OHIC Measure Alignment Work Group
2023 Annual Review of the Acute Care Hospital Aligned Measure Set
Measure Specifications

American College of Surgeons - Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

CMIT Measure ID: 1 | **CMIT ID:** 00001-02-C-HACRP | **Measure Type:** Outcome

Date of Information: 06/16/2023 | **Revision:** 10 | **Program:** Hospital Acquired Condition Reduction Program

View Description +

Properties

Date of Information	06/16/2023
Abbreviated Measure Title	Not Available
Description	Prototype measure for the facility adjusted Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM)for deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the ACS National Surgical Quality Improvement Program (ACS-NSQIP) or CDC National Health and Safety Network (NHSN). Measure includes a systematic, retrospective sampling of operative procedures in healthcare facilities. This single measure is applied to two operative procedures, colon surgeries and abdominal hysterectomies, and the measure yields separate SIRs and separate ARMs for each procedure.
Numerator	Deep incisional primary (DIP) and organ/space SSIs during the 30-day postoperative period among patients = 18 years of age, who undergo inpatient colon surgeries or abdominal hysterectomies. SSIs will be identified before discharge from the hospital, upon readmission to the same hospital, or during outpatient care or admission to another hospital (post-discharge surveillance). Case accrual will be guided by sampling algorithms as described below. Numerator Exclusion SSI events with PATOS* field = yes. Infection present at time of surgery (PATOS): PATOS denotes that there is evidence of an infection or abscess at the start of or during the index surgical procedure (in other words, it is present

	preoperatively). PATOS is a YES/NO field on the SSI Event form. PATOS does not apply if there is a period of wellness between the time of a preoperative condition and surgery. The evidence of infection or abscess must be noted/documented intraoperatively in an operative note or report of surgery. Only select PATOS = YES if it applies to the depth of SSI that is being attributed to the procedures (e.g., if a patient has evidence of an intraabdominal infection at the time of surgery and then later returns with an organ/space SSI the PATOS field would be selected as a YES. If the patient returned with a superficial or deep incisional SSI the PATOS field would be selected as a NO). The patient does not have to meet the NHSN definition of an SSI at the time of the primary procedure but there must be notation that there is evidence of an infection or abscess present at the time of surgery. PATOS is not necessarily diagnosis driven.
Denominator	An NHSN Operative Procedure is a procedure: that is included in the ICD-10-PCS or CPT NHSN operative procedure code mapping. And takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure And takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute s (FGI) or American Institute of Architects (AIA) criteria for an operating room when it was constructed or renovated11. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab. Exclusions: Otherwise eligible procedures that are assigned an ASA score of 6 are not eligible for NHSN SSI surveillance. Using multivariable logistic regression models for colon surgeries and abdominal hysterectomies, the expected number of SSIs is obtained. These expected numbers are summed by facility and surgical procedure and used as the denominator of this measure (see also 2a.8).
Denominator Exclusions	Persons under the age of 18, those having a procedure performed on an outpatient basis, procedures associated with SSI events where the PATOS = yes, those with ASA Class VI (6) are excluded. Note: Both primarily closed procedures and those that are not closed primarily are included in the denominator data.
Rationale	It is envisioned the use of this measure will promote SSI prevention activities which will lead to improved patient outcomes including reduction of avoidable medical costs, and patient morbidity and mortality.
Evidence	It is envisioned the use of this measure will promote SSI prevention activities which will lead to improved patient outcomes including reduction of avoidable medical costs, and patient morbidity and mortality. When SIRs are compared over time, assessment of performance can be made. In separate analyses, CDC and ACS have demonstrated a significant performance gaps in SIRs across facilities. The data cited above are unpublished, obtained from an internal analysis of ACS NSQIP and CDC NHSN data. These gaps have been repeatedly

	demonstrated since the inception of the program in published semiannual reports to ACS NSQIP participants
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	Yes
Program Name Abbreviation	HACRP
Program Status	Active

National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

CMIT Measure ID: 459 | **CMIT ID:** 00459-01-C-HACRP | **Measure Type:** Outcome

Date of Information: 06/16/2023 | **Revision:** 15 | **Program:** Hospital Acquired Condition Reduction Program

View Description +

Properties

Date of Information	06/16/2023
Abbreviated Measure Title	Not Available
Description	This measure calculates the total number of healthcare-associated CAUTI among patients in bedded inpatient care locations, from the total number of indwelling urinary catheter days for each location under surveillance for CAUTI during the associated data period. This measure is risk-adjusted.
Numerator	Total number of observed healthcare-associated CAUTI among patients in bedded inpatient care locations (excluding patients in Level II or III neonatal ICUs).
Denominator	Total number of predicted healthcare-associated CAUTI among inpatient care locations under surveillance for CAUTI during the data period, based on the national CAUTI baseline Data is calculated using the facility's number of catheter days and the following significant risk factors: Acute Care Hospitals: CDC Location, Facility bed size, Medical school affiliation, and Facility type Critical Access Hospitals: Medical school affiliation Long-Term Acute Hospitals: Average length of stay, Setting type, and Location type Inpatient Rehabilitation Facilities: Setting type, Proportion of admissions with traumatic and non-traumatic spinal cord dysfunction, Proportion of admissions with stroke
Denominator Exclusions	The following are not considered indwelling catheters by NHSN definitions: 1. Suprapubic catheters 2. Condom catheters 3. "In and out" catheterizations 4. Nephrostomy tubes Note, that if a patient has either a nephrostomy tube or a suprapubic catheter and also has an indwelling

	urinary catheter, the indwelling urinary catheter will be included in the CAUTI surveillance.
Rationale	Evidence that this measure promotes CAUTI prevention activities that will lead to improved patient outcomes including reduction of avoidable medical costs, and patient morbidity and mortality through reduced need for antimicrobials and reduced length of stay.
Evidence	In 2017, among the 2,589 hospitals in U.S. with enough CAUTI data to calculate a standardized infection ratio (SIR), 11% had an SIR significantly higher (worse) than 0.88, the value of the national SIR.
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	Yes
Program Name Abbreviation	HACRP
Program Status	Active

Cesarean Birth (eCQM)

CMIT Measure ID: 508 | **CMIT ID:** 00508-03-E-HIQR | **Measure Type:** Outcome

Date of Information: 02/20/2023 | **Revision:** 6 | **Program:** Hospital Inpatient Quality Reporting

