2020 Hospital Quality Incentive Payment (HQIP) Program

WORKING DRAFT

August 16, 2019
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I. 2020 Measures

Measures for the 2020 HQIP program are listed below. Hospitals will be requested to complete all six measure groups. Measures with an asterisk (*) denote new measures for the 2020 HQIP.

A. 2020 Measure Groups

1. Maternal Health and Perinatal Care Group

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Basis</th>
<th>Source</th>
<th>Measurement Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive Breast Feeding (PC-05)</td>
<td>The Joint Commission (TJC)/CMS</td>
<td>Hospital Reported</td>
<td>January 1, 2019 to December 31, 2019</td>
</tr>
<tr>
<td>Cesarean Section (PC-02)</td>
<td>The Joint Commission /CMS</td>
<td>Hospital Reported</td>
<td>January 1, 2019 to December 31, 2019</td>
</tr>
<tr>
<td>Perinatal Depression and Anxiety</td>
<td>Council on Patient Safety in Women’s Health Care</td>
<td>Hospital Reported</td>
<td>In place before May 1, 2019</td>
</tr>
<tr>
<td>Maternal Emergencies</td>
<td>National Partnership for Maternal Safety</td>
<td>Hospital Reported</td>
<td>In place before May 1, 2019</td>
</tr>
<tr>
<td>Reproductive Life/Family Planning</td>
<td>Department of Health Care Finance/US Office of Population Affairs</td>
<td>Department/Hospital Reported</td>
<td>In place before May 1, 2019</td>
</tr>
<tr>
<td>Incidence of Episiotomy*</td>
<td>Christiana Care Health System</td>
<td>Department</td>
<td>January 1, 2019 to December 31, 2019</td>
</tr>
</tbody>
</table>

2. Patient Safety Group

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Basis</th>
<th>Source</th>
<th>Measurement Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium difficile (C. Diff)</td>
<td>Center for Disease Control (CDC)</td>
<td>Department/Hospital Reported</td>
<td>January 1, 2019 to December 31, 2019</td>
</tr>
<tr>
<td>Sepsis*</td>
<td>HQIP</td>
<td>Hospital Reported</td>
<td>In place by April 30, 2020</td>
</tr>
<tr>
<td>Antibiotics Stewardship*</td>
<td>Colorado Department of Public Health and Environment (CDPHE), Colorado Hospital Association (CHA), Colorado Health Care Association (CHCA), Telligen</td>
<td>Hospital Reported</td>
<td>In place by April 30, 2020</td>
</tr>
<tr>
<td>Adverse Event</td>
<td>HQIP</td>
<td>Hospital Reported</td>
<td>January 1, 2019 to December 31, 2019</td>
</tr>
<tr>
<td>Culture of Safety Survey</td>
<td>Agency for Healthcare Research and Quality (AHRQ)</td>
<td>Hospital Reported</td>
<td>Within the 24 months prior to data collection</td>
</tr>
<tr>
<td>Handoffs and Signouts*</td>
<td>AHRQ, Joint-Commission</td>
<td>Hospital Reported</td>
<td>In place by April 30, 2020</td>
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3. **Patient Experience Group**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Basis</th>
<th>Source</th>
<th>Measurement Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)</td>
<td>AHRQ/ Hospital Compare Department</td>
<td>July 1, 2018 to June 30, 2019</td>
<td></td>
</tr>
<tr>
<td>Advance Care Plan</td>
<td>National Committee for Quality Assurance (NCQA) Hospital Reported</td>
<td>January 1, 2019 to December 31, 2019</td>
<td></td>
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</table>

B. 2020 Maintenance Measures

1. **Pulmonary Embolism /Deep Vein Thrombosis (PE/DTV)**

<table>
<thead>
<tr>
<th>Measure Steward</th>
<th>Data Source</th>
<th>Measurement Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRQ</td>
<td>CHA Hospital Report Card</td>
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</table>

2. **Central Line Associated Blood Stream Infections (CLABSI)**

<table>
<thead>
<tr>
<th>Measure Steward</th>
<th>Data Source</th>
<th>Measurement Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC</td>
<td>Colorado Department of Public Health and Environment (CDPHE)</td>
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3. **Early Elective Deliveries**

<table>
<thead>
<tr>
<th>Measure Steward</th>
<th>Data Source</th>
<th>Measurement Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Joint Commission</td>
<td>CMS</td>
<td>TBD</td>
</tr>
</tbody>
</table>

C. **New Measures**

- Episiotomy
- Sepsis
- Antibiotics Stewardship
- Handoffs and Signouts

D. **Retired Measures**

- Falls with Injury
- Regional Accountable Entity Engagement
- Substance Use
- Alternatives to Opioids In the Emergency Department
- Addressing Cost of Care
II. 2020 Measure Details

Measures for the 2020 HQIP program are listed below. Hospitals will be requested to complete all six measure groups. Measures with an asterisk (*) denote new measures for the 2020 HQIP.

