Quality Performer Spring Users Group Meeting

Spring 2016

PRESS GANEY®

Welcome & Introductions

PRESS GANEY®

Important Reminders and Data Management Updates

Spring 2016

PRESS GANEY

Important Reminders & Data Management Updates

Overview

- Evaluations & CEU's
- Important Reminders
- Quality Performer Development Updates
- Educational Resources
- Data Transmission
- Authorizations
- Cross Product Reports
- Data Management Best Practice
  - Initial Patient Populations

PRESS GANEY

4

Evaluations and CEU Certificates

Remember:

Complete online evaluation within 10 business days following meeting

Certificates will be emailed approximately 2 months after the meeting

Be sure to include correct email address

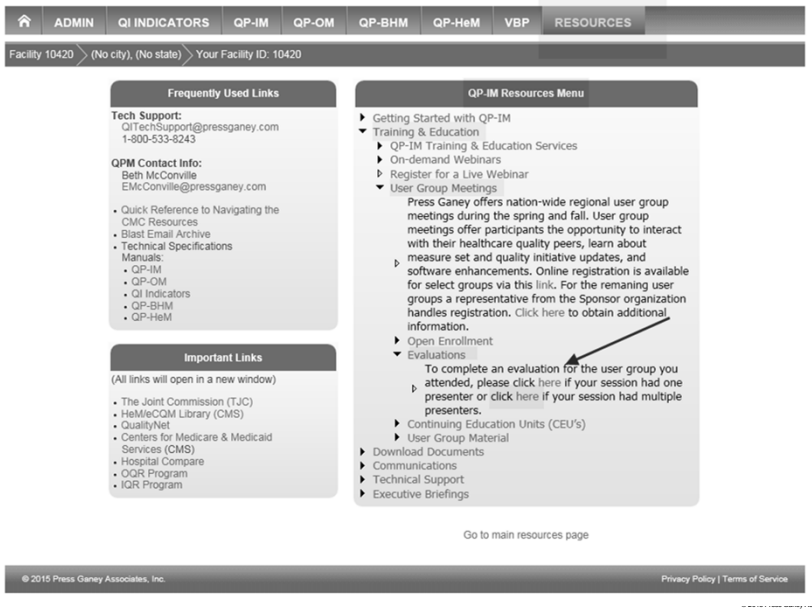
CEUs CAN NOT be provided without the online survey being completed within the timelines!

Directions for completing the survey are included in this presentation

PRESS GANEY®

5

Evaluations



Important Reminder

IQR & OQR QNet Administration Data Entry Reminders

- The system administrator for QNET needs to enter the following requirements directly into QNET:
  - Annually (04/01/16 through 05/15/16)
    - DACA
    - Influenza for HCP
    - IP and OP Structural Measures
    - Aggregate data (OP 29, 30 & 33)
  - Due quarterly
    - Web-based Measures (PC 01)
    - HCAHPS data
    - Population & Sampling (edits for chart abstracted measures)
    - HAI Measures
    - Clinical Process of Care Measures (vendor submitted)

Important Reminder

IPF QNet Administration Data Entry Reminders

- The system administrator for QNET needs to enter the following requirements directly into QNET:
  - Annually
    - DACA by 80/15/16
    - Influenza for HCP by 05/15/16
    - Structural Measures by 07/01/16 through 08/15/16
    - Chart-abstracted Measures by 07/01/16 through 08/15/16

QP & VBP Recent & Upcoming Development

Regulatory Biannual Updates for CMS/TJC and State Measure Reporting

- QP Core Measure updates for January 2016 discharges (4Q15/1Q16)
  - CMS/TJC updates for Inpatient Measures & Behavioral Health Measures (4Q)
    - CSV, Plus, Premium & Transmission changes (1Q)
  - CMS additional OM retroactive changes (announced 1/28/16) (1Q)
- QP Core Measure updates for July 2016 discharges (2Q)
  - CMS/TJC updates for Inpatient & Behavioral Health Measures
  - No changes for Outpatient Measures

Quality Performer HeM

- Patient list report added to Data Management Reports (1Q)
  - Ability to run report for multiple eMeasures
  - Ability to run report for multiple Measure Categories
- Dashboard and Usability enhancements (1Q)
  - Font and alignment changes
  - Medication route field changed to auto-fill fields
- QP Hospital eMeasures updates for 2017 eCQM requirements (pending regulatory changes)

QP & VBP Recent & Upcoming Development

Behavioral Health Measures

- Prospective Sampling for Behavior Health IPF Measures (Q1)

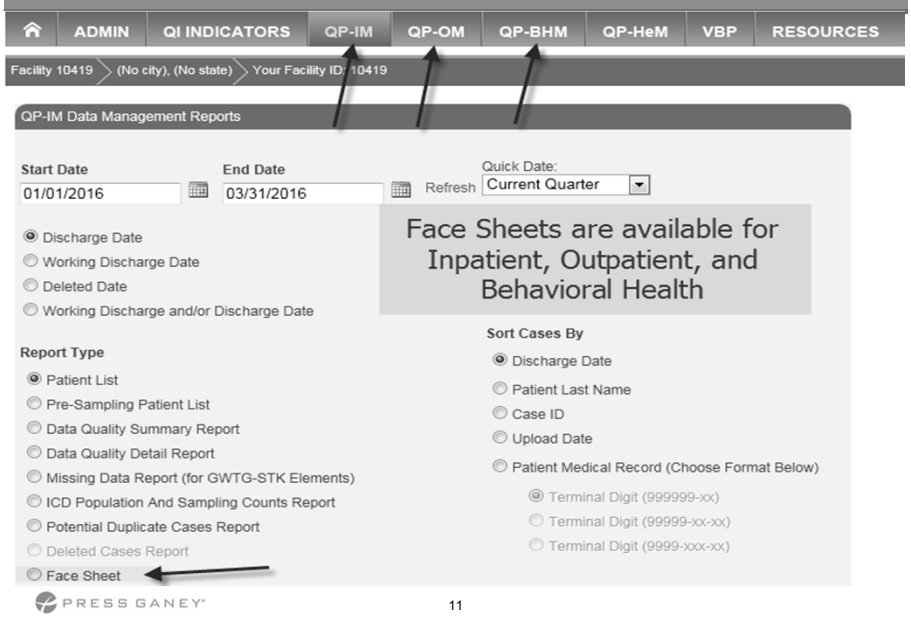
Reports and Analytics

- Added zip code information to Behavioral Health Measures CSV file (Q1)
- Increase the number of procedure codes displayed & analyzed (Q1)
  - Inpatient, Outpatient, & Behavioral Health Measures
- New option to run Rate Report for multiple measure sets (Q1)
- New Face Sheet report (Q1)
  - Blank Worksheets will no longer be available in reports area (only from Resources)
- Inpatient outstanding measures added to Premium Analytics (Q1)
  - Substance & Tobacco Cubes
- Sepsis Report (for July 2016 updates)

Annual Updates for Value Based Purchasing Calculator (VBP)

- Updated VBP with CMS FFY 2018 MedPar and Fiscal Year requirements (Q1)
- VBP Methodology Updates for 2016-2018 (Q1)

Face Sheets Available



PRESS GANEY

11

Paper Tools for Case Abstraction

These are maintained by CMS and are available at the following sites:

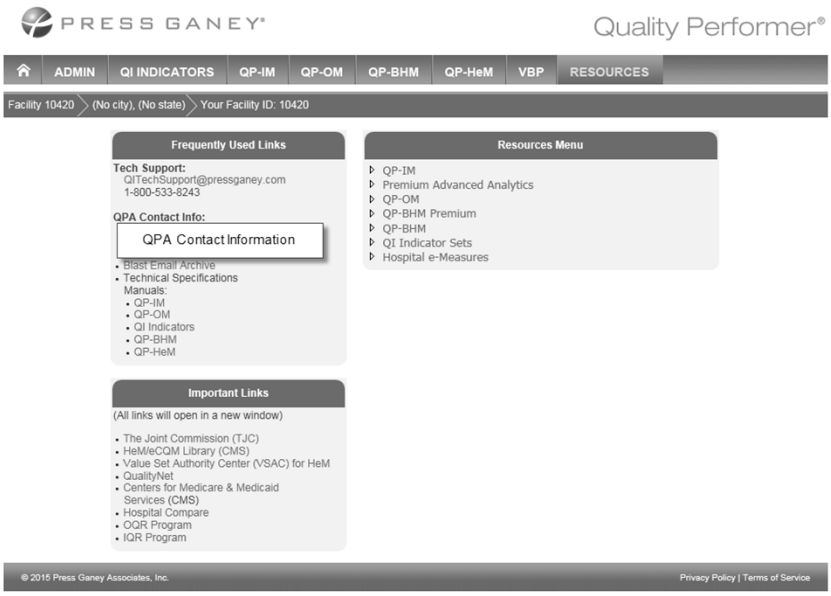
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1205442056833

PRESS GANEY

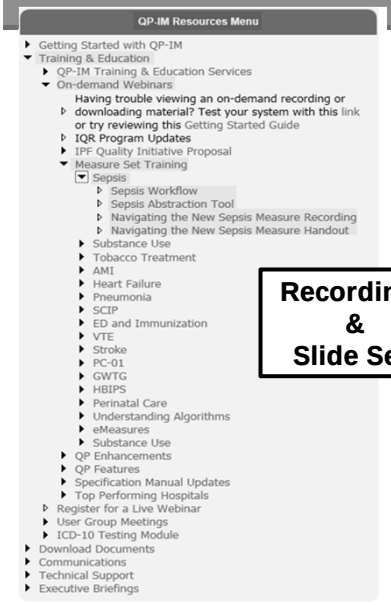
Behavioral Health – HSAG: http://www.qualityreportingcenter.com/inpatient/ipf/tools/

12

Support & Educational Resources



Educational Resources



Recordings & Slide Sets

- Individual Measure Set Trainings
  - Measure Lists
  - Measure Populations
    - Sepsis
    - HBIPS
    - eMeasures
  - Data Abstraction Guidelines
- Separate section for the Outpatient and Behavioral Health resources

PRESS GANEY

14

Quality Performer:

Data Transmission

PRESS GANEY

Data Transmission Services

- TJC / ORYX Transmission Service
- CMS / QNet Transmission Service
- Transmission Checklist
- GWTG Transmission Service

TJC Transmission

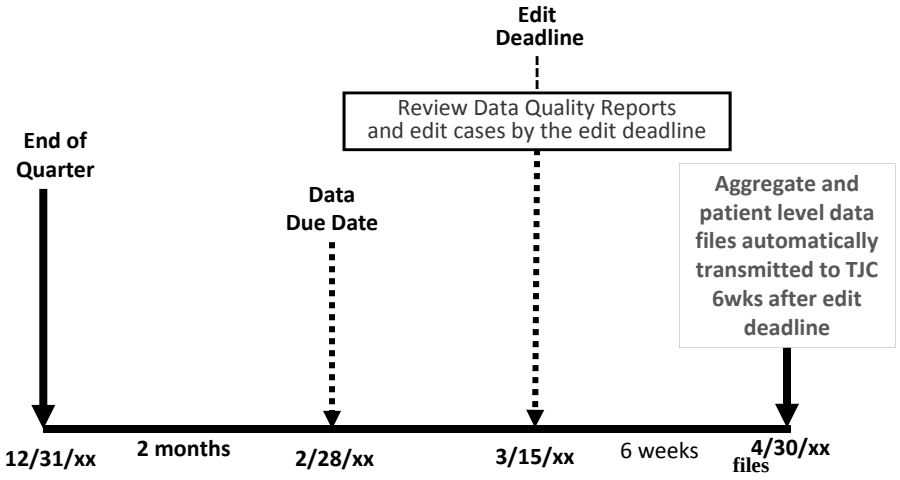
- The Joint Commission (TJC) Transmission Service:
  - One automatic quarterly transmission
    No action required from user
  - Patient-level and aggregate data
    - *Only cases uploaded by the Data Due Date are transmitted*
    - *They are transmitted "as is" on the Edit Deadline date*
  - May retransmit if data is incomplete
    - Fees apply

INPATIENT & OUTPATIENT DATA	
DATA DUE DATE TJC	EDIT DEADLINE TJC
05/31/20xx	06/15/20xx
08/31/20xx	09/15/20xx
11/30/20xx	12/15/20xx
02/28/20xx	03/15/20xx

TJC Transmission

- Data is transmitted only for measures TJC is expecting
- TJC measure selections for your facility are posted to Quality Performer/Admin Page/Joint Commission Selection Report
- Review the measure selections and notify TJC of any discrepancies or changes
- PG also requires an authorization form for measures to be transmitted to TJC

TJC Transmissions 4QXX

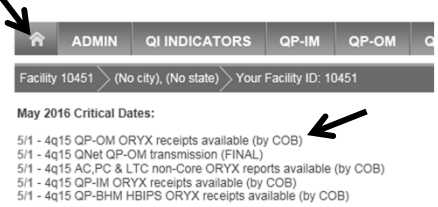


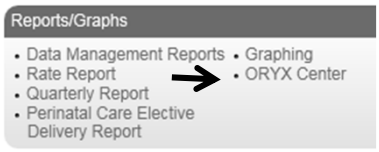
PRESS GANEY

19

TJC Transmission

After TJC Transmission Check ORYX Receipt





- Available date posted on Home Page
- Go to IM/OM tab
- Select ORYX Center on Reports/Graph menu
- Select ORYX Receipt
- Enter QTR, YR and Measure Set

PRESS GANEY

20

TJC Transmission

Sample Report

Report Type: ORYX Receipt
Report Period: Quarter 1 2014
Measure Set: Venous Thromboembolism (VTE)

Quality Performer℠
Data as of 03/15/2015

15971 VTE-1 VTE Prophylaxis

Facility Data						
	ICD Population	Numerator	Denominator	Observed Rate	Cases with Missing Data ('X')	Sample
Jan 2014	473	37	38	0.9737	0	Yes
Feb 2014	469	48	48	1.0000	0	Yes
Mar 2014	520	37	38	0.9737	0	Yes
Qtr 1 2014	**1462**	**122**	**124**	**0.9839**	**0**	**Yes**

15972 VTE-2 ICU VTE Prophylaxis

Facility Data						
	ICD Population	Numerator	Denominator	Observed Rate	Cases with Missing Data ('X')	Sample
Jan 2014	473	5	6	0.8333	0	Yes
Feb 2014	469	4	4	1.0000	0	Yes
Mar 2014	520	7	7	1.0000	0	Yes
Qtr 1 2014	**1462**	**16**	**17**	**0.9412**	**0**	**Yes**

15973 VTE-3 VTE Pts w/ Anticoag Overlap Rx

Facility Data						
	ICD Population	Numerator	Denominator	Observed Rate	Cases with Missing Data ('X')	Sample
Jan 2014	473	5	5	1.0000	0	Yes
Feb 2014	469	7	7	1.0000	0	Yes
Mar 2014	520	5	5	1.0000	0	Yes
Qtr 1 2014	**1462**	**17**	**17**	**1.0000**	**0**	**Yes**

This receipt confirms transmission of Core Measures data to TJC. The contents of this receipt reflect the HCO's database on the data due date.

PRESS GANEY

21

CMS Transmissions: Pop and Sample

- QNet Transmission Service:
  - Population & Sample Counts
    - One send 2 weeks before QNet deadline

POPULATION & SAMPLE	
PG Transmission CMS	QNET Deadline CMS
07/07/20xx	08/01/20xx
10/07/20xx	11/01/20xx
01/06/20xx	02/01/20xx
04/08/20xx	05/01/20xx

PRESS GANEY

22

CMS Transmissions: Pop and Sample

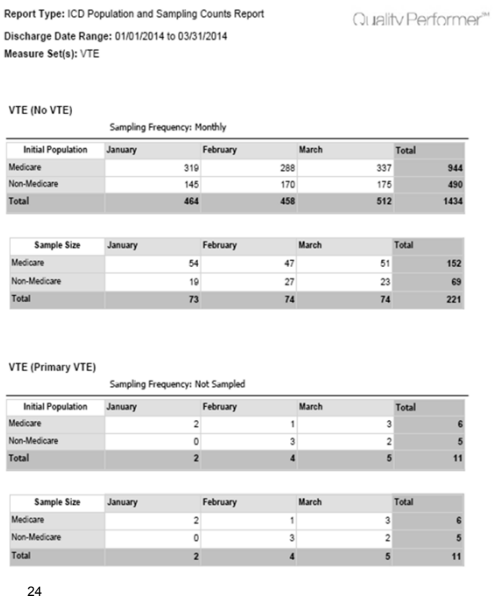
Automated Sample Size Adjustment Schedule

Time Period	TJC Auto Sample Adjust	Qnet Auto Sample Adjust
3q15	11/26/2015	1/10/2016
4q15	2/25/2016	4/10/2016
1q16	5/27/2016	7/11/2016
2q16	8/27/2016	10/11/2016
3q16	11/26/2016	1/10/2017
4q16	2/24/2017	4/10/2017

CMS Transmissions: Pop and Sample

- The data in the Population & Sampling Report is sent to CMS
- The facility is responsible for cross checking this data with an internal report of initial patient population
- If there are discrepancies the facility is responsible for making the edits in QNET

Sample Report



Report Type: ICD Population and Sampling Counts Report
QualityPerformer™
Discharge Date Range: 01/01/2014 to 03/31/2014
Measure Set(s): VTE

VTE (No VTE)
Sampling Frequency: Monthly

Initial Population	January	February	March	Total
Medicare	319	288	337	944
Non-Medicare	145	170	175	490
Total	464	458	512	1434

Sample Size	January	February	March	Total
Medicare	54	47	51	152
Non-Medicare	19	27	23	69
Total	73	74	74	221

VTE (Primary VTE)
Sampling Frequency: Not Sampled

Initial Population	January	February	March	Total
Medicare	2	1	3	6
Non-Medicare	0	3	2	5
Total	2	4	5	11

Sample Size	January	February	March	Total
Medicare	2	1	3	6
Non-Medicare	0	3	2	5
Total	2	4	5	11

CMS Transmissions: Inpatient & Outpatient Data

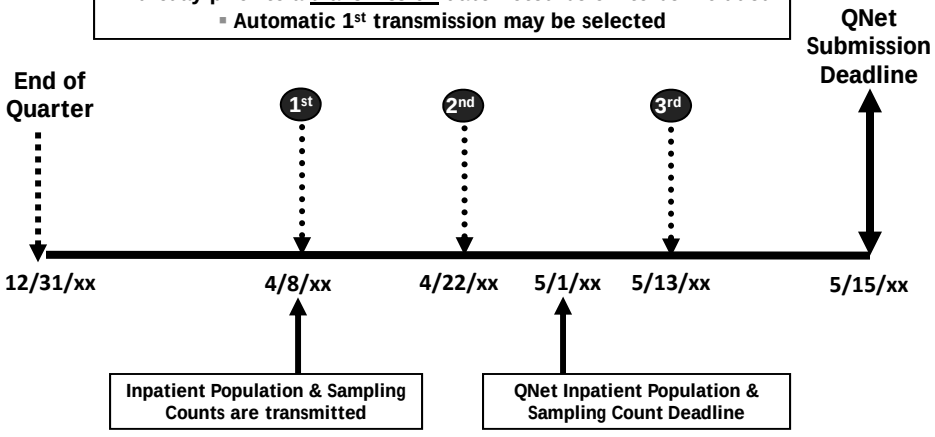
- IP & OP Patient Level Data
  - Multiple transmission opportunities each quarter
    - Inpatient: 2nd and 4th Friday of the month after the quarterly edit deadline
    - Outpatient: 1st and 3rd Friday of the month after the quarterly edit deadline
      - ➢ If there's a 5th Friday in a month, there is no transmission that day

PRESS GANEY

25

CMS IP Transmissions 4Qxx

- **3 scheduled inpatient QNet transmissions after the edit deadline**
- **Send page requests must be completed on or before 23:59 the Thursday prior to a *transmission* *date* noted below to be included**
- **Automatic 1st transmission may be selected**

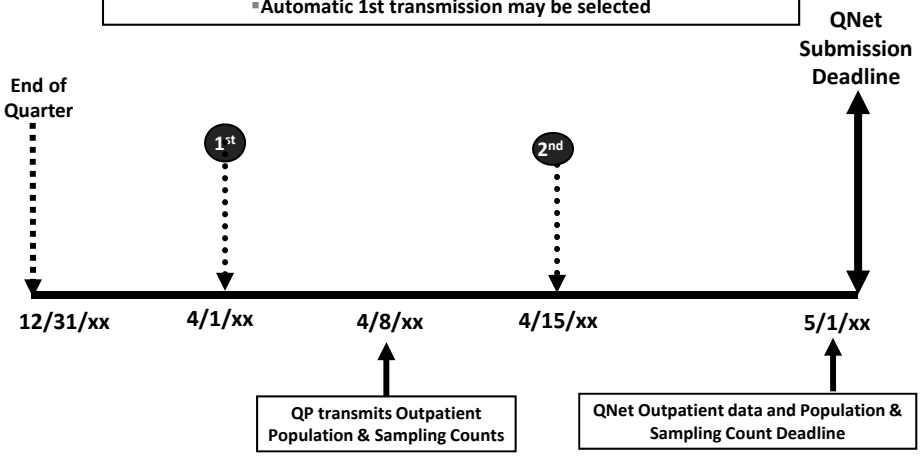


PRESS GANEY

26

CMS OP Transmissions 4Qxx

- 2 scheduled outpatient QNet transmissions after the edit deadline
- Send page requests must be completed on or before 23:59 the Thursday prior to a ***transmission date*** noted below to be included
- Automatic 1st transmission may be selected



PRESS GANEY

27

CMS Transmissions

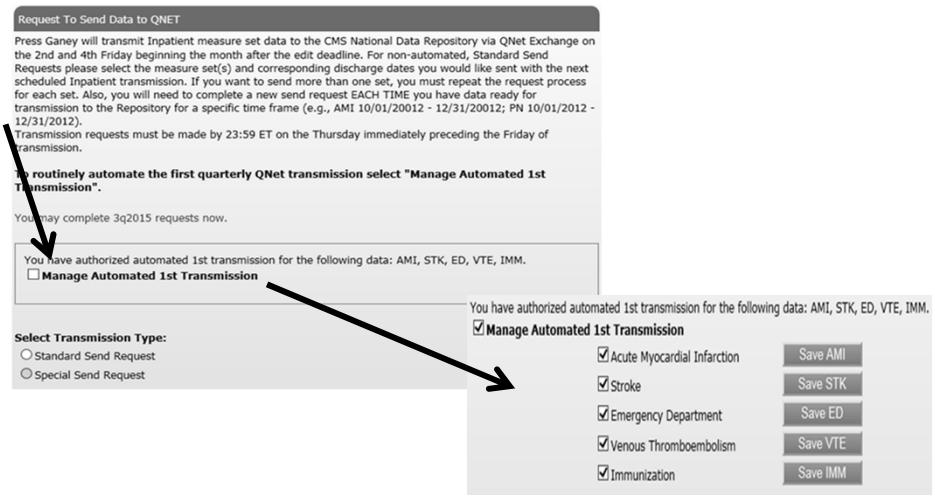
- QNet measure selections revisions for a quarter MUST be made BEFORE any cases for that quarter have been transmitted to QNet
- Once cases have been accepted, measure selection for that quarter is disabled
- Check to confirm all measure selections in QNet are correct each quarter BEFORE completing any transmission requests

PRESS GANEY

28

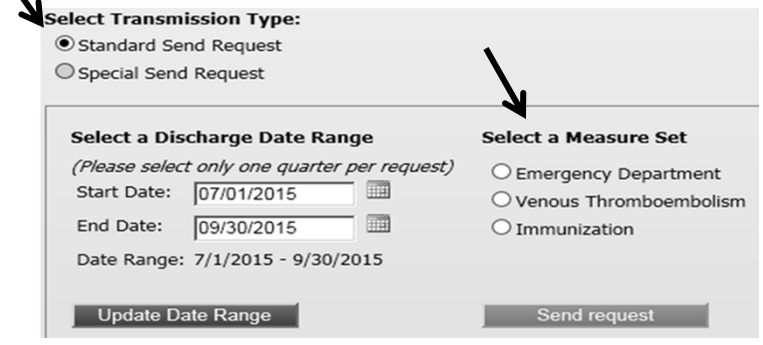
CMS Transmissions: Facility Responsibility

First transmission can be automated. This is a facility decision.



