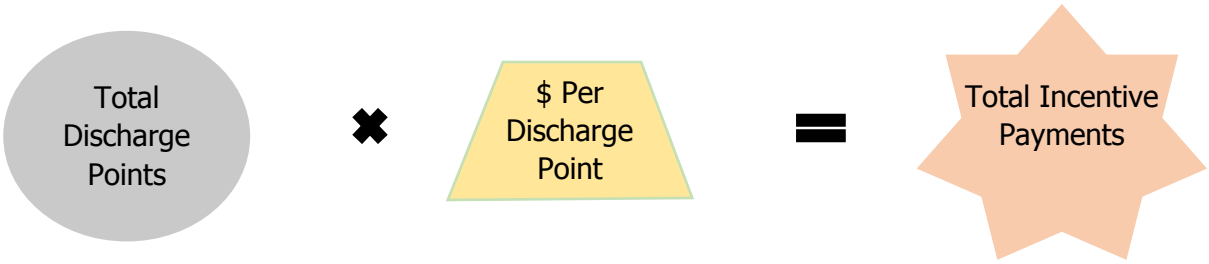
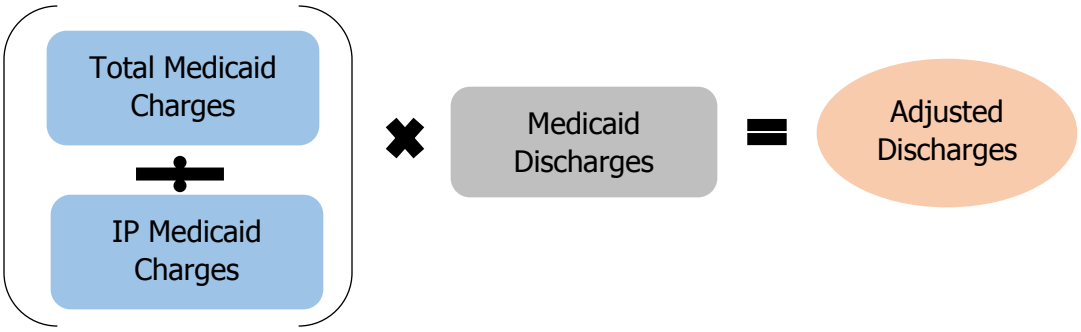


Adjusted discharges are calculated by dividing the total Medicaid charges by inpatient Medicaid charges. This quotient is multiplied by total inpatient Medicaid discharges to arrive at Adjusted Discharges. This calculation is done to derive a metric that represents total inpatient and outpatient volume combined.



Dollars per Discharge Point

A hospital's performance level determines the quality points earned. The $ per Discharge Point (above) is dependent on the total quality points earned by a hospital. The higher the total quality points, the more money each discharge point is worth.

Hospitals can earn anywhere from 0 to 80 points for the HQIP program. The points are then tiered. The tiering methodology is currently under development due to change from 2017 (50 points) to 2018 (80 points). This document will be updated and republished when tiering information is finalized.

An established council with both hospital staff and members who are former patients or family members of former patients.

Measure Criteria:

- The council must meet at least four (4) times in calendar year 2018. Note that planning meetings for PFAC do not count.
- At least three (3) council members must be former patients or family members of former patients.

The purpose of the council should be to provide advice and guidance regarding patient safety and/or patient experience issues identified by council members. There should be demonstration by the organization that such advice and guidance was taken into consideration in the planning and improvement of patient care experience and outcomes.

2. Patient Safety and Hospital Leadership

ONE of the following is conducted on a regular basis:

Leadership Safety Rounds. These are planned visits to the appropriate hospital departments by hospital executive(s) or senior leaders for the purpose of demonstrating leadership's commitment to a strong patient safety program and identifying and responding to patient safety concerns identified by hospital staff. A senior leader is defined as someone at a Division Director level or higher.

OR

Daily Leadership Safety Huddles/Briefings. These are short, daily meetings attended by a hospital executive or senior leader in which representatives from all departments gather to report on potential clinical safety concerns for the day. A senior leader is defined as someone at a Division Director level or higher.

Measure Criteria:

- Leadership Safety Rounds should be attended weekly by a hospital executive or senior leader. Hospital executives or senior leaders will round on at least 50% of the hospital departments during a year.

