Louisiana Hospital Association
Research and Education Foundation (LHAREF)
Encyclopedia of Measures (EOM)

Version #2021.2: 08/23/2021

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Version History

Version Number	Date Modified	Modified By	Description
2021.1	7/15/2021	M. Smith	Initial LHAREF EOM.
2021.2	8/23/2021	M. Smith	• Updated the reporting frequency for CDIFF_SIR and MRSA_SIR. • Added CAUTI and CLABSI SUR measures (all units) for reporting.

Summary of Changes

Version #2021.1:

- Initial Release

Version #2021.2:

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

Measure List

MEASURE NAME	DATA SOURCE	REPORTING HOSPITALS
Adverse Drug Events (ADE)		
ADE: Anticoagulation Safety	Self-Report	HQIC and QII Hospitals
ADE: Glycemic Management	Self-Report	HQIC and QII Hospitals
ADE: Naloxone Administration	Self-Report	HQIC and QII Hospitals
Catheter-Associated Urinary Tract Infection (CAUTI)		
CAUTI SIR – All Units Excluding NICUs	NHSN	HQIC and QII Hospitals
CAUTI SIR – All ICUs Excluding NICUs	NHSN	HQIC and QII Hospitals
CAUTI Rate – All Units Excluding NICUs	NHSN or Self-Report	HQIC and QII Hospitals
CAUTI Rate – All ICUs Excluding NICUs	NHSN or Self-Report	HQIC and QII Hospitals
CAUTI Utilization – All Units Excluding NICUs	NHSN or Self-Report	HQIC and QII Hospitals
CAUTI Utilization – All ICUs Excluding NICUs	NHSN or Self-Report	HQIC and QII Hospitals
CAUTI SUR – All Units Excluding NICUs	NHSN	HQIC and QII Hospitals
Central Line-Associated Bloodstream Infections (CLABSI)		
CLABSI SIR – All Units	NHSN	HQIC and QII Hospitals
CLABSI SIR – All ICUs	NHSN	HQIC and QII Hospitals
CLABSI Rate – All Units	NHSN or Self-Report	HQIC and QII Hospitals
CLABSI Rate – All ICUs	NHSN or Self-Report	HQIC and QII Hospitals
CLABSI Utilization – All Units	NHSN or Self-Report	HQIC and QII Hospitals
CLABSI Utilization – All ICUs	NHSN or Self-Report	HQIC and QII Hospitals
CLABSI SUR – All Units	NHSN	HQIC or QII Hospitals
Clostridioides Difficile (CDI)		
CDI SIR – All Units	NHSN	HQIC and QII Hospitals
CDI Rate – All Units	NHSN or Self-Report	HQIC and QII Hospitals
Falls		
Falls With Injury	Self-Report	HQIC and QII Hospitals
Methicillin-Resistant Staphylococcus Aureus (MRSA)		
MRSA Bacteremia SIR	NHSN	HQIC and QII Hospitals
MRSA Bacteremia Rate	NHSN or Self-Report	HQIC and QII Hospitals

MEASURE NAME	DATA SOURCE	REPORTING HOSPITALS
Opioid Stewardship		
FFS Opioid 90_MME Discharges	Medicare Fee for Service (FFS) (CMS)	HQIC Hospitals
Opioid: Surgical Discharges 12 or Fewer	Self-Report	HQIC and QII Hospitals
FFS Opioid Poisoning	Medicare FFS (CMS)	HQIC Hospitals
FFS Opioid Related Deaths	Medicare FFS (CMS)	HQIC Hospitals
Opioid: Opioid Use in ED	Self-Report	HQIC and QII Hospitals
Overall Harm		
Overall Harm	LHAREF	HQIC and QII Hospitals
Hospital-Acquired Pressure Injury (HAPI)		
HAPI (PSI-03) Rate	Self-Report	HQIC and QII Hospitals
AHRQ Pressure Ulcer Rate FFS	Medicare FFS (CMS)	HQIC Hospitals
Readmissions		
Readmissions, All-cause, 30-day	Self-Report	HQIC and QII Hospitals
Readmissions, Medicare FFS	Medicare FFS (CMS)	HQIC Hospitals
Sepsis		
Sepsis: Overall Mortality Rate	Self-Report	HQIC and QII Hospitals
FFS Expired Sepsis Cases	Medicare FFS (CMS)	HQIC Hospitals
Sepsis: Postoperative (PSI-13) Rate	Self-Report	HQIC and QII hospitals that perform surgery
FFS Postoperative Sepsis Rate	Medicare FFS (CMS)	HQIC Hospitals
Surgical Site Infections (SSI)		
SSI SIR – Colon Surgeries	NHSN	HQIC and QII hospitals **performing colon surgeries** and **reporting to NHSN**
SSI SIR – Abdominal Hysterectomies	NHSN	HQIC and QII hospitals **performing abdominal hysterectomies** and **reporting to NHSN**
SSI Rate – Colon Surgeries	NHSN or Self-Report	HQIC and QII hospitals **performing colon surgeries**
SSI Rate – Abdominal Hysterectomies	NHSN or Self-Report	HQIC and QII hospitals **performing abdominal hysterectomies**
Culture of Safety – Worker Safety		
Worker Safety: Workplace Violence	Self-Report	HQIC and QII Hospitals

Category: Adverse Drug Events (ADE)

