designation of how often or when it is taken, select “Yes”. • If there is documentation that the beta-blocker is a home/current medication and additional documentation indicates the beta-blocker was not taken daily, e.g., the medication reconciliation form lists a beta-blocker as a home/current medication, but documentation in the nurses notes state “patient denies taking beta-blocker every day", select “No”. • If there is documentation that the beta-blocker is on a schedule other than daily, select “No”. • If there is documentation that the beta-blocker was given on a “prn” basis for cardiac or non-cardiac reasons, select “No”.

Exclusions
•Patients less than 18 years of age •Patients who have a Length of Stay greater than 120 days •Patients enrolled in clinical trials •Patients whose ICD-9-CM principal procedure occurred prior to the date of admission •Patients who expired during the perioperative period •Pregnant patients taking a beta-blocker prior to arrival •Patients with a documented Reason for Not Administering Beta-Blocker-Perioperative •Patients with Ventriular Assist Devices or Heart Transplantation

Risk Adjustment
no risk adjustment necessary

Data Source
Administrative claims, Paper Records

Steward
CMS

Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0300 Endorsed
Measure Title
SCIP INF–4: Cardiac surgery patients with controlled 6AM postoperative serum glucose
National Quality Strategy Priority
Patient Safety, Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Safety	Process

Description
Cardiac surgery patients with controlled postoperative blood glucose (less than or equal to 180mg/dL) in the timeframe of 18 to 24 hours after Anesthesia End Time.

Numerator
Cardiac surgery patients with controlled postoperative blood glucose (less than or equal to ?180mg/dL) in the timeframe of 18 to 24 hours after Anesthesia End Time.

Denominator
Cardiac surgery patients with no evidence of prior infectionInclude patients with an ICD-9-CM Principle Procedure code or ICD-9-CM Other Procedure codes of selected surgeries ANDan ICD-9-CM for ICD-9-CM codes Principle Procedure code or ICD-9-CM Other Procedure codes of selected surgeries

Exclusions
Excluded Populations •Patients less than 18 years of age•Patients who have a length of Stay greater than 120 days•Patients who had a principal diagnosis suggestive of preoperative infectious diseases (as defined in Appendix A, Table 5.09 for ICD-9-CM codes)•Burn and transplant patients (as defined in Appendix A, Tables 5.14 and 5.15 for ICD-9-CM codes)•Patients enrolled in clinical trials•Patients whose ICD-9-CM principal procedure occurred prior to the date of admission•Patients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interest•Patients who discharged prior to 24 hours after Anesthesia End Time.

Risk Adjustment
no risk adjustment necessary
Data Source
Administrative claims, Paper Records
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0301 Endorsed
Measure Title
SCIP-INF-6- Surgery patients with appropriate hair removal
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Process

Description
Percentage of surgery patients with surgical hair site removal with clippers or depilatory or no surgical site hair removal.
Numerator
Surgery patients with surgical hair site removal with clippers or depilatory or no surgical site hair removal
Denominator
All selected surgery patientsInclude patients with an ICD-9-CM Principal Procedure Codes of selected surgeries.
Exclusions
Excluded Populations:Patients less than 18 years of agePatients who have a length of Stay greater than 120 daysPatients whose ICD-9-CM principal procedure was performed entirely by laparoscope. Patients enrolled in clinical trialsPatients whose ICD-9-CM principal procedure occurred prior to the date of admissionPatients who performed their own hair removal
Risk Adjustment
no risk adjustment necessary
Data Source
Electronic administrative data/claims, Electronic Health/Medical Record, Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0338 Endorsed
Measure Title
Home Management Plan of Care Document Given to Patient/Caregiver
National Quality Strategy Priority
Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Child Health	Process