Daily Leadership Safety Huddles/Briefings are conducted with the appropriate personnel seven days per week. A hospital executive or senior leader (or designee on weekends) will attend the meeting. A senior leader is defined as someone at a Division Director level or higher.

3. Patient Safety Survey

Completion of a survey that gathers data regarding hospital staffs' perceptions of the organization's safety culture and demonstration of actions taken by the hospital to address issues identified by survey responses.

One of the following is required:

3a. For hospitals new to conducting Patient Safety Survey: A validated Patient Safety Survey (such as AHRQ's) conducted in the first quarter of 2018, AND a project plan to improve the poorest scores is developed in the second quarter of 2018, AND that project plan is implemented in the second half of 2018.

OR

3b. For hospitals who have previously conducted a Patient Safety Survey: a validated Patient Safety Survey (such as AHRQ's) conducted in the last 24 months, AND a project plan to improve poorest scores was developed and is implemented throughout 2018.

Measure Criteria:

- Survey must include at least ten questions related to a safety culture and can be combined with another survey of hospital staff.
- Safety culture questions must be from a survey tool that has been tested for validity and reliability.
- Survey questions can be part of another survey tool as long as it meets the above criteria.
- Safety culture survey has been administered within the past 24 months.
- Actions taken in response to the survey should address those survey questions that demonstrated the poorest scores on the survey.

4. Daily Unit Safety Briefings/Huddles

These are short meetings held in nursing units and in clinical departments to identify possible patient safety issues or concerns.

Measure Criteria:

- Meetings should be held daily.
- Meetings should be led by unit or department leader or designee.
- All available department/unit staff should be present.

Patient Safety

1. Hospital Acquired Clostridium Difficile

This element is based on calendar year 2017 and is for all patients.

Hospitals must submit data for this measure to National Healthcare Safety Network (NHSN); this allows for risk adjusting and calculation of an SIR rate. NHSN rates are then used in the Colorado Department of Public Health and Environment's *Healthcare Associated Infections in Colorado* annual report. HCPF will pull hospital data from that report. *Hospitals that do not submit C-DIFF data to NHSN will receive a "0" for this element*.

2. Adverse Event Reporting

   This element is based on calendar year 2018 and is for all patients.

   Hospital describes system for reporting on and responding to Adverse Events.

   Measure Criteria:

- Must allow anonymous reporting.
- Reports should be received from a broad range of personnel.
- Summaries of reported events must be disseminated in a timely fashion.
- A structured mechanism must be in place for reviewing reports and developing action plans.

3. Falls with Injury

   This element is based on calendar year 2017 and is for all patients.

   The *Falls with Injury* measure is based on the definition provided by the National Quality Forum (NQF) for the number of documented patient falls with an injury level of moderate or greater on eligible unit types during the measurement period (the NQF measure also includes minor falls, which this HQIP measure does not). Measure specifics can be found on the NQF website (measure ID: 0202). Hospitals will be required to submit data from calendar year 2017 to HCPF (all patients regardless of payer).

   A patient injury fall is an unplanned descent to the floor with injury (moderate or greater) to the patient and occurs on an eligible reporting nursing unit*. Include falls when a patient lands on a surface where you would not expect to find a patient. Unassisted and assisted falls are to be included whether they result from physiological reasons (e.g., fainting) or environmental reasons (slippery floor). Also report patients that roll off of a low bed onto a mat as a fall.

   Hospitals will report four data points:

   1. Number of Moderate Injury Falls: resulted in suturing, application of steri-strips/skin glue, splinting, or muscle/joint strain.
   2. Number of Major Injury Falls: resulted in surgery, casting, traction, required consultation for neurological or internal injury or patients with coagulopathy who receive blood products as a result of a fall.
   3. Number of Falls Resulting in Death: the patient died as a result of injuries sustained from the fall (not from physiological events causing the fall).
   4. Total number of inpatient days for applicable units during calendar year 2017 (including observation patients on applicable units). To calculate Total Patient Days, refer to the NQF measure specification section: Patient Days Reporting Methods. (Note: hospitals will not multiply by 1000.)

   Included in the measure: inpatients, short-stay patients, observation patients, and same-day surgery patients who receive care on eligible inpatient units for all or part of a day: adult critical care, step-down, medical, surgical, medical-surgical combined, critical access and adult

rehabilitation inpatient units; patients of any age on an eligible reporting unit are included in the patient-day count.