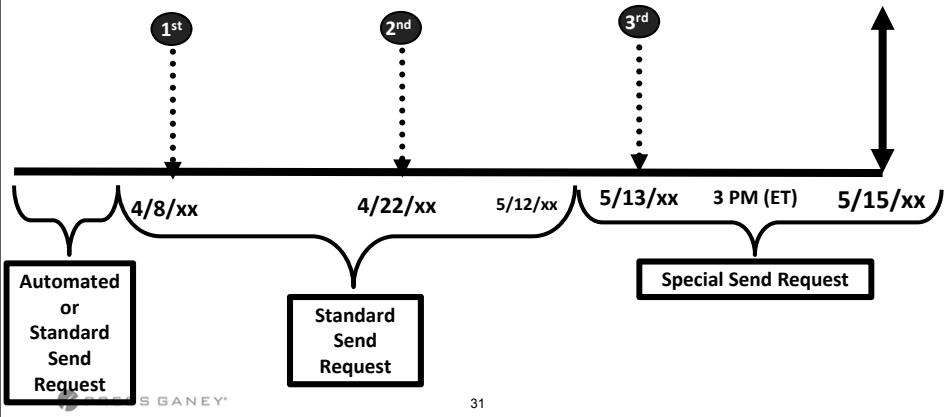
CMS Transmissions: Facility Responsibility

- Complete a Transmission request for each applicable measure set **each time** cases should be transmitted or each time requesting a transmission after the 1st automated transmission



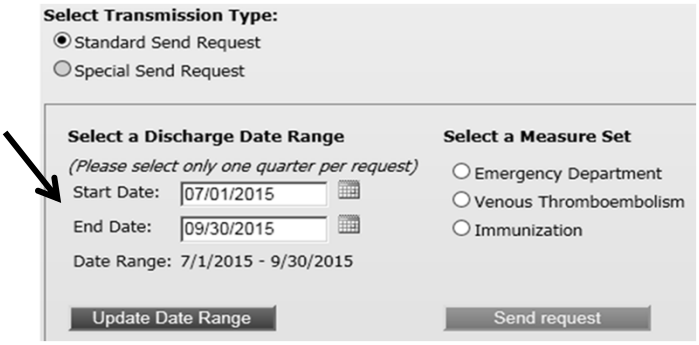
CMS Transmissions: Facility Responsibility

- What is the difference between a **Standard Send request** and a **Special Send request**?
- It's all about the timing



CMS Transmissions: Facility Responsibility

- Selecting a date range for transmission:
  - Inpatient: A Discharge Date range of one day to one full quarter can be selected
  - Outpatient: An Encounter Date range of one day to one full quarter can be selected



CMS Transmissions: Facility Responsibility

- Transmission requests must be completed on or before 23:59 ET the Thursday prior to a scheduled Friday transmission for cases to be included

Request To Send Data to QNET

Press Ganey will transmit Inpatient measure set data to the CMS National Data Repository via QNet Exchange on the 2nd and 4th Friday beginning the month after the edit deadline. For non-automated, Standard Send Requests please select the measure set(s) and corresponding discharge dates you would like sent with the next scheduled Inpatient transmission. If you want to send more than one set, you must repeat the request process for each set. Also, you will need to complete a new send request EACH TIME you have data ready for transmission to the Repository for a specific time frame (e.g., AMI 10/01/20012 - 12/31/20012; PN 10/01/2012 - 12/31/2012).

Transmission requests must be made by 23:59 ET on the Thursday immediately preceding the Friday of transmission.

- OP & IP Transmission requests are submitted separately

PRESS GANEY®

Transmission Calendar

PRESS GANEY®

Press Ganey IP and OP Submission Deadlines

The Critical Dates Calendar within QP takes precedence over this calendar

TIME PERIOD	IP & OP Data				ICD Population Recount	Pop & Sample		TJC	QNet Deadlines		ICD Population Recount	Aggregate Data *Facility Responsible For Data Entry into QNet*			
	TJC	TJC	CMS	CMS	TJC	CMS	CMS	TJC	CMS	CMS	TJC	PC-01	IPF Program Data	OP Web-Based Measures	IP Web-Based Measures
Discharge Quarter	Data Due Date	Edit Deadline	OP Data Transmission	IP Data Transmission	Posted in Data Center	PG Transmission	QNet Deadline	Transmission (6 weeks after Edit Deadline)	OP	IP	Deadline	Submission Period	Annual Data Submission	Annual Data Submission	Annual Data Submission
1q16	5/31/16	6/15/16	**7/1/16** 7/15/16	**7/8/16** 7/22/16 8/5/16 8/12/16	7/01/16	7/06/16	8/1/16	7/31/16	8/1/16	8/15/16	8/31/16	7/1 - 8/15/16	Submit 2015 Data 7/1 – 8/16/16	Submit 2015 Data 1/1 – 5/15/16	Submit 2015 Data 4/1 – 5/15/16
2q16	8/31/16	9/15/16	**10/7/16** 10/21/16	**10/14/16** 10/28/16 11/11/16	10/1/16	10/05/16	11/1/16	10/31/16	11/1/16	11/15/16	11/30/16	10/1 - 11/15/16			
3q16	11/30/16	12/15/16	**1/6/17** 1/20/17	**1/13/17** 1/27/17 2/10/17	1/1/17	1/05/17	2/1/17	1/31/17	2/1/17	2/15/17	2/28/17	1/1 - 2/15/17			
4q16	2/28/17	3/15/17	**4/7/17** 4/21/17	**4/14/17** 4/28/17 5/12/17	4/1/17	4/06/17	5/1/17	4/30/17	5/1/17	5/15/17	5/31/17	4/1 - 5/15/17			

IP & OP: First transmission can be automatically sent, the remainder require a request to transmit

Note: Special Transmission requests are accepted after each of the final scheduled transmissions listed above up to 3pm ET on the CMS deadline

DQR & Raw Report Live	*Quarterly Report 2 weeks after Edit Deadline*	*Orgs Receipt day after TJC transmission*	*National Comparison Report From TJC 1-3 months after TJC transmission*

PRESS GANEY®

CMS Transmissions

- Review QNet Data Submission Detail reports after **EVERY** transmission
  - QNet Provider Reports are generally available the Tuesday following a Friday transmission
- Correct cases as necessary
- Complete New Transmission Requests to have corrected cases retransmitted to QNet before deadline

CMS Transmissions

- Review the Request Log after each transmission
- Check the status has changed to SENT and check the SEND DATE (send date is also a link to a patient list)

Request Log

* **Type:**
R - Standard Send Request;
A - Automated 1st Transmission Request;
S - Special Send Request.
** **Status:**
Pending - Request will be included in the next scheduled transmission to QNET;
In Process - Request is being processed;
Sent - Transmission to QNet complete, check your submission detail reports on QNet Exchange.
Outdated - Start/End Date requested are outdated.

○ Current Quarter ◉ Two Quarters ○ All Requests

Measure Set	SCIP Modules	Start Date	End Date	Request Date	Type*	Status**	Send Date	Delete Request?
IMM	--	7/1/2015	9/30/2015	1/6/2016	R	In Process		
VTE	--	7/1/2015	9/30/2015	1/6/2016	R	In Process		
ED	--	7/1/2015	9/30/2015	1/6/2016	R	In Process		
IMM	--	4/1/2015	6/30/2015	11/9/2015	R	Sent	11/12/2015	
VTE	--	4/1/2015	6/30/2015	11/9/2015	R	Sent	11/12/2015	
ED	--	4/1/2015	6/30/2015	11/9/2015	R	Sent	11/12/2015	

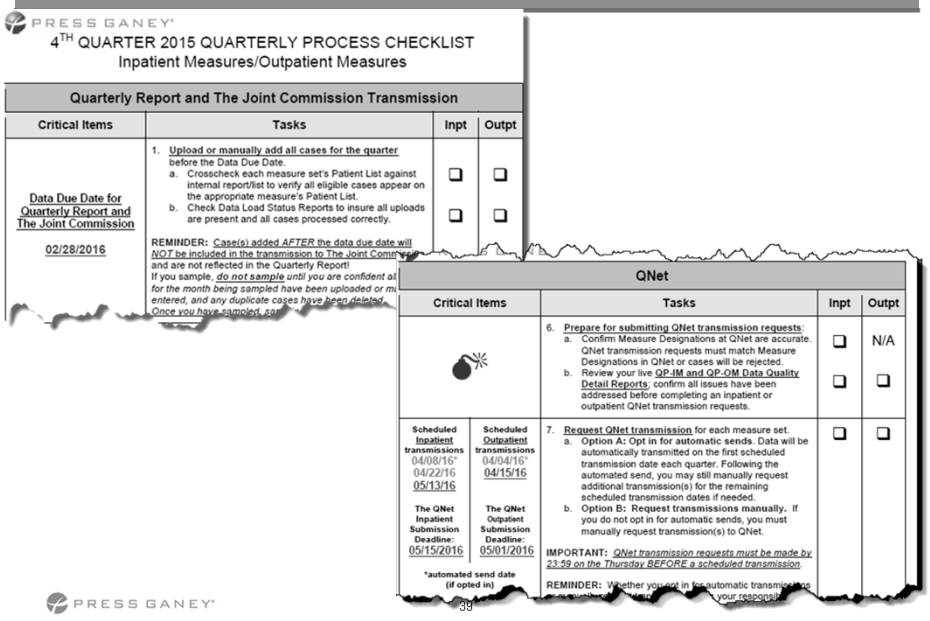
CMS Transmissions

- Editing data entry after a case is transmitted to QNet
  - Must request retransmission of that case
  - Must request original case be deleted from QNet if the case has been accepted and any of the following occur:
    - Edits remove the case from all measure sets
    - Edits move the case into a different measure set
    - Edits result in a duplicate case
      - Contact your QPA
      - Edit Pop & sample counts in QNet if necessary

CMS Transmissions

- If you miss the last scheduled QNet transmission and have cases that must still be transmitted:
  - It is **CRITICAL** that you call your QPA ASAP to request a "special transmission" to QNet before the QNet deadline**!**
- EXTREMELY IMPORTANT - <u>DO NOT</u> wait until the last minute!
  - Check your Inpatient and Outpatient QNet **Provider Participation Reports as soon as they become available (2 weeks BEFORE QNet's submission deadlines)** and confirm required case counts have been accepted

Process Checklist



PRESS GANEY

4TH QUARTER 2015 QUARTERLY PROCESS CHECKLIST
Inpatient Measures/Outpatient Measures

Quarterly Report and The Joint Commission Transmission

Critical Items	Tasks	Inpt	Outpt
Data Due Date for Quarterly Report and The Joint Commission 02/28/2016	1. Upload or manually add all cases for the quarter before the Data Due Date. a. Crosscheck each measure set's Patient List against internal report/list to verify all eligible cases appear on the appropriate measure's Patient List. b. Check Data Load Status Reports to insure all uploads are present and all cases processed correctly. REMINDER: Case(s) added *AFTER* the data due date will *NOT* be included in the transmission to The Joint Comm... and are not reflected in the Quarterly Report! If you sample, *do not sample* until you are confident al... for the month being sampled have been uploaded or m... entered, and any duplicate cases have been deleted. Once you have sampled, ...	❑ ❑	❑ ❑

QNet

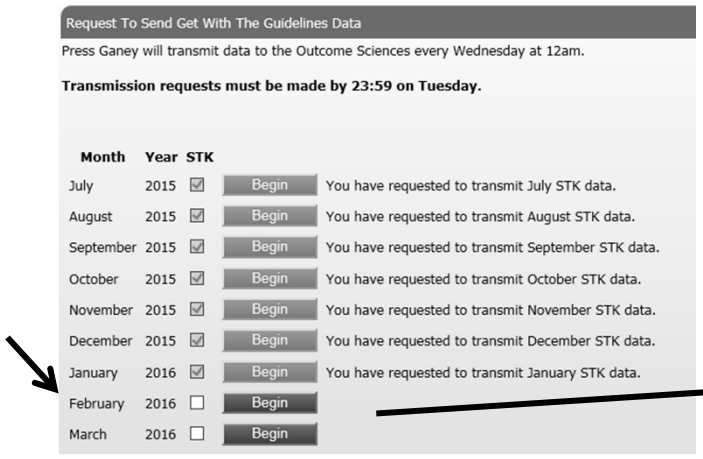
Critical Items	Tasks	Inpt	Outpt
	6. Prepare for submitting QNet transmission requests: a. Confirm Measure Designations at QNet are accurate. QNet transmission requests must match Measure Designations in QNet or cases will be rejected. b. Review your live QP-IM and QP-OM Data Quality Detail Reports; confirm all issues have been addressed before completing an inpatient or outpatient QNet transmission requests.	❑ ❑	N/A ❑
Scheduled Inpatient transmissions 04/08/16* 04/22/16 05/13/16 The QNet Inpatient Submission Deadline: 05/15/2016 Scheduled Outpatient transmissions 04/04/16* 04/15/16 The QNet Outpatient Submission Deadline: 05/01/2016 *automated send date (if opted in)	7. Request QNet transmission for each measure set. a. Option A: Opt in for automatic sends. Data will be automatically transmitted on the first scheduled transmission date each quarter. Following the automated send, you may still manually request additional transmission(s) for the remaining scheduled transmission dates if needed. b. Option B: Request transmissions manually. If you do not opt in for automatic sends, you must manually request transmission(s) to QNet. IMPORTANT: *QNet transmission requests must be made by 23:59 on the Thursday BEFORE a scheduled transmission.* REMINDER: Whether you opt in for automatic transmissions ... your responsibility ...	❑	❑

PRESS GANEY

39

GWTG Transmissions

- Electronic send request



Request To Send Get With The Guidelines Data

Press Ganey will transmit data to the Outcome Sciences every Wednesday at 12am.

Transmission requests must be made by 23:59 on Tuesday.

Month	Year	STK		
July	2015	☑	Begin	You have requested to transmit July STK data.
August	2015	☑	Begin	You have requested to transmit August STK data.
September	2015	☑	Begin	You have requested to transmit September STK data.
October	2015	☑	Begin	You have requested to transmit October STK data.
November	2015	☑	Begin	You have requested to transmit November STK data.
December	2015	☑	Begin	You have requested to transmit December STK data.
January	2016	☑	Begin	You have requested to transmit January STK data.
February	2016	☐	Begin	
March	2016	☐	Begin	

Once a request is submitted all the available STK cases are sent

PRESS GANEY

40

GWTG Transmissions

- Data transmitted to Quintiles on Wednesdays

GWTG Send Log

◉ Current Quarters ○ All Requests

Measure Set	Month	Year	Date Requested	Send date
STK	January	2016	02/01/2016	02/03/2016
STK	December	2015	02/01/2016	02/03/2016
STK	November	2015	01/19/2016	01/27/2016 01/20/2016

- After the month's send request is made new cases and modified cases are transmitted every subsequent Wednesday
- If there are no new cases or modified cases there is not an additional transmission

Authorization

QNET Authorization

- To authorize a third party vendor (Press Ganey) to submit data on a hospital's behalf,
  - access the online authorization process from the Secure Portal of QualityNet.
  - Vendor authorizations remain in effect until the hospital modifies the authorization.

QNET Authorization

In the "My Tasks" section find "Vendor Authorization"

- Select "ADD", "UPDATE" or "VIEW"
- Must have the Vendor Auth Role

QNET Authorization


Update Date(s) for Existing Vendor * Required Field PRINT

Vendor Name Vendor ID

Information
Vendor Authorization for ED or IMM will authorize clinical submissions for ED or IMM.
Information
Vendor Authorization for GLB will authorize population and sampling submissions for the Global initial patient populat

The vendor is to be authorized for the following measure set(s).

Measure Set	Discharge Date	Data Transmission Date
IQR-AMI	*Start / End	*Start / End
IQR-ED	*Start / End	*Start / End
IQR-GLB	*Start / End	*Start / End
IQR-HF	*Start / End	*Start / End
IQR-IMM	*Start / End	*Start / End
IQR-PC	Start 11/01/2014 / End	Start 09/27/2015 / End 06/30/2015

- Select the correct vendor; PG vendor ID is: V100063
- The “Data Transmission Date>Start” must be equal to or greater than the current date
- If ending a vendor auth it is recommended that the “Data Transmission Date>End” is not entered until all data has been transmitted
- Once an authorization has been submitted, the only dates that can be modified are future dates
- Vendor authorization takes effect immediately upon completion of the authorization

PRESS GANEY®

PRESS GANEY Authorization

AUTHORIZATION FORM FOR PRESS GANEY ASSOCIATES TO TRANSMIT DATA FOR THE HOSPITAL OUTPATIENT QUALITY DATA REPORTING PROGRAM (HOP QDRP)

To comply with the federal HIPAA privacy regulations, Press Ganey requires express written authorization to transmit your hospital's patient-level data to the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Quality Data Reporting Program Support Contractor, FMQAI.

Please complete this form and mail/fax it to:

Press Ganey Associates
6816 Deerpath Road
Elkridge, MD 21075-6234
Fax: 410-379-9551

_____ (the "Hospital"), of _____,
Hospital Name City, State

Quality Performer Facility Number _____, authorizes Press Ganey Associates (the "Project") to transmit patient-level data to the HOP QDRP support contractor, FMQAI. The Hospital authorizes the Project to transmit data for patients discharged with the clinical conditions for the following measure set:

Measure Set:	Effective with Encounters Beginning:
____ Hospital Outpatient Measures	_____

This authorization shall remain in effect until the Hospital sends written notice to the Project terminating the authorization, or until the Hospital's Agreement to Participate in the Project is terminated.

Hospital Authorization:

_____
Signature Date

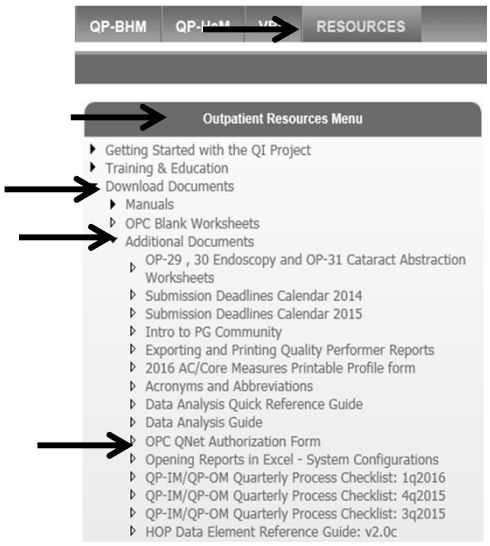
_____
Print Name and Title

_____
E-mail Telephone

- In addition to QNET Authorization Press Ganey requires the submission of an authorization form
- Submit a form when making changes to submission measures or when adding new measures for submission
- This authorization remains in effect until the facility sends a written notice terminating the authorization

PRESS GANEY Authorization

- Finding the PG form
  - Resources
  - Outpatient Resources
  - Download Documents
  - Additional Documents
  - OPC QNET Authorization Form



PRESS GANEY

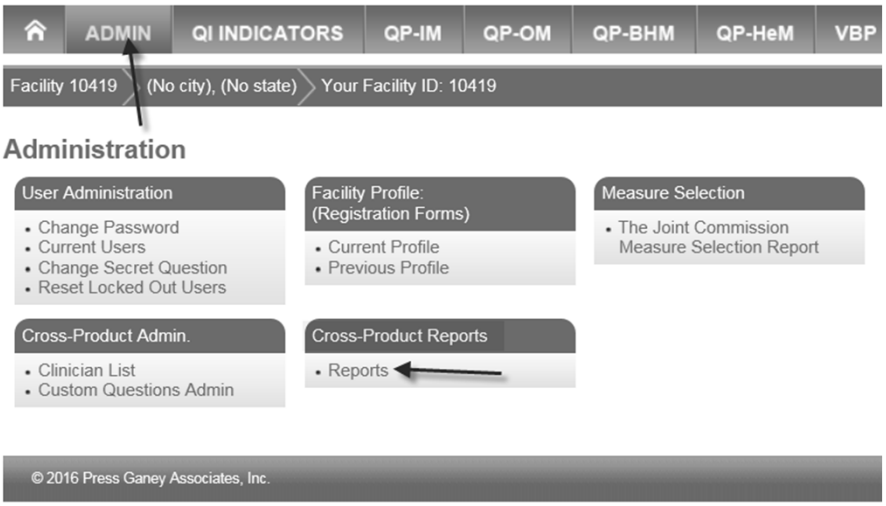
47

Quality Performer:

Cross Products Reports

PRESS GANEY

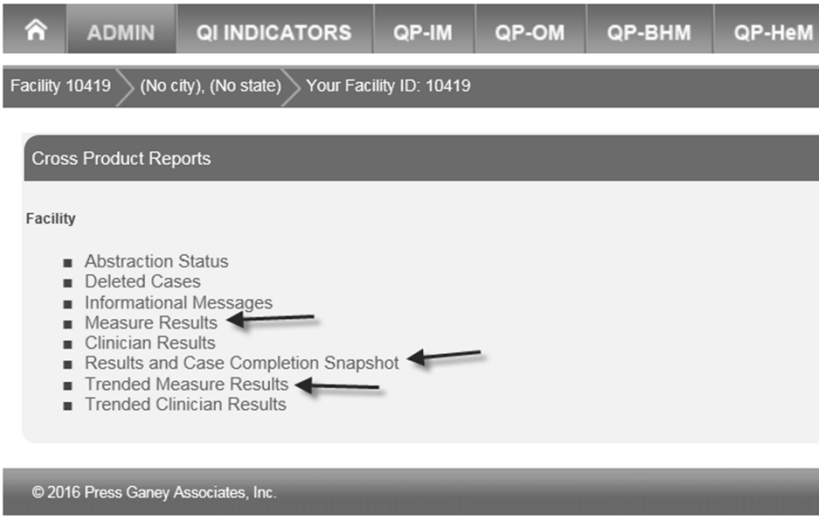
Cross Products Reports



PRESS GANEY

49

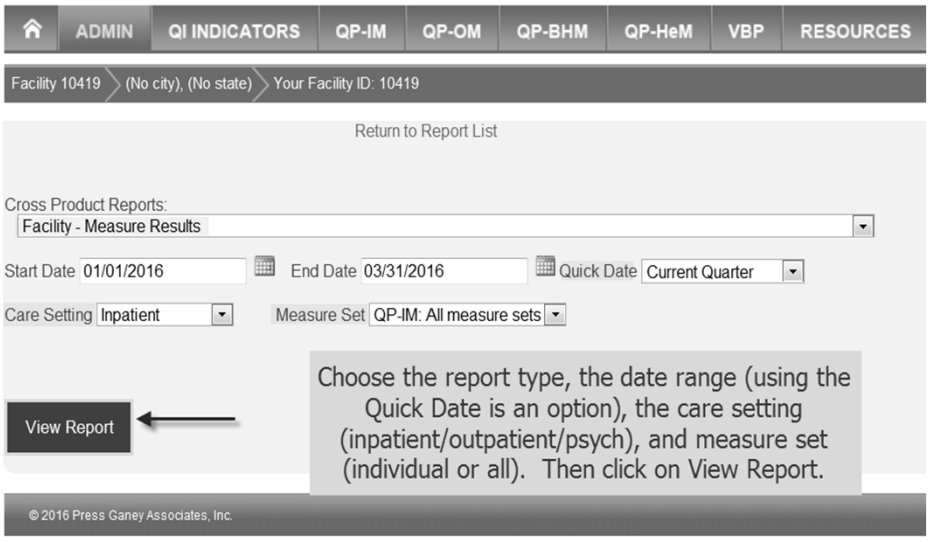
Cross Products Reports



PRESS GANEY

50

Cross Products Reports: Measure Results



PRESS GANEY

51

Cross Products Reports: Measure Results

Facility Measure Results

PRESS GANEY

QP-IM: All measure sets for date range 01/01/2016 to 03/31/2016

Facility: , , . FacilityID-10419

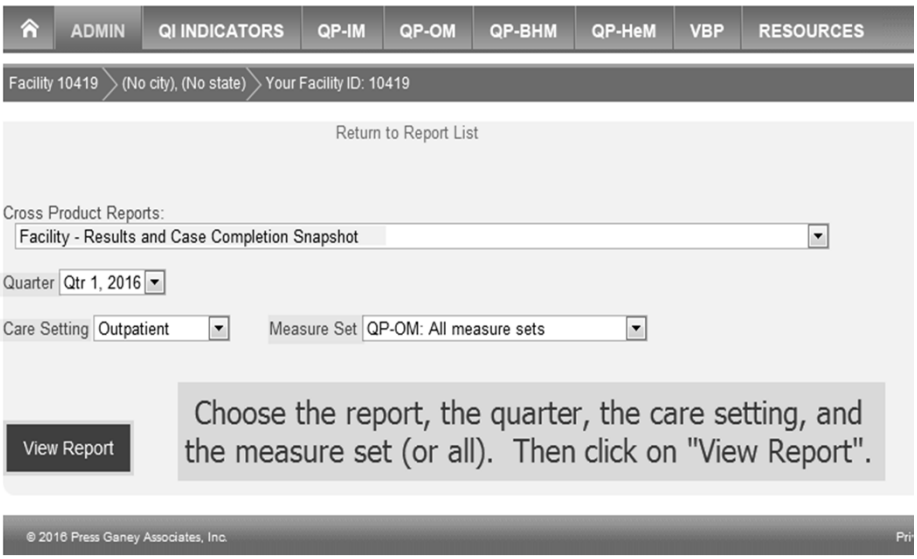
All underlined numbers are hyperlinks that take you to a patient drill down list.