1. Maternal Health and Perinatal Care Group
   a. Exclusive Breast Feeding

      This measure is based on activities from January 1, 2019 to December 31, 2019 and is for all patients regardless of insurance coverage.

      All hospitals will be required to report The Joint Commission (TJC) PC-05 data (NQF #0480) (#1). Hospitals can then choose one activity: #2, #3 or #4. There is no minimum denominator for this measure.

      Measure Criteria

      1. Hospitals will submit calendar year 2019 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 policies for hospitals not officially on the pathway to Baby-Friendly designation. Must implement all five (5) of The Ten Steps to Successful Breastfeeding by December 31, 2019. Must also provide a copy of the policy and a statement as to how staff is trained on the policy.

         I. Help mothers initiate breastfeeding within one hour of birth.

         II. Give infants no food or drink other than breast milk unless medically indicated.

         III. Practice rooming in - allow mothers and infants to remain together 24 hours a day.

         IV. Give no pacifiers or artificial nipples to breastfeeding infants.

         V. 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, 2019 and December 31, 2019
   I. From Discovery Phase to Development Phase.
   II. From Development Phase to Dissemination Phase.
   III. Dissemination Phase to Designation Phase

OR


Scoring

- Points earned for reporting PC-05 data (all or nothing).
- Highest number of points will be awarded to hospitals with Baby-Friendly Designation, and second-tier of points for those on the Pathway. The lowest tier of points will be awarded for hospitals that submit written breastfeeding policies but are not on the Pathway. Documentation will also be required to verify Pathway transition and Baby-Friendly Designation.

b. Cesarean Section

This measure is based on calendar year 2019 and is for all patients regardless of insurance status.

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.

Scoring

- Hospitals that meet the criteria outlined will be eligible to earn points.
- Points will be assigned based on relative performance with hospitals performing worse than minimum standard of 23.9% (Healthy People 2020) receiving no points and the remaining divided into terciles.

c. Perinatal Depression and Anxiety

Facilities must attest that this measure has been in place before May 1st, 2019 and is for all patients regardless of insurance status.

The Perinatal Depression and Anxiety measure is based on the Council on Patient Safety in Women’s Health Care Perinatal Depression and Anxiety. The measure has been revised to better suit the nature of care delivery in hospital environments. The measure is modeled after 4 “Rs”: Readiness, Recognition and Prevention, Response, Reporting/Systems Learning.

1. Readiness-Clinical Care Setting
   I. Provide documentation on the mental health screening tools used in the facility for screening during pregnancy/immediate postpartum period as well as any education materials and plans provided to clinicians and support staff on use of the identified screening tools and response protocol.
   II. Identify the individual who is responsible for driving adoption of the identified screening tools and response protocol.
2. Recognition and Prevention—Every Woman:
   I. Describe the process where the hospital obtains individual and family mental health history (including past and current medications) at intake and how it is reviewed and update as needed.
   II. Document the validated mental health screening provided at the hospital during patient encounters during pregnancy/immediate postpartum period.

3. Response—Every Case:
   I. Submit documentation on the facility’s stage-based response protocol for a positive mental health screen.
   II. Submit documentation on the emergency referral protocol for women with suicidal/homicidal ideation or psychosis.

4. Reporting/Systems Learning—Clinical Care Setting:
   I. Describe the policies and processes by which the hospital incorporates information about patient mental health into how it plans care.
   II. Report the number of patients screened, the number of positive screens and the number of positive screens that resulted in a documented action or follow up plan.

**Measure Criteria**

Hospitals should report the requested information and documentation that addresses each of the four “Rs” (1-4) in the measure.

**Scoring**

- To be scored, hospitals must submit complete information on at least two of four “Rs” (1-4)
- Scoring will be tiered with points earned for completion of two, three, or four “Rs” (1-4).
d. **Maternal Emergencies and Preparedness**

Facilities must attest that this measure has been in place before May 1st, 2019 and is for all patients regardless of insurance status.