Description
Documentation exists that the Home Management Plan of Care (HMPC) as a separate document, specific to the patient, was given to the patient/caregiver, prior to or upon discharge.
Numerator
Pediatric asthma inpatients with documentation that they or their caregivers were given a written Home Management Plan of Care Elements(HMPC) document that addresses all of the following: Appointment for follow-up care; Environmental control and control of other triggers; Method and timing of rescue actions; Use of controllers; and Use of relievers.
Denominator
Pediatric asthma inpatients discharged home, ICD-9-CM Principal Diagnosis Code of asthma (refer to Appendix A, Table 6.1)Pediatric asthma inpatient discharges age 2 through 17 yearsPediatric asthma inpatients discharged to home
Exclusions
Pediatric asthma inpatients ages 2 years old or 18 years or greater, pediatric asthma inpatients discharged to settings other than home
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Paper medical record/flow-sheet
Steward
Joint Commission Resources, Inc.
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 1

NQF Measure # and Status
0341 Endorsed
Measure Title
PICU Pain Assessment on Admission
National Quality Strategy Priority
Person- and Family-Centered Care,

Condition/Topic Area	Measure Type
Child Health	Process

Description
Percentage of PICU patients receiving: a. Pain assessment on admission, b. Periodic pain assessment.

Numerator
Number of patients who are assessed for pain on admission to the PICU

Denominator
Total number of patients in the PICUPICU patients <18 yrs of age

Exclusions

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Paper medical record/flow-sheet, Registry data

Steward
National Association of Children's Hospitals and Related Institutions
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 1

NQF Measure # and Status
0342 Endorsed
Measure Title
PICU Periodic Pain Assessment
National Quality Strategy Priority
Person- and Family-Centered Care,

Condition/Topic Area	Measure Type
Child Health	Process

Description
Percentage of PICU patients receiving: a. Pain assessment on admission, b. Periodic pain assessment.

Numerator
Number of PICU patients who are assessed for pain at a minimum of every six hours

Denominator
Total number of patients in the PICUPICU patients <18 yrs of age

Exclusions

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Paper medical record/flow-sheet, Registry data

Steward
National Association of Children's Hospitals and Related Institutions
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 1

NQF Measure # and Status
0434 Endorsed
Measure Title
STK-1 Venous Thromboembolism (VTE) Prophylaxis
National Quality Strategy Priority
Patient Safety, Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Stroke	Process

Description
Patients with an ischemic stroke or a hemorrhagic stroke and who are non-ambulatory should start receiving DVT prophylaxis by end of hospital day two.

Numerator
Non-ambulatory ischemic or hemorrhagic stroke patients who had DVT prophylaxis initiated by end of hospital day two.

Denominator
Ischemic or hemorrhagic stroke patients who are non-ambulatory at the end of hospital day 2.

Exclusions
• Patients who are discharged prior to end of hospital day 2:•Patients receiving comfort measures only by end of hospital day 2•Patients admitted for the performance of elective carotid endarterectomy•Patients ambulating by end of hospital day 2

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Electronic Clinical Data, Electronic Health/Medical Record, Lab data, Paper medical record/flow-sheet, Registry data
Steward
The Joint Commission
Contribution to the Program Set
Aligns with core measures

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0439 Endorsed
Measure Title
AMI-10 Statin Prescribed at Discharge
National Quality Strategy Priority
Prevention and Treatment of Leading Causes of Mortality,

Condition/Topic Area	Measure Type
Acute Myocardial Infarction	Process

Description
Ischemic stroke patients with LDL >/= 100 mg/dL, or LDL not measured, or, who were on cholesterol reducing therapy prior to hospitalization are discharged on a statin medication.
Numerator
Patients who were prescribed a statin medication at hospital discharge.
Denominator
All Ischemic stroke patients with an LDL³100 mg/dL, OR LDL not measured, OR who were on cholesterol reducing therapy prior to hospitalization.
Exclusions
• Patients discharged/transferred to another short term general hospital for inpatient care• Patients who expired• Patients who left against medical advice• Patients discharged to hospice• Patients receiving comfort measures only• Patients admitted for the performance of elective carotid endarterectomy
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Electronic Clinical Data, Electronic Health/Medical Record, Lab data, Paper medical record/flow-sheet, Pharmacy data, Re
Steward
The Joint Commission
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0453 Endorsed
Measure Title
SCIP INF–9: Postoperative urinary catheter removal on post-operative day 1 or 2 with day of surgery being day zero
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Process

Description
Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.