View Description

Properties

Date of Information	02/20/2023
Abbreviated Measure Title	Not Available
Description	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth.
Numerator	Inpatient hospitalizations for patients who deliver by cesarean section.
Denominator	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. ACOG defines nulliparous as a woman with a parity of zero. The eCQM logic concludes that a patient is nulliparous when ONE of the following is true: 1. Parity equals zero 2. Gravidity equals one 3. Preterm and Term births both equal zero.
Denominator Exclusions	Inpatient hospitalizations for patients with abnormal presentation or placenta previa during the encounter. Note that the chart-based measure excludes single stillbirth and patients with multiple gestations from the denominator. These concepts are mutually exclusive of the denominator requirement of live singleton newborn and therefore the logic does not address single stillbirth nor multiple gestation.
Rationale	The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean birth (CB) rates. Some hospitals' CB rates were over 50%. Hospitals with CB rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Symum et al., 2021). There is no data that higher rates improve any outcomes, yet the CB rates continue to rise. This measure seeks to focus attention on the most variable portion of the CB epidemic, the term labor CB in nulliparous women. This population segment accounts for the large majority of the variable portion of the CB rate and is the area most affected by subjectivity. As compared to other CB measures, what is different about NTSV CB rate (Primary CB in first births

	with term singleton pregnancies in head down position) is that there are clear cut quality improvement activities that can be done to address the differences. Main et al. (2012) found that over 60% of the variation among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. Rosenstein et al. (2021) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al.,1989; Goyert et al., 1989; Luthy et al., 2003, Symum et al., 2021). The dramatic variation in cesarean rates seen in all populations studied is striking. (Cesarean rates varied tenfold in US hospitals nationwide across hospitals, from 7.1 % to 69.9 % and there was a 15-fold variation among low-risk women, from 2.4% to 36.5% (Kozhimannil et al., 2013). A reduction in the number of nulliparous patients with live term singleton newborns in vertex position (NTSV) delivering by cesarean birth will result in increased patient safety, a substantial decrease in maternal and neonatal morbidity and substantial savings in health care costs. Successful quality improvement efforts incorporate audit and feedback strategies combined with provider and nurse education, guidelines and peer review. The measure will assist health care organizations (HCOs) to track nulliparous patients with live term singleton newborns in vertex position delivering by cesarean birth to reduce the occurrence. Nulliparous women have 4-6 times the cesarean birth rate than multiparous women thus the NTSV population is the largest driver of primary cesarean birth rate (Sakala et al. 2020). NTSV has a large variation among facilities, thus identifying an important population on which to focus quality improvement efforts. In addition, a reduction in primary cesarean births will reduce the number of women having repeat cesarean births (almost 90% of mothers who have a primary cesarean birth will have subsequent cesarean birth (CDC, 2020)). Thus, improvement in the rates of cesarean birth for the first birth will reduce the morbidity of all future births and avoid all the controversies with trial of labor after cesarean/elective repeat cesareans.
Evidence	Not Available
Denominator Exceptions	None
Numerator Exceptions	None
Risk Adjusted	No
Program Name Abbreviation	HIQR
Program Status	Active

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National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure

CMIT Measure ID: 460 | **CMIT ID:** 00460-01-C-HACRP | **Measure Type:** Outcome

Date of Information: 06/16/2023 | **Revision:** 16 | **Program:** Hospital Acquired Condition Reduction Program

View Description +

Properties

Date of Information	06/16/2023
Abbreviated Measure Title	Not Available
Description	Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in bedded inpatient care locations.
Numerator	Total number of observed healthcare-associated CLABSIs among patients in bedded inpatient care locations.
Denominator	Total number of central line days for each location under surveillance for CLABSI during the data period.
Denominator Exclusions	The following devices are excluded as central lines: - Non-lumened pacemaker wires and other non-lumened devices inserted into central blood vessels or the heart - Arterial catheters - Arteriovenous fistula - Arteriovenous graft - Extracorporeal membrane oxygenation (ECMO) - Hemodialysis reliable outflow (HERO) dialysis catheters - Intra-aortic balloon pump (IABP) devices - Atrial catheters (also known as transthoracic intra-cardiac catheters, those catheters inserted directly into the right or left atrium via the heart wall) - Peripheral IV or Midlines - Ventricular Assist Device (VAD)
Rationale	A substantial body of peer-reviewed studies and reviews document that CLABSI can be minimized through proper management of the central line. Efforts to improve central line insertion and maintenance practices, with early discontinuance of lines are recommended. These efforts

	result in decreased morbidity and mortality and reduced healthcare costs. Use of this measure to track CLABSIs through a nationalized standard for HAI monitoring, leads to improved patient outcomes and provides a mechanism for identifying improvements and evaluating prevention efforts.
Evidence	Among the 2,337 hospitals in U.S. with enough CLABSI data to calculate an SIR, 9% had an SIR significantly higher (worse) than 0.81, the value of the national
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	Yes
Program Name Abbreviation	HACRP
Program Status	Active

National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

CMIT Measure ID: 462 | **CMIT ID:** 00462-01-C-HACRP | **Measure Type:** Outcome

Date of Information: 06/16/2023 | **Revision:** 19 | **Program:** Hospital Acquired Condition Reduction Program

View Description +

Properties

Date of Information	06/16/2023
Abbreviated Measure Title	Not Available
Description	This measure calculates the total number of observed hospital-onset CDI LabID events among all inpatients in the facility, excluding well baby-nurseries and NICUs, from the total number of expected hospital-onset CDI LabID events, determined through the facility's number of inpatient days, bed size, affiliation with a medical school, microbiological test used to identify C. difficile, and community onset CDI admission prevalence rate.
Numerator	Total number of observed hospital-onset CDI LabID events among all inpatients in the facility, excluding well baby-nurseries and NICUs
Denominator	Total number of predicted hospital-onset CDI LabID events, calculated using the facility's number of inpatient days, facility type, CDI event reporting from Emergency Department and 24 hour observation units, bed size, ICU bed size, affiliation with medical school, microbiological test method used to identify C. difficile, and community-onset CDI admission prevalence rate.
Denominator Exclusions	Data from patients who are not assigned to an inpatient bed are excluded from the denominator counts, including outpatient clinics, 24-hour observation units, and emergency department visits. Inpatient rehab locations and inpatient psychiatric locations that have their own Centers for Medicare and Medicaid Services (CMS) Certification Number (CCN) are excluded. Additionally,