This measure is based on the National Partnership for Maternal Safety Consensus Bundle on Severe Hypertension During Pregnancy and the Postpartum Period.

Hospitals will report on the structure and process measures below through attestation, narratives that describe processes and provide supporting evidence. The Department will calculate the outcome measures based on claims data. The Department will evaluate the structure and process measures based on the Council on Patient Safety in Women’s Health Care Severe Hypertension in Pregnancy 4 “Rs”. (Readiness, Recognition and Prevention, Response, Reporting/Systems Learning).
Measure Criteria

Structure Measures:

Structure Measures will be evaluated through a combination of attestation and uploading of evidence or documentation. In order to receive points for structure measures, hospitals must answer structure measure A regarding hypertension or preeclampsia policy, and two of three remaining structure measures (B, C, or D).

For each structure measure, hospitals are advised to use the following crosswalk as guidance to determine the relevant “R’s” and their associated subcomponents in which documents and narratives submitted must address in order to fully satisfy the requirements for this measure.

Relevant “Rs”

<table>
<thead>
<tr>
<th>Structure Measure</th>
<th>Readiness</th>
<th>Recognition and Prevention</th>
<th>Response</th>
<th>Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (required)</td>
<td>1, 3, 6</td>
<td>1, 2, 3</td>
<td>1 (i-iii), 2 (i-vii)</td>
<td>N/A</td>
</tr>
<tr>
<td>B</td>
<td>1, 3, 6</td>
<td>1, 2</td>
<td>2 (i-vii)</td>
<td>N/A</td>
</tr>
<tr>
<td>C</td>
<td>1, 3, 4, 5, 6</td>
<td>1, 2, 3</td>
<td>1 (i-iii), 2 (i-vii)</td>
<td>N/A</td>
</tr>
<tr>
<td>D</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1, 2, 3</td>
</tr>
</tbody>
</table>

A. Does the facility have a severe hypertension or preeclampsia policy and procedure updated within the past 3 years that provides a standard approach for measuring blood pressure, treatment of severe hypertension or preeclampsia, administration of magnesium sulfate, and treatment of magnesium sulfate overdose?

B. Have any of the severe hypertension and preeclampsia processes (i.e. order sets, tracking tools) been incorporated into the facility’s electronic health record?

C. Has the facility developed obstetric-specific resources and protocols to support patients, families, and staff through major obstetric complications?

D. Has the facility established a system to perform regular formal debriefs and system-level reviews on all cases of severe maternal morbidity or major obstetric complications?
Compliance on the structure and process measures would be based on the 4 “Rs” criteria from the Council on Patient Safety in Women’s Health Care Severe Hypertension in Pregnancy which is listed below:

Readiness - Every Unit:

1. Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
2. Unit education on protocols, unit-based drills (with post-drill debriefs)
3. Process for timely triage and evaluation of pregnant and postpartum women with hypertension including Emergency Department (ED) and outpatient areas
4. Rapid access to medications used for severe hypertension/eclampsia:
5. Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include brief guide for administration and dosage.
6. System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

Recognition and Prevention - Every Patient:

1. Standard protocol for measurement and assessment of BP and urine protein for all pregnant and postpartum women
2. Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST and ALT)
3. Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia

Response - Every case of severe hypertension/preeclampsia:

1. Facility-wide standard protocols with checklists and escalation policies for management and treatment of:
   i. Severe hypertension
   ii. Eclampsia, seizure prophylaxis, and magnesium over-dosage
   iii. Postpartum presentation of severe hypertension/preeclampsia
2. Minimum requirements for protocol
   i. Notification of physician or primary care provider if systolic BP =/> 160 or diastolic BP =/> 110 for two measurements within 15 minutes
   ii. After the second elevated reading, treatment should be initiated ASAP
   iii. (preferably within 60 minutes of verification)
   iv. Includes onset and duration of magnesium sulfate therapy
   v. Includes escalation measures for those unresponsive to standard treatment
   vi. Describes manner and verification of follow-up within 7 to 14 days postpartum
   vii. Describe postpartum patient education for women with preeclampsia

Reporting/Systems Learning - Every Unit:

1. Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
2. Multidisciplinary review of all severe hypertension/eclampsia cases admitted to Intensive Care Unit (ICU) for systems issues Monitor outcomes and process metrics
Process Measures:

Process measures must be reported, and points can be earned by reporting data for all three process measures A, B, and C.