Measure	Numerator	Denominator	Value	UTDs	Failures	Exclusions
STK-4 - Thrombolytic Therapy	4	12	33.33%	N/A	8	6
ED-1a - Time from ED Arrival to ED Depart for Adm ED Pts - Overall Rate	N/A	6	450	10	N/A	4
ED-1b - Time from ED Arrival to ED Depart for Adm ED Pts - Rpting Measure	N/A	4	180	6	N/A	36
ED-1c - Time from ED Arrival to ED Depart for Adm ED Pts - Psych/Mental Hlth	N/A	2	990	4	N/A	425
ED-2a - Admit Decision Time to ED Depart Time for Adm Pts - Overall Rate	N/A	7	540	8	N/A	4
ED-2b - Admit Decision Time to ED Depart Time for Adm Pts - Rpting Measure	N/A	4	990	5	N/A	35
ED-2c - Admit Decision Time to ED Depart Time for Adm Pts - Psych/Mental Hlth	N/A	3	540	3	N/A	425
VTE-5 - VTE Warfarin Therapy Disch Instructions	1	5	20.00%	N/A	4	13
* VTE-6 - Hospital Acquired Preventable VTE	1	2	50.00%	N/A	1	32
IMM-2 - Influenza Imm	7	9	77.78%	N/A	2	115
SUB-1 - Alcohol Use Screening	26	54	48.15%	N/A	28	241
SUB-2 - Alcohol Use Brief Intervention Provided or Offered	2	4	50.00%	N/A	2	275
SUB-2a - Alcohol Use Brief Intervention	1	4	25.00%	N/A	3	275
SUB-3 - Alcohol and Other Drug Use Disorder Tx Provided or Offered at Disch	13	17	76.47%	N/A	4	255
SUB-3a - Alcohol and Other Drug Use Disorder Tx at Disch	7	17	41.18%	N/A	10	255
TOB-1 - Tobacco Use Screening	45	48	93.75%	N/A	3	241
TOB-2 - Tobacco Use Tx Provided or Offered	7	10	70.00%	N/A	3	250
TOB-2a - Tobacco Use Tx	4	10	40.00%	N/A	6	250
TOB-3 - Tobacco Use Tx Provided or Offered at Disch	8	11	72.73%	N/A	3	258
TOB-3a - Tobacco Use Tx at Disch	5	11	45.45%	N/A	6	258

PRESS GANEY

52

Cross Products Reports: Results and Case Completion Snapshot



PRESS GANEY

53

Cross Products Reports: Results and Case Completion Snapshot

	Current Quarter			Prior Quarter				Current Case Completion Status		
Measure Set	Numerator	Denominator	Value	Numerator	Denominator	Value	Change From Prior Quarter	Incomplete	Pending	Complete
QP-OM: AMI	0	0	NP	14	15	93.33%	N/A	10	0	0
QP-OM: Chest Pain	0	0	NP	19	21	90.48%	N/A	10	0	0
QP-OM: ED Throughput	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11	0	23
QP-OM: Stroke	1	1	100.00%	4	5	80.00%	20.00%	1	0	2
QP-OM: Pain Management	N/A	N/A	N/A	N/A	N/A	N/A	N/A	17	0	0
QP-OM: Colonoscopy - Average Risk	10	10	100.00%	40	45	88.89%	11.11%	1	0	11
QP-OM: Colonoscopy - High Risk	11	11	100.00%	56	60	93.33%	6.67%	0	0	13

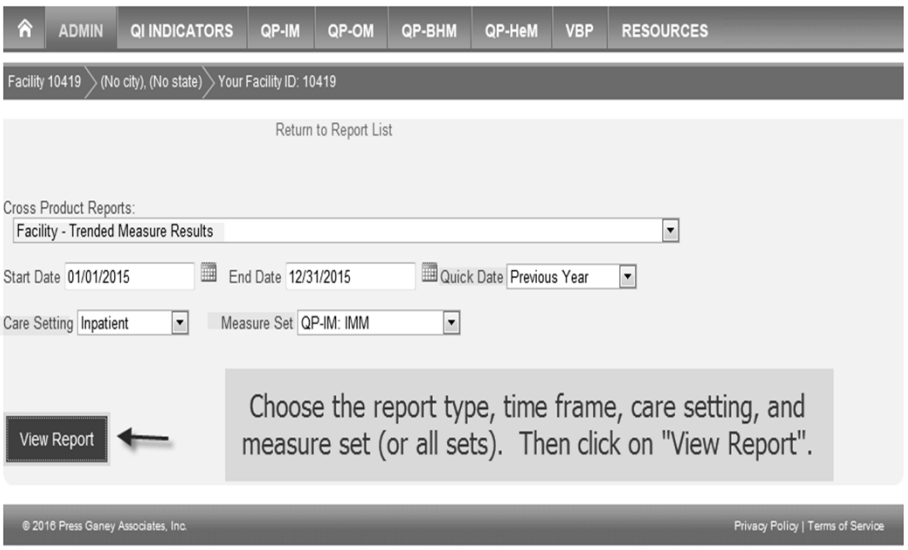
Notes:
The Measure Set Value Excludes Inverse Proportional Measures and Continuous Measures.

Shows improvements in green from one quarter to another. (Red if rates decreased.) Also shows abstraction status, except pending.

PRESS GANEY

54

Cross Products Reports: Trended Measure Results



PRESS GANEY

55

Cross Products Reports: Trended Measure Results

Facility Trended Measure Results

QP-IM: IMM

01/01/2015 to 12/31/2015

	Q1 2015			Q2 2015			Q3 2015			Q4 2015		
Measure	Num	Den	Value	Num	Den	Value	Num	Den	Value	Num	Den	Value
IMM-2: Influenza Imm	347	361	96.12%	0	0	NP	0	0	NP	446	455	98.02%

- May be run for any length of time
- All measures for inpatient, outpatient, or psych may be chosen
- Numerators, Denominators and Rates for each chosen measure

PRESS GANEY

56

System Reporting Functions

System facilities can be viewed at a corporate or division level

Cross Product Reports

Facility

- Abstraction Status
- Deleted Cases
- Informational Messages
- Measure Results
- Clinician Results
- Results and Case Completion Snapshot
- Trended Measure Results
- Trended Clinician Results

Division

- Abstraction Status
- Results and Case Completion Snapshot
- Measure Results
- Trended Measure Results

Corporation

- Abstraction Status
- Deleted Cases
- Measure Results
- Results and Case Completion Snapshot

PRESS GANEY

57

DATA MANAGEMENT BEST PRACTICE

PRESS GANEY

Troubleshooting:

Initial Patient Populations

PRESS GANEY

Initial Patient Populations

FAQ: Why is my case not in the population?

- Defining the population is the first step to estimate a hospital's performance
- A population is defined as
  - A collection of patients sharing a common set of universal measured characteristics, such as:
    - ICD 10 Codes
    - Procedure Codes
    - LOS
    - Age
- Each measure has a unique initial patient population definition which can be found in the Specifications Manual

Initial Patient Populations

Initial Patient Populations can be found in the CMS specs manual section 2 for each measure:

Section 2 - Measurement Information
Section 2.1 - Severe Sepsis and Septic Shock (SEP)
Section 2.2 - Venous Thromboembolism (VTE)
Section 2.3 - Stroke (STK)
Section 2.4 - Global Initial Patient Population (ED, IMM, TOB, SUB)
Section 2.5 - Emergency Department (ED)
Section 2.6 - Prevention 2.6.1 - Immunization (IMM) 2.6.2 - Substance Use (SUB) 2.6.3 - Tobacco Treatment (TOB)

Initial Patient Populations

Initial Patient Populations can be found in the JC specs manual for PC and HBIPS measure:

Specifications Manual for Joint Commission National Quality Core Measures

Google™ Custom Search

Table of Contents

- Acknowledgment and Conditions of Use
- Introduction
- Using the Specifications Manual for Joint Commission National Quality Core Measures

Section 1: Measure Information Forms

- Hospital Based Inpatient Psychiatric Services (HBIPS)
  - HBIPS-1
  - HBIPS-2
  - HBIPS-3
  - HBIPS-4
  - HBIPS-5
  - HBIPS-6
  - HBIPS-7
- Perinatal Care (PC)
  - PC-01
  - PC-02
  - PC-03
  - PC-04
  - PC-05

Set Measures
General Data Elements
Algorithm Output Data Elements
Measure Set Specific Data Elements
Related Materials
Perinatal Care (PC) Initial Patient Population
Initial Patient Population Algorithm
Sample Size Requirements

Initial Patient Populations

Behavioral Health Example

Problem:

- Case is not populating into:
  - PSY-TOB
  - PSY-SUB
  - PSY-IMM

	Total Cases	Incomplete Cases
HBIPS-1,4,5,6 & 7	84	0
HBIPS-2 & 3 (All)	84	
HBIPS-2 (Restraints)	3	
HBIPS-3 (Seclusions)	3	
PSY-SUB-1	0	0
PSY-TOB-1, 2 & 2a	0	0
PSY-IMM-2	0	0
All Cases		

Reason:

- The trigger for this issue is the following data element:
  - Is this an IPF case?
  - If this is marked as a "no" or uploaded automatically with this answer, the case will not populate the above measures.

Initial Patient Populations

Inpatient Example: Perinatal Care Measures 01, 02, 03*

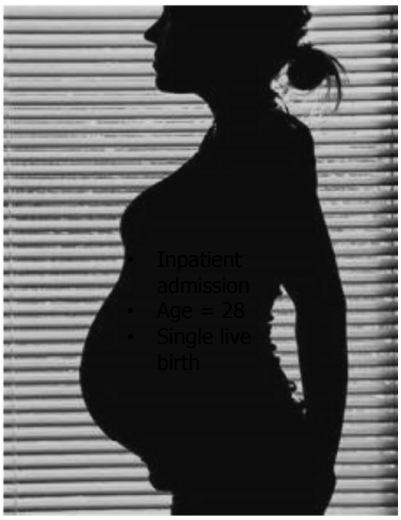
The PC measure set is unique in that there are two distinct Initial Patient Populations within the measure set, Mothers and Newborns.

- **Mothers**
  The population of the PC-Mother measures are identified using 4 data elements:
  - Admission Date
  - Birthdate
  - Discharge Date
  - Principal or Other Diagnosis Code
- These elements establish the population criteria:
  - Patients admitted to the hospital for inpatient acute care
  - **AND** Principal or Other **Procedure** Codes on Table 11.01.1
  - **AND** a Patient Age >= 8 years and < 65
  - **AND** a Length of Stay ≤ 120 days.

*PC 01/Elective Delivery; PC 02/Cesarean Birth; PC 03/Antenatal Steroids

Initial Patient Populations

In mother population



Not in mother population

PRESS GANEY

65

Initial Patient Populations

The most common reason why mothers are not in the initial population is because they do not have the **qualifying procedure code from Table 11.01.1**

Code	Shortened Description
10D00Z0	Extraction of Products of Conception, Classical, Open Approach
10D00Z1	Extraction of Products of Conception, Low Cervical, Open Approach
10D00Z2	Extraction of Products of Conception, Extraperitoneal, Open Approach
10D07Z3	Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening
10D07Z4	Extraction of Products of Conception, Mid Forceps, Via Natural or Artificial Opening
10D07Z5	Extraction of Products of Conception, High Forceps, Via Natural or Artificial Opening
10D07Z6	Extraction of Products of Conception, Vacuum, Via Natural or Artificial Opening
10D07Z7	Extraction of Products of Conception, Internal Version, Via Natural or Artificial Opening
10D07Z8	Extraction of Products of Conception, Other, Via Natural or Artificial Opening
10E0XZZ	Delivery of Products of Conception, External Approach

PRESS GANEY

66

Initial Patient Populations

Inpatient Example: Perinatal Care Measures 04 and 05*

- **Newborns**
  The population of the PC-Newborn measure are identified using 5 data elements:
  - Admission Date
  - Birthdate
  - Discharge Date (PC-05 only)
  - Principal or Other Diagnosis Code
  - Principal or Other Procedure Code
- Within the PC-Newborn population, there are two 2 subpopulations
  - Newborns with Blood Stream Infection
  - Newborns with Breast Feeding
- Each subpopulation
  - Is identified by age at admission
  - A specific group of diagnosis and procedure codes or lack thereof
  - Each subpopulation is processed independently
  - Newborns may fall in both subpopulations

*PC 04/Newborns with BSI; PC 05/Newborns with Breast Feeding

Initial Patient Populations

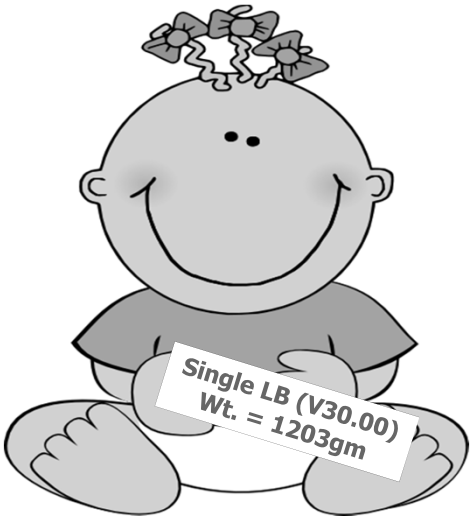
Newborns with BSI*

- Age at admission ≤ 2 days **AND** satisfy all the following 3 conditions:
  1. Does **not** have a Principle DX of Septicemia or Bacteremia
  2. Does have **ONE** of the following:
     A. Birth Weight >= 500g and <= 1499g (as entered or by DX code)
     B. Birth Weight >=1500g (as entered or by DX code)
     C. with **ANY** OF THE FOLLOWING:
        a. Major surgery or
        b. Mechanical ventilation
        c. Or Discharge Disposition of expired
        d. Or a Missing Discharge Disposition
        e. Or NO Principal Diagnosis Code of live newborn
     D. Birth Weight Missing or Unable To Determine (UTD).
  3. NO Other Diagnosis Code or Birth Weight < 500g

*There is no sampling for this measure

Initial Patient Populations

Am I in the newborn BSI population?



Am I in the newborn BSI population?

PRESS GANEY®

69

Initial Patient Populations

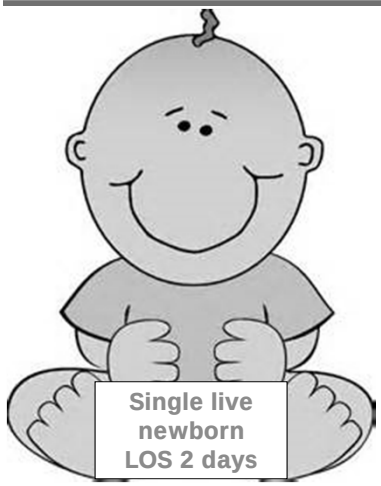
Newborns with Breast Feeding

- Age at admission ≤ 2 days
- Length of Stay ≤ 120 days
- A Principal Diagnosis Code of single liveborn infant
- **NO** Other Diagnosis Codes of Galactosemia
- **NO** Principal or Other Procedure Code for Parenteral Nutrition

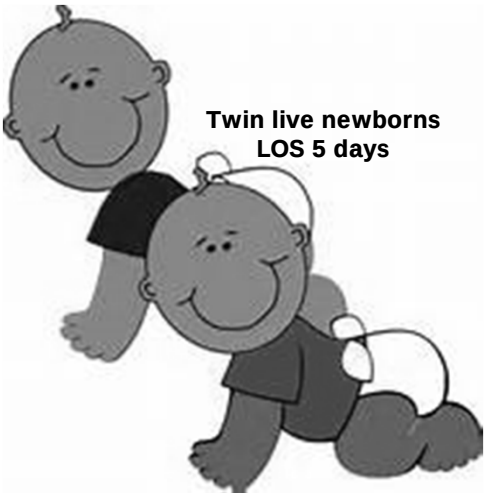
PRESS GANEY®

70

Initial Patient Populations



Am I in the Breast Feeding population?



Are we in the Breast Feeding population?

Initial Patient Populations

Outpatient Example: OP-4 and OP-5 Chest Pain

The population of the OP-4 and OP-5 Chest Pain measures is identified using 6 data elements:

- E/M Code
- Discharge Code
- Outpatient Encounter Date
- Birthdate
- Principal Diagnosis Code
- Other Diagnosis Codes

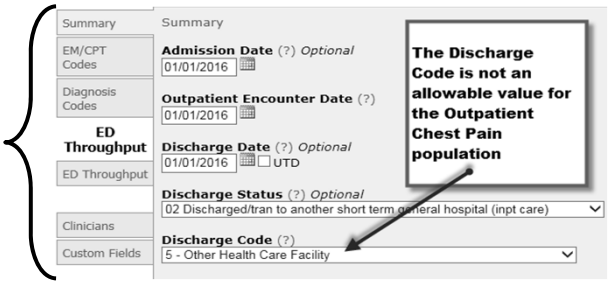
Patients are included in the population if they have:

- Discharged/transferred to a short-term general hospital for inpatient care or to a federal healthcare facility, **and**
- Age ≥ 18 years, **and**
- Principal or Other Diagnosis Codes for Chest Pain on OP Table 1.1a.

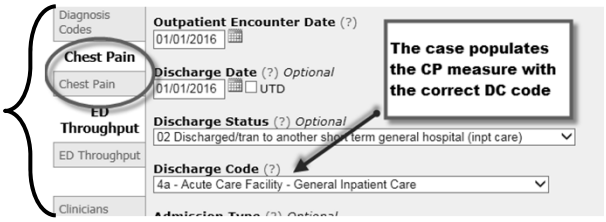
Initial Patient Populations

The most common reason why cases are not in the initial population is because they do not have the correct qualifying discharge code

Not in CP population



In CP population



PRESS GANEY

73

Questions

QUESTIONS

PRESS GANEY

74

IQR Specification Manual Updates
July 1, 2016– December 31, 2016
Version 5.1

PRESS GANEY

Inpatient Specifications Manual Updates

The National Hospital Inpatient Quality Measures Specifications Manual is your official source of complete information

(Version 5.1, effective with July 1, 2016 Discharges)

The following review provides an overview only and is NOT intended to be a substitute for detailed review of the Manual Revisions, including Release Notes, Data Element Definitions and Measure Information Forms

www.qualitynet.org

PRESS GANEY

Inpatient Measure Updates

PRESS GANEY

PRESS GANEY

Reminder: Retired Chart-abstracted Measures

Measure	Measure Name
AMI-7a *	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
IMM-1	Pneumococcal Immunization
SCIP-Inf-4	Cardiac Surgery Patients with Controlled Postoperative Blood Glucose
STK-01	Venous Thromboembolism (VTE) Prophylaxis
STK-06 *	Discharged on Statin Medication
STK-08 *	Stroke Education
VTE-1 *	Venous Thromboembolism Prophylaxis
VTE-2 *	Intensive Care Unit VTE Prophylaxis
VTE-3 *	VTE Patients with Anticoagulation Overlap Therapy

* Retained as voluntary eCQM

PRESS GANEY

78

Required Chart-abstracted Measures for CY 2016

Measure	Measure Name
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients
IMM-2	Influenza Immunization
PC-01	Elective Delivery *
STK-04	Thrombolytic Therapy
VTE-5	Venous Thromboembolism Warfarin Discharge Instructions
VTE-6	Hospital Acquired Potentially-Preventable Venous Thromboembolism
SEP-1	Severe Sepsis and Septic Shock: Management Bundle

* Collected in aggregate and submitted via Web-based tool

IQR eCQM Reporting Requirement

- A hospital will be required to report a minimum of 4 of the 28 available eCQMs for CY2016 reporting.
- Require hospitals to report for only one quarter (Q3 or Q4) of CY2016/FY2018 payment determination.
- **Submission** timeline: October 1, 2016 - February 28, 2017

Available eCQMs

ED-1	STK-5	AMI-8a	VTE-5	SCIP-INF-2a
ED-2	STK-6	AMI-10	VTE-6	SCIP-INF-9
ED-3*	STK-8	VTE-1	PC-01	EHDI-1a
STK-2	STK-10	VTE-2	PC-05	HTN**
STK-3	AMI-2	VTE-3	CAC-3	PN-6**
STK-4	AMI-7a	VTE-4	SCIP-INF-1a	

*ED-3 is an outpatient measure and not applicable for IQR
** Not Available in Quality Performer HeM

New Measures for CY 2016

Short Name	Measure Name	Measure Type
Patient Safety Culture	Hospital Survey on Patient Safety Culture	Structural
AMI Excess Days	Excess Days in Acute Care After Hospitalization for Acute Myocardial Infarction (AMI)	Claims
HF Excess Days	Excess Days in Acute Care After Hospitalization for Heart Failure (HF)	Claims
THA/TKA Payment	Hospital-Level Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty	Claims

Early Management Bundle, Severe Sepsis/Septic Shock

There are many changes for Sepsis beginning with July 1, 2016 discharges. Please review the Specification Manual thoroughly.

See separate Sepsis section.

VTE

No VTE sub-population and Primary VTE sub-population (VTE-1, VTE-2 and VTE-3) are retired from chart-abstracted measures.

Sampling for VTE Sub-population 3 – The Other VTE Only sub-population is **not eligible for sampling** and will use the entire Initial Patient Population for reporting.

Stroke

STK-1, 2, 3, 4, 5, 6, 8 and 10 are used for TJC Certification program. Please refer to The Joint Commission manual page at https://manual.jointcommission.org for their definitions and required elements.

TOB

Excluded Populations: Patients who have a duration of stay less than or equal to one day or greater than 120 days

Inpatient Data Element Updates

PRESS GANEY

PRESS GANEY

Data Element Updates

Impacts: *Alcohol Use Status (SUB-1)*

Rationale: The revision provides guidance on screening tools completed prior to admission to a psychiatric unit and clarifies how to identify cognitive impairment.

Description of Changes: Notes for Abstraction Change to:

- If patient has a blood alcohol test with a result of .08 or greater or the clinician documents the patient was acutely intoxicated per blood alcohol test results select Value "2."
- Screening may be done with a "validated" Single Alcohol Screening Question (SASQ) in order to identify those patients with no risk or low risk or who do not drink. Further screening should be done with a validated tool for those patients with a positive result to determine if there is need for a brief intervention.
- Refer to the Inclusion Guidelines for examples of commonly used validated screening tools; note that the CAGE, although a validated tool, is not recommended for this measure set

PRESS GANEY

88

Data Element Updates

Impacts: *Alcohol Use Status (SUB-1)* continued:

- The alcohol use status screening timeframe must have occurred within the first three days of admission. The day after admission is defined as the first day. EXCEPTION: If the screening was performed prior to admission to the psychiatric unit, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the psychiatric unit medical record.
- Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first three days of admission.

Refer to the Specifications Manual for full details

Data Element Updates

Impacts: *Brief Intervention (SUB-2)*

Rationale: The Definition and Notes for Abstraction were updated to provide additional information on the key components of a brief intervention.

Description of Changes:

Definition

Change to: A brief intervention is a single session or multiple sessions conducted by a qualified healthcare professional or trained peer support person, following a positive screen for unhealthy alcohol use. The intervention includes motivational discussion focused on increasing insight and awareness regarding alcohol use and motivation toward behavioral change. Brief interventions can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at risk as well as a vehicle for engaging those in need of more extensive levels of care.

Data Element Updates

Impacts: *Brief Intervention (SUB-2)* continued:

A brief intervention focuses on increasing the patient's understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to.

Data Element Updates

Impacts: *Brief Intervention (SUB-2)* continued:

Notes for Abstraction

Add new fifth bullet:

A brief intervention includes at a minimum the following three components:

a) Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems
b) Feedback linking alcohol use and health, including:-
   - Personalized feedback (i.e., explaining how alcohol use can interact with patient's medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications])

   OR

   - General feedback on health risks associated with drinking

c) Advice:- To abstain (if there are contraindications to drinking) OR
   - - To drink below recommended limits (specified for patient)

Data Element Updates

Impacts: ***Influenza Vaccination Status (IM M-2)***

Rationale: The Notes for Abstraction section has been updated to provide clarification for abstractors based on consultation with the Immunization Expert Work Group.

Description of Changes: **Notes for Abstraction**

Change fifth bullet to:

- If there is no documentation to support any of the Allowable Values 1-4, and there is physician/APN/PA documentation that they will administer the vaccine after discharge or physician/APN/PA documentation not to administer the vaccine for a reason other than those noted as acceptable in this data element, select value "5."