Excluded from the measure: visitors, students, staff members, falls on other units not eligible for reporting, falls by patients from an eligible reporting unit when the patient was not on unit at the time of fall (e.g., patient falls in radiology department); other unit types (e.g., pediatric, psychiatric, obstetrical, etc.).

*The nursing unit area includes the hallway, patient room and patient bathroom. A therapy room (e.g., physical therapy gym), even though physically located on the nursing unit, is not considered part of the unit.

Documentation for Culture of Safety and Patient Safety

Documentation should give a high-level picture of *Culture of Safety* and *Patient Safety* for the indicated time periods. We are interested in what is being done and the results/effect on patient care. It is important that all criteria below is addressed in the summary.

Culture of Safety:

1. Patient and Family Advisory Council. A short summary (1-2 paragraphs) that includes the following elements: the number of meetings to be held from January 1, 2018 to December 31, 2018, one or two of the major discussion topics from meetings held, and any actions planned or implemented as a result of the discussion.
2. Patient Safety and Hospital Leadership. A short summary (1-2 paragraphs) of some of the issues identified and addressed during these meetings/discussions.
3. Patient Safety Survey. A short summary (1-2 paragraphs) of survey findings as relates to the lowest scores, what is planned for 2018 as a result of the survey and the percentage of staff completing the survey.
4. Daily Unit Safety Briefings/Huddles. A short summary (1-2 paragraphs) of some of the issues identified and the number and description of the units on which briefings are conducted.

Patient Safety:

1. Hospital Acquired Clostridium Difficile. Hospitals must submit data for this measure to NHSN; this allows for risk adjusting and calculation of an SIR rate. NHSN rates are then used in the Colorado Department of Public Health and Environment's *Facility Infections* annual report. HCPF will pull hospital data from that report. Hospitals that do not submit C-DIFF data to NHSN will receive a "0" for this element.
2. Adverse Event Reporting. A short summary (1-2 paragraphs) describing the Adverse Reporting system, some of the issues identified and addressed as a result of adverse event reporting.
3. Falls with Injury. Hospitals will report four data points: number of Moderate Injury Falls, number of Major Injury Falls, Falls Resulting in Death, total number of inpatient days for applicable units during calendar year 2017. To calculate Total Patient Days, refer to the NQF measure specification section: Patient Days Reporting Methods. (Note: hospitals will not multiply by 1000.)

3. Discharge Planning (up to 20 points)

Advanced Care Planning

This element is based on calendar year 2017 and is for all patients.

The *Advance Care Planning* measure is based on the definition provided by the National Quality Forum (NQF) for the number of patients, regardless of payer, 65 years of age or older who have an advanced care plan documented in the medical record or who did not wish to provide an advance care plan. Measure specifics can be found on the NQF website (measure ID: 0326). Note that this measure includes initial hospital observation care services, inpatient services and critical care services (refer to NQF measure #0326 for CPT codes). Hospitals will be required to submit data from calendar year 2017 to HCPF. Sampling is allowed. There is no minimum denominator for this measure.

**Hospitals will also summarize their process for discussing/initiating advanced care planning when a patient does not have an ACP or when their ACP is not available to the hospital. This short summary (up to 2 paragraphs) will not be scored.

Care Transition Activities

This element is based on calendar year 2018 and is for all patients.

Identify activities in which your hospital is engaged from January 1, 2018 through December 31, 2018. Scoring is based upon number of engaged activities.

- Assigned staff conducts post-discharge phone call or post-discharge home visit.
- Assign care management responsibilities for patients who are high-risk for readmissions to ED or IP.
- Assigned staff discusses transitions to post-acute care services with patient and family prior to transition to foster understanding about next steps and to discuss any concerns.
- Coordinate medications across transitions from hospital to post-acute care services.
- Maintain an inventory of community resources available to patients.
- Engage local health coalitions to identify resources in areas where resources are scarce.
- Develop a medication action plan for vulnerable (high-risk) patients.
- Develop policies and training to address patient health literacy issues.
- Other care transition activities (no more than one "other" activity will be accepted)

** Providers will choose all that apply and will provide a brief summary that justifies how the hospital meets these elements. If you selected "Other," please describe in detail. This short summary (up to 2 paragraphs) will not be scored.