A. How many drills on maternal safety topics were performed in the facility during the past quarter or year?

B. What proportion of maternity care providers and nurses have completed a bundle or unit protocol-specific education program on severe hypertension and preeclampsia within the past 2 years?

C. How many women with sustained severe hypertension received treatment according to protocol within 1 hour of detection?

Outcome Measures:

Outcome measures will be calculated by the Department using claims data.

Denominator: All women during their birth admission (excluding those with ectopic pregnancies and miscarriages) with one of the following diagnosis codes:

- Gestational hypertension
- Severe preeclampsia
- HELLP syndrome
- Eclampsia
- Preeclampsia superimposed on pre-existing hypertension
- Chronic hypertension


Scoring

In order to receive full points, hospitals must answer Structure measure 1 and two of the three remaining measures (2,3,4) as well as all Process measures. Structure and Process Measures are each scored on an all-or-nothing basis.
e. Reproductive Life/Family Planning

Facilities must attest that this measure has been in place since May 1st, 2019 and is for all patients regardless of insurance status.

The proposed measure is a process measure where hospitals will attest that they have a program in place that offers counseling about all forms of postpartum contraception in a context that allows informed decision making. Immediate postpartum long-acting reversible contraception (LARC) should be offered as an effective option for postpartum contraception. The immediate postpartum period can be a particularly favorable time for discussion and initiation of contraceptive methods, including LARC.

If a hospital does not offer contraception counseling for religious or other reasons, it should attest that there is a program in place that offers counseling on reproductive life/family planning and describe how they communicate what family planning services are available.

Measure Criteria

The Department will calculate LARC insertion rates using the following claims-based measure: NQF #2902 Contraceptive Care - Postpartum (U.S. Office of Population Affairs)

Among women ages 15 through 44 who had a live birth, the percentage that is provided:

- A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) method of contraception within 3 days of delivery.
- A long-acting reversible method of contraception (LARC) within 3 days of delivery.

Scoring

- Pay for reporting, hospitals will attest that they have program in place that offers counseling about all forms of postpartum contraception or that they offer counseling on reproductive life/family planning. Hospitals are required to upload evidence or descriptions of their processes or policies.
• Points will be earned on an all or nothing basis.

f. Incidence of Episiotomy

This measure is a claims-based outcome measure. The measure is NQF# 0470 Incidence of Episiotomy - Percentage of vaginal deliveries (excluding those coded with shoulder dystocia) during which an episiotomy is performed.

Measure Criteria

Numerator: Number of episiotomy procedures (ICD-9 code 72.1, 72.21, 72.31, 72.71, 73.6; ICD-10 PCS:0W8NXZZ performed on women undergoing a vaginal delivery (excluding those with shoulder dystocia ICD-10; O66.0) during the analytic period- monthly, quarterly, yearly etc.

Denominator: All vaginal deliveries during the analytic period- monthly, quarterly, yearly etc. excluding those coded with a shoulder dystocia ICD-10: O66.0).

Scoring

• Scoring will be based on a ranking basis.

2. Patient Safety Group

These measures are mandatory for all hospitals is based on calendar year 2019 and is for all patients regardless of insurance status.

This measure is designed to promote patient safety in hospitals. Definitions, criteria and reporting requirements for each of these activities is provided below.

1. Hospital Acquired Clostridium Difficile Infections
2. Sepsis
3. Antibiotics Stewardship
4. Adverse Event Reporting
5. Culture of Safety Survey
6. Handoffs and Signouts
   I. Hospital Acquired Clostridium Difficile (C.diff) Infections

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. The Department will pull hospital data from that report. Hospitals that do not submit C. Diff data to NHSN will receive a zero for this element.

II. Sepsis

This process measure focuses on systems in place for improving the early identification and treatment of sepsis. Hospitals must:

1. Describe the protocols and alerts your facility has in place for identifying sepsis and for treating sepsis. If the protocols are different for different levels of care (e.g. ED vs inpatient), please describe the protocols and their differences.

2. Describe and provide evidence of the training that your facility has in place for orienting new providers and staff to your facility’s systems and protocols for addressing suspected sepsis cases.

3. Describe and provide evidence of the process of providing regular feedback to providers on sepsis identification and treatment results.