ADE: Anticoagulation Safety	
Measure Name Detail	Excessive Anticoagulation with Warfarin (Inpatients): Select one applicable measure based on the hospital's critical value: • ADE: Anticoagulation Safety for INR >3.5 • ADE: Anticoagulation Safety for INR >4 • ADE: Anticoagulation Safety for INR >5 • ADE: Anticoagulation Safety for INR >6
Measure ID	Select one applicable measure ID based on the hospital's critical value: • INR3.5 • INR4 • INR5 • INR6
Measure Type	Outcome
Measure Description	Adverse Drug Events (ADEs) related to Anticoagulation Safety: in patients experiencing excessive anticoagulation with warfarin
Numerator	Number of inpatients experiencing excessive anticoagulation with warfarin (INR greater than hospital critical value of 3.5, 4, 5 or 6)
Denominator	Number of inpatients receiving warfarin anticoagulation therapy
Denominator Exclusions	Patients with INR less than critical value or present on admission
Rate Multiplier	100
Data Source(s)	• Self-report measure that aligns with the hospital's critical value. • Numerator: incident reporting systems, trigger tools, pharmacists' intervention systems, medical record review, laboratory systems or administrative data. • Denominator: billing systems • For INRs outside of the specific critical values listed, please either round up to the next value or submit under INR5 as this will be the default submission.
Specifications/Definitions/ Recommendations	• Patients that experience more than one event at the determined value or greater during a hospital stay are only counted once. • An adverse event determination is related to the facility's administration of warfarin or Coumadin. • See Appendix A
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: ADE-1a (Oct. 2016 – March 2020) HEN2: ADE-1a (July 2015 – Sept. 2016)

Category: Adverse Drug Events (ADE)

ADE: Glycemic Management	
Measure Name Detail	Hypoglycemia in Inpatients Receiving Insulin: Select one applicable measure based on the hospital's critical value: • ADE: Glycemic Management for glucose <40 • ADE: Glycemic Management for glucose <50 • ADE: Glycemic Management for glucose <70
Measure ID	Select one applicable measure ID based on the hospital's critical value: • HYPO40 • HYPO50 • HYPO70
Measure Type	Outcome
Measure Description	Adverse Drug Events (ADE) related to glycemic management: Hypoglycemia in inpatients receiving insulin
Numerator	Number of patients receiving insulin who experience a hypoglycemic event (hypoglycemia defined as plasma glucose concentration of determined by the hospital critical value <40, <50 or <70)
Denominator	Number of inpatients receiving insulin
Denominator Exclusions	• Patients with hypoglycemia present on admission • Non-insulin receiving patients
Rate Multiplier	100
Data Source(s)	• Self-report measure that aligns with the hospital's critical value. • Numerator: incident reporting systems, trigger tools, pharmacists' intervention systems, medical record review, laboratory systems or administrative data. • Denominator: billing systems • For glucose values outside of the specific critical values listed, please either round up to the next glucose value or submit under HYPO50 as this will be the default submission.
Specifications/Definitions/ Recommendations	• Patients that experience more than one event at the determined value or greater during a hospital stay are only counted once. • An adverse event determination is related to the facility's administration of insulin. • See Appendix B
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period.
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: ADE-1b (Oct. 2016 – March 2020) HEN2: ADE-1b (July 2015 – Sept. 2016)

Category: Adverse Drug Events (ADE)

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

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

Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period.
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: ADE-1c (Oct. 2016 – March 2020) HEN2: ADE-1c (July 2015 – Sept. 2016)

Category: Catheter-Associated Urinary Tract Infection (CAUTI)

CAUTI: Standardized Infection Ratio (SIR) – Two Measures	
Measure Name Detail	(1) CAUTI SIR: All Units including ICU(s), excluding NICU(s) (2) CAUTI SIR: All ICUs, excluding NICU(s)
Measure ID	(1) CAUTI_SIR_All (2) CAUTI_SIR_ICU
Measure Type	Outcome
Measure Description	Number of observed CAUTIs per number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	All NICU locations
Rate Multiplier	n/a
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that report into NHSN but did not confer rights, SIR data will be self-reported by the hospital. • **For hospitals that do NOT report into NHSN, this measure is not applicable.**
Specifications/Definitions/ Recommendations	• Available from CDC NHSN. • CDC Urinary Tract Infection (UTI) Events • National Quality Forum (NQF) 0138
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CAUTI-1a & CAUTI-1b (Oct. 2016 – March 2020) HEN2: CAUTI-1a & CAUTI-1b (July 2015 – Sept. 2016)

Category: Catheter-Associated Urinary Tract Infection (CAUTI)

CAUTI Rate – Two Measures	
Measure Name Detail	(1) CAUTI Rate – All Units including ICU(s), excluding NICU(s) (2) CAUTI Rate – All ICU(s), excluding NICU(s)
Measure IDs	(1) CAUTI_RATE_All (2) CAUTI_RATE_ICU
Measure Type	Outcome
Measure Description	Number of healthcare associated CAUTIs per 1,000 catheter days
Numerator	Number of healthcare associated CAUTIs among patients in bedded inpatient care locations during the calendar month
Denominator	Number of indwelling urinary catheter days for bedded inpatient care locations during the calendar month
Denominator Exclusions	All NICU locations
Rate Multiplier	1,000
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do NOT report to NHSN or do NOT confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • CDC Urinary Tract Infection (UTI) Events • Rate denominator reported = utilization measure numerator reported
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CAUTI-2a & CAUTI-2b (Oct. 2016 – March 2020) HEN2: CAUTI-2a & CAUTI-2b (July 2015 – Sept. 2016)