Numerator
Number of surgical patients whose urinary catheter is removed on POD1 or POD2 with day of surgery being day zero.

Denominator
All selected surgical patients with a catheter in place postoperatively.

Exclusions
Patients less than 18 years of agePatients who have a length of Stay >120 daysPatients whose ICD-9-CM principal procedure was performed entirely by laparoscopePatients enrolled in clinical trials Patients whose ICD-9-CM principal procedure occurred prior to the date of admissionPatients who had other procedures requiring general or spinal anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the procedure of interest (during separate surgical episodes) during this hospital stayPatients who had a suprapubic catheter or had intermittent catheterization preoperatively. Patients who did not have a catheter in place postoperatively. Patients who had a urologic procedure performed during the same episode as the ICD-9-CM principal procedurePatients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interest.

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0469 Endorsed
Measure Title
Elective delivery prior to 39 completed weeks gestation
National Quality Strategy Priority
Patient Safety, Affordable Care,

Condition/Topic Area	Measure Type
Maternal Care	Outcome

Description
Percentage of babies electively delivered prior to 39 completed weeks gestation

Numerator
Any baby electively delivered prior to 39 completed weeks gestation

Denominator
All babies delivered at term (>or equal to 37 completed weeks gestation)

Exclusions

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Paper medical record/flow-sheet
Steward
Hospital Corporation of America
Contribution to the Program Set
Aligns with core measures

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 1

NQF Measure # and Status
0480 Endorsed
Measure Title
Exclusive Breastfeeding at Hospital Discharge
National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Maternal Care	Outcome

Description
Exclusive Breastfeeding (BF) for the first 6 mos of neonatal life has long been the expressed goal of WHO, DHHS, APA, and ACOG. ACOG has recently reiterated its position (ACOG 2007). A recent Cochrane review substantiates the benefits (Kramer, 2002). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Shealy, 2005; Taveras, 2004; Petrova, 2007; CDC-MMWR, 2007). Exclusive Beastfeeding rate during birth hospital stay has been calculated by the California Deparment of Public Health for the last several years using newborn genetic disease testing data. HP2010 and the CDC have also been active in promoting this measure. Holding pernatal and intrapartum providers accountable is an important way to incent greater efforts during the critical prenatal and immediate postpartum periods where BF attitudes are solidified.
Numerator
That proportion of the denominator that were fed by "breast only" since birth.
Denominator
Livebirths not discharged from the NICU, who had newborn genetic screening performed (standard in California, with an opt out possiblity.)
Exclusions
Infants in the NICU at time of newborn screen, TPN, other nutrition as defined below.
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Administrative claims , Electronic Clinical Data: Electronic Clinical Data, Paper Records
Steward
California Maternal Quality Care Collaborative
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 1

NQF Measure # and Status
0481 Endorsed
Measure Title
First temperature measured within one hour of admission to the NICU.
National Quality Strategy Priority

Condition/Topic Area	Measure Type
Maternal Care	Process

Description
Percent of NICU admissions with a birth weight of 501-1500g with a first temperature taken within 1 hour of NICU admission.
Numerator
Infants 501 to 1500 grams with first temperature taken within 1 hr of NICUadmission
Denominator
NICU admissions with BW 501 to 1500 grams
Exclusions
Outborn infants admitted more than 28 days after birth; outborn infants who had been home prior to admission
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Electronic Health/Medical Record, Paper medical record/flow-sheet, Registry data, Survey : Provider
Steward
Vermont Oxford Network
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 1

NQF Measure # and Status
0482 Endorsed
Measure Title
First NICU Temperature < 36 degrees C
National Quality Strategy Priority

Condition/Topic Area	Measure Type
Maternal Care	Outcome

Description
Percent of all NICU admissions with a birth weight of 501-1500g whose first temperature was measured within one hour of admission to the NICU and was below 36 degrees Centigrade.