	data from well-baby nurseries and NICUs are excluded from the denominator count.
Rationale	Clostridium difficile (C. diff) infection can cause fever diarrhea, fever, appetite loss, nausea, and abdominal pain. Most cases of C. diff infection occur in patients taking antibiotics. C. diff. Infections may be prevented or stopped from spreading to other patients when inpatient rehabilitation facilities use infection control steps recommended by CDC. The measure can then be used to drive prevention practices that will lead to improved outcomes, including the reduction of patient morbidity and mortality
Evidence	Clostridium difficile is responsible for a spectrum of C. difficile infections (CDI), including uncomplicated diarrhea, pseudomembranous colitis, and toxic megacolon which can, in some instances, lead to sepsis and even death. In recent years, a previously unrecognized strain of C. difficile with increased virulence and high levels of antimicrobial resistance has resulted in outbreaks in healthcare facilities in the United States. Additionally, CDI has become more common in the community setting, with increased risk in those with a recent inpatient stay in a healthcare facility. Significant increases in cost of inpatient care and post-hospitalization care have been seen in cases of CDI.
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	No
Program Name Abbreviation	HACRP
Program Status	Active

Elective Delivery

CMIT Measure ID: 229 | **CMIT ID:** 00229-01-C-HIQR | **Measure Type:** Process

Date of Information: 08/25/2022 | **Revision:** 9 | **Program:** Hospital Inpatient Quality Reporting

View Description

Properties

Date of Information	08/25/2022
Abbreviated Measure Title	Not Available
Description	Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed
Numerator	Patients with elective deliveries with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following: * Medical induction of labor as defined in Appendix A, Table 11.05 Medical Induction of Labor while not in Labor prior to the procedure * Cesarean birth as defined in Appendix A, Table 11.06 Cesarean Birth and all of the following: *not in Labor *no history of a Prior Uterine Surgery
Denominator	Patients delivering newborns with >= 37 and < 39 weeks of gestation completed with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 Delivery and with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1 Planned Cesarean Birth in Labor.
Denominator Exclusions	* ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 Conditions Possibly Justifying Elective Delivery * History of prior stillbirth * Less than 8 years of age * Greater than or equal to 65 years of age * Length of Stay > 120 days * Gestational Age < 37 or >= 39 weeks or UTD
Rationale	For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG,

1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009). According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean births and longer maternal length of stay. Interventions that decrease the chance of a cesarean delivery include avoiding non-medically indicated induction of labor prior to 39 weeks gestation (Quinlan and Murphy, 2015). Repeat elective cesarean births before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).

Evidence	Not Available
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	No
Program Name Abbreviation	HIQR
Program Status	Active

*Follow-Up After Emergency Department Visit for Mental Illness (FUM)**

***Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).**

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added a required exclusion for members who died during the measurement year.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Ages 6 years and older as of the date of the ED visit. Report three age stratifications and a total rate:

- 6–17 years.
- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment Date of the ED visit through 30 days after the ED visit (31 total days).

Allowable gap None.

Anchor date None.

Benefit Medical and mental health.

Event/diagnosis An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between

January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

Multiple visits in a 31-day period

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

ED visits followed by inpatient admission

Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusions

Exclude members who meet either of the following criteria:

- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUM-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	6-17	Benefit	Metadata
FollowUp7Day	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of Follow-Up After Emergency Department Visit for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	Age determination dates may be changed (6 years as of the date of the ED visit). Changing the denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an ED visit with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

*Follow-Up After Emergency Department Visit for Substance Use (FUA)**

***Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).**

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added instructions to report rates stratified by race and ethnicity for each product line.
- Added eligible population instructions for ED visits followed by residential treatment.
- Added a required exclusion for members who died during the measurement year.
- Added new data elements tables for race and ethnicity stratification.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS.*

Description

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Stratifications For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:

- *Race:*
  - White.
  - Black or African American.
  - American Indian or Alaska Native.
  - Asian.
  - Native Hawaiian or Other Pacific Islander.
  - Some Other Race.
  - Two or More Races.
  - Asked but No Answer.
  - Unknown.
  - Total.

- *Ethnicity:*
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked but No Answer.
  - Unknown.
  - Total.

Note: *Stratifications are mutually exclusive and the sum of all categories in each stratification is the total population.*

Ages

13 years and older as of the ED visit. Report two age stratifications and a total rate:

- 13–17 years.
- 18 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

The date of the ED visit through 30 days after the ED visit (31 total days).

Allowable gap

None.

Anchor date

None.

Benefit

Medical, chemical dependency and pharmacy.

Note: *Members with withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.*

Event/diagnosis

An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) ***or*** any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.

Multiple visits in a 31-day period

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

ED visits followed by inpatient admission

Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

ED visits followed by residential treatment

Exclude ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit. A code from any of the following meets criteria for residential treatment:

- Residential Behavioral Health Treatment Value Set.
- Psychiatric Residential Treatment Center (POS code 56).
- Residential Substance Abuse Treatment Facility (POS code 55).
- Residential Program Detoxification Value Set.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusions

Exclude members who meet either of the following criteria:

- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance

Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a mental health provider.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** a mental health provider.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An observation visit (Observation Value Set) ***with*** a mental health provider.
- A peer support service (Peer Support Services Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- A telephone visit (Telephone Visits Value Set), ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telephone visit (Telephone Visits Value Set), ***with*** a mental health provider.
- An e-visit or virtual check-in (Online Assessments Value Set), ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set), ***with*** a mental health provider.
- A substance use disorder service (Substance Use Disorder Services Value Set).
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set).
- A substance use service (Substance Use Services Value Set).
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists
Antagonist	• Naltrexone (oral)	• Naltrexone Oral Medications List
Antagonist	• Naltrexone (injectable)	• Naltrexone Injection Medications List
Partial agonist	• Buprenorphine (sublingual tablet)	• Buprenorphine Oral Medications List
Partial agonist	• Buprenorphine (injection)	• Buprenorphine Injection Medications List
Partial agonist	• Buprenorphine (implant)	• Buprenorphine Implant Medications List
Partial agonist	• Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	• Buprenorphine Naloxone Medications List

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).*
- *Refer to Appendix 3 for the definition of* mental health provider. *Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUA-A-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	13-17	Benefit	Metadata
FollowUp7Day	18+	EligiblePopulation	For each Stratification, repeat per Metric
	Total	ExclusionAdminRequired	For each Stratification, repeat per Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Table FUA-B-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions
FollowUp30Day	White	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	BlackOrAfricanAmerican	Indirect	Numerator	For each Metric and Stratification
	AmericanIndianOrAlaskaNative	Total	Rate	(Percent)
	Asian			
	NativeHawaiianOrOtherPacificIslander			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

Table FUA-C-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions
FollowUp30Day	HispanicOrLatino	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	NotHispanicOrLatino	Indirect	Numerator	For each Metric and Stratification
	AskedButNoAnswer*	Total	Rate	(Percent)
	Unknown**			

*AskedButNoAnswer is only reported for Source='Direct.'

