2022 Hospital Quality Incentive Payment (HQIP) Program

October 26, 2020

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CHASE

Colorado Healthcare Affordability and Sustainability Enterprise

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I. 2022 Measures

Measures for the 2022 HQIP program are listed below. Hospitals will be requested to complete all three measure groups. Measures with an asterisk (*) denote modified measures for the 2022 HQIP program year.

A. Maternal Health and Perinatal Care Group

Measure	Measure Basis	Source	Measurement Period
Exclusive Breastfeeding (PC-05)	The Joint Commission/CMS	Hospital Reported	January 1, 2021 to December 31, 2021
Cesarean Section (PC-02)	The Joint Commission/CMS	Hospital Reported	January 1, 2021 to December 31, 2021
Perinatal Depression and Anxiety	Council on Patient Safety in Women's Health Care	Hospital Reported	In place on April 30, 2022
Maternal Emergencies	National Partnership for Maternal Safety	Hospital Reported	In place on April 30, 2022
Reproductive Life/Family Planning	Department of Health Care Finance/US Office of Population Affairs	Department/ Hospital Reported	In place on April 30, 2022

B. Patient Safety Group

Measure	Measure Basis	Source	Measurement Period
Zero Suicide*	HQIP	Hospital Reported	In place by April 30, 2022
Reduction of Racial and Ethnic Disparities*	Council on Patient Safety in Women's Health Care	Hospital Reported	In place by April 30, 2022
Clostridium difficile (C. Diff)	Center for Disease Control (CDC)	Department/ Hospital Reported	October 1, 2020 to September 30, 2021
Sepsis*	HQIP	Hospital Reported	In place by April 30, 2022
Antibiotics Stewardship	CPHE	Hospital Reported	In place by April 30, 2022
Adverse Event	HQIP	Hospital Reported	January 1, 2021 to December 31, 2021
Culture of Safety Survey	Agency for Healthcare Research and Quality (AHRQ)	Hospital Reported	Within the 24 months prior to data collection
Handoffs and Signouts*	HQIP - based on Agency for Healthcare Research and Quality (AHRQ) & The Joint Commission	Hospital Reported	In place by April 30, 2022

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C. Patient Experience Group

Measure	Measure Basis	Source	Measurement Period
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	AHRQ/ Hospital Compare	Department	July 1, 2020 to June 30, 2021
Advance Care Plan	National Committee for Quality Assurance (NCQA)	Hospital Reported	January 1, 2021 to December 31, 2021

D. 2022 Maintenance Measures

1. Incidence of Episiotomy

Measure Steward	Data Source	Measurement Period
Christiana Care Health System	Department	January 1, 2021 to December 31, 2021

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

Measure Steward	Data Source	Measurement Period
AHRQ	CHA Hospital Report Card	January 1, 2021 to December 31, 2021

3. Central Line Associated Blood Stream Infections (CLABSI)

Measure Steward	Data Source	Measurement Period
CDC	Colorado Department of Public Health and Environment (CDPHE)	October 1, 2020 to September 30, 2021

4. Early Elective Deliveries

Measure Steward	Data Source	Measurement Period
The Joint Commission	CMS	October 1, 2020 to September 30, 2021

E. Modified Measures for 2022

- Zero Suicide
  - ✓ Criteria Modification- Hospitals must address additional elements in Levels III and IV
  - ✓ Scoring Modification: In order to be eligible for points, hospitals must complete all elements of Levels I and II
- Reduction of Racial and Ethnic Disparities
  - ✓ Building from the Reduction in Peripartum Racial and Ethnic Disparities measure introduced in the 2021 HQIP program year.
- Sepsis

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- ✓ Scoring Modification: Hospitals earn points for reporting the measure and additional points for any improvement hospitals can document on self-reported process of outcome measures

- Handoffs and Signouts
  - ✓ Scoring Modification: Hospitals can earn Level 4 points by reporting measurement results from the previous year.