Numerator
All NICU admissions with a birth weight of 501-1500g whose first temperature was measured within one hour of admission to the NICU and was <36 degrees C

Denominator
All NICU admissions with a birth weight of 501-1500g whose first temperature was measured within one hour of admission to the NICU.

Exclusions
Outborn infants admitted more than 28 days after birth; outborn infants who had been home prior to admission; infants without temperature taken within 1 hour of NICU admission

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Electronic Clinical Data, Paper medical record/flow-sheet, Survey : Provider
Steward
Vermont Oxford Network
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 1

NQF Measure # and Status
0484 Endorsed
Measure Title
Proportion of infants 22 to 29 weeks gestation treated with surfactant who are treated within 2 hours of birth.
National Quality Strategy Priority

Condition/Topic Area	Measure Type
Maternal Care	Process

Description
Number of infants 22 to 29 weeks gestation treated with surfactant within 2 hours of birth

Numerator
Number of infants 22 to 29 weeks gestation treated with surfactant within 2 hours of birth

Denominator
Number of infants 22 to 29 weeks gestation treated with surfactant at any time

Exclusions
Outborn infants admitted after 28 days; outborn infants who had previously been home.

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Electronic Health/Medical Record, Paper medical record/flow-sheet, Registry data, Survey : Provider
Steward
Vermont Oxford Network
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 1

NQF Measure # and Status
0485 Endorsed
Measure Title
Neonatal Immunization
National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Maternal Care	Process

Description
Percent of neonates with a length of stay greater than 60 days receiving DPT, Hepatitis B, Polio, Hib, and PCV immunizations in adherence with current guidelines.

Numerator
Patients from the denominator receiving the following immunizations according to current AAP guidelines: •DPT (DTP, DPT, DtaP, DTw-P-HbOC, DTwP-HIB, Acel-Imune, Tripedia, Infanrix, Tetramune [DTPH], Tripedia/ActHIB, TriHIBit, Certiva, Immunol)•HepB (Comvax, Recombivax HB, Engerix-B)•Polio (IPOL, IPV, OPV, Orimune, Poliovax)•Hib (PedvaxHIB, HibTITER, ProHIBit [PRP-D], Tetramune [DTPH], Tripedia/ActHIB, TriHIBit, ActHIB, OmniHIB [PRP-T], Comvax)•PCV (Prevnar, Pneumovax, Pnu-Imune).

Denominator
Neonates with a length of stay greater than 60 days.

Exclusions
Documented parent refusal and mortalities. The developer recommends that the measure be suspended when there are vaccine shortages rather than including vaccine unavailability as an exclusion.

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims
Steward
Child Health Corporation of America
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 2

NQF Measure # and Status
0496 Endorsed
Measure Title
OP–18/ED-3: Median Time from ED Arrival to ED Departure for Discharged ED Patients.
National Quality Strategy Priority
Person- and Family-Centered Care,

Condition/Topic Area	Measure Type
Emergency Department	Outcome

Description
Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department

Numerator

Denominator
Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department

Exclusions
Patients less than 18 years of age and patients who expired in the emergency department

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims, Lab data, Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 3

NQF Measure # and Status
0527 Endorsed
Measure Title
SCIP INF–1 Prophylactic antibiotic received within 1 hour prior to surgical incision
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Process

Description
Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.
Numerator
Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin, in Appendix C, Table 3.8, or a fluoroquinolone, in Appendix C, Table 3.10).
Denominator
All selected surgical patients with no evidence of prior infection. Table 5.10 is the complete table of selected major surgeries
Exclusions
Patients less than 18 years of agePatients who have a Length of Stay greater than 120 daysPatients who had a hysterectomy and a caesarean section performed during this hospitalizationPatients who had a principal diagnosis suggestive of preoperative infectious diseases (as defined in Appendix A, Table 5.09 for ICD-9-CMcodes)Patients whose ICD-9-CM principal procedure was performed entirely by LaparoscopePatients enrolled in clinical trialsPatients whose ICD-9-CM principal procedure occurred prior to the date of admissionPatients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interestPatients who had other procedures requiring general or spinal anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the procedure of interest (during separate surgical episodes) during this hospital stayPatients who were receiving antibiotics more than 24 hours prior to surgeryPatients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics)
Risk Adjustment
no risk adjustment necessary
Data Source
Electronic administrative data/claims, Electronic Health/Medical Record, Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0528 Endorsed
Measure Title
SCIP INF–2: Prophylactic antibiotic selection for surgical patients
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Process