**Unknown is only reported for Source='Indirect.'

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of Follow-Up After Emergency Department Visit for Substance Use

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination date(s) may be changed (i.e., age 13 as of ED visit). Changing denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	Only events and diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of SUD or any diagnosis of unintentional drug overdose, who had a follow-up visit).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added a required exclusion for members who died during the measurement year.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of discharge. Report three age stratifications and a total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	None.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).
4. Identify the discharge date for the stay.

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim), exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

Required exclusions

Exclude members who meet either of the following criteria:

- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members*.

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) ***with*** (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), ***with*** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider.
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*
- *Refer to Appendix 3 for the definition of* mental health provider. *Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	6-17	Benefit	Metadata
FollowUp7Day	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of Follow-Up After Hospitalization for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify inpatient stays and diagnoses. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a follow-up visit with a mental health practitioner).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)

CMIT Measure ID: 338 | **CMIT ID:** 00338-01-C-HIQR | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 11/18/2021 | **Revision:** 11 | **Program:** Hospital Inpatient Quality Reporting

View Description +

Properties

Date of Information	11/18/2021
Abbreviated Measure Title	Not Available
Description	HCAHPS is a 32-item survey instrument that produces 11 publicly reported measures: 7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transition); and 4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital). Please note: The FY 2020 Final Rule finalized the removal of the three Pain Management questions beginning with 10/1/19 discharges.
Numerator	The HCAHPS Survey asks recently discharged patients about aspects of their hospital experience that they are uniquely suited to address. The core of the survey contains 21 items that ask how often or whether patients experienced a critical aspect of hospital care, rather than whether they were satisfied with their care. Also included in the survey are four screener items that direct patients to relevant questions, five items to adjust for the mix of patients across hospitals, and two items that support Congressionally-mandated reports. Hospitals may include additional questions after the core HCAHPS items. HCAHPS is administered to a random sample of adult inpatients between 48 hours and six weeks after discharge. Patients admitted in the medical, surgical and maternity care service lines are eligible for the survey; HCAHPS is not restricted to Medicare beneficiaries. Hospitals may use an approved survey vendor or collect their own HCAHPS data if approved by CMS to do so.

	HCAHPS can be implemented in four survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition (IVR), each of which requires multiple attempts to contact patients. Hospitals must survey patients throughout each month of the year. IPPS hospitals must achieve at least 300 completed surveys over four calendar quarters. For full details, see the current HCAHPS Quality Assurance Guidelines, V.13.0, pp. 55-63, under the Quality Assurance button on the official HCAHPS On-Line Web site at http://www.hcahpsonline.org/globalassets/hcahps/quality-assurance/2018_qag_v13.0.pdf
Denominator	Eligibility for the HCAHPS Survey. The HCAHPS Survey is broadly intended for patients of all payer types who meet the following criteria: Eighteen (18) years or older at the time of admission Admission includes at least one overnight stay in the hospital An overnight stay is defined as an inpatient admission in which the patient's admission date is different from the patient's discharge date. The admission need not be 24 hours in length. For example, a patient had an overnight stay if he or she was admitted at 11:00 PM on Day 1, and discharged at 10:00 AM on Day 2. Patients who did not have an overnight stay should not be included in the sample frame (e.g., patients who were admitted for a short period of time solely for observation; patients admitted for same day diagnostic tests as part of outpatient care). Non-psychiatric MS-DRG/principal diagnosis at discharge Note: Patients whose principal diagnosis falls within the Maternity Care, Medical, or Surgical service lines and who also have a secondary psychiatric diagnosis are still eligible for the survey. Alive at the time of discharge Note: Pediatric patients (under 18 years old at admission) and patients with a primary psychiatric diagnosis are ineligible because the current HCAHPS instrument is not designed to address the unique situation of pediatric patients and their families, or the behavioral health issues pertinent to psychiatric patients. Exclusions from the HCAHPS Survey There is a two-stage process for determining whether a discharged patient can be included in the HCAHPS Sample Frame. The first stage is to determine whether the discharged patient meets the HCAHPS eligibility criteria, listed above. If the patient meets the eligibility criteria, then a second set of criteria is applied: Exclusions from the HCAHPS Survey. Patients who meet the eligible population criteria outlined above are to be included in the HCAHPS Sample Frame. However, there are a few categories of otherwise eligible patients who are excluded from the sample frame. These are: No-Publicity patients who request that they not be contacted (see below) Court/Law enforcement patients (i.e., prisoners); this does not include patients residing in halfway houses Patients with a foreign home address (the U.S. territories Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses and therefore, are not excluded) Patients discharged to hospice care (Hospice-home or Hospice-medical facility) Patients who are excluded because of state regulations Patients discharged to nursing homes and skilled nursing facilities No-Publicity patients are defined as those who voluntarily sign a no-publicity request while hospitalized or who directly request a survey vendor or hospital not to contact

