2020 Hospital Quality Incentive Payment (HQIP) Program

April 24, 2020

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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I. 2020 Measures

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

A. Maternal Health and Perinatal Care Measure Group

Measure	Measure Basis	Source	Measurement Period
Exclusive Breast Feeding (PC-05)	The Joint Commission (TJC)/CMS	Hospital Reported	January 1, 2019 to December 31, 2019
Cesarean Section (PC-02)	The Joint Commission/CMS	Hospital Reported	January 1, 2019 to December 31, 2019
Perinatal Depression and Anxiety	Council on Patient Safety in Women's Health Care	Hospital Reported	In place on April 30, 2020
Maternal Emergencies	National Partnership for Maternal Safety	Hospital Reported	In place on April 30, 2020
Reproductive Life/Family Planning	Department of Health Care Finance/US Office of Population Affairs	Department/ Hospital Reported	In place on April 30, 2020
Incidence of Episiotomy*	Christiana Care Health System	Department	January 1, 2019 to December 31, 2019

B. Patient Safety Measure Group

Measure	Measure Basis	Source	Measurement Period
Clostridium difficile (C. Diff)	Center for Disease Control (CDC)	Department/ Hospital Reported	January 1, 2019 to December 31, 2019
Adverse Event	HQIP	Hospital Reported	January 1, 2019 to December 31, 2019
Culture of Safety Survey	Agency for Healthcare Research and Quality (AHRQ)	Hospital Reported	Within the 24 months prior to data collection

C. Patient Experience Measure Group

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

D. 2020 Maintenance Measures

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

Measure Steward	Data Source	Measurement Period
AHRQ	CHA Hospital Report Card	TBD

2. Central Line Associated Blood Stream Infections (CLABSI)

Measure Steward	Data Source	Measurement Period
CDC	Colorado Department of Public Health and Environment (CDPHE)	TBD

3. Early Elective Deliveries

Measure Steward	Data Source	Measurement Period
The Joint Commission	CMS	TBD

E. New Measures

- Episiotomy

F. Postponed Measures for 2020

The following measures were originally planned for implementation in the 2020 HQIP program year. However, in response to the COVID-19 global pandemic, these hospital-reported measures will be postponed until 2021.

- Reduction of Peripartum Racial and Ethnic Disparities Patient Safety Bundle
- Sepsis
- Antibiotic Stewardship
- Handoff and Signouts

G. Retired Measures

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

II. Scoring Rubric

For the FFY2019-20 program year a total of 65 points are available for the successful completion of the following three measures: Perinatal and Maternal Care, Patient Safety and Patient Experience. Points will be normalized to 100 based on the scoring of available measures.

A. Maternal Health and Perinatal Care Measure Group

This measure group awards up to 30 total points for the successful completion of the following six sub-measures:

Measure	Measure Score	Proposed Scoring Method	Scoring Levels
a. Breast Feeding	5	Pay for PC-05 reporting, plus points depending on activity	3
b. C-section	5	Ranking method –no points awarded to equal to or above threshold rate	3
c. Pregnancy Related Depression	5	Pay for reporting—scoring tiered depending on no. of elements in place	3
d. Maternal Emergencies	5	Pay for reporting—points for Structure and Process Measures awarded on an all-or-nothing basis.	1-All or Nothing
e. Reproductive Life and Family Planning	5	Pay for reporting—points awarded on an all or nothing basis	1-All or Nothing
f. Incidence of Episiotomy*	5	Ranking method – points awarded for hospitals above Leapfrog benchmark; points awarded for improvement if below benchmark	3

B. Patient Safety Measure Group

This measure group awards up to 15 total points for the successful completion of the following three sub-measures:

Measure	Measure Score	Proposed Scoring Method	Scoring Levels
a. C. Diff infections	5	Ranking method based on “worse, same, better” ranking. Points only awarded to those in “same” or “better” categories	3
b. Adverse Event	5	Pay for reporting—points awarded on an all or nothing basis	1-All or Nothing
c. Culture of Safety Survey	5	Pay for reporting—points awarded on an all or nothing basis	1-All or Nothing