Description
Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).
Numerator
Surgical patients who received recommended prophylactic antibiotics for specific surgical procedures
Denominator
All selected surgical patients with no evidence of prior infection.Included Populations:An ICD-9-CM Principal Procedure Code of selected surgeries (as defined in Appendix A, Table 5.10 for ICD-9-CM codes).ANDAn ICD-9-CM Principal Procedure Code of selected surgeries (as defined in Appendix A, Table 5.01-5.08 for ICD-9-CM codes).
Exclusions
Excluded Populations:Patients less than 18 years of agePatients who have a length of Stay greater than 120 daysPatients who had a principal diagnosis suggestive of preoperative infectious diseases (as defined in Appendix A, Table 5.09 for ICD-9-CM codes)Patients whose ICD-9-CM principal procedure was performed entirely by LaparoscopePatients enrolled in clinical trialsPatients whose ICD-9-CM principal procedure occurred prior to the date of admissionPatients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interestPatients who expired perioperativelyPatients who were receiving antibiotics more than 24 hours prior to surgery (except colon surgery patients taking oral prophylactic antibiotics)Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics)Patients who did not receive any antibiotics before or during surgery, or within 24 hours after Anesthesia End Time (i.e., patient did not receive prophylactic antibiotics)Patients who did not receive any antibiotics during this hospitalization
Risk Adjustment
no risk adjustment necessary
Data Source
Electronic administrative data/claims, Electronic Health/Medical Record, Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0529 Endorsed
Measure Title
SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)
National Quality Strategy Priority
Patient Safety, Prevention and Treatment of Leading Causes of Mortality, Affordable Care,

Condition/Topic Area	Measure Type
Safety	Process

Description
Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time (48 hours for CABG or Other Cardiac Surgery). The Society of Thoracic Surgeons (STS) Practice Guideline for Antibiotic Prophylaxis in Cardiac Surgery (2006) indicates that there is no reason to extend antibiotics beyond 48 hours for cardiac surgery and very explicitly states that antibiotics should not be extended beyond 48 hours even with tubes and drains in place for cardiac surgery.
Numerator
Number of surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time (48 hours for CABG or Other Cardiac Surgery).
Denominator
All selected surgical patients with no evidence of prior infection.Included Populations:An ICD-9-CM Principal Procedure Code of selected surgeries (as defined in Appendix A, Table 5.10 for ICD-9-CM codes)ANDAn ICD-9-CM Principal Procedure Code of selected surgeries (as defined in Appendix A, Table 5.01-5.08 for ICD-9-CM codes)
Exclusions
Excluded Populations:Patients less than 18 years of agePatients who have a length of Stay greater than 120 daysPatients who had a principal diagnosis suggestive of preoperative infectious diseases (as defined in Appendix A, Table 5.09 for ICD-9-CM codes)Patients whose ICD-9-CM principal procedure was performed entirely by LaparoscopePatients enrolled in clinical trialsPatients whose ICD-9-CM principal procedure occurred prior to the date of admissionPatients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interestPatients who expired perioperativelyPatients who had other procedures requiring general or spinal anesthesia that occurred within three days (four days for CABG or Other Cardiac Surgery) prior to or after the procedure of interest (during separate surgical episodes) during this hospital stayPatients who were receiving antibiotics more than 24 hours prior to surgery (except colon surgery patients taking oral prophylactic antibiotics)Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics)Patients who did not receive any antibiotics during this hospitalization.Patients who received urinary antiseptics only (as defined in Appendix C, Table 3.11)Patients with Reasons to Extend Antibiotics.
Risk Adjustment
no risk adjustment necessary
Data Source
Electronic administrative data/claims, Electronic Health/Medical Record, Paper medical record/flow-sheet
Steward
CMS
Contribution to the Program Set
Aligns with core measures