4. Provide process measures and/or outcome measures your facility uses for tracking sepsis identification and treatment as well as any results for the purposes of quality improvement.

I. Antibiotics Stewardship

This measure is based on the work that the Colorado Department of Public Health and Environment (CDPHE), the Colorado Hospital Association (CHA), Colorado Health Care Association (CHCA), and Telligen have done on antibiotic stewardship working towards developing an Antibiotic Stewardship Honor Roll. This measure has four levels which will correspond to a tiered point structure. The levels are cumulative, e.g a hospital must achieve Level I to potentially achieve Level II. As proposed will have four levels as shown below.

Level 1, Commitment: The hospital demonstrates leadership support for antibiotic stewardship and has an antibiotic
stewardship committee that includes a physician and pharmacist that meets at least quarterly.

**Level 2, Education:** The hospital meets criteria for Level 1, as well as the following:

1. implements facility-specific treatment recommendations for common conditions, including community-acquired pneumonia, urinary tract infection, and skin and soft-tissue infection,
2. distributes an antibiogram annually or biannually, and
3. provides education to clinicians and other relevant staff on improving antibiotic prescribing at least annually.

**Level 3, Guidance:** The hospital meets criteria for Level 1 and Level 2, as well as the following:

1. implements one or more broad interventions to improve antibiotic use, such as antibiotic pre-authorization, prospective audit with feedback, antibiotic time-outs, or pharmacy-driven interventions designed for the antibiotic stewardship program, such as automatic alerts for, and de-escalation of, unnecessarily duplicative therapy, or time-sensitive automatic stop orders,
   - tracks antibiotic use (days of therapy or defined daily doses), and
2. reports antibiotic use to prescribers at least once every 6 months.

**Level 4, Collaboration:** The hospital meets criteria for Level 1, Level 2, and Level 3 as well as the following during the measurement period:

1. Collaborates with one or more facilities, such as other hospitals or long-term care facilities, to implement coordinated antibiotic stewardship, and
II. reports antibiotic use to the National Healthcare Safety Network (3 or more months).

Measure Details

Each level is cumulative, a hospital has to meet the conditions and provide documentation and supporting evidence for the highest level it wishes to obtain as well as those below it. (e.g. to achieve level 3 hospitals must meet the criteria and submit documentation that meets levels 1 - 3).

Level 1: Hospitals must answer yes to the following questions and provide supporting documentation:

I. Does your hospital have formal, written support from leadership (e.g., a policy statement) that supports efforts to improve antibiotic use (antibiotic stewardship)?

II. Is there a physician leader responsible for program outcomes of stewardship activities at your hospital?

III. Is there a pharmacist leader responsible for working to improve antibiotic use at your hospital?

IV. Is there an antibiotic stewardship committee that meets at least quarterly?

Documentation:

I. Documentation should include dates of antibiotic stewardship committee meetings and include the names and position descriptions of attendees (e.g., “physician leader”).

II. *Letter of support*: The letter must indicate support for improving antibiotic stewardship and attest that there is an antibiotic stewardship committee that includes physician and pharmacist leaders and meets at least quarterly.

Level 2: Does your hospital have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for the following common conditions (must answer yes to all)?

I. Community-acquired pneumonia

II. Urinary tract infection
III. Skin and soft-tissue infection

IV. Does your hospital produce an antibiogram (cumulative antibiotic susceptibility report) and distribute the antibiogram to prescribers annually or every other year?

V. Does your stewardship program provide education to clinicians and other relevant staff on improving antibiotic prescribing at least annually?

Documentation:

I. Upload evidence of facility-specific treatment guidelines based on national guidelines for community-acquired pneumonia, urinary tract infection, and skin and soft-tissue infection

II. Indicate general references to the national guidelines upon which facility-specific guidelines are based (e.g., Infectious Diseases Society of America).

III. Dates and topics of education to clinicians and staff, must include at least 1 training during the measurement period,

IV. Provide the date of the hospital’s latest antibiogram

V. Letter of support: including the information outlined in Level I as well as an attestation to the availability of facility-specific treatment guidelines based on national guidelines and attest to the education of clinicians and staff on antibiotic stewardship at least annually.

Level 3:

a. Does your hospital conduct any of the following broad interventions to improve antibiotic use? (yes to one or more)

I. Do specified antibiotic agents need to be approved by a designated physician or pharmacist prior to dispensing (i.e., pre-authorization) at your hospital?