Category: Catheter-Associated Urinary Tract Infection (CAUTI)

CAUTI: Urinary Catheter Device Utilization – Two Measures	
Measure Name Detail	(1) CAUTI Urinary Catheter Device Utilization – All units including ICU(s), excluding NICU(s) (2) CAUTI Urinary Catheter Device Utilization – All ICU(s), excluding NICU(s)
Measure IDs	(1) CAUTI_Util_All (2) CAUTI_Util_ICU
Measure Type	Process
Measure Description	Device utilization is the number of urinary catheter days per 100 patient days
Numerator	Number of indwelling urinary catheter days for bedded inpatient care locations during the calendar month
Denominator	Number of patient days for bedded inpatient care locations during the calendar month
Denominator Exclusions	All NICU locations
Rate Multiplier	100
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do not report to NHSN or do not confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • CDC Urinary Tract Infection (UTI) Events • **Utilization measure numerator reported = rate denominator reported**
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CAUTI-3a & CAUTI-3b (Oct. 2016 – March 2020) HEN2: CAUTI-3a & CAUTI-3b (July 2015 – Sept. 2016) (Re-baselined in 2015)

Category: Catheter-Associated Urinary Tract Infection (CAUTI)

CAUTI: Urinary Catheter Standard Utilization Ratio (SUR)	
Measure Name Detail	CAUTI Urinary Catheter SUR – All units including ICU(s), excluding NICU(s)
Measure IDs	CAUTI_SUR_All
Measure Type	Outcome
Measure Description	Number of observed catheter device days per number of predicted catheter device days
Numerator	Number of Observed Device Days
Denominator	Number of Predicted Device Days
Denominator Exclusions	All NICU locations
Rate Multiplier	n/a
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that report into NHSN but did not confer rights, SIR data will be self-reported by the hospital. • **For hospitals that do NOT report into NHSN, this measure is not applicable.**
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • CDC Urinary Tract Infection (UTI) Events • NHSN SUR Guide
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	n/a

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

CLABSI: Standardized Infection Ratio (SIR) – Two Measures	
Measure Name Detail	(1) CLABSI SIR – All Units including ICU(s) (2) CLABSI SIR – All ICU(s)
Measure IDs	(1) CLABSI_SIR_All (2) CLABSI_SIR_ICU
Measure Type	Outcome
Measure Description	Number of observed CLABSIs per number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	None
Rate Multiplier	n/a
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that report into NHSN but do NOT confer rights, SIR data will be self-reported by the hospital. • **For hospitals that do NOT report into NHSN, this measure is not applicable.**
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • Bloodstream Infection (BSI) Events • National Quality Forum (NQF) 0139
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Period	Monthly
Measure Reporting History:	HIIN: CLABSI-1a & CLABSI-1a (Oct. 2016 – March 2020) HEN2: CLABSI-1a & CLABSI-1b (July 2015 – Sept. 2016) (Re-baselined in 2015)

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

CLABSI Rate – Two Measures	
Measure Name Detail	(1) CLABSI Rate: All Units including ICU(s) (2) CLABSI Rate: All ICU(s)
Measure ID	(1) CLABSI_Rate_All (2) CLABSI_Rate_ICU
Measure Type	Outcome
Measure Description	Number of healthcare associated CLABSIs per 1,000 central line days
Numerator	Number of healthcare associated CLABSI among patients in bedded inpatient care locations during the calendar month
Denominator	Number of central line days in bedded inpatient care locations during the calendar month
Denominator Exclusions	None
Rate Multiplier	1,000
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do not report to NHSN or do not confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• Includes NICUs • Available from CDC NHSN • Bloodstream Infection (BSI) Events • **Rate denominator reported = utilization measure numerator reported**
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CLABSI-2a & CLABSI-2a (Oct. 2016 – March 2020) HEN2: CLABSI-2a & CLABSI-2b (July 2015 – Sept. 2016) (Re-baselined in 2015)

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

CLABSI: Central Line Utilization – Two Measures	
Measure Name Detail	(1) CLABSI Central Line Utilization – All Units including ICU(s) (2) CLABSI Central Line Utilization – All ICU(s)
Measure IDs	(1) CLABSI_Util_All (2) CLABSI_Util_ICU
Measure Type	Process
Measure Description	Number of central line days per 100 patient days
Numerator	Number of central line days in bedded inpatient care locations during the calendar month
Denominator	Number of patient days for bedded inpatient care locations during the calendar month
Denominator Exclusions	None
Rate Multiplier	100
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do not report to NHSN or do not confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • Bloodstream Infection (BSI) Events • **Utilization measure numerator reported = rate denominator reported**
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: CLABSI-3a & CLABSI-3a (Oct. 2016 – March 2020) HEN2: CLABSI-3a & CLABSI-3b (July 2015 – Sept. 2016) (Re-baselined in 2015)