4. Cesarean Section (up to 10 points)

This measure is based on calendar year 2017 and is for all patients.

The *Cesarean Section* measure is based on the Joint Commission calculation and sampling for PC-02 in the perinatal care measure set. This measure counts the number of qualified births (nulliparous women with a term, singleton baby in a vertex position) delivered by cesarean section. Sampling is allowed. Minimum denominator of 30 is required for this measure.

Measure criteria:

In order to receive a score for the hospital's Cesarean Section rate, the hospital will be required to describe their process for notifying physicians of their respective Cesarean Section rates and how they compare to other physicians' rates and the hospital average. This should be communicated to physicians through a regular report as well as through regular executive and team meetings (or equivalent). The report must be uploaded and must include at a minimum:

1. Physician's Cesarean Section rate.
2. The individual rates (not aggregated) of other physicians' Cesarean Section rates so as to provide a peer-to-peer comparison.
3. The hospital's average Cesarean Section rate.

The hospital has discretion over how to format the report and disclosures for statistical significance.

Hospitals will be required to upload a blank example of the report that is provided to physicians for this purpose.

5. Breastfeeding Practices (up to 10 points)

This measure is based on activities from January 1, 2017 – April 1, 2018 and is for all patients.

All hospitals will be required to submit PC-05 data (#1). Hospitals can then choose one activity: #2, #3 or #4. There is no minimum denominator for this measure.

1. Hospitals will submit calendar year 2017 data for The Joint Commission (TJC) PC-05, Exclusive Breast Milk Feeding measure (all patients, regardless of payer). Points will be given for reporting and will not be based upon the hospital's PC-05 rate. Sampling is allowed. There is no minimum denominator for this measure.

AND ONE OF THE FOLLOWING

2. Written breastfeeding polices for hospitals not officially on the pathway to Baby-Friendly designation. Must implement all five (5) of *The Ten Steps to Successful Breastfeeding* by April 1, 2018. Must also provide a copy of the policy and a statement as to how staff is trained on the policy:
    a. Help mothers initiate breastfeeding within one hour of birth.
    b. Give infants no food or drink other than breast milk unless medically indicated.
    c. Practice rooming in – allow mothers and infants to remain together 24 hours a day.
    d. Give no pacifiers or artificial nipples to breastfeeding infants.
    e. Breastfeeding support telephone number provided before discharge.

OR

3. *4-D Pathway* to Baby-Friendly Designation. Hospitals must move from one of the following *4-D Pathway* phases to the next during the time period of January 1, 2017 and April 1, 2018**.**
    a. From Discovery Phase to Development Phase
    b. From Development Phase to Dissemination Phase
    c. Dissemination Phase to Designation Phase

OR

4. Baby-Friendly Designation: hospitals officially receiving or maintaining Baby-Friendly designation at some point between January 1, 2017 and April 1, 2018**.**

6. Tobacco (TOB) and Substance Use (SUB) Screening and Follow-Up (up to 10 points)

These elements are based on calendar year 2017 and are for Medicaid patients only.

The *Screening for Tobacco Use* and *Tobacco Use Treatment Provided or Offered at Discharge* (TOB-01 and TOB-03) measures are based on the Joint Commission definitions for the number of patients 18 years of age or older who were screened within the first day of admission for tobacco use and, if positive, referred to or refused evidence based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge.

Hospitals will be required to submit data to HCPF from calendar year 2017 for Medicaid patients only. Rates for TOB-01 and TOB-03 must be submitted; however, only TOB-03 will be scored. Sampling is allowed. There is no minimum denominator for this measure.

AND

The *Alcohol use Screening and Alcohol and Other Drug use Disorder Treatment Provided or Offered at Discharge* (SUB-01 and SUB-03) measures are based on the Joint Commission definitions for the number of hospitalized patients 18 years of age or older who were screened within the first day of admission using a validated screening questionnaire for unhealthy alcohol use and, if positive, referred to or refused evidence based outpatient counseling OR received or refused a prescription for FDA-approved cessation medication at discharge.

Hospitals will be required to submit data to HCPF from calendar year 2017 for Medicaid patients only. Rates for SUB-01 and SUB-03 must be submitted; however, only SUB-03 will be scored. Sampling is allowed. There is no minimum denominator for this measure.