Change eighth bullet to:

- If it is documented in the chart that the patient's influenza vaccination status is "up to date" or "current," select Allowable Value "2." Documentation of "up to date" or "current" in the vaccination record that does not reference the influenza vaccine is not sufficient to select Allowable Value "2."

Data Element Updates

Impacts: *Influenza Vaccination Status (IMM-2)* continued:

Add new bullet:

- Documentation of the acronym "UTD," even with specific reference to the influenza vaccine, is not sufficient to select Allowable Value "2

Exclusion Guidelines for Abstraction:

Remove:

- Patients with anaphylactic allergy to eggs, anaphylactic latex allergy or other specific allergy/sensitivity to the vaccine. The allergy/sensitivity should be accompanied by the exact complication. Must be a specific allergy/sensitivity not just physician/advanced practice nurse/physician assistant (physician/APN/PA) preference.

- Documentation of an allergy is still an allowable value but no longer excludes the case from the population.

Data Element Updates

Impacts: *Prescription for Tobacco Cessation Medication (TOB-3, TOB-3a)*

Rationale: Notes for Abstraction were clarified to provide guidance regarding patient refusal during hospitalization, requirements when no prescription is written at discharge, and to provide examples of key components of counseling.

Description of Changes: Notes for Abstraction

Change to:

- All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor. In determining whether a tobacco cessation medication was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Varenicline and this is not included in any of the other discharge medication sources (e.g., discharge orders). Select Value "1" unless documentation elsewhere in the medical record suggests that it (tobacco cessation medication) was not prescribed at discharge.

Data Element Updates

Impacts: *Prescription for Tobacco Cessation Medication (TOB-3, TOB-3a)* continued:

- If documentation is contradictory (physician noted "d/c Varenicline" or "hold Varenicline" in the discharge orders, but Varenicline is listed in the discharge summary's discharge medication list) or after careful examination of circumstance, context, timing, etc., the documentation remains unclear, the case should be deemed unable to determine. Select Value "4."
- If the physician wishes the patient to continue on medication that does not require a prescription (for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling or quit line), select Value "1" if the medication is listed on the discharge medication list.
- If the patient does not have a residence in the USA, Value "3" must be selected
- If the patient refused tobacco cessation medication during the hospitalization, a prescription must be offered again at the time of discharge. Select Value "4" if documentation reflects that a prescription for cessation medication was not offered at the time of discharge.

Data Element Updates

Impacts: *Reason for No Administration of VTE Prophylaxis (VTE-6)*

Rationale: This change is to decrease abstractor burden regarding patients transferred from the emergency room.

Description of Changes: Definition :
Add: or pharmacist

Allowable Values

Y (Yes) There is physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered any time between arrival and the performance of a VTE Diagnostic Test.

N (No) There is no physician/APN/PA or pharmacist of documentation why VTE prophylaxis was not administered any time between arrival and the performance of a VTE Diagnostic Test, or unable to determine from medical record documentation

Data Element Updates

Impacts: *Reason for No Administration of VTE Prophylaxis (VTE-6)* continued:

Inclusion Guidelines for Abstraction Change to: None

Exclusion Guidelines for Abstraction Change to:

- Continuous IV Heparin infusion prior to the diagnostic test
- Low Risk Assessment

Data Element Updates

Impacts: *Reason for No Tobacco Cessation Medication at Discharge*
Rationale: Notes for Abstraction were clarified to provide guidance regarding patient refusal during hospitalization, requirements when no prescription is written at discharge, and to provide examples of key components of counseling.

- Reasons for not prescribing FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.
- An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not prescribing another of the cessation medications.
- In determining whether there is a reason documented by physician/APN/PA or pharmacist for not prescribing tobacco cessation medications, the reason must be explicitly documented (e.g., "No tobacco cessation medication as patient is post-operative and nicotine may place them at risk for impaired wound healing") or clearly implied (e.g.,"Patient becomes anxious when they take tobacco cessation medication"). If reasons are not mentioned in the context of cessation medication, do not make inferences (e.g., Do not assume that a tobacco cessation medication is not being prescribed because of the patient's history of recent surgery alone).

Data Element Updates

Reason for No Tobacco Cessation Medication at Discharge (TOB-3, TOB-3a) continued:

- When conflicting information is documented in the medical record, select Value "No" for the indicated reasons present for not prescribing the tobacco cessation medications.
- If the reason for not prescribing FDA-approved cessation medication is documented at any time during the hospitalization, additional documentation of the reason at the time of discharge is not required.
- Documentation by the physician, advanced practice nurse (APN), physician assistant (PA) or pharmacist that the patient refused tobacco cessation medication is not considered a valid reason for no tobacco cessation medication at discharge. If refusal is documented as the reason, select Value "No."

Data Element Updates

Impacts: *Reason for No Tobacco Cessation Medication During the Hospital Stay (TOB-2, TOB-2a)*

Rationale: Language was clarified to provide better guidance to the abstractor in the Notes for Abstraction. Additional language was added for documentation requirements for the reason for no cessation medication during the hospital stay. The time frame to provide interventions was changed based on recommendations from the TOB Technical Advisory Panel.

Description of Changes: Definition

Remove: within the first three days of admission

Notes for Abstraction: Change to:

- In determining whether there is a reason documented by physician/APN/PA or pharmacist or not administering tobacco cessation medications, the reason must be explicitly documented (e.g., "No tobacco cessation medication as patient is post-operative and nicotine may place them at risk for impaired wound healing") or clearly implied (e.g., "Patient becomes anxious when they take tobacco cessation medication"). If reasons are not mentioned in the context of cessation medication, do not make inferences (e.g., Do not assume that a tobacco cessation medication is not being prescribed because of the patient's history of recent surgery alone).

Data Element Updates

Reason for No Tobacco Cessation Medication During the Hospital Stay (TOB-2, TOB-2a) continued:

- When conflicting information is documented in the medical record, select Value "No" for the indicated reasons present for not administering the tobacco cessation medications
- Documentation by the physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist that the patient refused tobacco cessation medication is not considered a valid reason for no tobacco cessation medication during the hospitalization. If refusal is documented as the reason, select Value "No."

Data Element Updates

Impacts: *Reason for Not Initiating IV Thrombolytic (STK-4)*

Definition: Reasons for not initiating IV thrombolytic.

Add:
Documentation by a physician/APN/PA that the patient has "no neurological deficit" or "normal neurological exam" in the emergency department

Exclusion Guidelines for Abstraction:

Delay in hospital arrival greater than 2 hours

Data Element Updates

Impacts: *Referral for Outpatient Tobacco Cessation Counseling (TOB-3, TOB-3a)*

Notes for Abstraction additions:

- If a referral is made to a Quitline, defined as a telephone counseling in which at least some of the contact is initiated by the Quitline counselor to deliver tobacco use interventions, select Value "1." If the patient directly calls the Quitline during the hospitalization, documentation must reflect that staff was present during the call to verify that an appointment was set.
- If the patient refused practical counseling during the hospitalization, a referral must be offered again at the time of discharge. Select Value "5" if a referral was not offered at the time of discharge.

Data Element Updates

Impacts: *Time Last Known Well (STK-4)*

Notes for Abstraction additions:

- The Time Last Known Well must be a time prior to the patient's Arrival Time. Do not use times after hospital arrival for Time Last Known Well.
- If the time is noted to be "less than" a period of time prior to ED arrival, assume the maximum range. Example:
  - Time Last Known Well less than one hour ago. Subtract one hour from the time of arrival to compute time last known well.

Data Element Updates

Impacts : *Tobacco Use Status (TOB-1)*

Notes for Abstraction additions/clarifications:

- If there is ***any*** documentation that the patient either currently uses tobacco products or is an ex-user that quit less than 30 days prior to admission, select the appropriate allowable value for the type of product used. **In other words, even if there is conflicting documentation about tobacco use, the abstractor must select the Value reflecting that the patient uses tobacco.**
- **If there is documentation that the patient has not used any tobacco products during the past 30 days prior to admission, continued assessment for the type, volume and frequency does not need to be performed.**
- **There is no requirement to capture volume and frequency of use for patients using only smokeless tobacco.**

Data Element Updates

Impacts : Tobacco Use Status *(TOB-1)* continued:

Notes for Abstraction additions/clarifications:

- The tobacco use status screening timeframe must have occurred within the first day of admission. This includes the day of admission which is defined as day zero, and the day after admission which is defined as the first day.

  EXCEPTION:
  - If the screening was performed prior to admission to the psychiatric unit, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the psychiatric unit medical record.

Data Element Updates

Impacts : Tobacco Use Status *(TOB-1)* continued:

Notes for Abstraction additions/clarifications:

- If there is documentation within the first day of admission that the patient was psychotic with documented symptoms, e.g., hallucinating, non-communicative, catatonic, etc., which prevented them from answering questions reliably, they would be considered cognitively impaired.
- If there is documentation that the patient was intubated the entire first day of admission, select Value “6” as the patient is unable to answer.
- If there is documentation of any of the examples of cognitive impairment below within the first day of admission, select Value “6” regardless of conflicting documentation.
  - Dementia
  - Psychotic/psychosis

Data Element Updates

Impacts : Tobacco Use Treatment Practical Counseling *(TOB-2, TOB-2a)*

Definition: Practical counseling requires **a one-on-one** interaction with the patient to address **at a minimum** the following **three components**: recognizing danger situations, developing coping skills, and providing basic information about quitting.

Notes for Abstraction additions:

- A pamphlet with basic information about quitting, recognizing danger situations and how to develop coping skills may be given to the patient; however, the caregiver must still document what was discussed with the patient from the pamphlet. Giving the patient a pamphlet alone does not constitute practical counseling which requires a one-on-one interaction with the patient.
- Triggers and/or roadblocks are the same as danger situations.

Data Element Updates

Impacts : Tobacco Use Treatment Practical Counseling, *(TOB-2, TOB-2a)* continued:

- Coping skills covered in practical counseling might include learning new ways to manage stress, exercising, relaxation breathing, changing routines and distraction techniques to prevent tobacco use.
- Basic information on quitting covered in practical counseling might include the benefits of quitting tobacco, how to quit techniques and available resources to support quitting.

Data Element Updates

Impacts: *VTE Confirmed (VTE-6)*

Notes for Abstraction additions:

- If conflicting documentation between providers is present, select "Yes".
- For patients with radiology reports that state "low probability" or "inconclusive test results" on any of the acceptable VTE Diagnostic Tests, select "No."
- If there is physician/APN/PA documentation that the patient had a VTE, select "Yes."

Data Element Updates

Impacts: *VTE Prophylaxis Status (VTE-6)*

Suggested Data Collection Question: Was VTE prophylaxis administered between the admission date and the VTE Diagnostic Test order date?

Notes for Abstraction additions:

- When the VTE is diagnosed within four days prior to arrival you may select "Yes." Use calendar days to determine this timeframe.

Refer to Appendix H, Table 2.1 VTE Prophylaxis Inclusion Table.

The Specifications Manual for Joint Commission National Quality Measures Version 2016A

Discharges 07-01-16 (3Q16) through 12-31-16 (4Q16)

Perinatal Care

PC-01, PC-02, PC-03, PC-04, PC-05

Clinical trial was removed, since this is a rare occurrence and in order to align with the eCQM version of the measure.

Data Elements

Admission to NICU (PC-05)

Rationale - Clarification was added to address admissions for observation.

- If the newborn is admitted to the NICU for observation or transitional care, select allowable value no. Transitional care is defined as a stay of 4 hours or less in the NICU. There is no time limit for admission to observation.

Data Elements

Labor (PC-01)

Clarification was added for acceptable documentation for labor.

Change the second and third paragraphs under the notes for abstraction to:

Documentation of labor by the clinician should be abstracted at face value, e.g., admit for management of labor, orders for labor, etc. There is no requirement for acceptable descriptors to be present in order to answer "yes" to labor. Documentation of regular contractions with or without cervical change, e.g.:

- contractions every 4 to 5 minutes
- regular contractions and dilation
- effacement 50% with contractions every 3 minutes
- steady contractions

Data Elements

Number of Previous Live Births (PC-02)

Clarification was added for using parity from the EHR

Parity may be used for the number of previous deliveries resulting in a live birth if zero is documented. For any number greater than zero, parity may ONLY be used provided there is additional documentation indicating the same number of live births experienced prior to this hospitalization. If the number for parity documented in the EHR is "one" and includes the delivery for the current hospitalization, abstract zero for previous live births.

Data Elements

Term Newborn (PC-05)

Additional clarification was added to determine if the newborn was term.

Change the first paragraph under to notes for abstraction to:

Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. Estimated gestational age (EGA) may be used to determine gestational age, including a range of numbers that are 37 weeks or greater, e.g., 37-38 weeks gestation.

Data Elements

HBIPS-4, 6 and 7 have been retired throughout the document

Patient Status at Discharge element added to HBIPS-5

5 HBIPS elements have been retired:

- Continuing Care Plan-Discharge Medications
- Continuing Care Plan-Next Level of Care
- Continuing Care Plan-Principal Discharge Diagnosis
- Continuing Care Plan-Reason for Hospitalization
- Patient Referral to Next Level of Care Provider

PRESS GANEY

2016 SPRING USER GROUP

2016 HOSPITAL OQR PROGRAM UPDATES

PRESS GANEY

OVERVIEW

- **Outpatient Specifications Manual Updates**
  - Data Dictionary Revisions
  - Measure Changes
  - New Measure
- **Measure Authorization**
  - QNET
  - Press Ganey
- **Measure Sets -- CY2016 Data Collection**

Outpatient Specification Manual Updates

- Version 8.1
  - Effective October 1, 2015 encounters
  - Applies to 4Q15
- Version 9.0a
  - Effective with January 1, 2016 encounters
  - Applies to 1Q16 & 2Q16
- Version 9.1
  - Effective with July 1, 2016 encounters
  - Applies to 3Q16 & 4Q16

Outpatient Specification Manual Update
Version 8.1 (October 1, 2015 – December 31, 2015)
(Supplemental Document 2)

APPENDIX A CONVERSION TO ICD-10

- The Version 8.1 Supplemental Document 2 was released in December to cover encounters through 12/31/15. Changes in the Supplemental Document will also be in effect for subsequent versions of the manual.

- Changes made to Appendix A reflect an updated crosswalk between ICD-9 and ICD-10:
  - Table 1.1: Acute Myocardial Infarction (AMI) Diagnosis Codes
  - Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes
  - Table 8.0: Ischemic and Hemorrhagic Stroke
  - Table 9.0: Long Bone Fracture

APPENDIX A CONVERSION TO ICD-10

Table 1.1: Acute Myocardial Infarction Diagnosis Codes

- Four ICD-10 codes were added to Table 1.1: Acute Myocardial Infarction.
- These codes are related to post procedural and intraoperative acute myocardial infarctions.

Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes

- Thirty-five ICD-10 codes were added to Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes.
- The majority of the codes are related to atherosclerotic heart disease and angina.
- One ICD-10 code related to pleurodynia was removed from Table 1.1a.

APPENDIX A CONVERSION TO ICD-10

Table 8.0: Ischemic and Hemorrhagic Stroke

- One ICD-10 code was de-duplicated so that it is only listed once in Table 8.0: Ischemic and Hemorrhagic Stroke (I63.49: [cerebral infarction] due to embolism of other cerebral artery).

Table 9.0: Long Bone Fracture

- Eighty-nine ICD-10 codes were added to Table 9.0: Long Bone Fracture.
- The majority of the codes are for long bone fractures related to osteoporosis, pathologic fractures, pathologic fractures in neoplastic disease, and fractures following insertion of orthopedic implant.
- One hundred and fifty ICD-10 codes were removed from Table 9.0: Long Bone Fracture.
- The majority of the codes are related to fractures of the ankle and wrist.

Outpatient Specification Manual Update
Version 9.0a
(January 1, 2016 – June 30, 2016)

Initial ECG Interpretation

- Collected for: OP-1, OP-2, OP-3
- The term "potential" should be disregarded (neither an Inclusion nor an Exclusion term)

Transfer for Acute Coronary Intervention

- Collected for: OP-3
- Clarify that an abstractor may select value "1: There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention" if the specifically defined reason for transfer "for cath lab" is listed in the emergency department record.

Probable Cardiac Chest Pain

- Collected for: OP-4, OP-5
- The *Inclusion Guidelines* were updated to include "chest tightness."

Aspirin Received

- Collected for: OP-4
- The *Definition* and the *Allowable Values* were updated to clarify that aspirin should be administered in the emergency department prior to transfer.

ECG Time

- Collected for: OP-5
- Additional clarification regarding abstraction when multiple ECGs are documented.

Arrival Time

- Collected for: All Records (used in algorithm for OP-1, OP-2, OP-3, OP-5, OP-18, OP-20, OP-21, OP-23)
- The list of *Only Acceptable Sources* was updated to specify that the Emergency Department Record may include the ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, and ED x-ray reports.

ED Departure Time

- Collected for: OP-3, OP-18
- Clarify for patients who are placed into observation services, the time of the physician/APN/PA order for observation should be used for the ED Departure Time data element.

Provider Contact Time

- Collected for: OP-20
- Clarify that if there is documentation that a provider had direct, personal contact with a patient during an examination and that this was the first direct encounter between the patient and the provider, then this time may be abstracted even if it is not specifically documented as *Provider Contact Time* in the medical record.
- Updated to indicate that documentation of a provider writing an order, beginning the patient note, or making other documentation regarding a patient in the medical record is not sufficient for the *Provider Contact Time* data element because there is no evidence that the provider had direct, personal contact with the patient during these actions.
- Updated to clarify that documentation of a re-examination is not acceptable for the *Provider Contact Time* data element.

Head CT or MRI Scan Interpretation Date

- Collected for: OP-23
- Examples were added to the *Notes for Abstraction* to provide additional clarification regarding abstraction when multiple interpretations are documented.
- The *Notes for Abstraction* were updated to clarify that the date associated with the *Head CT or MRI Scan Interpretation Time* should be abstracted as the *Head CT or MRI Scan Interpretation Date*.

OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures

- In Version **9.0a**, Table 1 was replaced with the following language: "Please refer to Specifications Manual v9.1 for the updated categories and HCPCS for Outpatient Surgical Procedures."
- •In Version **9.1**, Table 1 will be updated in late 2016 to reflect the outpatient surgical procedures most frequently performed in CY 2016.

OP-27: Influenza Vaccination Coverage among Healthcare Personnel

- Data must be entered via the National Healthcare Safety Network (NHSN) website using the facility's CMS Certification Number (CCN).
- The data submission deadline is May 15 annually.

OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval

- Measure Description
  - "50 years and older" was changed to "50 to 75 years of age"
- Denominator
  - "50 years and older" was changed to "50 to 75 years of age"
- Denominator Criteria (Eligible Cases)
  - Added "and ≤ 75"
- Added examples to Denominator Exclusions:
  - Diverticulitis documented in the medical record and a follow-up interval of 5 years in the colonoscopy report
  - Family history of colon cancer and a follow-up interval of 3 years documented in the colonoscopy report
  - Less than adequate prep documented in the medical record with a repeat colonoscopy in 3 years in the colonoscopy report
- Additional instructions
  - Added "A range that includes '10 years' (e.g.: 7 to 10 years) is not acceptable."

OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous/Polyps

- Denominator Criteria (Eligible Cases)
  - The following CPT codes have been inactivated and were removed:
    - » 44393
    - » 45355
    - » 45383
- Denominator Exclusions
  - *changed to:* "Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy inadequate prep, piecemeal removal of adenomas/*polyps*, or last colonoscopy found greater than 10 adenomas/*polyps*)"

OP-30 continued…

- Added to Denominator Exclusions:
  - "For a system reason all of the following must be present in the medical record:
    - The interval since the last colonoscopy is less than 3 years;

      and
    - A medical reason for an interval of less than 3 years is not documented;

      and
    - A "system reason" is documented (e.g., previous colonoscopy report not available, unable to locate last colonoscopy report)."

OP 29 & 30

- In Quality Performer
  - Quarterly and annual reconciliation of the denominator sample size requirement is provided by the Quality Performer Support Team
    - Cases will be added as needed / as available
  - Modifiers 52, 53, 73 and 74 are not identified in QP
    - Self monitor
    - Delete as necessary
  - Annual Colonoscopy report is available

Note: 52-reduced services; 53: discontinued procedure; 73:Discont. OutPat Hosp/ACS Prior to Anesthesia; 74: Discont. OutPat Hosp/ACS After Anesthesia

OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

- *Data Collection Approach* section added:
  - "Include procedures performed from the beginning of the reporting year through 90 days prior to the end of the reporting period. This will allow the postoperative period to occur."
- *Definition for Survey* language updated to:
  - "The same data collection instrument used pre-operatively **must** be used post-operatively."
- The following last sentence added to the *Definition for Survey* section:
  - "For each of the VF tools (VF-14 or VF-8R), all questions have equal weight; only non-missing questions are included, and the total weight is 100."

VOLUNTARY MEASURE

OP-31: Cataracts continued:

- When utilizing the web-based data submission tool in the Secure Portal of QualityNet, the measure status will display as incomplete until you enter data (you may enter zero).
- Data collection & submission for OP-31 is voluntary for 2016.
  - This means that a status of incomplete for OP-31 has no effect on your calendar year 2017 payment determination;
  - however, any numeric value entered that results in a measure rate for OP-31 will be publicly reported.
- How OP-31 data will be publicly reported on Hospital Compare:
  - If the data entered for both numerator and denominator are zeroes,
    - NA with Footnote 5 will display.
  - If the data fields are left blank,
    - NA with Footnote 5 will display.
  - If data are entered with a denominator between 1 and 10,
    - Footnote 1 will be used, and the data will not be displayed.
  - If data are entered with a denominator of 11 or above,
    - the rate will be displayed.
- This will hold true regardless of the numerator. For example:
  - 0/100 will have a 0% rate display
  - 100/100 will have a 100% display

VOLUNTARY MEASURE

OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (Claims Based)

- CPT/HCPCS codes that define the *patient cohort* have two codes added:
  - 45388 – Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
  - G6024 – Colonoscopy, flexible; proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare
- Exclusion refined:
  - Colonoscopies for patients who lack continuous enrollment in Medicare FFS Parts A and B in the *7 days* after the procedure. (was 1 month)

OP-32 continued:

- Exclusions expanded:
  - Colonoscopies for patients with a history of inflammatory bowel disease (IBD) or diagnosis of IBD at time of index colonoscopy.
  - Colonoscopies for patients with a history of diverticulitis or diagnosis of diverticulitis at time of index colonoscopy.
- Exclusions table added with diagnosis codes (ICD-9 and ICD-10) for IBD and diverticulitis exclusions above.
- Exclusions added:
  - Colonoscopies that occur on the same hospital outpatient claim as an ED visit.
  - Colonoscopies that occur on the same hospital outpatient claim as an observation stay.
  - Colonoscopies followed by a subsequent outpatient colonoscopy procedure within 7 days.

OP-33: External Beam Radiotherapy for Bone Metastases (EBRT)

- Percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive EBRT with an acceptable fractionation scheme.
- Numerator:
  - All patients, regardless of age, with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, and 8Gy/1fxns. The data for the numerator may be found in the consultation and office visit notes, outpatient treatment center record, and problem/diagnosis list.
- Denominator:
  - All patients with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT. The data for the denominator may be found in the consultation and office visit notes, outpatient treatment center record, and other-treatment summaries.

PRESS GANEY®

147

Sampling Size Requirements per hospital for EBRT:

Population Per Year	Sampling Requirements
≤ 39	Include all cases
40–200	40
201–500	20% of cases
≥ 501	100
Population per Quarter	**Sample Requirements**
< 10	Include all cases
10 – 50	10
51 – 125	20% of cases
>= 126	25
Population Per Month	**Sampling Requirements**
< 4	Include all cases
4 – 16	4
17 – 41	20% of cases
>=42	9

OP-33: EBRT continued:

Why is this measure important?

- Prevention of radiation therapy overuse
- Unnecessary exposure to radiation
- Increase in patient safety
- Ensure appropriate use of EBRT
- Shorter and less painful treatment options
- Patient benefits
- Decrease frequency and severity of side effects

OP-33: EBRT continued:

Who needs to report?