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

CLABSI: Central Line Standard Utilization Ratio (SUR)	
Measure Name Detail	CLABSI Central Line SUR– All Units including ICU(s)
Measure IDs	CLABSI_SUR_All
Measure Type	Outcome
Measure Description	Number of observed central line device days per number of predicted central line device days
Numerator	Number of Observed Device Days
Denominator	Number of Predicted Device Days
Denominator Exclusions	None
Rate Multiplier	n/a
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that report into NHSN but do NOT confer rights, SIR data will be self-reported by the hospital. • **For hospitals that do NOT report into NHSN, this measure is not applicable.**
Specifications/Definitions/ Recommendations	• Available from CDC NHSN • Bloodstream Infection (BSI) Events • NHSN SUR Guide
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	n/a

Category: Clostridioides Difficile (CDI)

CDI Standardized Infection Ratio (SIR)	
Measure Name Detail	CDI SIR – All Units
Measure ID	CDI_SIR
Measure Type	Outcome
Measure Description	The number of hospital-onset CDI observed infections divided by the number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	• Predicted infection count less than one • No data reported during baseline period
Rate Multiplier	n/a
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that report into NHSN but do NOT confer rights, SIR data will be self-reported by the hospital. • **For hospitals that do NOT report into NHSN, this measure is NOT applicable.**
Specifications/Definitions/ Recommendations	Available from CDC NHSN
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period.
Reporting Timeline	Quarterly
Measure Reporting History:	HIIN: CDI-1a (Oct. 2016 – March 2020) HEN2: CDI-1a (July 2015 – Sept. 2016)

Category: Clostridioides Difficile (CDI)

CDI Rate, Hospital Onset LabID Events	
Measure Name Detail	CDI Rate – All Units
Measure ID	CDI_LabID
Measure Type	Outcome
Measure Description	The number of hospital-onset CDI per 10,000 patient days
Numerator	Number of hospital-onset LabID CDI events
Denominator	Number of patient days
Denominator Exclusions	• Inpatient rehab facilities or inpatient psychiatric facilities with separate CCN • All NICU locations
Rate Multiplier	10,000
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do not report to NHSN or do not confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	Available from CDC NHSN
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Period	Monthly
Measure Reporting History:	HIIN: CDI-1b (Oct. 2016 – March 2020) HEN2: CDI-1b (July 2015 – Sept. 2016)

Category: Falls

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

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

Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: Falls-1 (Oct. 2016 – March 2020) HEN2: Falls-1 (July 2015 – Sept. 2016)

Category: Methicillin-Resistant Staphylococcus Aureus MRSA

MRSA Bacteremia Standardized Infection Ratio (SIR)	
Measure Name Detail	MRSA Bacteremia SIR
Measure ID	MRSA_SIR
Measure Type	Outcome
Measure Description	Number of observed MRSA per number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	• Inpatient rehab facilities or inpatient psychiatric facilities with a separate CCN • All NICU locations • Predicted infection count less than one • No data reported during baseline period
Rate Multiplier	n/a
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that report into NHSN but do NOT confer rights, SIR data will be self-reported by the hospital. • **For hospitals that do NOT report into NHSN, this measure is NOT applicable.**
Specifications/Definitions/ Recommendations	Available from CDC NHSN
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Quarterly
Measure Reporting History:	HIIN: MRSA-1 (Oct. 2016 – March 2020) HEN2: MRSA-1 (July 2015 – Sept. 2016)

Category: Methicillin-Resistant Staphylococcus Aureus MRSA

MRSA Bacteremia Rate Hospital-Onset Events	
Measure Name Detail	MRSA Bacteremia Rate (Hospital-Onset Events)
Measure ID	MRSA_Rate
Measure Type	Outcome
Measure Description	Number of hospital-onset MRSA bacteremia events
Numerator	MRSA bacteremia events
Denominator	Patient days
Denominator Exclusions	None
Rate Multiplier	1,000
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do not report to NHSN or do not confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	Available from CDC NHSN
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Timeline	Monthly
Measure Reporting History:	HIIN: MRSA-2 (Oct. 2016 – March 2020) HEN2: MRSA-2 (July 2015 – Sept. 2016)

Category: Medicare Fee-for-Service

For **HQIC hospitals only**, the following list of measures are being collected using hospital Medicare administrative data (i.e., claims-based data) submitted to the HQIC by the Centers for Medicare and Medicaid Services.

No reporting action by the hospital is necessary.

Medicare Fee-for-Service Measures

Measure Name	Discharges with Opioids Totaling Over 90 MME per Day **(FFS 90 MME Discharges)**
Measure ID	90_MME_DISCHARGE_FFS_MEDICARE

Measure Name	Opioid Poisoning Among Hospital Inpatients **(FFS Opioid Poisoning)**
Measure ID	OPIOID_POISONING_FFS_MEDICARE

Measure Name	Opioid-Related Deaths Among Hospital Inpatients **(FFS Opioid Related Deaths)**
Measure ID	OPIOID_DEATH_FFS_MEDICARE

Measure Name	AHRQ PSI-03 Pressure Ulcer (PrU), Stage 3+ **(FFS AHRQ Pressure Ulcer Rate)**
Measure ID	PSI03_FFS_MEDICARE

Measure Name	30-day All-Cause Readmission Rate **(Readmissions, Medicare FFS)**
Measure ID	READM_30DAY_FFS_MEDICARE

Measure Name	Postoperative Sepsis Rate (PSI-13) **(FFS Postoperative Sepsis Rate)**
Measure ID	PSI13_FFS_MEDICARE

Measure Name	Sepsis Cases that Expired While in the Hospital **(FFS Expired Sepsis Cases)**
Measure ID	SEPSIS_MORTALITY_FFS_MEDICARE

For specifics on each measure, refer to Appendix D.