II. Scoring Rubric

For the FFY2021-22 program year a total of 100 points are available for the successful completion of the following three measures: Perinatal and Maternal Care, Patient Safety and Patient Experience

A. Maternal Health and Perinatal Care Group

This measure awards up to 21 total points for the successful completion of the following seven sub-measures:

Measure	Measure Score	Proposed Scoring Method	Scoring Levels
Exclusive Breast-feeding (PC-05)	1	Pay for reporting—points awarded on an all or nothing basis	1-All or Nothing
C-section	5	Ranking method -no points awarded to equal to or above threshold rate	3
Perinatal Related Depression	5	Pay for reporting—scoring tiered depending on no. of elements in place	2
Maternal Emergencies	5	Pay for reporting—points for Structure and Process Measures awarded on an all-or-nothing basis.	1-All or Nothing
Reproductive Life and Family Planning	5	Pay for reporting—points awarded on an all or nothing basis	1-All or Nothing

B. Patient Safety Group

This measure awards up to 59 total points for the successful completion of the following six sub-measures:

Measure	Measure Score	Proposed Scoring Method	Scoring Levels
Zero Suicide	10	Pay for reporting - scoring tiered depending on no. of elements in place	3
Reduction of Racial and Ethnic Disparities	10	Pay for reporting—points awarded for Readiness; additional points for each additional element, up to 5	2

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Measure	Measure Score	Proposed Scoring Method	Scoring Levels
C. Diff infections	5	Ranking method based on "worse, same, better" ranking. Points only awarded to those in "same" or "better" categories	3
Sepsis	7	Pay for reporting—scoring tiered depending on no. of elements in place	2
Antibiotics Stewardship	10	Pay for reporting—scoring tiered depending on no. of elements in place	4
Adverse Event	5	Pay for reporting—points awarded on an all or nothing basis	1-All or Nothing
Culture of Safety Survey	5	Pay for reporting—points awarded on an all or nothing basis	1-All or Nothing
Handoffs and Sign-outs	7	Pay for reporting—scoring tiered depending on no. of elements in place	4

C. Patient Experience 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
HCAHPS composite 5	5	Ranking method—points awarded to top three quartiles only	3
HCAHPS composite 6	5	Ranking method—points awarded to top three quartiles only	3
HCAHPS composite 7	5	Ranking method—points awarded to top three quartiles only	3
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
1	1	N/A	N/A	N/A
5	5	N/A	N/A	N/A
5	3	5	N/A	N/A
5	1	3	5	N/A
7	5	7	N/A	N/A
7	3	4	5	7
10	5	One point for each additional bullet	N/A	N/A

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Total Possible	Level 1	Level 2	Level 3	Level 4
10	5	7	10	N/A
10	3	5	7	10

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III. 2022 Measure Details

Measures for the 2022 HQIP program are listed below. Hospitals will be requested to complete all six measure groups.

A. Maternal Health and Perinatal Care Group

1. Exclusive Breast-Feeding (PC-05)

This measure is based on activities from January 1, 2021 to December 31, 2021 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

Hospitals will submit calendar year 2021 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.

Scoring

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

Exclusive Breastfeeding (PC-05) Scoring Rubric

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

2. Cesarean Section

This measure is based on calendar year 2021 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

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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 23.6% (Healthy People 2030) 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, 2022 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

a. 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.
b. Identify the individual who is responsible for driving adoption of the identified screening tools and response protocol.

2. Recognition and Prevention-Every Woman:
   a. 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.
   b. Document the validated mental health screening provided at the hospital during patient encounters during pregnancy/immediate postpartum period.
3. Response-Every Case:
   a. Submit documentation on the facility's stage-based response protocol for a positive mental health screen.
   b. Submit documentation on the emergency referral protocol for women with suicidal/homicidal ideation or psychosis.
4. Reporting/Systems Learning-Clinical Care Setting:
   a. Describe the policies and processes by which the hospital incorporates information about patient mental health into how it plans care.
   b. Report the number of patients screened, the number of positive screens and the number of positive screens that resulted in a documented action or follow up plan.