II. Does a designated physician or pharmacist routinely review courses of therapy for specified antibiotic agents and provide verbal or written feedback to prescribers with 72 hours after
the initial orders (i.e., prospective audit with feedback) at your hospital?

III. Is there a formal antibiotic time-out procedure during which clinicians review the appropriateness of antibiotics within 72 hours after the initial orders?

IV. Pharmacy-driven interventions for antibiotic stewardship including at least one of the following:

a. automatic alerts and de-escalation of therapy in situations where therapy might be unnecessarily duplicative,

or time-sensitive automatic stop orders for specified antibiotic prescriptions?

b. Does your hospital monitor antibiotic use (consumption) at the unit and/or hospital-wide level by one of the following metrics? (yes to one or more)

I. By counts of antibiotic(s) administered to patients per day (Days of Therapy; DOT). DOT is defined as an aggregate sum of days for which any amount of a specified antimicrobial agent is administered or dispensed to a particular patient (numerator) divided by a standardized denominator (e.g., patient-days, days present, or admissions).

a. By number of grams of antibiotics used (Defined Daily Dose, DDD)? (DDD is defined as the aggregate number of grams of each antibiotic purchased, dispensed, or administered during a period of interest divided by the World Health Organization-assigned DDD and divided by a standard denominator (e.g., patient-days, days present, or admissions)).

b. Does your hospital report information to staff on improving antibiotic use and resistance? (yes to one or more)

I. Does your stewardship program share facility-specific reports on antibiotic use with prescribers at least once every 6 months?
II. Do prescribers receive direct, personalized communication about how they can improve their antibiotic prescribing at least once every 6 months?

Documentation:

I. Provide a description of the process for the above intervention(s) (pre-authorization, prospective audit with feedback, antibiotic time-out, or pharmacy-driven intervention), including:
   a. What antimicrobial agents are targeted by the intervention,
   b. Who implements the intervention,
   c. How the intervention is implemented, AND
   d. When the intervention is implemented (during the course of patient care).

II. Provide a description of how DOT or DDD are measured, and

III. what antibiotic utilization information is reported to prescribers and how. Include examples of antibiotic utilization reports.

IV. Letter of support including the information outlined in Levels 1 and 2 as well as:
   a. The letter must attest to facility practice of one or more of the above broad interventions to improve antibiotic use (antibiotic pre-authorization, prospective audit with feedback, antibiotic time-out, or pharmacy interventions), the tracking of antibiotic days of therapy or defined daily doses, and the report of antibiotic use data to prescribers at least once every six months.

Level 4: In order to achieve this level, the hospital must complete both activities.

I. Has your hospital collaborated with one or more facilities, such as other hospitals or long-term care facilities, to implement coordinated antibiotic stewardship?
a. Examples include shared infectious diseases physician or pharmacy oversight of antibiotic stewardship activities among multiple facilities, implementation of broad interventions to improve antibiotic use as defined for Level 3, Guidance, to multiple facilities, multi-facility efforts to track and report antibiotic use, or participation in a state or national public health collaborative.

II. Does your hospital regularly report antibiotic use data to NHSN via the Antibiotic Use and Resistance Module (3 or more months during the measurement period)?

Documentation:

III. Description and evidence of the dates of collaboration, the name and facility type of collaborating facilities, and a description of the coordinated intervention.

IV. Provide the dates of reporting antibiotic use data to NHSN, as well as evidence of the reporting.

V. Letter of support to include all of the information in Levels 1-3 and letter must attest to hospital participation in collaborative antibiotic stewardship efforts with other healthcare facilities and report of ≥3 months of antibiotic use data to NHSN.

VI. Adverse Event Reporting

1. Must allow anonymous reporting.

2. Reports should be received from a broad range of personnel.

3. Summaries of reported events must be disseminated in a timely fashion.

4. A structured mechanism must be in place for reviewing reports and developing action plans.

VII. Handoffs and Signouts

Step 1: Hospitals must identify the areas of handoffs and signouts that they need to improve on and focus on the area that has the most need. Hospitals should look at both areas that have the
greatest need for improvement and areas with the highest severity of potential harm. This can be accomplished by reviewing the results of their patient safety survey or other means. These handoffs and signouts can be between different levels of care, between departments, or other areas where providers transition care between themselves or other hospital staff.