Category: Opioid Stewardship

Opioid Stewardship: Surgical Discharges with 12 or Fewer Opioid Pills	
Measure Name Detail	Surgical Discharges with 12 or Fewer Opioid Pills Prescribed
Measure ID	Opioid_Discharge
Measure Type	Process
Measure Description	Rate of surgical patients discharged with opioid prescriptions totaling 12 pills or fewer including patients that did not receive opioid prescription on discharge
Numerator	Number of surgical patients receiving opioid prescriptions at discharge with 12 pills or fewer
Denominator	Number of hospital surgical discharges
Denominator Exclusions	• Patients under 18 years of age • Patients with active cancer • Patients with sickle cell disease • Patients discharged from hospital to hospice • Orthopedic surgeries such as total hip, total knees or back reconstructions
Rate Multiplier	None
Data Source(s)	Self-report numerators and denominators based on discharge prescriptions, patient problem list, and discharge count. Sample of 10 patients a month can be used to reduce burden if manual process is required.
Specifications/Definitions/ Recommendations	The problem list should include a diagnosis of cancer or sickle cell disease.
Baseline Period	January – July 2021
Reporting Timeline	Monthly, beginning August 2021
Measure Reporting History:	n/a

Category: Opioid Stewardship

Opioid Stewardship: Opioid Use in the ED

Measure Name Detail	Overall Opioid Use in the Emergency Department
Measure ID	ED_Opioid
Measure Type	Outcome
Measure Description	Total morphine milligram equivalents units (MMEs) per Emergency Department visit
Numerator	Total MMEs administered in the Emergency Department
Denominator	Number of Emergency Department visits
Denominator Exclusions	• Under 18 years of age • Patients with active cancer based on problem list (C-codes) • Patients with sickle cell disease based on problem list (D57 codes) • Patients enrolled in hospice • Patients administered buprenorphine or methadone • Patients administered fentanyl for procedural sedation
Rate Multiplier	None
Data Source(s)	• Numerators and denominators will be self-reported. • Reports may originate from manual data collection, automated drug cabinet systems, and electronic medical records.
Specifications/Definitions/ Recommendations	• Opioids, all routes excluding oral liquid
Baseline Period	January – July 2021
Reporting Timeline	Monthly, beginning August 2021
Measure Reporting History:	n/a

OPIOID	MME Conversion Table
Codeine	0.15/mg
Fentanyl	0.1/mcg
Hydrocodone	1/mg
Hydromorphone	4/mg
Levorphanol	11/mg
Meperidine	0.1/mg
Morphine	1.0/mg
Oxycodone	1.5/mg
Oxymorphone	3.0/mg
Tapentadol	0.4/mg
Tramadol	0.1/mg

Category: Overall Harm

Overall Harm Measure – All Facilities	
Measure Name Detail	Overall Harm
Measure ID	Overall_Harm
Measure Type	Outcome
Measure Description	Total rate of patient harm across targeted measures
Numerator	Number of harms from all measures
Denominator	Number of patient days
Denominator Exclusions	Any exclusions that apply within each individual measure numerator
Rate Multiplier	1,000
Data Source(s)	Numerator and denominator will be calculated by the LHAREF Team based upon data provided for the included measures.
Specifications/Definitions/ Recommendations	Measures counted in harm rate include: • CAUTI_RATE_All • CLABSI_RATE_All • CDI_LABID • MRSA_Rate • HAPI_PSI03 • SEPSIS_MORTALITY
Baseline Period	Baseline period will be based upon individual applicable measure.
Reporting Period	Monthly beginning January 2021
Measure Reporting History:	n/a

Category: Pressure Injury, Hospital-Acquired (HAPI)

Pressure Injury, Hospital-Acquired (HAPI) Rate, Stage 3+ (PSI-03)	
Measure Name Detail	Pressure Injury Rate, Stage 3+
Measure ID	HAPI_PSI03
Measure Type	Outcome
Measure Description	Rate of Stage III, Stage IV, unstageable pressure ulcers or unstageable (secondary diagnosis) among surgical or medical patients ages 18 years and older that are not present on admission
Numerator	Number of patients with Stage III, Stage IV, or Unstageable Pressure Ulcers
Denominator	Number of surgical or medical discharges, for patients ages 18 years and older
Denominator Exclusions	• Length of stay less than 3 days • Cases with a principal stage III or IV (or unstageable) or deep tissue injury pressure ulcer diagnosis • Cases with all secondary diagnosis of Stage III or IV pressure ulcer (or unstageable) or deep tissue injury that is present on admission. • Severe burns (>= 20% body surface area) • Exfoliative disorders of the skin (>=20% body surface area) • Obstetric cases
Rate Multiplier	1,000
Data Source(s)	Self-reported
Specifications/Definitions/ Recommendations	Available from AHRQ (2021 version): PSI-03
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Period	Monthly
Measure Reporting History:	HIIN: PrU-1 (Oct. 2016 – March 2020) HEN2: PrU-1 (July 2015 – Sept. 2016)