Measure Criteria

Hospitals should report the requested information and documentation that addresses each of the four "Rs" (1-4) in the measure. Screening rates under the Reporting/Systems Learning category must be greater than 0 in order to receive points.

Scoring

To be scored and earn points, hospitals must submit complete information on at least three of four "Rs" (1-4).

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

Perinatal Depression and Anxiety Scoring Rubric

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

4. Maternal Emergencies and Preparedness

Facilities must attest that this measure has been in place since April 30, 2022 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.

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Relevant "Rs"

Structure Measure	Readiness	Recognition and Prevention	Response	Reporting
A (required)	1, 3, 6	1, 2, 3	1 (a-c), 2 (a-g)	N/A
B	1, 3, 6	1, 2	2 (a-c)	N/A
C	1,3,4,5,6	1,2,3	1 (a-c), 2 (a-g)	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?

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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:

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

Reporting/Systems Learning – Every Unit:

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

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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 all Structure elements and Process elements to earn points. Structure and Process elements 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

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5. Reproductive Life/Family Planning

Facilities must attest that this measure has been in place since April 30, 2021 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

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

B. Patient Safety Group

These measures are mandatory for all hospitals is based on calendar year 2021 and is for all patients regardless of insurance status.

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

1. Zero Suicide
2. Reduction of Racial and Ethnic Disparities Patient Safety Bundle
3. Hospital Acquired Clostridium Difficile Infections
4. Sepsis
5. Antibiotics Stewardship
6. Adverse Event Reporting
7. Culture of Safety Survey
8. Handoffs and Signouts

1. Zero Suicide

Zero Suicide is a new measure being introduced to the Patient Safety measure group in the 2022 HQIP program year. Hospitals will earn points for the successful completion of measure levels. Levels are cumulative, for example, hospitals must complete measure level I to be eligible to earn points for completing measure level II. In order to receive the highest points, hospitals must complete all four levels. The four levels of this measure are:

Level I: Leadership and Planning
Level II: Training
Level III: Identify, Treat, Engage
Level IV: Transition and Improve

Level I: Leadership and Planning

1. Leadership Buy-In

   a. **Deliverable:** Hospitals must submit a written commitment from CEO/leadership highlighting that suicide prevention is a core priority of the health system.

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b. **Deliverable**: Hospitals must submit a formal plan to begin implementation of the framework, including conducting an annual organizational self-survey[1] and an annual workforce survey[2]

2. Implementation Team

a. Health system forms a Zero Suicide implementation team that meets regularly and drives Zero Suicide work forward. The team will include representation from clinical workforce, non-clinical workforce, IT/data specialist, quality improvement specialist. Ideally the team would also include, a person with lived experience of receiving care in the health system.

b. **Deliverable:** Hospitals must submit a description of the implementation team, its membership and qualifications.

3. Organizational Self-Survey

a. **Deliverable:** Implementation team must take and submits the survey annually, identifying opportunities for system improvement and participate in the monthly Zero Suicide learning collaborative hosted by the Office of Suicide Prevention.

i. Resource: Organizational Self-Survey

ii. Resource: Team participation in the monthly Zero Suicide learning collaborative hosted by the Office of Suicide Prevention

4. Work Plan

a. **Deliverable**: The hospital must submit a plan for implementing Zero Suicide framework within the health system that identifies strengths, weaknesses, opportunities for improvements, systemic barriers, and additional resource needs. The intention of the workplan is for hospitals to conduct preparation for implementing the Zero Suicide framework including:

- Preparing the project charter;
- Conducting a SWOT analysis and environmental scan;
- Identifying necessary recourses and stakeholders;
- Developing systems of evaluation and continuous improvement;

[1] See Level I.3.a
[2] See Level II.1.a

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- And how the elements identified of the Zero Suicide Work Plan Template that will be addressed as part of your implementation process.