C. Patient Experience Measure Group

This measure awards up to 20 total points for the successful completion of the following four sub-measures:

Measure	Measure Score	Proposed Scoring Method	Scoring Levels
a. HCAHPS Communication about Medicine Composite 5	5	Ranking method—points awarded to top three quartiles only	3
b. HCAHPS Discharge Information Composite 6	5	Ranking method—points awarded to top three quartiles only	3
c. HCAHPS Care Transition Composite 7	5	Ranking method—points awarded to top three quartiles only	3
d. Advance Care Planning	5	Ranking method—points only awarded to those above performance threshold	3

D. Scoring Rubric- Points per Scoring Level

Total Possible	Level 1	Level 2	Level 3	Level 4
4	2	3	4	N/A
5	1	3	5	N/A

III. 2020 Measure Details

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

A. Maternal Health and Perinatal Care Measure Group

1. Exclusive Breast Feeding

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

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

Measure Criteria

1. Hospitals will submit calendar year 2019 data for The Joint Commission (TJC) PC-05, Exclusive Breast Milk Feeding measure (all patients, regardless of payer). Points will be given for reporting and will not be based upon the hospital's PC-05 rate. Sampling is allowed. There is no minimum denominator for this measure.

AND ONE OF THE FOLLOWING

2. Written breastfeeding policies for hospitals not officially on the pathway to Baby-Friendly designation. Must implement all five (5) of The Ten Steps to Successful Breastfeeding by December 31, 2019. Must also provide a copy of the policy and a statement as to how staff is trained on the policy.
    i. Help mothers initiate breastfeeding within one hour of birth.
    ii. Give infants no food or drink other than breast milk unless medically indicated.
    iii. Practice rooming in – allow mothers and infants to remain together 24 hours a day.
    iv. Give no pacifiers or artificial nipples to breastfeeding infants.
    v. Breastfeeding support telephone number provided before discharge.

OR

3. 4-D Pathway to Baby-Friendly Designation. Hospitals must move from one of the following 4-D Pathway phases to the next during the time period of January 1, 2019 and December 31, 2019

   i. From Discovery Phase to Development Phase.
   ii. From Development Phase to Dissemination Phase.
   iii. Dissemination Phase to Designation Phase

OR

4. Baby-Friendly Designation: hospitals officially receiving or maintaining Baby-Friendly designation at some point between January 1, 2019 and December 31, 2019.

Scoring

Points earned for reporting PC-05 data (all or nothing).

Highest number of points will be awarded to hospitals with Baby-Friendly Designation, and second-tier of points for those on the Pathway. The lowest tier of points will be awarded for hospitals that submit written breastfeeding policies but are not on the Pathway. Documentation will also be required to verify Pathway transition and Baby-Friendly Designation.

PC-05 Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
1	1	N/A	N/A	N/A

Exclusive Breast Feeding Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
4	2	3	4	N/A

2. Cesarean Section

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

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

Measure Criteria

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

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

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

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

Scoring

Hospitals that meet the criteria outlined will be eligible to earn points.

Points will be assigned based on relative performance with hospitals performing worse than minimum standard of 23.9% (Healthy People 2020) receiving no points and the remaining divided into terciles.

Cesarean Section Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	1	3	5	N/A

3. Perinatal Depression and Anxiety

Facilities must attest that this measure has been in place since April 30, 2020 and is for all patients regardless of insurance status.

The Perinatal Depression and Anxiety measure is based on the Council on Patient Safety in Women's Health Care Perinatal Depression and Anxiety. The measure has been revised to better suit the nature of care delivery in hospital environments.

The measure is modeled after 4 "Rs": Readiness, Recognition and Prevention, Response, Reporting/Systems Learning.