7. ED Process Measure (up to 10 points)

This measure is based on calendar year 2018 and is for Medicaid ED patients.

1. Summarize your hospital's policy and practice related to non-opioid alternatives to pain management in the ED. This short narrative of up to two (2) paragraphs will not be scored.

AND all five elements must be in place during the period January 1, 2018 through December 31, 2018.

a. All discharged ED patients are given information about local primary care clinics if they have no PCP.
b. All discharged ED patients are provided information about available nurse advice lines.
c. ED policies or guidelines that state providers will not provide replacement prescriptions for opioids that are lost, expired or stolen are in effect by January 1, 2018. Hospital will be required to submit a copy of this policy/guideline.
d. ED policies or guidelines are in place indicating no long-acting opioids are prescribed in the ED are in effect by January 1, 2018. Hospital will be required to submit a copy of this policy/guideline. **Policy/guideline must be explicitly clear that long-acting opioids will not be prescribed in the ED, except in compelling circumstances for cancer and end-of-life patients, to be specifically documented by the physician on why they are necessary beyond standard choices.
e. Provide Training to ED staff on issues such as: Trauma Informed Care, Mental Health 1st Aid, and Zero Suicide. Training provided is at the hospital's discretion.

8. HCAHPS (up to 10 points)

This data is taken from Hospital Compare in July 2018 and is for all patients.

This measure is based on the question on the HCAHPS survey showing the percentage of patients who gave the hospital a rating of a "9" or "10" on a scale from 0 (lowest) to 10 (highest). Data from this measure will be taken from the most current data on Hospital Compare in order to provide a patient-mix adjustment.

9. 30 Day All-Cause Readmissions, CMS methodology (up to 10 points)

This data is calculated by HCPF and is based on calendar year 2017 for all Medicaid patients.

The *30 Day All Cause Readmission* calculation is defined by the Centers for Medicare and Medicaid Services (CMS) and counts Medicaid clients with readmissions during calendar year 2017. Hospitals do not need to submit data for this measure. Patients must be continuously enrolled in Medicaid for at least 365 days prior to the discharge date to be included in this measure; therefore, the numerators, denominators and subsequent readmission rates will be lower than a hospital calculates with its own data. Minimum sample size of 30 is required for this measure. Here is a link to the specifications for this Readmissions measure.

Maintenance Measures:

Maintenance Measures are measures that are important to quality of care and patient safety but have little room for improvement over current statewide performance levels. The HQIP Subcommittee will continue to review the statewide rates to be sure that gains are maintained. No points are assigned for Maintenance Measures.

MM #1: PE/DVT (no points). Hospitals do not need to submit data for this measure. The data source for this measure is the Colorado Hospital Report Card.

MM #2: CLABSI (no points). Hospitals do not need to submit data for this measure. The data source for this measure is the NHSN data submitted to the Colorado Department of Public Health and Environment and will be obtained from the annual *Health Care Associated Infections Report in Colorado* report.

MM #3 Early Elective Deliveries (no points). Hospitals do not need to submit data for this measure. This measure uses the TJC calculation and sampling for PC-01 in the perinatal care measure set. The data source for this measure is Hospital Compare.

Measure Resources

Internet Resources

Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO) Engagement

Department of Health Care Policy and Financing, RCCO Information

Department of Health Care Policy and Financing BHO Information

Culture of Safety/Patient Safety

The Joint Commission Patient Safety Information

AHRQ - Voluntary Patient Safety Event Reporting (Incident Reporting)

Patient and Family Advisory Council Toolkit, 1

Patient and Family Advisory Council Toolkit, 2

Patient and Family Advisory Council Toolkit, Pediatric

IHI - Hospital Safety Leadership

Safety Huddle Video

Patient Safety Survey from AHRQ Note that the Colorado Hospital Association provides access to the Patient Safety Survey via an online tool for hospital use. Survey results are calculated and provided to the hospital for analysis and planning.