1. Hospitals must provide a narrative description of the area they are addressing. They should provide evidence that quality needs to be improved in this area. Examples of transitions include:

   I. Operating room to intensive care unit
   II. Emergency department to inpatient
   III. Intensive care unit to floor
   IV. Perioperative services to next level of care
   V. Intraoperative: provider to provider
   VI. Postoperative: OR to Post Anesthesia Care Unit (PACU)

Step 2: Hospitals must describe the process they are using to address handoffs and transitions by doing the following:

1. Identify the leader of the initiative.
2. Describe the actions being taken to improve handoffs and signouts.
3. Document any standardized methodologies or mnemonics being implemented (e.g IPASS, SBAR, etc.)
4. Document any training that has been done in the past year to address this issue or training plans to be conducted.

Step 3: Hospitals must describe how they will measure the implementation and performance of the program and complete the following tasks:

1. Describe how it plans to measure progress on this initiative in HQIP 2021
2. Potential measurement strategies include:

I. Tracking how many times a handoff or signout uses the appropriate protocol

II. Reviewing incident reports and documenting the times there are handoff issues pre-intervention vs post-intervention
   a. Assess the extent of communication issues during handoffs
   b. Note which types of communication issues are attributed to handoffs based on information in incident reports

III. Handoff direct observation (pre-intervention and post-intervention)
   a. Record presence or absence of key elements
   b. Analyze quality (presence of distractions, attentiveness of speaker and recipient, asking important clinical questions etc.)

IV. Surveys to providers and staff about their perceptions of handoff process/perceived barriers to improvements in the handoff process

V. Examples based on care settings:
   a. Operating Room (OR) to Intensive Care Unit (ICU):

VI. Review handoffs using the following:
   a. Handoff assessment tool (checklist of items essential to reports from the transmitting OR team to the receiving ICU team)
   b. Past medical history, reason for ICU admission, allergies, airway, breathing/ventilation, circulation/hemodynamics, inputs, outputs, drains/lines, complications, plan, team contact information, and family information
c. Score the quality of hand off delivery (concise, clear, and organized hand-offs receive higher scores)

d. Score the recipient based on eye contact, affirmatory statements, head nodding, note taking, and question asking.

3. Transfer to ICU:

   I. Analyze critical messages (CM) for the following information:
      a. Time till Rapid Response Team (RRT) activation
      b. Message quality
      c. Presence of vitals
      d. Quality/timeliness of physician response

4. Hospitals must document the process of communicating feedback on handoffs and signouts to hospital staff to facilitate continuous improvement.

Scoring

- For Hospital Acquired Clostridium Difficile infections points will be earned based on hospital performance over self, with points earned for maintaining the same rate or improving.
- Adverse Event Reporting and Culture of Safety Survey are pay for reporting; points will be earned on an all or nothing basis.
- Culture of Safety Survey will be scored on an all or nothing basis.
- Sepsis will be scored on all or nothing basis.
- Antibiotics Stewardship will be scored based on achieved tiers.
- For Handoffs and signouts will scored on an all or nothing basis.

3. Patient Experience Group

   II. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
The Department will collect data for three HCAHPS composites from Hospital Compare:

1. Composite 5: Communication About Medicines (questions 16, 17)
2. Composite 6: Discharge Information (questions 19, 20)
3. Complex 7: Care transition (questions 23, 24, 25)

III. Advance Care Planning (ACP)

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 2019 to the Department. Sampling is allowed. There is no minimum denominator for this measure.

Hospitals are also required to 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.

**Scoring**

- Each HCAPHS Composite measure will be evaluated independently using a ranking method. Points will be earned based on quartile tiering; the top quartile will receive maximum points, the second and third quartiles will receive lower tier of points, and the lowest quartile will receive no point.

- Advanced Care Planning will be scored by setting a performance threshold and then awarding points based on rank. Only those above the performance threshold earn points.
III. Maintenance Measures

Maintenance Measures are those 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 perinatal care measure set. The data source for this measure is Hospital Compare.

IV. Sampling

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

<table>
<thead>
<tr>
<th>Annual number of patients meeting measure denominator</th>
<th>Minimum required sample size “n”</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;=1551</td>
<td>311</td>
</tr>
<tr>
<td>391-1551</td>
<td>20% of discharges in denominator</td>
</tr>
<tr>
<td>78-390</td>
<td>78</td>
</tr>
<tr>
<td>0-77</td>
<td>No sampling, 100% of the patient population is required</td>
</tr>
</tbody>
</table>
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.