Category: Readmissions

Readmissions: Hospital-Wide, All-Cause, 30-Day	
Measure Name Detail	30-day All-Cause Readmission Rate per 100 Admissions
Measure ID	READ-1
Measure Type	Outcome
Measure Description	Rate of all-cause readmissions for all patients 18 years of age and older that arise from acute clinical events requiring urgent rehospitalization **to the same hospital** within 30 days of discharge.
Numerator	Number of inpatients returning as an acute care inpatient within 30 days of date of discharge. Patients admitted to a different level of care (e.g., rehabilitation facilities, hospice) are not counted as readmissions
Denominator	Patients discharged alive
Denominator Exclusions	Patients that expired in the index stay
Rate Multiplier	100
Data Source(s)	Numerators and denominators will be reported by hospitals and obtained either through administrative data, billing systems or other tracking systems.
Specifications/Definitions/ Recommendations	• Facilities should follow the CMS definition of a readmission. This definition is explained in the "Frequently asked questions about readmissions" chapter, available on Quality Net. "Chapter 3 – Readmissions Measures," section "Defining readmissions" beginning on page 7. This is the same definition as is used for Medicare readmission measure but includes all payors. • Measure is not risk-adjusted.
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Period	Monthly
Measure Reporting History:	HIIN: Read-1 (Oct. 2016 – March 2020) HEN2: Read-1 (July 2015 – Sept. 2016)

Category: Sepsis

Sepsis: Overall Mortality Rate	
Measure Name Detail	Sepsis Overall Mortality Rate
Measure ID	SEPSIS_MORTALITY
Measure Type	Outcome
Measure Description	Rate of patients with a principal or secondary diagnosis code from the SEP-1 inclusion criteria who have a discharge status of expired.
Numerator	Number of patients with sepsis diagnosis and discharge status of expired
Denominator	Number of patients with any principal or secondary diagnosis code from SEP-1 inclusion criteria Table 4.01 (the list is located on page 10)
Denominator Exclusions	Patients with COVID ICD-10 Code U071
Rate Multiplier	1,000
Data Source(s)	Numerators and denominators will be reported by hospitals.
Specifications/Definitions/ Recommendations	ICD-10 codes are located on page 10 in Table 4.01
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Period	Monthly
Measure Reporting History:	HIIN: Sepsis-1d (Oct. 2016 – March 2020) HEN2: Sepsis-1d (July 2015 – Sept. 2016)

Category: Sepsis

Sepsis: Postoperative Rate	
Measure Name Detail	Sepsis Postoperative Rate
Measure ID	Sepsis_PSI13
Measure Type	Outcome
Measure Description	Postoperative sepsis cases (secondary diagnosis) per 1,000 elective surgical discharges for patients ages 18 years and older
Numerator	Discharges among cases meeting the inclusion and exclusion rules for the denominator, with any AHRQ designated secondary ICD-10 diagnosis codes for sepsis, SEPT12D
Denominator	Elective surgical discharges for patients ages 18 years and older, with any listed ICD-10-PCS procedure codes for an operating room procedure. Codes listed here.
Denominator Exclusions	• Principal ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for sepsis (SEPTI2D*) • Principal ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for infection (Appendix F: INFECID) • MDC 14 (pregnancy, childbirth, and puerperium) • With an ungroupable DRG (DRG=999) • With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)
Rate Multiplier	1,000
Data Source(s)	Numerators and denominators will be self-reported by hospitals.
Specifications/Definitions/ Recommendations	PSI_13_Postoperative_Sepsis_Rate.pdf
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Period	Monthly
Measure Reporting History:	HIIN: Sepsis-1a (Oct. 2016 – March 2020) HEN2: Sepsis-1a (July 2015 – Sept. 2016)

Category: Surgical Site Infection (SSI)

Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) – Two Measures	
Measure Name Detail	(1) SSI SIR, Colon Surgeries (2) SSI SIR, Abdominal Hysterectomies
Measure ID	(1) SSI_Colon_SIR (2) SSI_AbHyst_SIR
Measure Type	Outcome
Measure Description	Number of observed SSIs per number of predicted infections
Numerator	Number of observed infections
Denominator	Number of predicted infections
Denominator Exclusions	None
Rate Multiplier	n/a
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that report into NHSN but did NOT confer rights, SIR data will be self-reported by the hospital. • **For hospitals that do NOT report into NHSN, this measure is NOT applicable.**
Specifications/Definitions/ Recommendations	• CDC NHSN • Additional resources: CDC
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Period	Monthly
Measure Reporting History:	HIIN: SSI-1a and SSI-1b (Oct. 2016 – March 2020) HEN2: SSI-1a and SSI-1b (July 2015 – Sept. 2016)

Category: Surgical Site Infection (SSI)