HQA approved	CMS Status Meaningful Use
Yes	Under consideration-priority 3

NQF Measure # and Status
0716 Endorsed
Measure Title
Healthy Term Newborn
National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Maternal Care	Outcome

Description
Percent of term singleton livebirths (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care.

Numerator
The absence of conditions or procedures reflecting morbidity that happened during birth and nursery care to an otherwise normal infant.

Denominator
The denominator is composed of singleton, term (>=37 weeks), inborn, livebirths in their birth admission. The denominator further has eliminated fetal conditions likely to be present before labor. Maternal and obstetrical conditions (e.g. hypertension, prior cesarean, malpresentation) are not excluded unless evidence of fetal effect prior to labor (e.g. IUGR/SGA).

Exclusions
Denominator exclusions: multiple gestations, preterm, congenital anomalies or fetuses affected by selected maternal conditions.

Risk Adjustment
No risk adjustment or risk stratification
Data Source
Electronic administrative data/claims
Steward
California Maternal Quality Care Collaborative (CMQCC)
Contribution to the Program Set
Aligns with core measures

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 1

NQF Measure # and Status
1354 Endorsed
Measure Title
Hearing screening prior to hospital discharge (EHDI-1a)
National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Maternal Care	Process

Description
This measure assesses the proportion of births that have been screened for hearing loss before hospital discharge.*Numbering within the parentheses references the US national extension quality measure identifiers developed for the Use Cases published in the Integrating the Healthcare Enterprise (IHE) Quality, Research and Public Health (QRPH) EHDI Technical Framework Supplement available at www.ihe.net/Technical_Framework/index.cfm#quality

Numerator
Numerator contains all live births during the measurement time period born at a facility and screened for hearing loss prior to discharge.

Denominator
All live births during the measurement time period born at a facility and discharged without being screened OR screened prior to discharge.

Exclusions
Patient deceased prior to discharge and without being screened, parental refusal, or not performed due to medical exclusion.

Risk Adjustment
no risk adjustment necessary
Data Source
Electronic Health/Medical Record, Public health data/vital statistics, Registry data
Steward
Centers for Disease Control and Prevention
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 2

NQF Measure # and Status
Not NQF Endorsed
Measure Title
HF-2 & HF-3 to be combined into a single new measure.
National Quality Strategy Priority

Condition/Topic Area	Measure Type
Heart Failure	Process

Description
New measure will combine HF-2 that looks at left ventricular function assessment, and HF-3 that looks at prescribing ACE-I or ARB for LVSD.

Numerator
TBD
Denominator
TBD
Exclusions
TBD
Risk Adjustment
Data Source
Steward
CMS
Contribution to the Program Set

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
IMM-1 Pneumonia Immunization
National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Immunizations	Process

Description
This prevention measure addresses acute care hospitalized inpatients 65 years of age and older (IMM-1b) AND inpatients aged between 6 and 64 years (IMM-1c) who are considered high risk and were screened for receipt of 23-valent pneumococcal polysaccharide vaccine (PPV23) and were vaccinated prior to discharge if indicated. The numerator captures two activities; screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to PPV23, patients who were offered and declined PPV23 and patients who received PPV23 anytime in the past are captured as numerator events.
Numerator
Inpatient discharges who were screened for PPV23 status and received PPV23 prior to discharge, if indicated.
Denominator
Inpatient discharges 65 years of age and older, and 6 through 64 years of age who have a high risk condition.
Exclusions
Patients less than 6 years of age; Patients who expire prior to hospital discharge; Patients who are pregnant; Patients with an organ transplant during the current hospitalization
Risk Adjustment
Data Source
Steward
CMS
Contribution to the Program Set
#1653 under consideration in Population Health Prevention project