	them (Do Not Call List). These patients should be excluded from the HCAHPS Survey. However, documentation of patients no-publicity status must be retained for a minimum of three years. Court/Law enforcement patients (i.e., prisoners) are excluded from HCAHPS because of both the logistical difficulties in administering the survey to them in a timely manner, and regulations governing surveys of this population. These individuals can be identified by the admission source (UB-04 field location 15) 8 Court/Law enforcement, patient discharge status code (UB-04 field location 17) 21 Discharged/transferred to court/law enforcement, or patient discharge status code 87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission. This does not include patients residing in halfway houses. Patients with a foreign home address are excluded from HCAHPS because of the logistical difficulty and added expense of calling or mailing outside of the United States (the U.S. territories - Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign address
Denominator Exclusions ⓘ	There is a two-stage process for determining whether a discharged patient can be included in the HCAHPS Sample Frame. The first stage is to determine whether the discharged patient meets the HCAHPS eligibility criteria, listed above. If the patient meets the eligibility criteria, then a second set of criteria is applied: Exclusions from the HCAHPS Survey. Patients who meet the eligible population criteria outlined above are to be included in the HCAHPS Sample Frame. However, there are a few categories of otherwise eligible patients who are excluded from the sample frame. These are: No-Publicity patients Patients who request that they not be contacted (see below) Court/Law enforcement patients (i.e., prisoners); this does not include patients residing in halfway houses Patients with a foreign home address (the U.S. territories Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses and therefore, are not excluded) Patients discharged to hospice care (Hospice-home or Hospice-medical facility) Patients who are excluded because of state regulations Patients discharged to nursing homes and skilled nursing facilities No-Publicity patients are defined as those who voluntarily sign a no-publicity request while hospitalized or who directly request a survey vendor or hospital not to contact them (Do Not Call List). These patients should be excluded from the HCAHPS Survey. However, documentation of patients no-publicity status must be retained for a minimum of three years. Court/Law enforcement patients (i.e., prisoners) are excluded from HCAHPS because of both the logistical difficulties in administering the survey to them in a timely manner, and regulations governing surveys of this population. These individuals can be identified by the admission source (UB-04 field location 15) 8 Court/Law enforcement, patient discharge status code (UB-04 field location 17) 21 Discharged/transferred to court/law enforcement, or patient discharge status code 87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission. This does not include patients residing in halfway houses.

	Patients with a foreign home address are excluded from HCAHPS because of the logistical difficulty and added expense of calling or mailing outside of the United States (the U.S. territories - Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses and therefore, are not excluded). Patients discharged to hospice care are excluded from HCAHPS because of the heightened likelihood that they will expire before the survey process can be completed. Patients with a Discharge Status of 50 Hospice home or 51 Hospice medical facility would not be included in the sample frame. Discharge Status is the same as the UB-04 field location 17. Some state regulations place further restrictions on patients who may be contacted after discharge. It is the responsibility of the hospital/survey vendor to identify any applicable regulations and to exclude those patients as required by law or regulation in the state in which the hospital operates. Patients discharged to nursing homes and skilled nursing facilities are excluded from HCAHPS. This applies to patients with a Discharge Status (UB-04 field location 17) of: 03 Skilled nursing facility 61 SNF Swing bed within hospital 64 Certified Medicaid nursing facility 83 Skilled nursing facility with a planned acute care hospital inpatient readmission 92 Certified Medicaid nursing facility with a planned acute care hospital inpatient readmission Hospitals/Survey vendors must retain documentation that verifies all exclusions and ineligible patients. This documentation is subject to review. Note: Patients must be included in the HCAHPS Survey sample frame unless the hospital/ survey vendor has positive evidence that a patient is ineligible or fits
Rationale	The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS (pronounced H-caps), also known as the CAHPS Hospital Survey*, is a 32-item survey instrument and data collection methodology for measuring patients perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there were no common metrics and no national standards for collecting and publicly reporting information about patient experience of care. Since 2008, HCAHPS has allowed valid comparisons to be made across hospitals locally, regionally and nationally. Three broad goals have shaped HCAHPS. First, the standardized survey and implementation protocol produce data that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of HCAHPS results creates new incentives for hospitals to improve quality of care. Third, public reporting enhances accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the Centers for Medicare & Medicaid Services (CMS) and the HCAHPS Project Team have taken substantial steps to assure that the survey is credible, practical and actionable.
Evidence	Not Available

Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	No
Program Name Abbreviation	HIQR
Program Status	Active

Hospital Commitment to Health Equity

CMIT Measure ID: 1660 | **CMIT ID:** 01660-01-C-HIQR | **Measure Type:** Structure

Date of Information: 09/21/2022 | **Revision:** 3 | **Program:** Hospital Inpatient Quality Reporting

View Description

Properties

Date of Information	09/21/2022
Abbreviated Measure Title	Not Available
Description	Among Medicare beneficiaries, racial and ethnic minority individuals, individuals with limited English proficiency or disabilities often receive lower quality of care and higher rates of readmission and complications than beneficiaries without these characteristics. Strong and consistent hospital leadership can be instrumental in setting specific, measurable, and attainable goals to advance equity priorities and improve care for all beneficiaries. This includes promoting an organizational culture of equity through equity-focused leadership, commitment to robust demographic data collection, and active review of disparities in key quality outcomes, which are assessed in this measure.
Numerator	This structural measure assesses hospital commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations. The measure will include five attestation-based questions, each representing a separate domain of commitment. A hospital will receive a point for each domain where they attest to the corresponding statement (for a total of 5 points). For questions with multiple elements, attestation of all elements is required in order to qualify for the measure numerator. Question 1. Hospital commitment to reducing disparities is strengthened when equity is a key organizational priority. Please attest that your hospital has a strategic plan for achieving health equity and that it includes all of the following elements. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator): a) Our hospital strategic plan identifies priority populations who currently experience health disparities. b) Our hospital strategic plan identifies equity goals and discrete action steps to

	achieving these goals. c) Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals. d) Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations. Question 2. Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator): a) Our hospital collects demographic and social determinant of health information on the majority of our patients. b) Our hospital has training for staff in culturally sensitive collection of demographic and social determinant of health information. c) Our hospital inputs demographic and social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology. Question 3. Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator): a) Our hospital stratifies key performance indicators by demographic variables to identify equity gaps and includes this information on hospital performance dashboards. b) Our hospital stratifies key performance indicators by social determinant of health to identify equity gaps and includes this information on hospital performance dashboards. Question 4. Health disparities are evidence that high quality care has not been delivered equally to all patients. Engagement in quality improvement activities can improve quality of care for all patients. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator): a) Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities. Question 5. Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator): a) Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. b) Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and social factors.
Denominator	The denominator for each hospital is 5 which represents the total number of questions. The measure is calculated as the number of complete attestations / total number of questions. There is no partial credit for any question. Attestation of all elements is required in order to qualify for the measure numerator For example, if a hospital affirmatively attests to all elements for only 2 questions; the final score is 40% (2 complete attestations / 5 total questions)

Denominator Exclusions	None
Rationale	Not Available
Evidence	Not Available
Denominator Exceptions	None
Numerator Exceptions	None
Risk Adjusted	No
Program Name Abbreviation	HIQR
Program Status	Active

Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data

CMIT Measure ID: 356 | **CMIT ID:** 00356-07-C-HIQR | **Measure Type:** Outcome

Date of Information: 11/15/2022 | **Revision:** 5 | **Program:** Hospital Inpatient Quality Reporting

View Description

Properties

Date of Information	11/15/2022
Abbreviated Measure Title	Not Available
Description	This measure estimates a hospital-level, risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission within 30 days of hospital discharge for any eligible condition. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of readmissions are planned and do not count in the readmission outcome. The target population is Medicare Fee-for-Service (FFS) beneficiaries who are 65 years or older, and hospitalized in non-federal short-term acute care hospitals and critical access hospitals. This Hybrid HWR measure is a re-engineered version of the HWR measure 1789, the Hospital-Wide Readmission Measure, which was developed for patients 65 years and older using Medicare claims and is currently publicly reported in the Hospital Inpatient Quality Reporting Program. This reengineered measure uses clinical data elements from the electronic health record in addition to Claims for risk adjustment.
Numerator	The outcome for this measure is 30-day readmission. We define readmission as an inpatient acute care admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from an eligible index admission. If a patient has more than one unplanned admission (for any reason) within 30

	days after discharge from the index admission, only one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission.
Denominator	The measure includes admissions for patients that meet all of the following inclusion criteria: 1. Enrolled in Medicare FFS Part A for the 12 months prior to the date of admission and during the index admission; 2. Aged 65 or over; 3. Discharged alive from a non-federal short-term acute care hospital; 4. Not transferred to another acute care facility
Denominator Exclusions	The measure excludes index admissions for patients: 1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals; 2. Without at least 30 days post-discharge enrollment in Medicare FFS; 3. Discharged against medical advice (AMA); 4. Admitted for primary psychiatric diagnoses; 5. Admitted for rehabilitation; or 6. Admitted for medical treatment of cancer
Rationale	The goal of this measure is to improve patient outcomes by providing patients, physicians, hospitals, and policy makers with information about hospital-level, risk-standardized all cause unplanned readmission rates among Medicare beneficiaries 65 years and older admitted to all non-federal US acute care hospitals. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Complex and critical aspects of care, such as communication between providers, prevention of and response to complications, patient safety, and coordinated transitions to the outpatient environment, all contribute to patient outcomes but are difficult to measure by individual process measures. The goal of outcomes measurement is to risk-adjust for patients conditions at the time of hospital admission and then evaluate patient outcomes. This measure was developed to identify institutions whose performance is better or worse than would be expected based on their patient case mix and hospital service mix, and therefore promote hospital quality improvement and better inform consumers about care quality. Hospital-wide readmission is a priority area for outcomes measure development as it is an outcome that is likely attributable to care processes and is an important outcome for patients. Measuring and reporting readmission rates will inform healthcare providers and facilities about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care received by Medicare patients. The measure will also provide patients with information that could guide their choices, as well as increase transparency for consumers. This Hybrid HWR measure incorporates both data from claims as well as clinical data elements pulled from the EHR in risk adjustment of the readmission models. Some benefits of including the clinical data elements are: 1. Inclusion of patient-level clinical data related to severity of

	illness is responsive to providers who continue to express preference for using patient-level clinical data, and provides an opportunity to incorporate clinical data into outcome measures. 2. Hospitals will increasingly use EHR data to assess severity of illness and patients risk of poor outcomes. This provides an opportunity to align the measure with clinical decision support systems that many providers utilize to alert care teams about patients at increased risk of poor outcomes in real time during the inpatient stay. 3. Collecting a simple core set of clinical data elements that perform well as risk-adjustment variables (for illness severity) across conditions can greatly reduce the cost and effort of future measure development, improve harmonization, and create opportunity for longitudinal assessment of patient status and quality of care across settings. 4. These core clinical data elements will provide measure developers with a standard set of reliable data that can be used as a starting place when building risk-adjustment models for quality measures using clinical data.
Evidence	Not Available
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	Yes
Program Name Abbreviation	HIQR
Program Status	Active

National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure

CMIT Measure ID: 463 | **CMIT ID:** 00463-01-C-HACRP | **Measure Type:** Outcome

Date of Information: 06/16/2023 | **Revision:** 14 | **Program:** Hospital Acquired Condition Reduction Program

View Description +

Properties

Date of Information	06/16/2023
Abbreviated Measure Title	Not Available
Description	Standardized infection ratio (SIR) and Adjusted Ranking Metric (ARM) of hospital-onset unique blood source MRSA Laboratory-identified events (LabID events) among all inpatients in the facility
Numerator	Total number of observed hospital-onset unique blood source MRSA LabID events among all inpatients in the facility.
Denominator	The expected number of hospital-onset unique blood source MRSA LabID events, calculated using the facility s number of inpatient days, bed size, affiliation with medical school, and community-onset MRSA bloodstream infection admission prevalence rate.
Denominator Exclusions	Data from patients who are not assigned to an inpatient bed in an applicable location are excluded from the denominator counts. Denominator counts exclude data from inpatient rehabilitation units and inpatient psychiatric units with unique CMS Certification Numbers (CCN) than the acute care facility.
Rationale	The SIR compares a healthcare facility's performance compared to a national baseline. Facilities are able to see whether the number of hospital-onset C. difficile LabID events that they have reported compares to the number that would be expected, given national data. The measure

Return to Top

	can then be used to drive prevention practices that will lead to improved outcomes, including the reduction of patient morbidity and mortality.
Evidence	Clostridium difficile is responsible for a spectrum of C. difficile infections (CDI), including uncomplicated diarrhea, pseudomembranous colitis, and toxic megacolon which can, in some instances, lead to sepsis and even death. In recent years, a previously unrecognized strain of C. difficile with increased virulence and high levels of antimicrobial resistance has resulted in outbreaks in healthcare facilities in the United States. Additionally, CDI has become more common in the community setting, with increased risk in those with a recent inpatient stay in a healthcare facility. Significant increases in cost of inpatient care and post-hospitalization care have been seen in cases of CDI.
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	Yes
Program Name Abbreviation	HACRP
Program Status	Active

Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite

CMIT Measure ID: 135 | **CMIT ID:** 00135-04-C-MODEL/BPCIA | **Measure Type:** Composite