- Not limited to cancer hospitals
- Applicable to any hospital that conducts and bills Medicare for outpatient radiation oncology
- Facilities that do not perform EBRT should report "zero" in the numerator and denominator

OP-33: EBRT continued:

Submission of the data

- Chart-abstracted measure, web-based aggregate data entry at QNet
- Submitted via the online submission tool through QualityNet annually
  - Denominator count
  - Numerator count
- The first encounter period began on January 1, 2016
- The first submission deadline will be **May 15, 2017**
- Validation: none

PRESS GANEY

151

OP-33: EBRT continued:

Denominator Population

- All patients, regardless of age, with any ICD-10 code:
  - C79.51 Secondary malignant neoplasm of bone or
  - C79.52 Secondary malignant neoplasm of bone marrow
- **AND** one of the following CPT Codes for Radiation Therapy:
  - 77402 Simple
  - 77407 Intermediate
  - 77412 Complex

PRESS GANEY

152

OP-33: EBRT continued:

- **Excluding**
- Documentation of:
  - Previous radiation treatment to the same anatomic site
  - Treated with radiosurgery or SBRT (CPT 77371, 77372, 77432, 77373, 77435)
  - Participation in a prospective clinical protocol or registry study
  - Femoral axis cortical involvement greater than 3 cm in length
  - A prior surgical stabilization procedure
  - Spinal cord compression (ICD-10-CM G95.20 or G95.29), cauda equina compression (ICD-10-CM G83.4), or radicular pain (ICD-10 M54.10 – M54.18)
  - Patient declines treatment
  - Economic, social or religious reasons

PRESS GANEY

153

OP-33: EBRT continued:

- **Numerator Population**
  - All patients
  - Regardless of age
  - Painful bone metastases
  - No previous radiation to the same anatomic site
  - Receive EBRT with one of the following fractional schemes:
    - 30Gy/10fxns
    - 24Gy/6fxns
    - 20Gy/5fxns
    - 8Gy/1fxn

Gy = Gray: Dose/Measurement
Fxns = Fractions: Number of fractions or treatments
30Gy/10 fxns: 3 Gy each treatment for 10 treatments

PRESS GANEY

154

OP-33: EBRT continued:

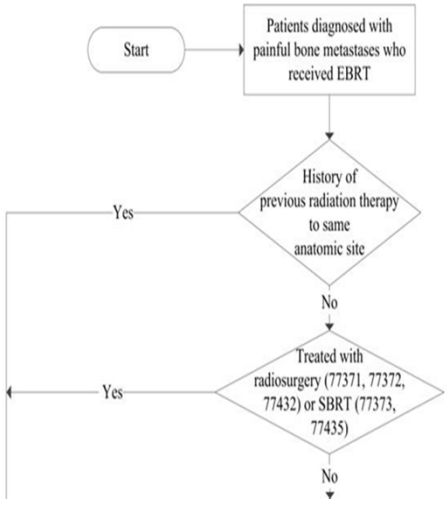
Data Source

- Radiation oncologist consultation note
- Physician office progress note
- Radiation flow sheet
- Radiology report
- Data from Cancer Registry are <u>not</u> applicable

PRESS GANEY

155

OP 33 Flowchart



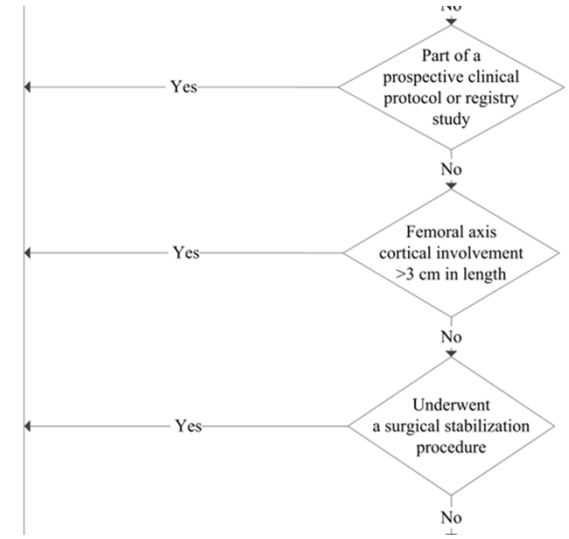
Sampling Size Requirements per year for OP-33

Population Per Year	Sampling Requirements
≤ 39	Include all cases
40-200	40
201-500	20% of cases
≥ 501	100

PRESS GANEY

156

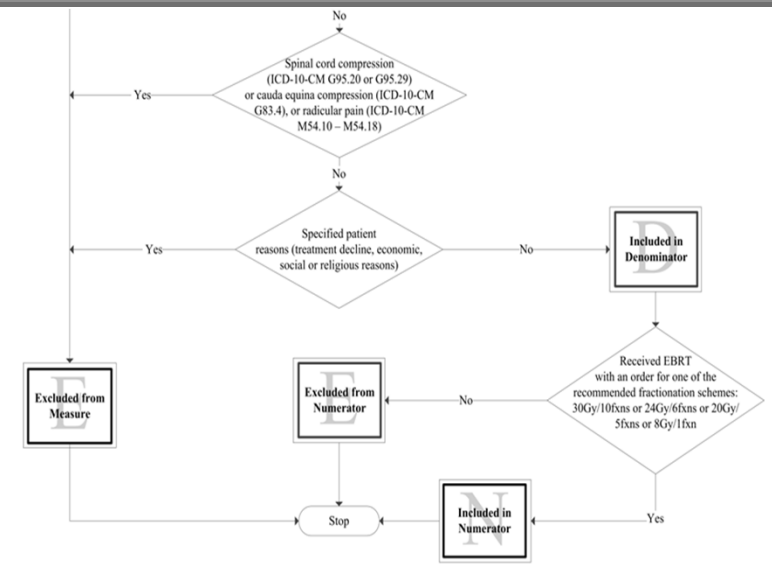
OP 33 Flowchart



PRESS GANEY

157

OP 33 Flowchart



PRESS GANEY

158

OP 33 Measure Support in QP

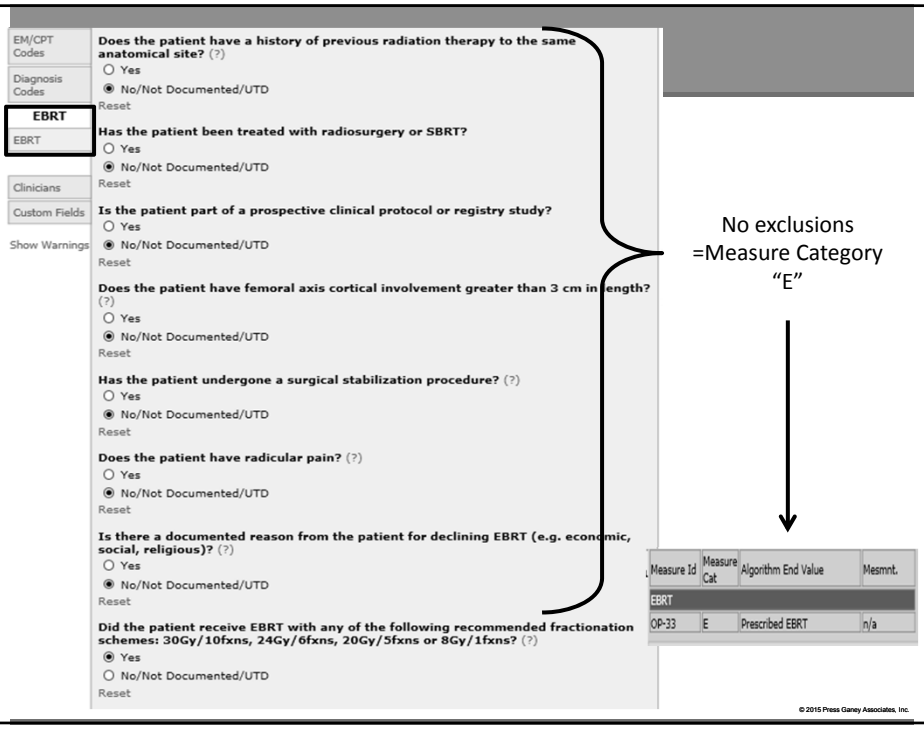
- Data Management Reports are available for OP: 33
  - Patient Lists
  - Data Quality Reports
  - Population & Sampling Counts Report
  - Potential Duplicate Cases Report
  - Deleted Cases Report
  - Patient - Specific Worksheets

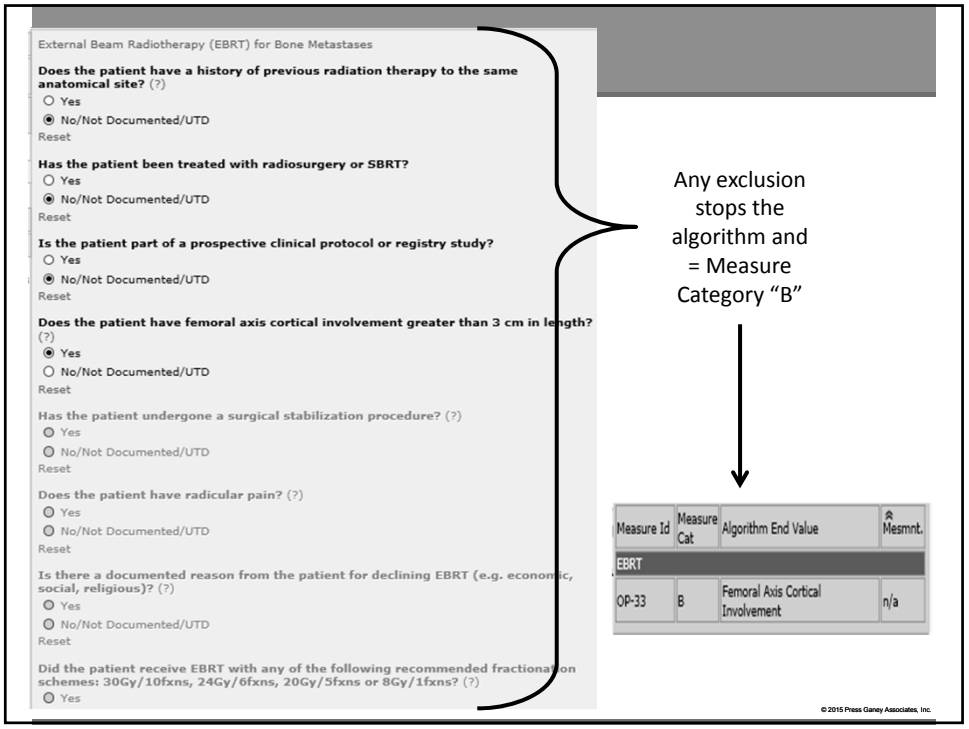
OP 33 Measure Support in QP

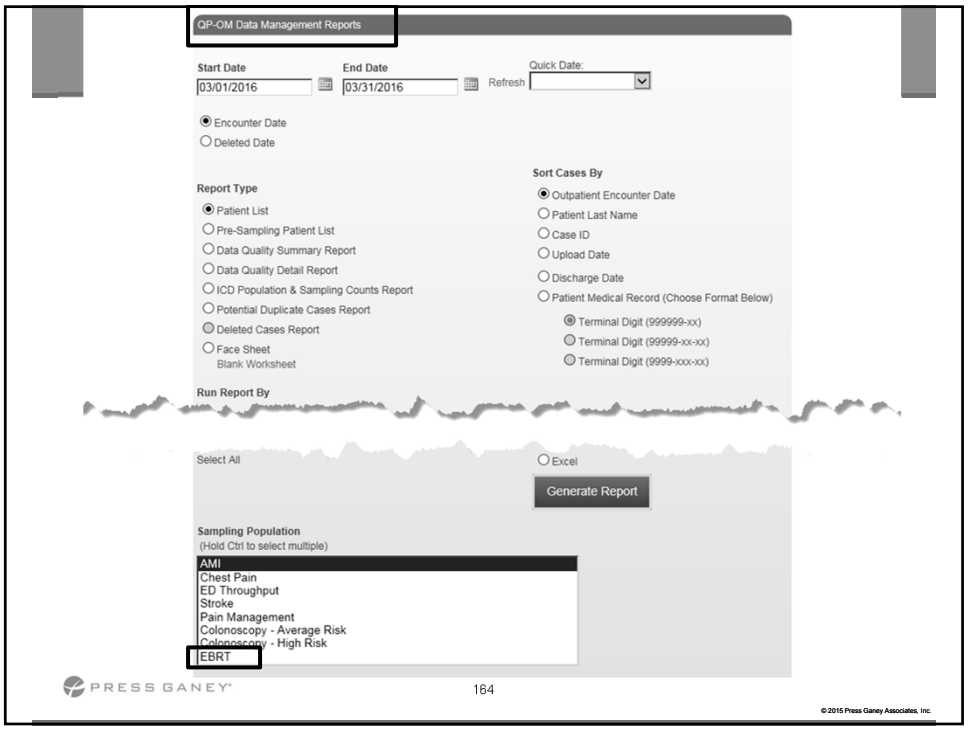
- Enter Case Data
  - The option to enter case data for the EBRT cases has been added to the Enter Case Data criteria page
- Sampling
  - CMS allows sampling the EBRT measure

OP 33 Measure Support in QP

- Measure Rate Reports
  - EBRT measure options have been added to the reports and graphing features
  - This includes a new Structured Measure report entitled EBRT Report
    - Selecting this option opens a parameters page enter a start and end month and year for the report
    - The report provides monthly and quarterly totals for numerator and denominator counts, and measure rates
  - A Rate Report is also available for this measure providing numerator, denominator and measure rates by quarter.




External Beam Radiotherapy (EBRT) for Bone Metastases
Does the patient have a history of previous radiation therapy to the same anatomical site? (?)
Yes
No/Not Documented/UTD
Reset
Has the patient been treated with radiosurgery or SBRT?
Yes
No/Not Documented/UTD
Reset
Is the patient part of a prospective clinical protocol or registry study?
Yes
No/Not Documented/UTD
Reset
Does the patient have femoral axis cortical involvement greater than 3 cm in length? (?)
Yes
No/Not Documented/UTD
Reset
Has the patient undergone a surgical stabilization procedure? (?)
Yes
No/Not Documented/UTD
Reset
Does the patient have radicular pain? (?)
Yes
No/Not Documented/UTD
Reset
Is there a documented reason from the patient for declining EBRT (e.g. economic, social, religious)? (?)
Yes
No/Not Documented/UTD
Reset
Did the patient receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns or 8Gy/1fxns? (?)
Yes
Any exclusion stops the algorithm and = Measure Category "B"
Measure Id
Measure Cat
Algorithm End Value
Mesmnt.
EBRT
OP-33
B
Femoral Axis Cortical Involvement
n/a
© 2015 Press Ganey Associates, Inc.


QP-OM Data Management Reports
Start Date
03/01/2016
End Date
03/31/2016
Refresh
Quick Date:
Encounter Date
Deleted Date
Report Type
Patient List
Pre-Sampling Patient List
Data Quality Summary Report
Data Quality Detail Report
ICD Population & Sampling Counts Report
Potential Duplicate Cases Report
Deleted Cases Report
Face Sheet
Blank Worksheet
Sort Cases By
Outpatient Encounter Date
Patient Last Name
Case ID
Upload Date
Discharge Date
Patient Medical Record (Choose Format Below)
Terminal Digit (999999-xx)
Terminal Digit (99999-xx-xx)
Terminal Digit (9999-xxx-xx)
Run Report By
Select All
Excel
Generate Report
Sampling Population
(Hold Ctrl to select multiple)
AMI
Chest Pain
ED Throughput
Stroke
Pain Management
Colonoscopy - Average Risk
Colonoscopy - High Risk
EBRT
PRESS GANEY
164
© 2015 Press Ganey Associates, Inc.

Additional Updates

Additional Updates

- Removed
  - OP-15: Use of Brain CT in the ED for Atraumatic Headache
- Changed
- OP 34: Emergency Department Transfer Communication (EDTC)
  - Proposed measure for Jan 2017 encounters NOT ADOPTED
    - Aggregate data submission for the CY2019 payment determination
    - 26 elements
    - Considered too burdensome in its current format

Additional Updates

- Reporting Period
  - Web-based measures
    - **January 1 through May 15**
  - Begins with CY2017 payment determination
  - Vendor submission of aggregate data is not an option
  - Facility will manually enter aggregate counts into QNET

Outpatient Specification Manual Update Version 9.1 (July 1, 2016 – December 31, 2016)

OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures

- Clarification on data submission requirements
  - the categories and HCPCS for Outpatient Surgical Procedures will be updated in late 2016

Hospital OQR Program Measures CY2018 Payment

Hospital OQR Program Measurement Set for CY 2018 Payment

Reflects Encounters Starting January 1, 2016

Measure ID	Measure Name	Chart Abstracted	Claims Based	Structural
OP-1:	Median Time to Fibrinolysis	X		
OP-2:	Fibrinolytic Therapy Received w/in 30 Minutes	X		
OP-3:	Median Time to Transfer to Another Facility for ACI	X		
OP-4:	Aspirin at Arrival	X		
OP-5:	Median Time to ECG	X		
OP-8:	MRI Lumbar Spine for Low Back Pain		X	
OP-9:	Mammography Follow-up Rates		X	
OP-10:	Abdomen CT - Use of Contrast Material		X	
OP-11:	Thorax CT - Use of Contrast Material		X	
OP-12:	Ability for Providers w/ HIT to Receive Lab Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data			X
OP-13:	Cardiac Imaging for Preoperative Risk Assessment for Non-cardiac Low-Risk Surgery		X	
OP-14:	Simultaneous Use of Brain CT and Sinus CT		X	
~~OP-15:~~	~~Use of Brain CT in the Emergency Department for Atraumatic Headache~~	~~End 12/31/15~~	X	
OP-17:	Tracking Clinical Results Between Visits			X
OP-18:	Median Time from ED Arrival to ED Departure for Discharged ED Patients	X		
OP-20:	Door to Diagnosis Evaluation by a Qualified Medical Professional	X		
OP-21:	ED - Median Time to Pain Management for Long Bone Fracture	X		
OP-22:	ED - Patient Left Before Being Seen			X
OP-23:	ED - Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation w/in 45 Minutes of Arrival	X		
OP-25:	Safe Surgery Checklist Use ***			X
OP-26:	Hospital Outpatient Volume Data on Selected Outpatient Procedures ***			X
OP-27:	Influenza Vaccination Coverage Among Healthcare Personnel (via NHSN)			X
OP-29:	Endoscopy/Poly Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	X*		
OP-30:	Endoscopy/Poly Surveillance: Colonoscopy Interval for Pts w/ a Hx of Adenomatous Polyps - Avoidance of Inappropriate Use	X*		
OP-31:	Cataracts - Improvement in Pt's Visual Function w/in 90 Days Following Cataract Surgery	Voluntary		
OP-32:	Facility 7-Day risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy		X	
OP-33:	External Beam Radiotherapy for Bone Metastases			X

PRESS GANEY®

171

Thank you!

Q&A

PRESS GANEY®

Sepsis Updates

Inpatient Specification Manual v5.1

July 1 – December 31, 2016 Discharges

PRESS GANEY

Sepsis Specifications Manual Updates

Early Management Bundle, Severe Sepsis/Septic Shock

- Required by CMS for IPPS Hospitals for IQR Program
  - Optional for Critical Access Hospitals (CAH)
- Requirement started 4th Quarter 2015
  - Discharges beginning 10/1/2015

PRESS GANEY

174

Sepsis Specifications Manual Updates

The National Hospital Inpatient Quality Measures Specifications Manual is your official source of complete information

(Version 5.1, effective with July1, 2016 Discharges)

The following review provides an overview only and is NOT intended to be a substitute for detailed review of the Manual Revisions, including Release Notes, Data Element Definitions and Measure Information Forms

www.qualitynet.org

PRESS GANEY

175

Sepsis Specification Manual Updates v5.1

Version 5.0b

Section 2 - Measurement Information
Section 2.1 - Acute Myocardial Infarction (AMI)
Section 2.2 - Severe Sepsis and Septic Shock (SEP)
Section 2.3 - Surgical Care Improvement Project (SCIP)
Section 2.4 - *Reserved for future use*
Section 2.5 - Children's Asthma Care (CAC)
Section 2.6 - Venous Thromboembolism (VTE)
Section 2.7 - Stroke (STK)
Section 2.8 - Global Initial Patient Population (ED, IMM, TOB, SUB)
Section 2.9 - Emergency Department (ED)
Section 2.10 - Prevention 2.10.1 - Immunization (IMM) 2.10.2 - Tobacco Treatment (TOB) 2.10.3 - Substance Use (SUB)

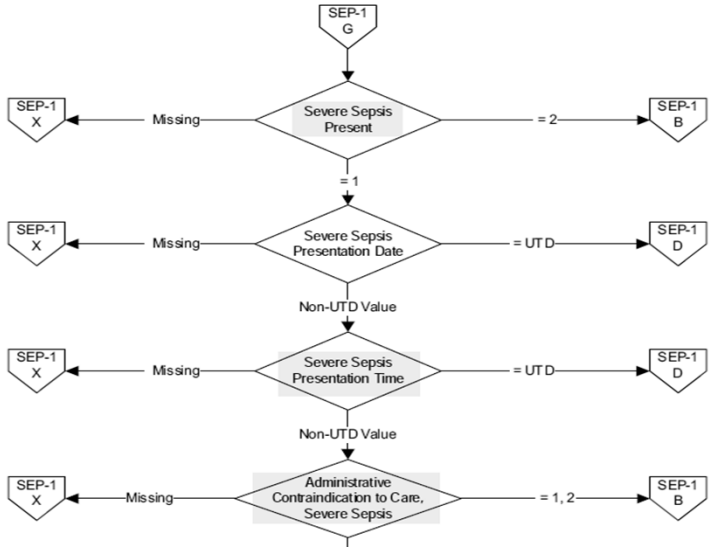
Version 5.1

Section 2 - Measurement Information
Section 2.1 - Severe Sepsis and Septic Shock (SEP)
Section 2.2 - Venous Thromboembolism (VTE)
Section 2.3 - Stroke (STK)
Section 2.4 - Global Initial Patient Population (ED, IMM, TOB, SUB)
Section 2.5 - Emergency Department (ED)
Section 2.6 - Prevention 2.6.1 - Immunization (IMM) 2.6.2 - Substance Use (SUB) 2.6.3 - Tobacco Treatment (TOB)

PRESS GANEY

176

Severe Sepsis Present



PRESS GANEY

177

Severe Sepsis Present

Notes for Abstraction:

- In order to establish the presence of severe sepsis, there are three criteria, all **three** of which must **be met within 6 hours of each other**.
  - **a) Documentation of a suspected source of clinical infection**. There may be reference to "possible infection from xx", "suspect infection from xx", or similar reference in progress notes, consult notes, or similar physician/APN/PA documentation
    - Nursing documentation referencing an infection, suspected infection, or current treatment of an infection is acceptable. Exclude documentation of viral or fungal infections.
  - **b) Two or more** manifestations of systemic infection according to the Systemic Inflammatory Response Syndrome (SIRS) criteria, which are:
    - Temperature > 38.3 C or < 36.0 C
    - Heart rate (pulse) > 90
    - Respiration > 20 per minute
    - White blood cell count > 12,000 or < 4,000 or > 10% bands

PRESS GANEY

178

Severe Sepsis Present

Notes for Abstraction: (continued)

- c. **Organ dysfunction**, evidenced by **any one of the following**:
  - Systolic blood pressure (SBP) < 90, or mean arterial pressure < 65, or a systolic blood pressure decrease of more than 40 mmHg
    - Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, severe sepsis or septic shock and not other causes.
  - Acute respiratory failure as evidenced by a **new need** for invasive **or** non-invasive mechanical ventilation. Invasive mechanical ventilation requires an endotracheal or tracheostomy tube.
    - Non-invasive mechanical ventilation (may be referred to as BiPAP) uses a mask.
  - Creatinine > 2.0, or urine output < 0.5 mL/kg/hour for 2 hours
  - Bilirubin > 2 mg/dL (34.2 mmol/L)
  - Platelet count < 100,000
  - INR > 1.5 or aPTT > 60 sec
  - Lactate > 2 mmol/L (18.0 mg/dL)

Severe Sepsis Present

Notes for Abstraction: (continued)

- **Do not include** evidence of organ dysfunction that is considered to be due to a chronic condition or medication (e.g., Creatinine >2 for a patient with end stage renal disease, INR > 1.5 for a patient on Warfarin, decrease in SBP associated with administration of a blood pressure medication).
- All three criteria (a, b, and c) **must** be met in order to choose Value "1."

Administrative Contraindication to Care: Severe Sepsis (NEW)

Definition: Documentation of refusal of blood draw, fluid administration, or antibiotic administration prior to or within 6 hours following presentation of severe sepsis.

Question: Did the patient or surrogate decision-maker decline consent for blood draw, fluid administration, or antibiotic administration prior to or within 6 hours following presentation of severe sepsis?

Administrative Contraindication to Care: Severe Sepsis (NEW)

Allowable Values:

1. (Yes) There is documentation by a physician/APN/PA that the patient or decision-maker has refused either blood draw, fluid administration, or antibiotic administration prior to or within 6 hours following presentation of severe sepsis.
2. (Yes) There is a witnessed consent form for either blood draw, fluid administration, or antibiotic administration that is marked "refused" prior to or within 6 hours following presentation of severe sepsis.
3. (No) There is no physician/APN/PA documentation or witnessed consent form that the patient or decision-maker has refused either blood draw, fluid administration, or antibiotic administration prior to or within 6 hours following presentation of severe sepsis.