Surgical Site Infection (SSI) Rate – Two Measures	
Measure Name Detail	(1) SSI Rate, Colon Surgeries (2) SSI Rate, Abdominal Hysterectomies
Measure ID	(1) SSI_Colon_Rate (2) SSI_AbHyst_Rate
Measure Type	Outcome
Measure Description	(1) Number of colon surgical site infections based on CDC NHSN definition (2) Number of abdominal hysterectomy surgical site infections based on CDC NHSN definition
Numerator	Total number of surgical site infections based on CDC NHSN definition
Denominator	All patients having any of the procedures included in the selected NHSN operative procedure category
Denominator Exclusions	None
Rate Multiplier	100
Data Source(s)	• Recommended: For hospitals that report to NHSN and confer rights, numerators and denominators will be obtained from NHSN. • For hospitals that do NOT report to NHSN or do NOT confer rights, numerators and denominators will be self-reported.
Specifications/Definitions/ Recommendations	• CDC NHSN • Additional resources: CDC
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Period	Monthly
Measure Reporting History:	HIIN: SSI-2a and SSI-2b (Oct. 2016 – March 2020) HEN2: SSI-2a and SSI-2b (July 2015 – Sept. 2016)

Category: Culture of Safety - Worker Safety

Worker Safety: Violence	
Measure Name Detail	Worker Safety - Workplace Violence
Measure ID	WS_Violence
Measure Type	Outcome
Measure Description	Number of worker harm events related to workplace violence
Numerator	Number of worker harm events related to workplace violence
Denominator	Number of full-time equivalents (FTEs)
Denominator Exclusions	n/a
Rate Multiplier	100
Data Source(s)	Self-report data reported on Occupational Safety & Health Administration (OSHA) Violence Incidence Report Form
Specifications/Definitions/ Recommendations	• Occupational Safety & Health Administration Compliance Assistance Quick Start • CDC NIOSH Workplace Violence Definition
Baseline Period	• Preferred: Calendar year 2019 • Alternate: Oldest 12, 9, 6, or 3-month consecutive period
Reporting Period	Monthly
Measure Reporting History:	HIIN: WS-1c (Oct. 2016 – March 2020) HEN2: WS-1c (July 2015 – Sept. 2016)

Appendix A:
Additional Information for Excessive Anticoagulation with Warfarin (Inpatients)

The definition of an adverse drug event is any injury resulting from medication use, including physical harm, mental harm, or loss of function.

Very few clinical situations other than a warfarin adverse event can cause an INR > critical value(unless a facility is a liver transplant center or deal with other special patient populations not typically targeted for this measure). For this reason, it is acceptable for general acute care facilities to assume that all excessive INR results are from patients on warfarin. It is not necessary to cross check records to confirm patients were on warfarin for the purposes of this data submission.

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

Data Collection Tips:

- Create/utilize laboratory reports for INRs greater than agreed upon value for inpatients receiving warfarin therapy.
- Connect with pharmacists; they may already be collecting these data.
- Partner with IT and pharmacy to create electronic reports for real-time monitoring and improvement.
- Patients with multiple INRs above threshold during an admission, only count as one event.
- Consider assuming that all high INRs are from patients receiving warfarin. The lab should be able to provide the numerator and pharmacy can provide the denominator. Be sure to keep your data collection metrics and scope consistent through the year.
- If collecting house-wide data is not currently possible, focus on collecting data from just those units where warfarin is most often administered, and then work towards collecting house-wide.

The Institute for Healthcare Improvement's (IHI) trigger tool includes a list of known ADE triggers and instructions for measuring the number and degree of harmful medication events.

Link back to measure specifications.

Appendix B:
Additional Information for Hypoglycemia in Inpatients Receiving Insulin

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

Data Collection Tips:

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

Link back to measure specifications.

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

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

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

Data Collection Tips:

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

Link back to measure specifications.

Appendix D:
Medicare Fee-for-Service (FFS) Measure Specifications

Medicare fee-for-service measures collected for HQIC hospitals only - No reporting action required by hospital

FFS 90 MME Discharges

Measure Name	Discharges with Opioids Totaling Over 90 MME per Day
Measure ID	90_MME_DISCHARGE_FFS_MEDICARE
Measure Description	Rate of patients receiving opioid prescriptions at discharge exceeding 90 Milligram Morphine Equivalent (MME) per day per live acute inpatient hospital discharges.
Numerator	Number of patients receiving opioid prescriptions at discharge exceeding 90 MME per day
Denominator	Number of encounters where the patient was discharged alive (see exclusion criteria)
Denominator Exclusions	• Patients with active cancer • Patients with sickle cell disease • Patients discharged from hospital to hospice
Specifications/Definitions/ Recommendations	• Patients with active cancer include those with the following ICD-10 codes: C00-D09, D10-D3A, and D37-D49. • Patients with sickle cell disease include those with the following ICD-10 codes: D57.0-D57.8.
Baseline Period	Calendar year 2019
Reporting Period	Monthly, beginning January 2021
Data Source	**Medicare FFS measure - No reporting action required by hospital.**

FFS Opioid Poisoning

Measure Name	Opioid Poisoning Among Hospital Inpatients
Measure ID	OPIOID_POISONING_FFS_MEDICARE
Measure Description	Rate of patients with opioid poisoning, not present on admission, per acute inpatient hospital discharges
Numerator	Number of acute inpatient hospital discharges with a diagnosis of opioid poisoning that was not present on admission
Denominator	Number of acute inpatient hospital discharges
Denominator Exclusions	None
Specifications/Definitions/ Recommendations	Hospital patients with opioid poisoning include those with ICD-10 codes T40.1, T40.2, T40.3, or T40.4 not present on admission. The code T40.1, Poisoning – Heroin, is included because if the poisoning was not present at admission, then the hospital is responsible for the safety of the patient during the inpatient stay.
Baseline Period	Calendar year 2019
Reporting Period	Monthly, beginning January 2021
Data Source	**Medicare FFS measure - No reporting action required by hospital.**