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 3

NQF Measure # and Status
Not NQF Endorsed
Measure Title
IMM-2 Flu Immunization
National Quality Strategy Priority
Health and Well-Being,

Condition/Topic Area	Measure Type
Immunizations	Process

Description
This prevention measure addresses acute care hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The numerator captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine and patients who received the vaccine during the current year's influenza season but prior to the current hospitalization are captured as numerator events.
Numerator
Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated
Denominator
Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March.
Exclusions
Patients less than 6 months of age; Patients who expire prior to hospital discharge; Patients with an organ transplant during the current hospitalization; Patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but provider has not yet been received
Risk Adjustment
Data Source
Steward
CMS
Contribution to the Program Set
#1659 under consideration in Population Health Prevention project

HQA approved	CMS Status Meaningful Use
	Under consideration-priority 3

PPS-Exempt Cancer Hospital Quality Reporting Program: Measures under Consideration

NQF Measure # and Status
0220 Endorsed
Measure Title
Adjuvant hormonal therapy
National Quality Strategy Priority
Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Breast Cancer	Process

Description
Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, who's primary tumor is progesterone or estrogen receptor positive recommended for tamoxifen or third generation aromatase inhibitor (considered or administered) within 1 year (365 days) of diagnosis
Numerator
Consideration or administration of tamoxifen or third generation aromatase inhibitor initiated within 1 year (365 days) of date of diagnosis.
Denominator
Include if all of the following characteristics are identified:WomenAge >=18 at time of diagnosisKnown or assumed to be first or only cancer diagnosisEpithelial malignancy onlyPrimary tumors of the breastAJCC T1c or Stage II or IIIPrimary tumor is estrogen receptor positive or progesterone receptor positiveAll or part of 1st course of treatment performed at the reporting facility2Known to be alive within 1 year (365 days) of date of diagnosis
Exclusions
Exclude, i f any of the following characteristics are identified:MenUnder age 18 at time of diagnosisSecond or subsequent cancer diagnosisTumor not originating in the breastNon-epithelial malignanciesStage 0, in-situ tumorAJCC T1mic, T1a, or T1b tumorStage IV, metastatic tumorPrimary tumor is estrogen receptor negative and progesterone receptor negativeNone of 1st course therapy performed at reporting facilityDied within 1 year (365 days) of diagnosis
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Paper medical record/flow-sheet
Steward
American College of Surgeons
Contribution to the Program Set _(aligment w/ core measures, par
Aligns with core measures

HQA approved	CMS Status PPS-Exempt Cancer Hospital Quality Reporting
	Add-1

NQF Measure # and Status
0223 Endorsed
Measure Title
Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
National Quality Strategy Priority
Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Colon Cancer	Process

Description
Percentage of patients under the age of 80 with AJCC III (lymph node positive) colon cancer for whom adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery
Numerator
Consideration or administration of chemotherapy initiated within 4 months (120 days) of date of diagnosis.
Denominator
Include, if all of the following characteristics are identified:Age 18-79 at time of diagnosisKnown or assumed to be first or only cancer diagnosisPrimary tumors of the colonEpithelial malignancy only At least one pathologically examined regional lymph node positive for cancer (AJCC Stage III)All or part of 1st course of treatment performed at the reporting facility2Known to be alive within 4 months (120 days) of diagnosis
Exclusions
Exclude, if any of the following characteristics are identified:Under age 18 at time of diagnosisOver age 79 at time of diagnosisSecond or subsequent cancer diagnosisTumor not originating in the colonTumor originating in the appendixNon-epithelial malignanciesAll pathologically examined regional lymph nodes are negativeStage IV, metastatic tumorNone of 1st course therapy performed at reporting facilityDied within 4 months (120 days) of diagnosis
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Paper medical record/flow-sheet, Registry data
Steward
American College of Surgeons
Contribution to the Program Set _(aligment w/ core measures, par
Aligns with core measures