1. Readiness-Clinical Care Setting
    i. Provide documentation on the mental health screening tools used in the facility for screening during pregnancy/immediate postpartum period as well as any education materials and plans provided to clinicians and support staff on use of the identified screening tools and response protocol.
    ii. Identify the individual who is responsible for driving adoption of the identified screening tools and response protocol.
2. Recognition and Prevention-Every Woman:
    i. Describe the process where the hospital obtains individual and family mental health history (including past and current medications) at intake and how it is reviewed and update as needed.
    ii. Document the validated mental health screening provided at the hospital during patient encounters during pregnancy/immediate postpartum period.
3. Response-Every Case:
    i. Submit documentation on the facility's stage-based response protocol for a positive mental health screen.
    ii. Submit documentation on the emergency referral protocol for women with suicidal/homicidal ideation or psychosis.
4. Reporting/Systems Learning-Clinical Care Setting:
    i. Describe the policies and processes by which the hospital incorporates information about patient mental health into how it plans care.
    ii. Report the number of patients screened, the number of positive screens and the number of positive screens that resulted in a documented action or follow up plan. Hospitals can report this data using any 12-month time period between January 1, 2019 and April 30, 2020.

Measure Criteria

Hospitals should report the requested information and documentation that addresses each of the four "Rs" (1-4) in the measure. Screening rates under the

Reporting/Systems Learning category must be greater than 0 in order to receive points.

Scoring

To be scored, hospitals must submit complete information on at least two of four "Rs" (1-4)

Scoring will be tiered with points earned for completion of two, three, or four "Rs" (1-4).

Perinatal Depression and Anxiety Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	1	3	5	N/A

4. **Maternal Emergencies and Preparedness**

Facilities must attest that this measure has been in place since April 30, 2020 and is for all patients regardless of insurance status.

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

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

Measure Criteria

Structure Measures:

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

For each structure measure, hospitals are advised to use the following crosswalk as guidance to determine the relevant "R's" and their associated

subcomponents in which documents and narratives submitted must address in order to fully satisfy the requirements for this measure.

Relevant "Rs"

Structure Measure	Readiness	Recognition and Prevention	Response	Reporting
A (required)	1, 3, 6	1, 2, 3	1 (i-iii), 2 (i-vii)	N/A
B	1, 3, 6	1, 2	2 (i-vii)	N/A
C	1,3,4,5,6	1,2,3	1 (i-iii), 2 (i-vii)	N/A
D	N/A	N/A	N/A	1,2,3

A. Does the facility have a severe hypertension or preeclampsia policy and procedure updated within the past 3 years that provides a standard approach for measuring blood pressure, treatment of severe hypertension or preeclampsia, administration of magnesium sulfate, and treatment of magnesium sulfate overdose?
B. Have any of the severe hypertension and preeclampsia processes (i.e. order sets, tracking tools) been incorporated into the facility's electronic health record?
C. Has the facility developed obstetric-specific resources and protocols to support patients, families, and staff through major obstetric complications?
D. Has the facility established a system to perform regular formal debriefs and system-level reviews on all cases of severe maternal morbidity or major obstetric complications?

Compliance on the structure and process measures would be based on the 4 "Rs" criteria from the Council on Patient Safety in Women's Health Care Severe Hypertension in Pregnancy which is listed below:

Readiness – Every Unit:

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

Recognition and Prevention – Every Patient:

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

Response – Every case of severe hypertension/preeclampsia:

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

Reporting/Systems Learning – Every Unit:

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

Process Measures:

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

A. How many drills on maternal safety topics were performed in the facility during the past calendar year?
B. What proportion of maternity care providers and nurses have completed a bundle or unit protocol– specific education program on severe hypertension and preeclampsia within the past 2 years?
C. How many women with sustained severe hypertension received treatment according to protocol within 1 hour of detection over the past calendar year? Collect the total number of women with sustained severe hypertension as well as the women who received treatment according to protocol within 1 hour of detection.