Administrative Contraindication to Care: Severe Sepsis (NEW)

Notes for Abstraction:

- **Only acceptable sources are physician/APN/PA documentation or a witness-signed consent form marked "refused."**
- Consent forms either signed or unsigned by the patient or decision-maker that are marked "refused" and witnessed by a physician, APN, or PA or other hospital personnel, are acceptable.
- Documentation of refusal of blood draw, fluid administration, or antibiotic administration that is present prior to or within 6 hours following presentation of severe sepsis can be used.

Exclusion Guidelines for Abstraction:

- Unwitnessed consent forms

Directive for Comfort Care **or Palliative Care**, Severe Sepsis

Definition: Directive for Comfort Care refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Palliative Care is the identification, prevention, and treatment of suffering by means of assessment of the physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient's quality of life. Palliative care ensures a partnership between practitioner, patient, and family to provide support in decision making at any stage in the patient's care.

Directive for Comfort Care **or Palliative Care**, Severe Sepsis

Question: Did physician/APN/PA documentation of comfort measures only or palliative care occur?

Allowable Values:

1. (Yes) Physician/APN/PA documentation of comfort measures only or palliative care was prior to or within **3 hours of the presentation of severe sepsis**.
2. (No) Physician/APN/PA documentation of comfort measures only or palliative care was **not prior to or within 3 hours of presentation of severe sepsis, or not documented or time is unclear.**

Initial Lactate Level: Collected, Date, and Time

Inclusion Guidelines for Abstraction:

- Lactate level drawn
- Lactate level collected
- Lactic acid drawn

Broad Spectrum or Other Antibiotic Administration Date/Time

Definition: The earliest date/time on/at which an antibiotic was administered intravenously if given in the time window of 24 hours preceding and 3 hours after *Severe Sepsis Presentation Time*.

Question: What was the earliest date/time on/at which an antibiotic was administered intravenously if given in the time window of 24 hours preceding and 3 hours after *Severe Sepsis Presentation Time*?

Notes for Abstraction:

- If antibiotics were administered intravenously (IV) within 24 hours prior to *Severe Sepsis Presentation Time*, abstract the earliest date/time that IV antibiotic was given. This may be the same date/time as the date/time of presentation or may be a date/time any time before presentation.

Broad Spectrum or Other Antibiotic Administration Date/Time

Notes for Abstraction: (continued)

- If the patient was started on IV antibiotics within the 3 hours following the date and time of presentation of severe sepsis, and not on antibiotics in the 24 hours prior to the date and time of presentation of severe sepsis, abstract the earliest date/time on which the first dose of antibiotic was given. This may be the same date/time as the date/time of presentation or may be a date or time after presentation.
- If more than one IV antibiotic was given within the 3 hours after the presentation of severe sepsis, and the patient did not receive an IV antibiotic in the 24 hours before severe sepsis presentation, abstract the dose given closest to the time of presentation of severe sepsis

Broad Spectrum or Other Antibiotic Administration Date/Time

Notes for Abstraction: (continued)

- If IV antibiotics were administered both 24 hours prior to and within 3 hours after the time of presentation of severe sepsis, abstract the earliest time that an IV dose of antibiotic was given.
- Stop abstracting 3 hours after the presentation of severe sepsis.
- If no antibiotic was given in the 24 hours before or 3 hours after the severe sepsis presentation date and time, enter "UTD."

Broad Spectrum or Other Antibiotic Administration Selection

Definition: The selection of the intravenous (IV) antibiotic administered within 3 hours following the presentation of severe sepsis.

Question: Was the intravenous (IV) antibiotic administered within 3 hours after the date and time of presentation of severe sepsis consistent with antibiotic selection guidelines detailed in the Notes for Abstraction?

Allowable Values:

1. (Yes) The IV antibiotic that was given within 3 hours following the presentation of severe sepsis is consistent with antibiotic selection guidelines.
2. (No) The IV antibiotic that was given within 3 hours following the presentation of severe sepsis is not consistent with antibiotic selection guidelines.

Broad Spectrum or Other Antibiotic Administration Selection

Notes for Abstraction:

- If there is one IV antibiotic given to the patient within 3 hours after presentation of severe sepsis that is on the monotherapy table in Appendix C, Table 5.0, choose Value "1"
  - (Table 5.0 contains the names of all broad spectrum antibiotics approved as monotherapy).
- If the administered IV antibiotics were NOT on Table 5.0, determine if the IV antibiotics are on Table 5.1 in Appendix C. Determine the class the administered IV antibiotics belong to, based on the class name in the shaded row above the antibiotic names.

Broad Spectrum or Other Antibiotic Administration Selection

Notes for Abstraction:

- Next, refer to the following Combination Antibiotic Therapy Table to determine if an antibiotic from a class in both Column A and Column B were given.
- There must be at least one from a class in column A and at least one from a class in column B administered to select Value "1." Review the chart to see that both drugs were started or given within 3 hours of severe sepsis presentation and if so, choose Value "1." If both drugs were not started or given, choose Value "2."
- If no IV antibiotics were administered in the three hour time window, choose Value "2."

Broad Spectrum or Other Antibiotic Administration Selection

Notes for Abstraction: (continued)

- If an IV antibiotic from Table 5.0 or an appropriate combination of IV antibiotics from Table 5.1 is not started or given within the 3 hours following presentation of severe sepsis, but there is a lab report or physician/APN/PA documentation indicating the causative organism and susceptibility is known and an IV antibiotic identified as appropriate to treat the causative organism is given within 3 hours following presentation of severe sepsis, choose Value "1."
- **NOTE**: Metronidazole (Flagyl) is not represented on any table because it is not approved for monotherapy and if given, must be given with 2 other combination antibiotic therapy drugs. Since giving those 2 antibiotic therapy drugs will allow Value "1" to be chosen, the metronidazole is not required to be administered or abstracted.

Broad Spectrum or Other Antibiotic Administration Selection

Table 5.0 Antibiotic Monotherapy, Sepsis

Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Doribax	Doripenem
Doripenem	Doripenem
Eratepenem	
Invanz	
Imipenem/Cilastatin	
Meropenem	
Merrem	
Primaxin	
Cefotaxime	
Claforan	

Combination Antibiotic Therapy Table

Column A		Column B
Aminoglycosides OR Aztreonam OR Ciprofloxacin	+	Cephalosporins (1st and 2nd Generation) OR Clindamycin IV OR Daptomycin OR Glycopeptides OR Linezolid OR Macrolides OR Penicillins

Table 5.1 Antibiotic Generic/Trade Name Crosswalk, Sepsis

Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Aminoglycosides	
Amikacin	Amikacin
Garamycin	Gentamicin
Gentamicin	Gentamicin
Kanamycin	Kanamycin
Kantrex	Kanamycin
Nebcin	Tobramycin
Tobramycin	Tobramycin
Aztreonam	
Azactam	Aztreonam

Initial Lactate Level Result

Definition: Documentation of the initial lactate level result.

Question: What was the **initial** lactate level **result**?

Allowable Values:

1. **(<= 2)** The initial lactate level was less than or equal to 2, or there was no initial lactate level collected.
2. **(> 2 and < 4.0)** The initial lactate level was greater than 2.0 and less than 4.0.
3. **(>= 4)** The initial lactate level was 4.0 or more, or there is no result in the chart, or unable to determine the result.

Repeat Lactate Level Collection

Notes for Abstraction:

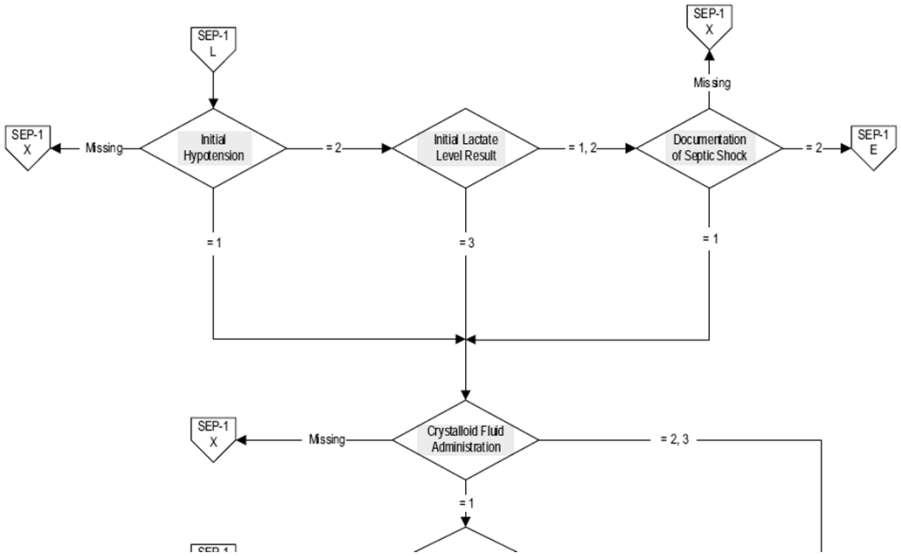
- A **repeat** lactate level is the **next** lactate level drawn **after** the **initial** lactate level if the initial lactate is elevated (>2.0).

Inclusion Guidelines for Abstraction:

- Lactate level drawn
- Lactate level collected
- Lactic acid drawn

******The same 2 changes were made for Repeat Lactate Level Collection Date and Time***

Initial Hypotension (NEW)



Initial Hypotension (NEW)

Definition: Documentation of the presence of initial hypotension **6 hours prior to or within 6 hours following *Severe Sepsis Presentation Date and Time.*** The criteria for determining that initial hypotension was present are as follows:

- systolic blood pressure (SBP) <90, or
- mean arterial pressure (MAP) <65 or
- a decrease in systolic blood pressure by >40 mmHg. **Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection or severe sepsis and not other causes.**

Initial Hypotension (NEW)

Suggested Data Collection Question: Was initial hypotension present 6 hours prior to or within 6 hours following *Severe Sepsis Presentation Date and Time*?

Allowable Values:

1. (Yes) Hypotension was present 6 hours prior to or within 6 hours following Severe Sepsis presentation.
2. (No) Hypotension was not present 6 hours prior to or within 6 hours following Severe Sepsis presentation.

Initial Hypotension (NEW)

Notes for Abstraction:

- If the organ dysfunction criteria for determining *Severe Sepsis Present* is evidenced based upon blood pressure readings, select Value "1."
- If hypotension was present within 6 hours prior to or within 6 hours following *Severe Sepsis Presentation Date and Time*, select Value "1."
- If hypotension was not present within 6 hours prior to or within 6 hours following *Severe Sepsis Presentation Date and Time*, select Value "2."

Suggested Data Sources:

- Entire ED record
- Nurses notes
- Physician/APN/PA notes
- Vital signs record or flow sheet

Initial Lactate Level Result

Notes for Abstraction:

- Use the **result** for the **initial** lactate level drawn in the data element **Initial Lactate Level Collection**.
- If there was **no initial lactate level collected, choose Value "1."**
- If there was an initial lactate level collected **but there is no result or the result cannot be determined, choose Value "3."**
- Continue reviewing for a repeat lactate level if the initial lactate level is elevated (>2), refer to *Repeat Lactate Level Collection*.

Inclusion Guidelines for Abstraction:

- Lactate results
- Lactic acid results

Documentation of Septic Shock (NEW)

Definition: Physician/APN/PA documentation of septic shock within 6 hours following the presentation of severe sepsis.

Suggested Data Collection Question: Was physician/APN/PA documentation of septic shock within 6 hours following the presentation of severe sepsis present in the medical record?

Allowable Values:

1. (Yes) There was physician/APN/PA documentation of septic shock within 6 hours of *Severe Sepsis Presentation Date and Time*.
2. (No) There was not physician/APN/PA documentation of septic shock within 6 hours of *Severe Sepsis Presentation Date and Time*.

Documentation of Septic Shock (NEW)

Notes for Abstraction:

- If there was physician/APN/PA documentation of confirmed, suspected, or possible septic shock within 6 hours of *Severe Sepsis Presentation Date and Time*, select Value "1."
- If there was not physician/APN/PA documentation of confirmed, suspected, or possible septic shock within 6 hours of *Severe Sepsis Presentation Date and Time*, select Value "2."

Suggested Data Sources:

- Physician/APN/PA notes

Inclusion Guidelines for Abstraction:

- Septic shock
- Suspected septic shock
- Possible septic shock
- Severe sepsis with septic shock

Crystalloid Fluid Administration

Definition: Documentation of administration of crystalloid fluids prior to, at the time of, or after the presentation of initial hypotension, initial lactate >=4, or documentation of septic shock.

Suggested Data Collection Question: Were crystalloid fluids administered prior to, at the time of, or after the presentation of initial hypotension, initial lactate >=4, or documentation of septic shock?

Crystalloid Fluid Administration

Allowable Values:

1. (Yes) 30 mL/kg of crystalloid fluids were ordered and administered prior to, at the time of, or after the presentation of initial hypotension, initial lactate >=4, or documentation of septic shock.
2. (No) Less than 30 mL/kg of crystalloid fluids were ordered and administered prior to, at the time of, or after the presentation of initial hypotension, initial lactate >=4, or documentation of septic shock, or unable to determine volume ordered.
3. (No) Crystalloid fluids were not administered prior to, at the time of, or after the presentation of initial hypotension, initial lactate >=4, or documentation of septic shock, or unable to determine whether or not they were administered.

Crystalloid Fluid Administration

Notes for Abstraction:

- The ONLY acceptable fluids are crystalloid or balanced crystalloid solutions (such as 0.9% sodium chloride solution, normal saline, Lactated Ringers Solution, PlasmaLyte, or Normosol).
- Only abstract crystalloid fluids given for the presence of severe sepsis with hypotension, OR for the presence of severe sepsis with a lactate >=4 mmol/L, OR physician/APN/PA documentation of septic shock.
- Do not abstract crystalloid solutions that are used to flush IV lines or give medications such as antibiotics.

Crystalloid Fluid Administration

Notes for Abstraction:

- **To determine the volume**, first **calculate** the patient weight in kilograms. To do this, divide the weight in pounds by 2.2. Next, **multiply** the weight in kilograms by 30; the **result** is the number of mL of IV that **should be specified in the physician/APN/PA order.**
  - **Example:**
    - Patient weight is 160 pounds. 160/2.2 = 72.72. 72.72 x 30 = 2182 (mL). Physician order is "Infuse 2400 mL 0.9% Normal Saline over the next two hours." Choose Value "1" (2400 mL is greater than 2182).
  - **Example:**
    - Patient weight is 160 pounds. 160/2.2 = 72.72. 72.72 x 30 = 2182 (mL). Physician order is "Give 1000 mL Lactated Ringers over the next 4 hours." Choose Value "2" (1000 mL is less than 2182).

Crystalloid Fluid Administration

Notes for Abstraction: (continued)

- Physician/APN/PA orders are required for the fluids. The order must include the type of fluid, the volume of fluid, and a rate or time over which the fluids are to be given. If the type of fluid, IV route, rate or duration over which to give the fluids is missing, choose Value "2."
- If the crystalloid fluid order is equivalent to 30 mL/kg, the IV route is indicated, and a specific time over which the IV fluids are to be given or a rate is not in the order, but the terms "bolus" or "wide open" are included in the order, this is acceptable. The terms "bolus" and "wide open" imply the fluids will be administered rapidly and are acceptable in place of a specific rate or infusion duration.

Crystalloid Fluid Administration

Notes for Abstraction: (continued)

- If crystalloid fluids are given at a usual rate, maintenance rate or at a "Keep Vein Open" (KVO) rate, which for purposes of the measure is 1000 mL over 8 hours (125 mL/hour) or less, choose Value "2."
- The volume of crystalloid fluids ordered may be in a single order or a series of multiple orders. If the total volume of crystalloid fluids ordered is less than 30 mL/kg, choose Value "2."
- Use the weight documented closest to and prior to the order for crystalloid fluids. If a weight is not documented prior to the crystalloid fluid order, use the weight recorded closest to and after the crystalloid fluid order.

Crystalloid Fluid Administration

Notes for Abstraction: (continued)

- Use the patient's actual weight. Use estimated weight only if actual weight is not available to determine the volume of crystalloid fluids the patient should receive. Do not use ideal weight.
- If there is documentation the infusion was stopped prior to 30 mL/kg being completely infused, select Value "2."

Suggested Data Sources:

- Ambulance or transport vehicle records
- Entire ED record
- IV therapy record
- Medication Administration Record
- Patient weight record
- Physician/APN/PA orders

Crystalloid Fluid Administration

Inclusion Guidelines for Abstraction:

- 0.9% saline solution
- Lactated Ringers Solution
- normal saline
- Normosol
- PlasmaLyte

Crystalloid Fluid Administration Date/Time

Definition: The date/time on/at which crystalloid fluids were initiated for initial hypotension, initial lactate >=4, or documentation of septic shock.

Question: What was the **earliest** date/time on/at which crystalloid fluids were initiated for initial hypotension, initial lactate >=4, or documentation of septic shock?

Notes for Abstraction:

- If a single order is written for the entire 30 mL/kg volume, use the date the crystalloid solution was started as an IV infusion.
- If a single order for the equivalent of 30 mL/kg is written and the infusion is given over multiple infusions, use the start date of the first crystalloid fluid infusion.

Crystalloid Fluid Administration Date/Time

Notes for Abstraction:

- If multiple orders are written that total 30 mL/kg or more, use the start date of the crystalloid fluid infusion that completes the 30 mL/kg volume.
- If a crystalloid infusion is running at a maintenance rate (125 mL/hour or less) and the rate is increased to administer the 30 mL/kg, use the date the infusion rate is increased.
- In some cases, the crystalloid fluid will be infusing prior to the time of presentation of septic shock; if so, use the date/time the unit of fluid was started or hung.

Crystalloid Fluid Administration Date/Time

Notes for Abstraction: (continued)

- Example: Septic Shock presentation date and time was 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 3000 mL of 0.9% Normal Saline over 2 hours is written. The total volume is given as 3 separate infusions of 1000 mL each. The first of the three infusions is started on 08-14-20xx at 22:00. The C*rystalloid Fluid Administration Date* was 08-14-20xx.
- Example: Septic Shock presentation date and time was 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 1000 mL of 0.9% Normal Saline over 60 minutes is written and started on 08-14-20xx at 22:00. An order for another 1000 mL of Normal Saline is written and started on 08-14-20xx at 23:15. A third order for 1000 mL of Normal Saline is written and started on 08-15-20xx at 00:30. The *Crystalloid Fluid Administration Date* was 08-15-20xx.

Crystalloid Fluid Administration Date/Time

Notes for Abstraction:

- Do not abstract the date that fluids were ordered.
- Do not abstract the date that IV access was started; abstract the date/time that the crystalloid fluid infusion began.
- Do not abstract crystalloid solutions that are used to flush IV lines or give medications such as antibiotics.

Septic Shock Present, and Date/Time

Notes for Abstraction:

- Use the date/time on/at which the last sign of septic shock was noted or the last laboratory value was reported. **The criteria for *Septic Shock Present* are**:
  a) There **must** be documentation of **severe sepsis present**.

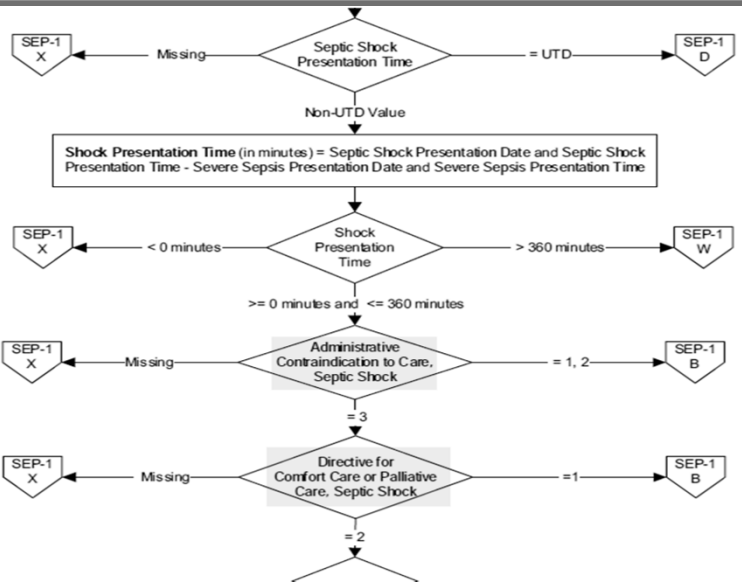
  AND

  b) Hypotension persists in the hour after the conclusion of the 30 mL/kg Crystalloid Fluid Administration, evidenced by
  - Systolic blood pressure (SBP) < 90, or
  - Mean arterial pressure < 65 or
  - A decrease in systolic blood pressure by > 40 mmHg
    - **Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, severe sepsis or septic shock and not other causes.**

      » **OR**

  Tissue hypoperfusion is present evidenced by
  - Initial Lactate level is >= 4 mmol/L

Septic Shock Present



Septic Shock Present

Notes for Abstraction:

*******Bullet Removed:**

- If crystalloid fluids were not administered after the presentation date and time of severe sepsis, choose Value "2."

Inclusion Guidelines for Abstraction:

- Septic Shock
- r/o septic shock
- Differential diagnosis: septic shock
- Possible septic shock
- **Severe Sepsis with Septic Shock**

Administrative Contraindication to Care: Septic Shock (NEW)

Definition: Documentation of refusal of blood draw, fluid administration, or vasopressor administration prior to or within 6 hours following presentation of septic shock.

Question: Did the patient or surrogate decision-maker decline consent for blood draw, fluid administration, or vasopressor administration prior to or within 6 hours following presentation of septic shock?

Administrative Contraindication to Care: Septic Shock (NEW)

Allowable Values:

1. (Yes) There is documentation by a physician/APN/PA that the patient or decision-maker has refused either blood draw, fluid administration, or vasopressor administration prior to or within 6 hours following presentation of septic shock.
2. (Yes) There is a witnessed consent form for either blood draw, fluid administration, or vasopressor administration that is marked "refused" prior to or within 6 hours following presentation of septic shock.
3. (No) There is no physician/APN/PA documentation or witnessed consent form that the patient or decision-maker has refused either blood draw, fluid administration, or vasopressor administration prior to or within 6 hours following presentation of septic shock.

Administrative Contraindication to Care: Septic Shock (NEW)

Notes for Abstraction:

- Only acceptable sources are physician/APN/PA documentation or a witness- signed consent form marked "refused."
- Consent forms either signed or unsigned by the patient or decision-maker that are marked "refused" and witnessed by a physician, APN, PA or other hospital personnel, are acceptable.
- Documentation of refusal of blood draw, fluid administration, or vasopressor administration that is present prior to or within 6 hours following presentation of septic shock can be used.

Exclusion Guidelines for Abstraction:

- Unwitnessed consent forms

Directive for Comfort Care **or Palliative Care**, Septic Shock

Definition: Directive for Comfort Care refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Palliative Care is the identification, prevention, and treatment of suffering by means of assessment of the physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient's quality of life. Palliative care ensures a partnership between practitioner, patient, and family to provide support in decision making at any stage in the patient's care.

Directive for Comfort Care **or Palliative Care**, Septic Shock

Question: Did physician/APN/PA documentation of comfort measures only or palliative care occur?

Allowable Values:

1. (Yes) Physician/APN/PA documentation of comfort measures only or palliative care was prior to or within **6 hours of the presentation of septic shock**.
2. (No) Physician/APN/PA documentation of comfort measures only or palliative care was **not prior to or within 6 hours of presentation of septic shock, or not documented or time is unclear**.