IHI - Standup Daily Unit Safety Briefings

Falls - NQF website (Falls, measure ID: 0202)

Discharge Planning

ACP - NQF website (ACP, measure ID: 0326)

ACP - Colorado MOST Form

Cesarean Section

The Joint Commission, PC-02 Cesarean Section

Breastfeeding Practices

The Joint Commission: PC-05, Exclusive Breast Milk Feeding

Baby Friendly USA

CDPHE Breastfeeding Essentials

CDPHE Colorado Baby Friendly Hospital Collaborative: offered through the Colorado Department of Public Health and Environment, supports participating hospitals to improve breastfeeding rates and practices by providing training, resources and opportunities to improve policies and processes that impact breastfeeding outcomes, and ultimately help hospitals achieve Baby-Friendly designation.

Tobacco and Substance Use

The Joint Commission Manual: (download zip file for TOB-01, TOB-03 and SUB-01, SUB-03 measure specifications)

HCAHPS

HCAHPS on Hospital Compare

30 Day All-Cause Readmissions

CMS PCR Methodology

Defining High-Utilizer:

The Department offers this guideline to determine patients considered to be high-utilizers, as relates to the RCCO/BHO engagement measure. Generally, three (3) or more ER visits or hospital admissions per year indicate higher than average utilization. It is important that you identify what constitutes high-utilization at your hospital.

Defining (Vulnerable) Patients with High-Risk for Readmissions:

The Department offers these guidelines for determining which patients are high-risk for readmission to the hospital, as relates to the Care Transition measure. These predictive risk elements are derived from AHRQ and from the Society of Hospital Medicine's Project Boost. This is not an inclusive list, and it is important that you identify (vulnerable) patients with high-risk for readmission by appropriately considering your hospital setting and your patients' situation. Things to consider when identifying your hospital's patients that have a high-risk for readmission:

- Patients with polypharmacy (e.g., >10 routine medications) or who are on high-risk medications including anticoagulants in combination, insulin, digoxin, and narcotics, etc.
- Patients who screen positive for depression, have a history of depression, who have persistent mental illness, or who screen positive for substance abuse.
- Patients with significant comorbidities, like cancer, stroke, diabetic complications, COPD, or heart failure or patients with multiple minor comorbidities.
- Patients with frailty, deconditioning, or other physical limitations that impair or limit their ability to significantly participate in their own care (e.g. perform activities of daily living, medication administration, and participation in post-hospital care).
- Patients with poor health literacy (i.e., unable to understand and/or implement their care plan) or for whom English is not a primary language.
- Patients without a reliable caregiver to assist with the discharge process and to assist with care after the patient is discharged.
- Patients identified with a high than average readmission rate.
- Patients identified on the basis of population readmission rates, such as payer type (e.g., duals) or discharge disposition (e.g., discharges to post-acute care) or high utilization.

(Sources: Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions, and Risk Assessment – 8P Project Boost Project Boost Implementation Toolkit)

Sampling

Hospitals that use The Joint Commission (TJC) sampling for a measure can report the data as sampled for TJC.

Hospitals that are not TJC accredited may sample using the methodology below, which is based on TJC sampling requirements

For those measures that are not submitted to TJC, hospitals can use the methodology below, regardless of TJC submission for other measures (e.g., Advanced Care Planning—NQF 0326).

Sample Size Requirements

Hospitals can use sampling to report HQIP measures. The size of the sample depends on the number of cases that qualify for a measure. Hospitals need to use the next highest whole number when determining their required sample size. The sample must be a random sample (e.g., every third record, every fifth record, etc.), taken from the entire 12 months of the year and cannot exclude cases based

on physician, other provider type or unit. Hospitals can choose to use simple random sampling or systematic random sampling

Hospitals selecting sample cases must include at least the minimum required sample size. The sample size table below shows the number of cases needed to obtain the required sample size. A hospital may choose to use a larger sample size than is required.

Hospitals selecting sample cases for a measure must ensure that the annual patient population and annual sample size for each measure sampled meet the following conditions:

Annual Sample Size

Annual number of patients meeting measure denominator	Minimum Required Sample Size "n"
>=1551	311
391-1551	20% of discharges in denominator
78 -390	78
0-77	No sampling, 100% of the patient population is required.

Examples

- A hospital's number of patients meeting the criteria for advanced care planning is 77 patients for the year. Using the above table, no sampling is allowed – 100% of the cases should be reviewed.
- A hospital's number of patients meeting the criteria for advanced care planning is 401 patients for the year. Using the above table, the required sample size is 80 cases (401 x .20 = 80) for the year.