Date of Information: 03/14/2023 | **Revision:** 1 | **Program:** Bundled Payment for Care Improvement Advanced Model (BPCI-A)

View Description

Properties

Date of Information	03/14/2023
Abbreviated Measure Title	Not Available
Description	Not Available
Numerator	CMS PSI 90 measure is not limited to BPCI Advanced Beneficiaries. More detailed measure specifications, as well as inclusion and/or exclusion criteria, are in the links provided in the “Other Resources” table, including the “CMS Measures Inventory Tool: PSI 90” and the ten PSI measure ICD-10-CM/PCS specification overviews. (Please refer to the table within Fact Sheet)
Denominator	The CMS PSI 90 measure is not limited to BPCI Advanced Beneficiaries. More detailed measure specifications, as well as inclusion and/or exclusion criteria, are in the links provided in the “Other Resources” table, including the “CMS Measures Inventory Tool: PSI 90” and the ten PSI measure ICD-10-CM/PCS specification overviews. (Please refer to the table within Fact Sheet)
Denominator Exclusions	Not Available
Rationale	Not Available
Evidence	Not Available
Denominator Exceptions	Not Available
Numerator Exceptions	Not Available
Risk Adjusted	No

Return to Top

Program Name Abbreviation	MODEL/BPCIA
Program Status	Active

Screening for Social Drivers of Health Measure and the Screen Positive Rate for Social Drivers of Health Measure

In the FY 2023 IPPS/LTCH PPS final rule, CMS includes two new measures that hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program will be required to report on, the Screening for Social Drivers of Health Measure and the Screen Positive Rate for Social Drivers of Health Measure.

Performance Measure Name: Screening for Social Drivers of Health

Description: The Screening for Social Drivers of Health Measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. To report on this measure, hospitals will provide: (1) The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for each of the five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; and (2) the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted.

Measure Numerator: The numerator consists of the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay.

Measure Denominator: The denominator consists of the number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

Exclusions: The following patients will be excluded from the denominator: (1) Patients who opt- out of screening; and (2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay.

Clarifying Information: The Screening for Social Drivers of Health measure will be calculated as the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission screened for all five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) divided by the total number of patients 18 years or older on the date of admission admitted to the hospital. Hospitals would report using their CCN through the Hospital Quality Reporting (HQR) System.

Performance Measure Name: Screen Positive Rate for Social Drivers of Health

Description: The Screen Positive Rate for Social Drivers of Health Measure provides information on the percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HSRN, and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

Measure Numerator: The numerator consists of the number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HSRN, and who *screen positive* for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety.

Measure Denominator: The denominator consists of the number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

Exclusions: The following patients would be excluded from the denominator: 1) Patients who opt-out of screening; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay.

Clarifying Information: The result of this measure would be calculated as *five separate rates*. Each rate is derived from the number of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.

Additional Resources:

For more information about the CMMI Accountable Health Communities Model screening tool and case studies about implementing SDOH screening: https://innovation.cms.gov/innovation-models/ahcm

For a listing of various screening tools, including those that include the five SDOH domains specified in the measure:

https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison

Severe Obstetric Complications (eCQM)

CMIT Measure ID: 1633 | **CMIT ID:** 01633-01-E-HIQR | **Measure Type:** Outcome

Date of Information: 03/02/2023 | **Revision:** 7 | **Program:** Hospital Inpatient Quality Reporting

View Description

Properties

Date of Information	03/02/2023
Abbreviated Measure Title	Not Available
Description	Patients with severe obstetric complications which occur during the inpatient delivery hospitalization.
Numerator	Inpatient hospitalizations for patients with severe obstetric complications (not present on admission that occur during the current delivery encounter) including the following: - Severe maternal morbidity diagnoses (see list below) - Severe maternal morbidity procedures (see list below) - Discharge disposition of expired Severe Maternal Morbidity Diagnoses: - Cardiac: Acute heart failure, Acute myocardial infarction, Aortic aneurysm, Cardiac arrest/ventricular fibrillation, Heart failure/arrest during procedure or surgery - Hemorrhage: Disseminated intravascular coagulation. Shock - Renal: Acute renal failure - Respiratory: Adult respiratory distress syndrome, Pulmonary edema - Sepsis - Other OB: Air and thrombotic embolism, Amniotic fluid embolism, Eclampsia, Severe anesthesia complications - Other Medical: Puerperal cerebrovascular disorder, Sickle cell disease with crisis Severe Maternal Morbidity Procedures: - Blood transfusion - Conversion of cardiac rhythm - Hysterectomy - Temporary tracheostomy - Ventilation
Denominator	Inpatient hospitalizations for patients delivering stillborn or live birth with greater than or equal to 20 weeks, 0 days gestation completed.
Denominator Exclusions	Inpatient hospitalizations for patients with confirmed diagnosis of COVID with COVID-related respiratory condition or patients with confirmed diagnosis of COVID with COVID-related respiratory procedure.
Rationale	The United States experiences higher rates of maternal morbidity and mortality than most other developed countries. These rates have continued to trend upward in recent decades. Research indicates that the overall rate

of severe maternal morbidity (SMM) has increased by almost 200% between 1993 and 2014 to 144 per 10,000 delivery hospitalizations, with more than 25,000 women per year experiencing obstetric complications.Recent maternal mortality data from 2018 reveal that 658 women died from maternal causes, resulting in a rate of 17.4 deaths per 100,000 live births, with 77% of the deaths attributed to direct obstetric causes like hemorrhage, preeclampsia, obstetric embolism, and other complications. This has prompted national health experts and organizations to prioritize quality improvement strategies to mitigate risk of adverse outcomes among maternal populations. The U.S. Department of Health & Human Services (HHS) has also called for action to improve maternal health and outcomes and outlines seven actions for healthcare professionals, including participating in quality improvement and safety initiatives.There are currently only a small number of quality measures focused on maternal health, and those implemented at the national level are mostly process measures and limited in scope. While these existing measures aim to promote coordination of care and standardize health care processes, maternal health outcome measures are sorely needed. Measures that are focused on maternal health outcomes will address the patient safety priority area under the Meaningful Measures 2.0 framework, and likewise will use EHR data to address interoperability, another meaningful measure area for assessing quality of health care.