FFS Opioid Related Deaths

Measure Name	Opioid-Related Deaths Among Hospital Inpatients
Measure ID	OPIOID_DEATH_FFS_MEDICARE
Measure Description	Rate of patients discharged expired per number of hospital inpatients discharged with a diagnosis code for opioid poisoning not present on admission.
Numerator	Number of patients discharged expired
Denominator	Number of acute inpatient hospital discharges with a diagnosis code of opioid poisoning, not present on admission
Denominator Exclusions	None
Specifications/Definitions/ Recommendations	Hospital patients with opioid poisoning include those with ICD-10 T40.1, T40.2, T40.3, or T40.4 not present on admission. The code T40.1, Poisoning – Heroin, is included because if the poisoning was not present at admission, then the hospital is responsible for the safety of the patient during the inpatient stay.
Baseline Period	Calendar year 2019
Reporting Period	Monthly, beginning January 2021
Data Source	**Medicare FFS measure - No reporting action required by hospital.**

FFS AHRQ Pressure Ulcer Rate

Measure Name	AHRQ PSI-03 Pressure Ulcer (PrU), Stage 3+
Measure ID	PSI03_FFS_MEDICARE
Measure Description	Number of Stage III, Stage IV, unstageable pressure ulcers or unstageable (secondary diagnosis) among surgical or medicalpatients ages 18 years and older that are not present on admission.
Numerator	Number of patients with Stage III, Stage IV, or Unstageable Pressure Ulcers
Denominator	Number of surgical or medical discharges for patients ages 18 years and older
Denominator Exclusions	• Length of stay less than 3 days. • Cases with a principal stage III or IV (or unstageable) or deep tissue injury pressure ulcer diagnosis • Cases with all secondary diagnosis of Stage III or IV pressure ulcer (or unstageable) or deep tissue injury that is present on admission. • Severe burns (>= 20% body surface area) • Exfoliative disorders of the skin (>=20% body surface area) • Obstetric cases
Specifications/Definitions/ Recommendations	Available from AHRQ (2020 version): PSI-03
Baseline Period	Calendar year 2019
Reporting Period	Monthly, beginning January 2021
Data Source	**Medicare FFS measure - No reporting action required by hospital**

Readmissions, Medicare FFS

Measure Name	30-day All-Cause Readmission Rate per 100 Admissions (Medicare Fee-For-Service)
Measure ID	READM_30DAY_FFS_MEDICARE
Measure Description	Rate of all-cause, unplanned readmissions for all patients 18 years of age and older that arise from acute clinical events requiring urgent rehospitalization within 30 days of discharge. There will be no risk adjustment.
Numerator	Number of inpatients returning as an acute care inpatient within 30 days of date of discharge - unplanned
Denominator	Number of at-risk inpatient discharges
Denominator Exclusions	Listed within the below reference document
Specifications/Definitions/ Recommendations	2020 All-Cause Hospital-Wide Measure Updates and Specifications Report: Hospital-Wide Readmissions (5/1/2020)
Baseline Period	Calendar year 2019
Reporting Period	Monthly, beginning January 2021
Data Source	**Medicare FFS measure - No reporting action required by hospital**

FFS Postoperative Sepsis Rate

Measure Name	Postoperative Sepsis Rate (PSI-13)
Measure ID	PSI13_FFS_MEDICARE
Measure Description	Postoperative sepsis cases (secondary diagnosis) per 1,000 elective surgical discharges for patients ages 18 years and older.
Numerator	Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10 diagnosis codes for sepsis
Denominator	Elective surgical discharges for patients ages 18 years and older, with any listed ICD-10 procedure codes for an operating room procedure. Elective surgical discharges are defined by specific MS-DRG codes with admission type recorded as elective.
Denominator Exclusions	• Principal ICD-10 diagnosis code (or secondary diagnosis present on admission) for sepsis, among patients otherwise qualifying for numerator • Principal ICD-10 diagnosis code (or secondary diagnosis present on admission) for infection, among patients otherwise qualifying for numerator • MDC14 (pregnancy, childbirth, and puerperium) • Missing gender, age, quarter, year, or principal diagnosis
Specifications/Definitions/ Recommendations	Available from AHRQ (2020 version): PSI13
Baseline Period	Calendar year 2019
Reporting Period	Monthly, beginning January 2021
Data Source	**Medicare FFS measure - No reporting action required by hospital**

FFS Expired Sepsis Cases

Measure Name	Sepsis Cases that Expired While in the Hospital
Measure ID	SEPSIS_MORTALITY_FFS_MEDICARE
Measure Description	Rate of patients with a principal or secondary diagnosis code from theSEP-1 inclusion criteria who have a discharge status of expired.
Numerator	Number of patients with sepsis diagnosis and discharge status of expired
Denominator	Number of patients with any principal or secondary diagnosis codes from SEP-1 inclusion criteria
Denominator Exclusions	Patients with COVID ICD-10 code U071
Specifications/Definitions/ Recommendations	None
Baseline Period	Calendar year 2019
Reporting Period	Monthly, beginning January 2021
Data Source	**Medicare FFS measure - No reporting action required by hospital**

Link back to Measure List.