Outcome Measures:

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

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

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

Numerator: Among those patients counted in the denominator, cases with any Severe Maternal Morbidity code (as detailed on the Alliance for Innovation on Maternal Health website: www.safehealthcareforeverywoman.org/wp-content/uploads/2017/09/AIM-SMM-Codes-List_Latest.xlsx

Scoring

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

Maternal Emergencies and Preparedness Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	5	N/A	N/A	N/A

5. <u>Reproductive Life/Family Planning</u>

Facilities must attest that this measure has been in place since April 30, 2020 and is for all patients regardless of insurance status.

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

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

Measure Criteria

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

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

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

Scoring

Pay for reporting, hospitals will attest that they have program in place that offers counseling about all forms of postpartum contraception or that they

offer counseling on reproductive life/family planning. Hospitals are required to upload evidence or descriptions of their processes or policies.

Points will be earned on an all or nothing basis.

Reproductive Life and Family Planning Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	5	N/A	N/A	N/A

6. **Incidence of Episiotomy**

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

Measure Criteria

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

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

Scoring

Proposed scoring methodology is to award points for those better than the Leapfrog benchmark of 5%[1]. For hospitals that are worse than the benchmark award points based on improvement.

Incidence of Episiotomy Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	1	3	5	N/A

B. Patient Safety Measure Group

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

[1]www.leapfroggroup.org/ratings-reports/rate-episiotomy

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

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

1. **Hospital Acquired Clostridium Difficile (C.diff) Infections**

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

   Scoring

   For Hospital Acquired Clostridium Difficile infections points will be earned based on hospital performance over self, with points earned for maintaining the same rate or improving.

   Hospital Acquired Clostridium Difficile (C.diff) Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	1	3	5	N/A

2. **Adverse Event Reporting**

   Hospitals must report on their adverse event reporting system and attest that the following components are in place:

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

   Additionally, hospitals must provide a written narrative describing their adverse event reporting system as well as the two types of adverse events most frequently

reported through the system in the last calendar year, and how those particular issues were addressed.

Scoring

Adverse Event Reporting is pay for reporting; points will be earned on an all or nothing basis.

Adverse Event Reporting Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	5	N/A	N/A	N/A

3. **Culture of Safety Survey**

To receive points, hospitals will attest to using the AHRQ survey OR provide the following:

- A copy of the survey instrument
- A copy of the key findings of the survey highlighting areas where performance is low, and improvements can be made
- A copy of the plan to address low performing areas

Measure Criteria

- Survey must include at least ten questions related to a safety culture.
- Culture of Safety questions must be from a survey tool that has been tested for validity and reliability.
- Survey questions can be part of another survey tool as long as it meets the above criteria.
- Culture of Safety survey has been administered within the 24 months prior to the data collection.
- Action taken in response to the survey should address those survey questions that demonstrated the poorest score on the survey.

Scoring

Culture of Safety is pay for reporting; points will be earned on an all or nothing basis.

Culture of Safety Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	5	N/A	N/A	N/A

C. Patient Experience Measure Group

1. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The Department will collect data for three HCAHPS composites from Hospital Compare:

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

2. Advance Care Planning (ACP)

The Advance Care Planning measure is based on the definition provided by the National Quality Forum (NQF) for the number of patients, regardless of payer, 65 years of age or older who have an advanced care plan documented in the medical record or who did not wish to provide an advance care plan. Measure specifics can be found on the NQF website (measure ID: 0326). Note that this measure includes initial hospital observation care services, inpatient services and critical care services (refer to NQF measure #0326 for CPT codes). Hospitals will be required to submit data from calendar year 2019 to the Department. Sampling is allowed. There is no minimum denominator for this measure.

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

Scoring

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

HCAHPS Composite 5-7 Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	1	3	5	N/A

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

Advanced Care Planning Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
5	1	3	5	N/A

IV. Maintenance Measures

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

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

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

MM #3 Early Elective Deliveries (no points). Hospitals do not need to submit data for perinatal care measure set. The data source for this measure is Hospital Compare.

V. Sampling

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

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

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

Annual Sample Size

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

Examples

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