HQA approved	CMS Status PPS-Exempt Cancer Hospital Quality Reporting
	Add-1

NQF Measure # and Status
0559 Endorsed
Measure Title
Combination chemotherapy is considered or administered within4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer.
National Quality Strategy Priority
Effective Communication and Care Coordination,

Condition/Topic Area	Measure Type
Breast Cancer	Process

Description
Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, who's primary tumor is progesterone and estrogen receptor negative recommended for multiagent chemotherapy (considered or administered) within 4 months (120 days) of diagnosis.
Numerator
Consideration or administration of multi-agent chemotherapy initiatedwithin 4 months (120 days) of date of diagnosis.
Denominator
Include, if all of the following characteristicsare identified:- Women.- Age 18-69 at time of diagnosis.- Known or assumed to be first or only cancer diagnosis.- Primary tumors of the breast.- AJCC T1c, Stage II or III.- Epithelial malignancy only.- Primary tumor is estrogen receptor negative and progesterone receptor negative.- All or part of 1st course of treatment performed at the reporting facility.- Known to be alive within 4 months (120 days) of diagnosis.
Exclusions
Exclude, if any of the following characteristicsare identified:-Men.-Under age 18 at time of diagnosis.- Over age 69 at time of diagnosis.- Second or subsequent cancer diagnosis.- Tumor not originating in the breast.- Non-epithelial malignancies.- Stage 0, in-situ tumor.- AJCC T1mic,T1a, or T1b tumor.- Stage IV, metastatic tumor.- Primary tumor is estrogen receptor positive or progesterone receptor positive.- None of 1st course therapy performed at reporting facility.- Died within 4 months (120 days) of diagnosis.
Risk Adjustment
No risk adjustment or risk stratification
Data Source
Paper medical record/flow-sheet, Registry data
Steward
American College of Surgeons
Contribution to the Program Set _(aligment w/ core measures, par
Aligns with core measures

HQA approved	CMS Status PPS-Exempt Cancer Hospital Quality Reporting
	Add-1

NQF Measure # and Status
Not NQF Endorsed
Measure Title
PSM-001-10 - National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
Standardized Infection Ratio (SIR) of health care-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • Other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. Only locations where patients reside overnight are included, i.e., inpatient locations.
Numerator
Total number of observed healthcare-associated CLABSI among patients in ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.
Denominator
Total number of expected CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population. Central line device- day denominator data that are collected differ according to the location of the patients being monitored.
Exclusions
Exclusions:1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines 2. Peripheral intravenous lines are excluded from this measure

Risk Adjustment
Data Source
Steward
CDC
Contribution to the Program Set _(aligment w/ core measures, par

HQA approved	CMS Status PPS-Exempt Cancer Hospital Quality Reporting
	Add-1

NQF Measure # and Status
Not NQF Endorsed
Measure Title
PSM-003-10 - National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
National Quality Strategy Priority
Patient Safety,

Condition/Topic Area	Measure Type
Safety	Outcome

Description
Standardized infection ratio (SIR) of health care-associated, catheter-associated urinary tract infections (CAUTI) will be calculated among patients in the following patient-care locations:- Specialty care areas (SCAs),- Adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations- Intensive care units (ICUs) (excluding patients in neonatal ICUs [NICUs: Level II/III and Level III nurseries])- Other inpatient locations (excluding Level I and Level II nurseries)Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. Only locations where patients reside overnight are included, i.e., inpatient locations.
Numerator
Total number of observed healthcare-associated CAUTI among inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II nurseries).
Denominator
Total number of expected CAUTIs, which is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure
Exclusions
Denominator Exclusions:Non-indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters 3. "In and out" catheterizations Numerator Exclusion: patients in NICUs, Level I and Level II nurseries
Risk Adjustment
Data Source
Steward
CDC
Contribution to the Program Set _(aligment w/ core measures, par

HQA approved	CMS Status PPS-Exempt Cancer Hospital Quality Reporting
	Add-1