▲ Return to Top

Evidence

Although the United States (US) is one of the most developed countries, there continues to be a staggering increase in the number of pregnant women who suffer from complications associated with Severe Maternal Morbidity (SMM). It has been found that rates of SMM are steadily increasing in the US. Fourteen in every 1,000 perinatal pregnant women have experienced hemorrhage, embolism, hypertension, stroke, and other serious complications. Racial and ethnic disparities for women who identify as minority are significant; they are at considerably higher risk for developing these complications than are Non-Hispanic White women. Additionally, recent maternal mortality data from 2018 reveal that 658 women died from maternal causes, resulting in a rate of 17.4 deaths per 100,000 live births, with 77% of the deaths attributed to direct obstetric causes like hemorrhage, preeclampsia, obstetric embolism, and other complications. Per report from the Center for Disease Control and Prevention (CDC), the overall rate of SMM increased almost 200%, from 49.5 per 10,000 delivery hospitalizations in 1993 to 144.0 per 10,000 delivery hospitalizations in 2014.1 This increase has been mostly driven by blood transfusions, which increased by almost 400% in that period. Excluding blood transfusions, there has been a 22.4% increase in SMM, from 28.6 in 1993 to 35.0 in 2014. Increasing rates of SMM are resulting in increased healthcare costs, longer hospitalization stays and short- and long-term negative outcomes on a woman's health. National evaluation of hospitals' performance on maternal morbidity and mortality is limited because there are currently no maternal morbidity or obstetric complications outcome measures in national reporting programs. Current quality

	measures related to pregnancy and maternal health proposed for or in public reporting programs are largely process measures (e.g., Maternity Care: Post-partum Follow Up and Care Coordination) and outcome measures related to delivery type (e.g., PC-01 Elective Delivery). The high maternal mortality and morbidity rates in the United States present unique opportunities for large-scale quality measurement and improvement activities. Statistics on preventability vary but suggest that a considerable proportion of maternal morbidity and mortality events could be prevented. This measure will therefore assist in the discovery and understanding of SMM outcomes and disparities in maternal outcomes, which can lead to improvements in the safety and quality of maternal care necessary to reduce SMM and mortality rates.
Denominator Exceptions	None
Numerator Exceptions	Not applicable
Risk Adjusted	Yes
Program Name Abbreviation	HIQR
Program Status	Active

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

CMIT Measure ID: 678 | **CMIT ID:** 00678-01-C-HIQR | **Measure Type:** Composite

Date of Information: 12/21/2022 | **Revision:** 8 | **Program:** Hospital Inpatient Quality Reporting

View Description

Properties

Date of Information	12/21/2022
Abbreviated Measure Title	Not Available
Description	This measure focuses on adults 18 years and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, it assesses measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. As reflected in the data elements and their definitions, the first three interventions should occur within three hours of presentation of severe sepsis, while the remaining interventions are expected to occur within six hours of presentation of septic shock.
Numerator	Patients who received ALL of the following: Within three hours of presentation of severe sepsis: * Initial lactate level measurement * Broad spectrum or other antibiotics administered * Blood cultures drawn prior to antibiotics AND received within six hours of presentation of severe sepsis. ONLY if the initial lactate is elevated: * Repeat lactate level measurement AND within three hours of initial hypotension: * Resuscitation with 30 mL/kg crystalloid fluids OR within three hours of septic shock: * Resuscitation with 30 mL/kg crystalloid fluids AND within six hours of septic shock presentation, ONLY if hypotension persists after fluid administration: * Vasopressors are administered AND within six hours of septic shock presentation, if hypotension persists after fluid administration or initial lactate >= 4 mmol/L: * Repeat volume status and tissue perfusion assessment is performed

Denominator	Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis, or Septic Shock and not equal to U07.1 (COVID-19).
Denominator Exclusions	* Patients with an ICD-10-CM Principal or Other Diagnosis Code of U07.1 (COVID-19) * Directive for Comfort Care or Palliative Care within six hours of presentation of severe sepsis * Directive for Comfort Care or Palliative Care within six hours of presentation of septic shock * Administrative contraindication to care within six hours of presentation of severe sepsis * Administrative contraindication to care within six hours of presentation of septic shock * Length of Stay >120 days * Transfer in from another acute care facility * Patients enrolled in a clinical trial for sepsis, severe sepsis or septic shock treatment or intervention * Patients with severe sepsis who are discharged within six hours of presentation * Patients with septic shock who are discharged within six hours of presentation * Patients receiving IV antibiotics for more than 24 hours prior to presentation of severe sepsis
Rationale	The evidence cited for all components of this measure is directly related to decreases in organ failure, overall reductions in hospital mortality, length of stay, and costs of care. A principle of sepsis care is that clinicians must rapidly treat patients with an unknown causative organism and unknown antibiotic susceptibility. Since patients with severe sepsis have little margin for error regarding antimicrobial therapy, initial treatment should be broad spectrum to cover all likely pathogens. As soon as the causative organism is identified, based on subsequent culture and susceptibility testing, de-escalation is encouraged by selecting the most appropriate antimicrobial therapy to cover the identified pathogen, safely and cost effectively (Dellinger, 2012). The care interventions in SEP-1 when provided as a composite lead to a significant reduction in hospital length of stay, re-admission rates, and mortality (Levy, 2018 and Bauer, 2020). Mortality benefit for each data element singularly has also been observed (Whitfield, 2020). Multicenter efforts to promote bundles of care for severe sepsis and septic shock were associated with improved guideline compliance and lower hospital mortality (Ferrer, 2008 and Rhodes, 2015). Even with compliance rates of less than 30%, absolute reductions in mortality of 4-6% have been noted (Levy, 2010 and Ferrer, 2008). Absolute reductions in mortality of over 20% have been seen with compliance rates of 52% (Levy, 2010). Coba et al. has shown that when all bundle elements are completed and compared to patients who do not have bundle completion, the mortality difference is 14% (2011). Thus, there is a direct association between bundle compliance and improved mortality. Without a continuous quality initiative (CQI), even these compliance rates will not improve and will decrease over time (Ferrer, 2008). Multiple studies have shown that, for patients with severe sepsis, standardized order sets, enhanced bedside monitor display, telemedicine, and comprehensive CQI feedback is feasible, modifies clinician behavior, and is associated with decreased hospital mortality (Thiel, 2009; Micek, 2006; Winterbottom, 2011; Schramm, 2011; Nguyen, 2007; Loyola, 2011).

Evidence	Not Available
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	No
Program Name Abbreviation	HIQR
Program Status	Active