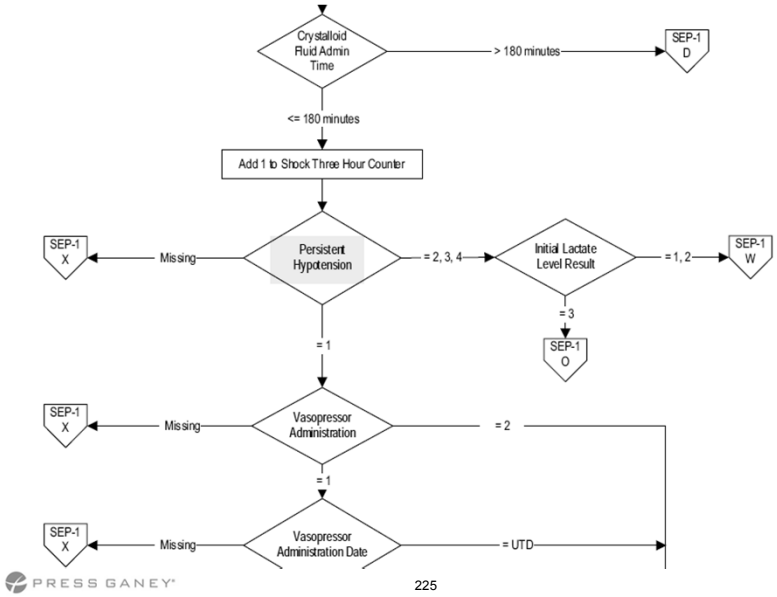
Directive for Comfort Care **or Palliative Care**, Septic Shock

Inclusion Guidelines for Abstraction: ***

- Brain dead
- Brain death
- Comfort care
- Comfort measures
- Comfort measures only (CMO)
- Comfort only
- DNR-CC
- End of life care
- Hospice
- Hospice care
- Organ harvest
- Palliative Care
- Terminal care
- Terminal extubation

****Same for Directive for Comfort Care or Palliative Care, Severe Sepsis*

Persistent Hypotension



Persistent Hypotension

Definition: Documentation of the presence of persistent hypotension or new hypotension following the administration of 30 mL/kg of crystalloid fluids in septic shock. **The criteria for determining that hypotension was persistent are as follows:**

- **In the one hour following administration of crystalloid fluids, <u>two or more consecutive blood pressure readings</u> of either:**
  - Systolic blood pressure (SBP) < 90, or
  - Mean arterial pressure (MAP) < 65 or
  - A decrease in systolic blood pressure by > 40 mmHg
    - Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, severe sepsis or septic shock and not other causes.

Persistent Hypotension

Question: Was persistent hypotension **or new hypotension** present within one hour of the conclusion of crystalloid fluid administration?

Allowable Values:

1. (Yes) Crystalloid fluids were administered at a **volume of 30 mL/kg** and **persistent hypotension or new hypotension was present** within one hour of conclusion of fluid administration.
2. (No) **Persistent hypotension or new hypotension was not present** within one hour of the conclusion of crystalloid fluid administration at a volume of 30 mL/kg.
3. (No) or UTD The patient was **not assessed for persistent hypotension or new hypotension** within the one hour after the conclusion of crystalloid fluid administration at a volume of 30 mL/kg, or Unable to Determine.
4. (Not applicable) Crystalloid **fluids were not administered**, **or** crystalloid fluids were administered but at a volume **less than 30 mL/kg.**

Persistent Hypotension

Notes for Abstraction:

- **Begin abstracting at the time that crystalloid fluid administration concludes**; abstract for the time period that follows for the next hour only. Choose Value "1" if persistent hypotension **or new hypotension** was present, choose Value "2" if persistent hypotension **or new hypotension** was not present.
- If the completion time of the 30 mL/kg crystalloid fluid infusion **is documented** in the medical record use that time as the start for the one hour within which to determine presence of persistent hypotension **or new hypotension**.
- If there is physician/APN/PA or nursing **documentation indicating a low blood pressure reading is erroneous or questioning the validity of a low blood pressure reading**, do not consider that reading for determining the presence of persistent hypotension **or new hypotension**.

Vasopressor Administration

Definition: Documentation of administration of an intravenous vasopressor in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration.

Question: Was an intravenous vasopressor administered in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration?

Vasopressor Administration

Allowable Values:

1. (Yes) The patient was given an intravenous vasopressor in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock.
2. (No) The patient was not given an intravenous vasopressor in the time window beginning at septic shock presentation and ending 6 hours after the time of presentation of septic shock.

Vasopressor Administration

Notes for Abstraction:

- Vasopressor administration information should only be abstracted from documentation that demonstrates actual administration of the vasopressor.
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
  - Acceptable examples of administration include: "vasopressor running" and "vasopressor given."

Vasopressor Administration

Notes for Abstraction: (continued)

- If a vasopressor was infusing at the time of presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration, choose Value "1." For example, septic shock patient was triaged in the ED at 08:00. The patient was receiving Levophed via an IV at the time of triage – choose Value "1."
- If a vasopressor was not started within the acceptable time frame, select Value "2."

Inclusion Guidelines for Abstraction:

- None

Vasopressor Administration Date/Time

Definition: The date on which an intravenous vasopressor was administered within 6 hours following the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration.

Question: What was the date on which an intravenous vasopressor was administered within 6 hours following the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration?

Vasopressor Administration Date/Time

Notes for Abstraction:

- Vasopressor administration information should only be abstracted from documentation that demonstrates actual administration of the vasopressor. o Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
  - Acceptable examples of administration include: "vasopressor running" and "vasopressor given."
- If a vasopressor was infusing at the time of presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration, or the vasopressor was infusing at the time of septic shock and multiple doses were subsequently given, abstract the date the vasopressor that was infusing at the time of presentation of septic shock was initiated.

Inclusion Guidelines for Abstraction:

- None

Vital Signs Review Performed

Notes for Abstraction:

- Vital signs review is done to assess overall status. The review must include temperature, pulse (also referred to as heart rate), respirations, and systolic and diastolic blood pressure reading.
  - Example: Temp 100.4, Pulse 96, Resp. 20, BP 102/70
  - Example: T 100.4, P 96, R 20, BP 102/70
  - Example: T 100.4, HR 96, R 20, BP 102/70
  - Example: TPR 100.4/96/20, BP 102/70
- If **all four evaluations** (Temperature, Pulse or Heart Rate, Respirations, Blood Pressure) **are not included**, choose Value "2."

Cardiopulmonary Evaluation Date/Time

Definition: Documentation of the date indicating a cardiopulmonary evaluation was performed by a physician/APN/PA.

Question: On/at what date/time was a cardiopulmonary evaluation performed and documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Notes for Abstraction:

- If **multiple** cardiopulmonary evaluations were documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date of the evaluation that was documented **latest** within the time window

Cardiopulmonary Evaluation Performed

Definition: Documentation of performance of a cardiopulmonary evaluation to assess the status of the heart and lungs.

Question: Was a cardiopulmonary evaluation performed and documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Allowable Values:

1. (Yes) Cardiopulmonary evaluation was performed and documented by a physician/APN/PA.
2. (No) Cardiopulmonary evaluation was not performed and documented by a physician/APN/PA, or unable to determine.

Cardiopulmonary Evaluation Performed

Notes for Abstraction:

- If **both** heart and lung evaluations **are not included**, choose Value "2."
- If **multiple** cardiopulmonary evaluations were documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, use the evaluation that was documented **latest** within the time window
- If there are **no** cardiopulmonary evaluations documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, **choose Value "2."**

Capillary Refill Examination Date/Time

Definition: Documentation of the date indicating a capillary refill examination was performed.

Question: On what date/time was a capillary refill examination documented by a physician/advanced practice nurse/physician assistant (physician/APN/PA) in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Notes for Abstraction:

- Start abstracting at the crystalloid fluid administration date and time and stop abstracting six hours after the presentation of septic shock date and time.

Capillary Refill Examination Date/Time

Notes for Abstraction: (continued)

- If multiple capillary refill examinations were documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date and time of the examination that was documented latest within the time window.

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Consultation notes
- Emergency Department record
- History and physical
- Progress notes

Capillary Refill Examination Performed

Definition: Documentation of performance of a capillary refill examination.

Question: Was a capillary refill examination documented by a physician/advanced practice nurse/physician assistant (physician/APN/PA) in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Allowable Values:

1. (Yes) Capillary refill examination was documented by a physician/APN/PA.
2. (No) Capillary refill examination was not documented by a physician/APN/PA, or unable to determine.

Capillary Refill Examination Performed

Notes for Abstraction:

- The assessment of circulatory adequacy may include such terms as "capillary refill," "capillary fill," "nail bed refill," "mottled," or similar terms, or make reference to peripheral perfusion.
- Capillary refill must be documented by a physician/APN/PA between crystalloid fluid administration date and time and six hours after the presentation of septic shock date and time in order to choose Value "1."
- If multiple capillary refill examinations were documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date and time of the examination that was documented latest within the time window.

Capillary Refill Examination Performed

Notes for Abstraction: (continued)

- If there are no capillary refill examinations documented beginning at the crystalloid fluid administration date and time and ending six hours after the time and date of septic shock presentation, choose Value "2."

Inclusion Guidelines for Abstraction:

- Capillary fill
- Capillary refill
- Nail bed refill
- Cap refill
- Peripheral perfusion

Peripheral Pulse Evaluation Performed

Definition: Documentation of performance of a peripheral pulse evaluation.

Question: Was a peripheral pulse evaluation documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Peripheral Pulse Evaluation Performed

Allowable Values:

1. (Yes) Peripheral pulse evaluation was documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time.
2. (No) Peripheral pulse evaluation was not documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, or unable to determine.

Peripheral Pulse Evaluation Performed

Notes for Abstraction:

- If there are **multiple** peripheral pulse evaluations documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the procedure that was documented **latest** within the time window.
- If there are **no peripheral pulse evaluations** documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, choose Value "2."

Peripheral Pulse Evaluation Date/Time

Definition: Documentation of the date/time indicating a peripheral pulse evaluation was performed.

Question: On what date/time was a peripheral pulse evaluation documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Peripheral Pulse Evaluation Date/Time

Notes for Abstraction: (continued)

- **Peripheral pulse evaluation is done to assess circulatory status** and **may** include reference to either radial pulse, dorsalis pedis (or DP) pulse, or posterior tibialis (or PT) pulse.
- If **multiple** peripheral pulse evaluations were documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date/time of the procedure that was documented **latest** within the time window.

Skin Examination Performed

Definition: Documentation of performance of a skin examination.

Question: Was a skin examination documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Allowable Values:

1. (Yes) Skin examination was documented by a physician/APN/PA
2. (No) Skin examination was not documented by a physician/APN/PA, or unable to determine

Skin Examination Performed

Notes for Abstraction: (continued)

- If **multiple** skin examinations were documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date and time of the examination that was documented **latest** within the time window.
- If there are **no** skin examinations documented beginning at the crystalloid fluid administration date and time and ending six hours after the time and date of septic shock presentation, choose Value "2."

Inclusion Guidelines for Abstraction:

- Flushed
- Mottled
- Pale
- Pallor
- Pink

Skin Examination Date/Time

Definition: Documentation of the date/time indicating a skin examination was performed.

Question: On what date/time was a skin examination documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Skin Examination Date/Time

Notes for Abstraction:

- Skin examination is done to assess superficial circulatory status and must include reference to skin color.
- The assessment of skin color may include such terms as "flushed," "mottled," "pale," "pallor," "pink," or similar terminology.
- If **multiple** skin examinations were documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date of the examination that was documented **latest** within the time window.

Central Venous Oxygen Measurement

Definition: Documentation of measurement of central venous oxygen within 6 hours after presentation of septic shock.

Question: Was a central venous oxygen measurement obtained within 6 hours after the presentation of septic shock?

Allowable Values:

1. (Yes) Central Venous Oxygen Measurement was obtained within 6 hours after the presentation of septic shock.
2. (No) Central Venous Oxygen Measurement was not obtained within 6 hours after the presentation of septic shock, or unable to determine.

Central Venous Oxygen Measurement

Notes for Abstraction:

- If there are multiple central venous oxygen measurements, abstract the first one that occurs after the time and date of septic shock presentation.
- Central Venous Oxygen measurement may be expressed as SvO2 or ScvO2.
- There must be documentation reflecting the oxygen reading was obtained via central venous catheter. A notation such as via "central catheter" or "CVP catheter" or "central venous oximetry catheter" with an oxygen reading or the oxygen reading recorded on a flow sheet in an area designated for central venous catheter readings is acceptable.

Central Venous Oxygen Measurement Date/Time

Definition: The date/time on/at which the first central venous oxygen measurement was obtained within 6 hours after the presentation of septic shock.

Question: What was the **earliest** date/time on/at which the first central venous oxygen measurement was obtained within 6 hours after the presentation of septic shock?

Central Venous Oxygen Measurement Date/Time

Notes for Abstraction:

- If there are **multiple** central venous oxygen measurements, abstract the **first** one that occurs within 6 hours after the time and date of septic shock presentation.
- There must be documentation reflecting the oxygen reading was obtained via central venous catheter. A notation such as via "central catheter" or "CVP catheter" or "central venous oximetry catheter" with an oxygen reading or the oxygen reading recorded on a flow sheet in an area designated for central venous catheter readings is acceptable.

Passive Leg Raise Exam Date/Time

Definition: Documentation of the date/time indicating a passive leg raise was performed.

Question: On what date/time was a passive leg raise examination documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Passive Leg Raise Exam Performed

Definition: Documentation of performance of a passive leg raise examination.

Question: Was there physician/APN/PA documentation that a passive leg raise examination performed by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Passive Leg Raise Exam Performed

Allowable Values:

1. (Yes) Passive leg raise examination was documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time.
2. (No) Passive leg raise examination was not documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, or unable to determine.

Passive Leg Raise Exam Performed

Notes for Abstraction:

- Only abstract physician/APN/PA documentation indicating a passive leg raise was performed.
- If there are **multiple** passive leg raise examinations documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date and time of the procedure that was documented **latest** within the time window.
- If there are **no passive leg raise examinations** documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time choose Value "2."

Passive Leg Raise Exam Date/Time

Notes for Abstraction:

- Only abstract physician/APN/PA documentation indicating actual performance of a passive leg raise exam.
- If **multiple** passive leg raise examinations were documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date/time of the examination that was documented **latest** within the time window.

PRESS GANEY

261

Sepsis Algorithm

Inpatient Specification Manual v5.1

July 1 – December 31, 2016 Discharges

PRESS GANEY

Review of Algorithm

Data Element Answers that Cause Exclusions*
(Measure Category "B")

- ***Transfer From Another Hospital or ASC***
  - (Value "yes")
- ***Severe Sepsis Present***
  - (Value "2")
- ***Administrative Contraindication to Care, Severe Sepsis***
  - (Values "1,2")
- ***Directive for Comfort Care/Palliative Care, Severe Sepsis***
  - (Value "1")
- ***Administrative Contraindication to Care, Septic Shock***
  - (Values "1,2")
- ***Directive for Comfort Care/Palliative Care, Septic Shock***
  - (Value "1")

****Calculations of times may also cause Measure Category "B".*

PRESS GANEY

263

Review of Algorithm

Data Element Answers that Cause Failures*
(Measure Category "D")

- ***Severe Sepsis Presentation Date/Time***
  - (Value "UTD")
- ***Discharge Time***
  - (Value "UTD")
- ***Initial Lactate Level Collection***
  - (Value "2")
- ***Initial Lactate Level Date/Time***
  - (Value "UTD")
- ***Broad Spectrum or Other Antibiotic Administration***
  - (Value "2")
- ***Broad Spectrum or Other Antibiotic Administration Date/Time***
  - (Value "UTD")

****Calculations of times may also cause Measure Category "D".*

PRESS GANEY

264

Review of Algorithm

Data Element Answers that Cause Failures*
(Measure Category "D")

- ***Broad Spectrum or Other Antibiotic Selection***
  - (Value "2)
- ***Blood Culture Collection***
  - (Value "2")
- ***Blood Culture Collection Date/Time***
  - (Value "UTD")
- ***Repeat Lactate Level Collection***
  - (Value"2")
- ***Repeat Lactate Level Collection Date/Time***
  - (Value "UTD")
- ***Crystalloid Fluid Administration***
  - (Values "2,3")

****Calculations of times may also cause Measure Category "D".*

Review of Algorithm

Data Element Answers that Cause Failures*
(Measure Category "D")

- ***Crystalloid Fluid Administration Date/Time***
  - (Value "UTD")
- ***Septic Shock Presentation Date/Time***
  - (Value "UTD")
- ***Vasopressor Administration***
  - (Value "2")
- ***Vasopressor Administration Date/Time***
  - (Value "UTD")
- ***Persistent Hypotension***
  - (Values "3,4")

****Calculations of times may also cause Measure Category "D".*

Sepsis Detail Report

Coming in July!!

PRESS GANEY®

Sepsis Detail Report **Draft**

Product: QP-IM
Report Type: Sepsis Detail Report - Quarterly
Facility ID:
Facility: 10369
Display Date Range: 07/01/2016 to 09/10/2016
Measure Set: SEP

Quality Performer℠

			Data from Cases Sampled			Algorithm End Value (Reasons for Failures)								
						Severe Sepsis Fail					Septic Shock Fail			
3rd Quarter 2016	Initial Sepsis Population (Cat B, D, E, X)	Cases Sampled	Excluded Cases (Cat B)	Sepsis Passed (Cat E)	Sepsis Failed (Cat D)	Antibiotic Timing	No Initial Lactate Level	Blood Culture Timing	Repeat Lactate Level Collection	Repeat Lactate Timing	Crystalloid Fluids Timing	Vasopressor Timing	6 Hour Counter	Incomplete Cases (Cat X)
Jul	55	32	2	25	5	1	0	1	1	0	1	1	3	24
Aug	170	36	5	17	14	1	3	1	2	2	3	2	2	20
Sep	30	32	7	15	10	2	2	2	1	1	1	1	2	20
Qtr. Total	255	100	14	57	29	4	5	4	4	3	5	4	7	64

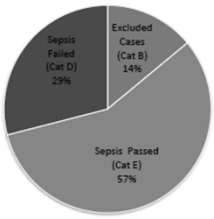
PRESS GANEY®

Sepsis Detail Report **Draft**

Product: QP-IM
Report Type: Sepsis Detail Report - Quarterly
Facility ID:
Facility: 10369
Display Date Range: 07/01/2016 to 09/10/2016
Measure Set: SEP

Quality Performer℠

Sepsis Cases Sampled



Sepsis Reason for Failure

PRESS GANEY®

269

Thank You

Value-Based Purchasing (VBP)

Updated: March 11, 2016

PRESS GANEY

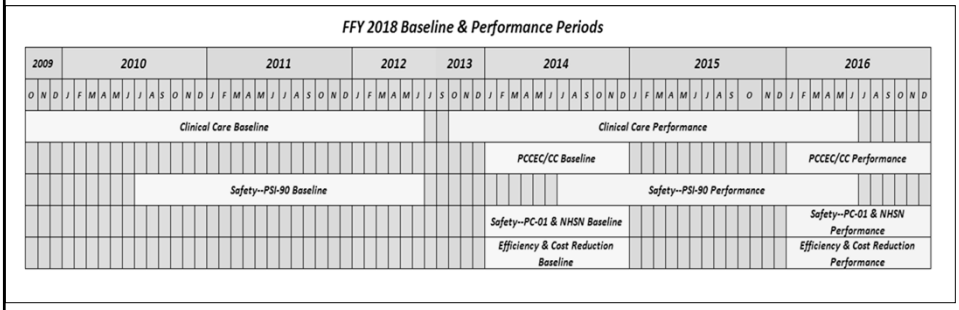
Overview of Value-Based Purchasing

- VBP established by Affordable Care Act, which added Section 1886(o) to the Social Security Act
  - Built on the Hospital Inpatient Quality Reporting (IQR) measure reporting infrastructure
  - Rewards better value and patient outcomes, not just volume
  - Funded by reductions from participating hospitals' base operating DRG payments (1.00% → 2.00% Hold Back)
  - Uses measures specified under Hospital IQR Program
    - Must be reported on Hospital Compare for at least 1 year before inclusion in VBP
  - "Hospital" defined in Subsection (d) of Section 1886(d)(B) of Social Security Act

Summary of FFY 2018 VBP Changes

- Usual revision of Floor, Achievement Threshold and Benchmark values
  - Metrics moving towards improved performance each year
- A new "Patient & Caregiver-Centered Experience of Care/Care Coordination" dimension, "*3-item Care Transition*"
- The "Clinical Care—Process" domain eliminated
  - No clinical process measures remain
- The "Clinical Care—Outcomes" domain has been renamed "Clinical Care"
  - 30-day survival for AMI, HF and PN
- "*PC-01 Elective Delivery"* moved to "Safety" domain

Value-Based Purchasing: Program Year FFY 2018



Summary of FFY 2018 VBP Changes

- A hospital must receive scores on at least three of the four domains in order to receive a VBP Score.
- Minimum domain scoring requirements:
  - Report a minimum number of 100 HCAHPS surveys
  - Report a minimum number of 25 cases for the MSPB-1 measure
  - Receive a minimum of 2 measure scores in Clinical Care
    - Report a minimum number of 25 cases for each mortality measure

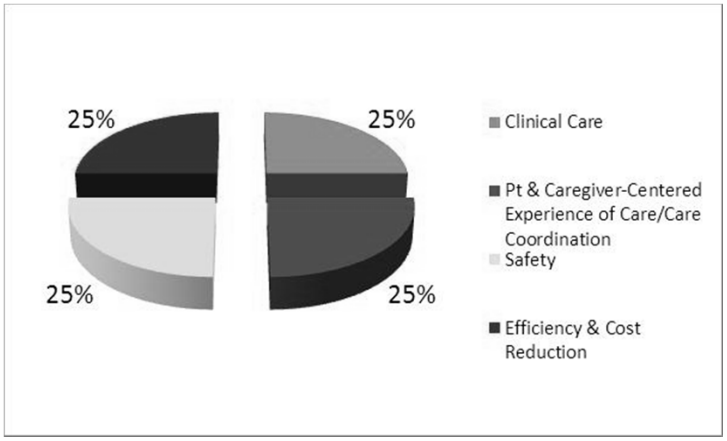
Summary of FFY 2018 VBP Changes

- Minimum scoring requirements (continued):
  - Receive a minimum of 3 measure scores within the Safety domain.
    - Report a minimum of three cases for any underlying indicator for the PSI-90 measure
      - *PSI 03 Pressure Ulcer Rate*
      - *PSI 06 Iatrogenic Pneumothorax Rate*
      - *PSI 07 Central Line-Related Bloodstream Infections*
      - *PSI 08 Post-op Hip Fracture*
      - *PSI 12 Post-op PE or DVT Rate*
      - *PSI 13 Post-op Sepsis Rate*
      - *PSI 14 Post-op Wound Dehiscence Rate*
      - *PSI 15 Accidental Puncture or Laceration Rate*

Summary of FFY 2018 VBP Changes

- Minimum scoring requirements (continued):
  - Report a minimum of 1 predicted infection for the NHSN-based surveillance measures
    - *CAUTI*
    - *CLABSI*
    - *Clostridium difficile Infection*
    - *MRSA Bacteremia*
    - *Surgical Site Infection (SSI)*
      - *SSI: Colon*
      - *SSI: Abdominal Hysterectomy*
  - Report a minimum of 10 cases for the PC-01 measure

Domain Weighting for FFY 2018



Summary of VBP Enhancements in 2016

- Moved from monthly VBPC User News to periodic VBPC Quick News
  - Better focus on 'need to know' items
  - Reduces email burden
- Refined normalization of financial estimates for PCCEC/CC
- Refined calculations for Surgical Site Infections (SSI) to improve Safety domain estimates
- Updated Achievement Threshold & Benchmark
  - PSI-90
  - AMI Mortality
  - HF Mortality
  - PN Mortality

Partnering with Press Ganey for Value-Based Purchasing

Partnering with Press Ganey for VBP

Partnering with Press Ganey for VBP

- Keeping on top of VBP
  - VBP Score and Domain Raw Scores
  - Estimated Financial Impact
  - Baseline and performance periods
  - Threshold and benchmark
  - Scoring on achievement and improvement
  - Scoring for HCAHPS consistency score
- Calculator How-to
  - Track your facility's performance
  - "Up to the minute updating"
  - Modeling performance scenarios

Questions?

PRESS GANEY

283

ELECTRONIC CLINICAL QUALITY MEASURES

eCQM

PRESS GANEY

Overview

- The Transition to eMeasures
- eCQM Final Rule FY 2018
- The Joint Commission on eCQM's
- Quality Performer – HeM
- HeM – Lessons Learned
- eCQM Resources

The Transition to eMeasures

The Transition to eMeasures

"Learning from early adopters can help smooth the transition to electronic clinical quality measures."

By Elizabeth McConville, RN

- "A smooth transition to eCQM data will accelerate progress toward the aim of improving the patient experience and reducing patient suffering, but only if the data are accurate and complete."
- "The transition to eCQMs should progress through three phases:
  - Accepting the technology
  - Modifying workflows to support accurate reliable data capture
  - Establishing trust in the data"

PRESS GANEY

287

eCQM Final Rule FY 2018

eCQM IPPS Final Rule

FY 2018 Inpatient Quality Reporting Program Final Rule
(effective 01/01/2016 discharges)

- Mandatory eCQM Submission
  - Select 4 eCQM's
  - Report 1 quarter only: 3Q16 or 4Q16
  - Submission deadline: February 28, 2017
- Selected eCQM's must be submitted *in addition* to required chart-abstracted measures

CMS Available eCQM's

29 Available eCQMs				
ED-1	VTE-1	STK-2	PC-01	CAC-3
ED-2	VTE-2	STK-3	PC-05	
ED-3*	VTE-3	STK-4		PN-6**
	VTE-4	STK-5	AMI-2	
SCIP-Inf-1a	VTE-5	STK-6	AMI-7a	
SCIP-Inf-2a	VTE-6	STK-8	AMI-8a	EHDI-1a
SCIP-Inf-9		STK-10	AMI-10	HTN**

*ED 3 is an outpatient measure and not applicable for IQR
**Not available in QP-HeM

eCQM Reporting and Successful Transmission

eCQM Reporting for IQR Incentive Program

- EHR must be 2014 or 2015 CEHRT (Certified Electronic Health Record Technology)
- Data must be submitted electronically via QRDA1 file
- eCQM data submitted for CY16 reporting will not be posted on the Hospital Compare website
- CY 2016 reporting will apply to FY 2018 payment determinations
- Meeting this requirement satisfies the CQM reporting requirement for the EHR Incentive Program

Successful eCQM Submission

- Successful submission is defined as:
  - submission of at least four eCQMs through the QualityNet Secure Portal which can be reported as any combination of:
    - QRDA files with patients meeting the Initial Patient Population of the applicable measures
    - Zero denominator declarations
    - Case threshold exemptions

Successful eCQM Submission

Zero Denominator Declaration Clarification

- A zero denominator can be used when both:
  - A hospital's EHR system is certified for an eCQM; and
  - A hospital does not have patients that meet the denominator criteria of that eCQM
- Submitting a zero denominator counts as a successful submission for both the EHR Incentive Program and the IQR Program

Successful eCQM Submission

Case Threshold Exemption Clarification

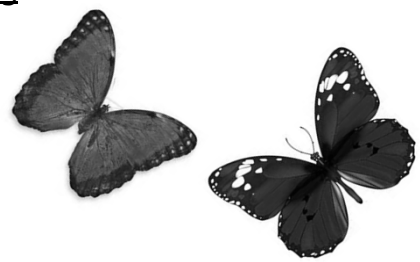
- For the EHR Incentive and IQR Programs, the Case Threshold Exemption can be used when both:
  - A hospital's EHR system is certified to report data
  - There are five or fewer discharges during the relevant EHR reporting quarter
- If an EH or CAH qualifies for an exemption for the eCQM, that eCQM counts toward meeting the program requirement
  - Hospitals do **NOT** have to utilize the Case Threshold Exemption
  - They can submit applicable QRDA files if they choose

Successful eCQM Submission

- Facilities that submit eCQM data to meet IQR program requirements will also meet the EHR Incentive Program eCQM requirements with one submission.
- If facilities, such as critical access hospitals (CAHs), are not required to participate in the IQR program, they may voluntarily submit one calendar year of aggregate data for 16 of the eCQM's through the CMS Registration and Attestation System.
- Note: All other EHR incentive program requirements, including core and menu set measures, will need to be reported through attestation for complete program fulfillment.

Successful eCQM Submission

- If a hospital will be submitting CY 2016 eCQM data for itself, it will need to:
  - Register for a QualityNet account (for new users only)
  - Request the EHR Data Upload role by contacting the QualityNet Help Desk at qnetsupport@hcqis.org



Successful eCQM Submission

- If a hospital will be using a vendor to submit data on its behalf, the hospital will need to:
  - Complete Steps 1 and 2 above to gain access to the QualityNet Secure Portal
  - Authorize a vendor(s) to submit date on the hospital's behalf, utilizing the Vendor Authorization screen
  - The vendor will need:
    - a QualityNet account
    - the EHR Data Upload Role
    - access to the QualityNet Secure Portal

Successful eCQM Submission

- Submission period for production QRDA files begins **October 2016** and runs through **February 28, 2017**
- Data must be submitted as production files to meet program data submission requirements with patients meeting the Initial Patient Population of the applicable measures

Successful eCQM Submission

Pre-Submission Validation Application

- A downloadable tool available on QNET
- Was developed in response to interest and demand from the quality reporting community to validate QRDA I files
- Allows submitters to catch and correct errors prior to data submission
- Provides validation feedback
- Allows valid files to be separated and submitted while invalid files are identified for error correction
- Does not currently provide any measure calculations or measure data checks
- The PSVA tool will validate against HL7 QRDA Cat I R3 Base Standard and most of the 2016 CMS IG rules

Joint Commission on eCQM's

TJC Reporting Options

- Joint Commission accredited hospitals will continue to have flexibility in meeting The Joint Commission's ORYX performance measure reporting requirements for 2016 through one of three reporting options:
  - **Option 1** – vendor submission of quarterly data on six of nine sets of **chart-abstracted measures** (four sets for Critical Access Hospitals)
    - Data must be reported on all measures in the chart-abstracted measure sets
  - **Option 2** – vendor submission of data on six of the eight sets of **electronic clinical quality measures (eCQMs)** (four sets for Critical Access Hospitals).
  - **Option 3** – vendor submission of data on six sets of measures using a **combination of chart-abstracted measure sets and eCQM sets**. (four sets for Critical Access Hospitals).

Hospitals Electing to Report eCQM's to TJC

- Hospitals that are unable to report on all eCQMs in the eCQM set may report on as few as one measure in an eCQM set
  - ***Data MUST be reported on AT LEAST ONE eCQM in the eCQM SET(s) selected***
- Required to collect and report monthly data for all three months in either or both the 3rd quarter or 4th quarter of 2016
- Data for either or both quarters are due at The Joint Commission no later than **March 15, 2017**
- Must capture and report on data utilizing the June 2015 AU measures
- Must submit data through a Joint Commission-listed vendor that supports the eCQM sets
- The Joint Commission **will not publicly report the 2016 eCQM data on Quality Check.** Data and hospital performance on the eCQMs will only be displayed in the ORYX Performance Measure Report for internal hospital use only.

TJC Option 3 Example

	Chart-abstracted measure sets selected	eCQM sets selected Data MUST be reported on AT LEAST ONE eCQM in the eCQM SETS selected.	Additional measure sets needed to meet requirement for six measure sets
Hospital A	PC (5 measures) ED (2 measures) STK (1 measure)	ePC eED eSTK	0
Hospital B	PC ED	ePC eED	2
Hospital C	VTE (2 measures)	eVTE	4

eCQM's Available for TJC Selection

Joint Commission Measure Sets Effective January 1, 2016

Measure Set	Retired/Temporarily Inactivated Chart Abstracted Measure	Retained Chart Abstracted Measures	Electronic Clinical Quality Measures (eCQM)
AMI	**Retired** AMI-7a		eAMI-7a, eAMI-8a
SCIP	**Retired** SCIP INF-4		eSCIP-INF-1 eSCIP-INF-9
CAC	**Retired** CAC-3		eCAC-3
VTE	**Retired** VTE-1, VTE-2, VTE-3	VTE-5, VTE-6	eVTE-1, eVTE-2, eVTE-3, eVTE-4, eVTE-5, eVTE-6
Stroke (STK)	**Retired** STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10	STK-4	eSTK-2, eSTK-3, eSTK-4, eSTK-5, eSTK-6, eSTK-8, eSTK-10
ED		ED-1a, ED-2a	eED-1a, eED-2a
IMM	**Retired** IMM-1	IMM-2	
HBIPS*	**Retired** HBIPS-4, HBIPS-6, HBIPS-7	HBIPS-1**, HBIPS-2**, HBIPS-3**, HBIPS-5**	
TOB	**Temporarily Inactivated** TOB-4	TOB-1, TOB-2, TOB-3	
SUB	**Temporarily Inactivated** SUB-4	SUB-1, SUB-2, SUB-3	
Perinatal Care*** (PC)		PC-01, PC-02, PC-03, PC-04, PC-05	ePC-01, ePC-05/5a
Hospital Out Patient (OP)		OP-1, OP-2, OP-3, OP-4, OP-5, OP-18, OP-20, OP-21, OP-23	
EHDI (Early Hearing Detection and Intervention)			EHDI-1a

PRESS GANEY®

305

Quality Performer HeM

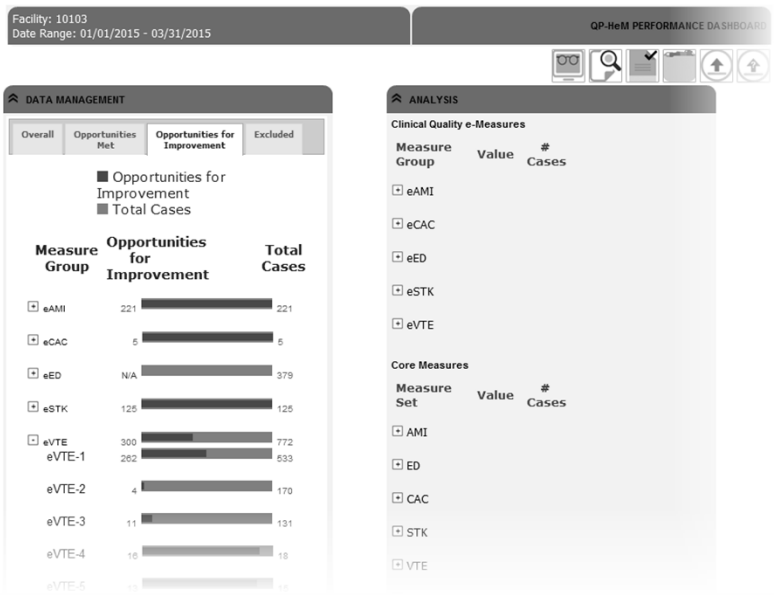
Quality Performer® HeM

- ONC certified by The Drummond Group for 2015 CEHRT
  - Certified Meaningful Use Module
  - Certified eCQM transmission vendor
- Easily view and analyze patient-level data
- Familiar features and functionality
  - Case review screens
  - Measure category report
  - On-screen measure logic help and information
  - Quick and easy report generation
    - Data Management Reports
    - Rate Reports
    - Data Analysis Reports

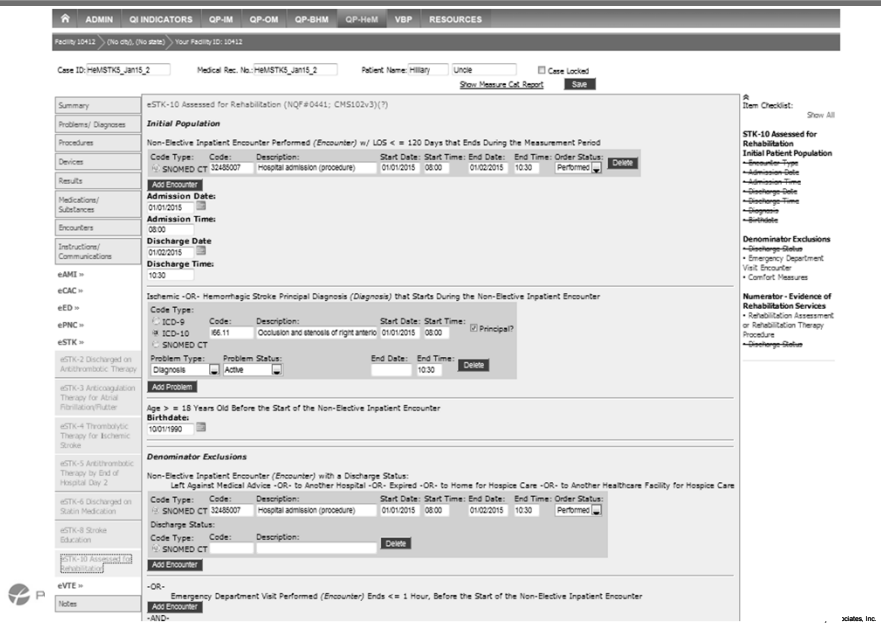
PRESS GANEY®

307

Quality Performer® HeM



Using Quality Performer® HeM



Quality Performer® HeM

Quality Performer® HeM

Product: Hospital eMeasures
Report Type: Rate Report - Quarterly
Facility: Test Fac 10103, Elkridge, MD
Facility ID: 10103
Display Date Range: Q1 2015 - Q1 2015
eMeasure Group: eVTE

Quality Performer℠

eMeasure ID: eVTE-1 **eMeasure Name:** Venous Thromboembolism Prophylaxis

Numerator: Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after: hospital admission or surgery end date

Denominator: All patients

	Numerator	Denominator	Rate	Excluded	Exceptions
1st Quarter 2015					
Jan	271	533	0.5084	349	0
Feb	0	0	NP	0	0
Mar	0	0	NP	0	0
Qtr Total	271	533	0.5084	349	0

eMeasure ID: eVTE-2 **eMeasure Name:** Intensive Care Unit Venous Thromboembolism Prophylaxis

Numerator: Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after: ICU

PRESS GANEY®

311

HeM Lessons Learned

HeM Lessons Learned

- Identify Stakeholders
  - Have the right people in the room
    - IT Department
    - Quality Department
    - EHR vendor representative

Facilities that have not done this step find they must go back and do it

- Establish Team
  - Cross train IT and Quality
  - Define roles
  - Define resources
  - Set goals and deadlines

Facilities that have not done this step submit many failed files and then realize they must go back and do it

PRESS GANEY

313

HeM Lessons Learned

Facilities that do not do this step are usually pulling the wrong data into their file and repeatedly going back to the drawing board

- Capture the Data
  - Identify where data exists
  - Identify all areas data is collected
  - Use hard stops (judiciously)
  - Automate process functions

- Validate Data
  - Ensure the captured data is consistently complete
  - Assess the mapping of data elements
  - Run reports early in the process

Facilities that do not do this step have low rates or low populations

PRESS GANEY

314

HeM Lessons Learned

- Monitor progress
  - How does the eCQM rate look in comparison to the chart-abstracted rate
  - Monitor patient satisfaction scores – is there a negative impact
  - This is a major accomplishment requiring a substantial team effort

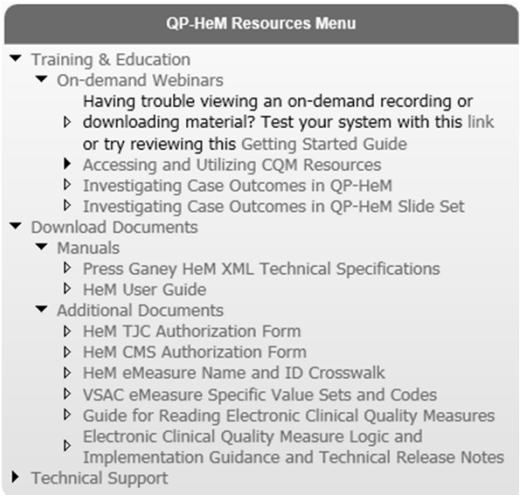
PRESS GANEY

315

eCQM Resources

eCQM Resources

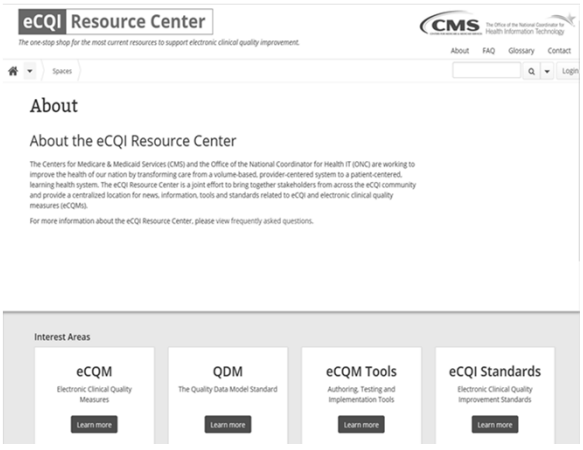
QP - HeM Resources



eCQM Resources

eCQI Resource Center

https://ecqi.healthit.gov/



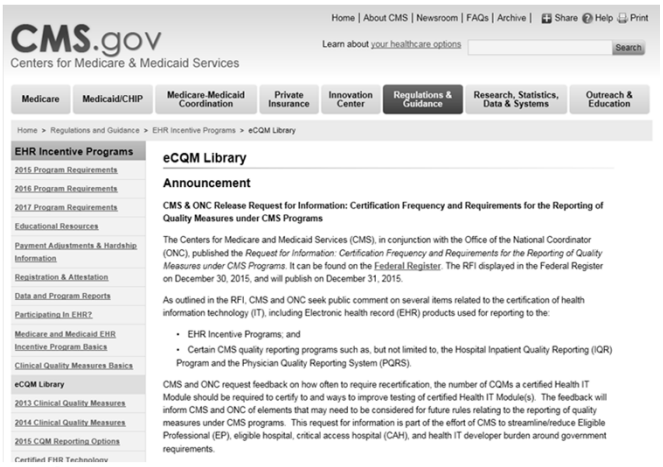
Resources for use at various stages of electronic clinical quality improvement (eCQI)

- Information about standards and tools to support eCQI
- Links to external resources related to eCQMs and data reporting:
  - ONC JIRA issue trackers
  - Measure Authoring Tool (MAT)
  - Value Set Authority Center (VSAC)
  - National Quality Strategy resources

eCQM Resources

eCQM Library

https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html

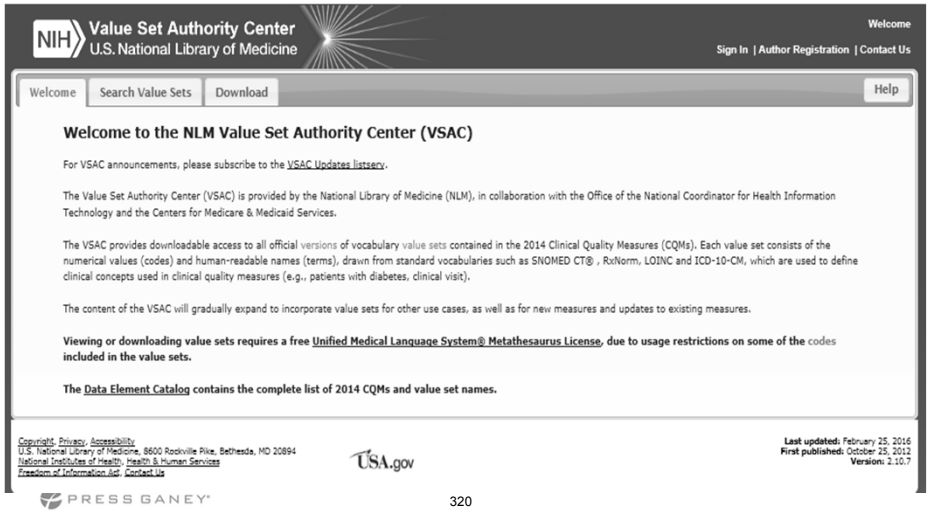


- The eCQM Library contains:
  - eCQM specifications for Eligible Providers and Eligible Hospitals
  - CMS QRDA Implementation Guides
  - Additional resources such as a Guide to Reading eCQMs

eCQM Resources

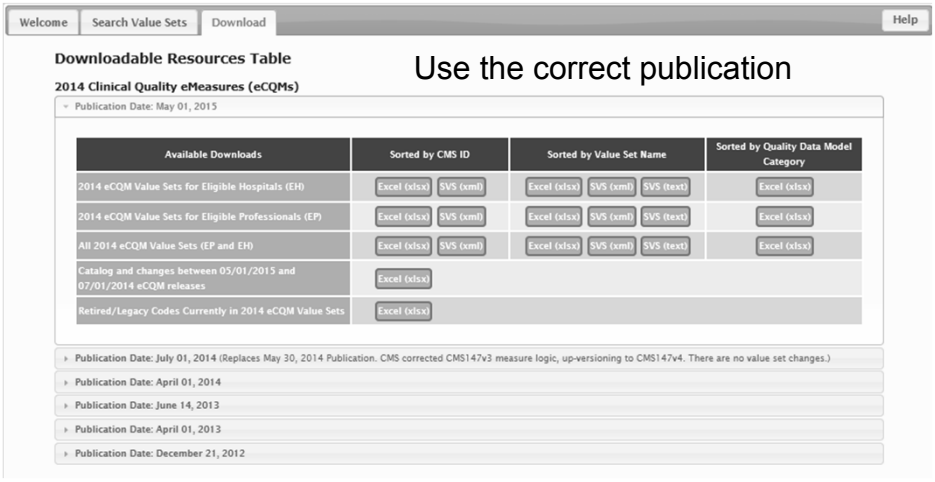
Value Set Authority Center

https://vsac.nlm.nih.gov/



eCQM Resources

Value Set Authority Center



eCQM Resources

eCQM Name and ID Crosswalk

CMS ID	NQF ID	measure name
100	0142	AMI-2 ASA on Discharge
60	0164	AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
53	0163	AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival
30	0639	AMI-10 Statin Prescribed at Discharge
26	N/A	CAC Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
55	0495	ED-1 Median Time from ED arrival to ED Departure for Admitted ED Patients
111	0497	ED-2 Median Admit Decision Time to ED Departure Time for Admitted Patients
32	0496	ED-3 Median Time from ED Arrival to ED Departure for Discharged ED patients
113	0469	PC-01 Elective Delivery
9	0480	PC-05 Exclusive Breast Milk Feeding
185	0716	Healthy Term Newborn (Press Ganey not implementing)
31	1354	Hearing Screening Prior to Hospital Discharge (EDHI-1a)(Perinatal Care)
188	0147	PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients (Press Ganey not implementing)
171	0527	SCIP-1 Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
172	0528	SCIP-2 Prophylactic Antibiotic Selection for Surgical Patients
178	0453	SCIP-9 Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery being Day Zero
104	0435	STK-2 Discharge on Antithrombotic Therapy
71	0436	STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter
91	0437	STK-4 Thrombolytic Therapy
72	0438	STK-5 Antithrombotic Therapy by End of Hospital Day 2
105	0439	STK-6 Discharged on Statin Medication
107	N/A	STK-8 Stroke Education
102	0441	STK-10 Assessed for Rehabilitation
108	0371	VTE-1- Venous Thromboembolism Prophylaxis
190	0372	VTE-2 -Intensive Care Venous Thromboembolism Prophylaxis
73	0373	VTE-3- Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
109	N/A	VTE-4- Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram
110	N/A	VTE-5-Venous Thromboembolism Discharge Instructions
114	N/A	VTE-6-Incidence of Potentially Perventable Venous Thromboembolism

N/A = No longer NQF Endorsed

eCQM Resources

Links to other helpful resources

- https://www.qualitynet.org/
- qnetsupport@hcqis.org
- QualityNet Help Desk
- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html
- https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_627 (EHR LISTSERV)
- http://www.qualityreportingcenter.com/inpatient/ecqm-archived-events/
- http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf (Final Rule)

Thank You

Questions

Driving Quality Measures Compliance Discussion & Networking

- Please enter in Topics for your UG discussions and networking opportunities
- We would like your feedback on the Web Based User Group Meetings?

Evaluations and CEU Certificates

Remember:

Complete online evaluation within 10 business days following meeting

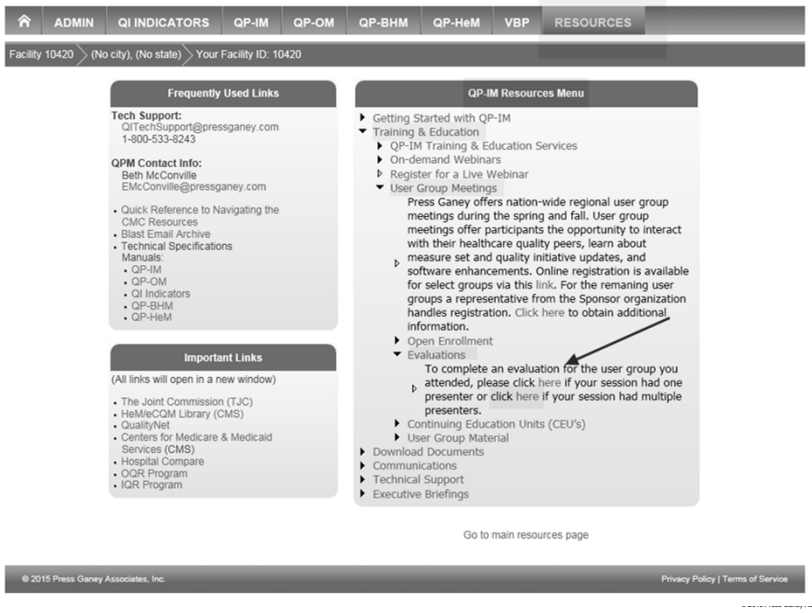
Certificates will be emailed approximately 2 months after the meeting

Be sure to include correct email address

CEUs CAN NOT be provided without the online survey being completed within the timelines!

Directions for completing the survey are included in this presentation

Evaluations



Thank You for joining us and we look forward to seeing you in person for our Fall Sessions!!!