    i. Resource: Zero Suicide Work Plan Template

Level II: Training

1. Workforce Survey
    a. **Deliverable**: The implementation team must administer the workforce survey annually and submit results.
    b. Survey results are used to formulate training plans and other system changes.
        i. Resource: Workforce Survey
2. Non-clinical Workforce Training
    a. All non-clinical staff should receive gatekeeper-level[3] or better suicide prevention training. Staff that have the most interaction with patients (front desk staff, customer relations) should get priority, but the goal of the program is to train 100% of health system staff.
    b. **Deliverable**: The hospital must submit a training plan that includes what curricula the system will use for non-clinicians, how trainings will be implemented, how they will be tracked, plans for sustainability of training, list of needed resources. Examples of acceptable trainings are:
        i. Applied Suicide Intervention Skills Training (ASIST)
        ii. Question, Persuade, Refer (QPR): Gatekeeper Training for Suicide Prevention
        iii. Suicide Alertness for Everyone: Tell, Ask, Listen, and Keep Safe (safeTALK)
    c. **Deliverable**: The hospital must create and submit an annual report that includes number and percentage of non-clinical staff trained.
        i. Resource: Office of Suicide Prevention can provide training modules and materials.
3. Clinical Workforce Training

3 Gatekeeper training provides an overview of suicide prevention. Participants learn how to recognize suicidal behavior, how to respond, and where to make a referral and find help. It does not teach how to do a clinical assessment of a person at risk for suicide. See: http://zerosuicide.sprc.org/toolkit/train#quicktabs-train=2

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a. The goal of the program is for all clinicians should receive suicide prevention training relevant to their roles within a system. Trainings must cover core competencies of screening, assessment, safety planning, and lethal means counseling[4]. Some trainings, like Collaborative Assessment and Management of Suicidality (CAMS) cover more than one of these competencies. Other skills relevant to clinicians' duties, such as intake, discharge planning, and follow-up services should be included in training plans to meet varying needs of system clinicians. Examples of acceptable trainings are:

    i. Assessing and Managing Suicide Risk (AMSR)
    ii. Assessment of Suicidal Risk Using the Columbia Suicide Severity Rating Scale (C-SSRS)
    iii. Counseling on Access to Lethal Means (CALM)
    iv. Collaborative Assessment and Management of Suicidality (CAMS)
    v. Safety Planning Intervention for Suicide Prevention

b. **Deliverable**: The hospital must submit a training plan that includes what trainings are selected to meet various needs, how they will be implemented, how they will be communicated to clinical staff as well as medical staff (including key personnel for program staff not employed by the hospital), how they will be tracked, how trainings will be sustained, and what additional resources are needed.

c. **Deliverable**: The hospital must submit an annual report that includes number and percentage of staff that have received each type of identified core competency training (screening, assessment, safety planning, and lethal means counseling) and additional trainings.

    i. Resource: Office of Suicide Prevention can connect teams with training modules, training events and other resources

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Level III: Identify, Treat, Engage

1. Screening

    a. Screening procedures applicable for all patients are implemented (gold standard is universal screening). Screening procedures that ensure that 100% of individuals who screen positive for suicide risk are provided with

[4] Lethal means counseling helps reduce access to the methods people use to kill themselves including firearms and potentially dangerous medications.

full assessment for safety, collaborative safety planning and lethal means counseling (i.e. what tool(s) will be used, what staff will administer, when, what training is necessary to achieve this, what EHR tools are available to assist and track)

b. **Deliverable**: On an annual basis, submit a report including the number and percentage of individuals who were screened for suicide risk and how many of those people screened positive in the prior year.

2. Assessment

a. Assessment procedures to ensure that 100% of individuals who screen positive for suicide risk are provided with full assessment for safety

b. **Deliverable**: On an annual basis, submit a report including the number and percentage of individuals who screened positive for suicide risk who received a safety assessment

3. Safety Planning

a. Policy and procedures that ensure 100% of individuals who screen positive for suicide risk work with a clinician to create an effective (ideally a collaborative) safety plan

b. **Deliverable**: On an annual basis, submit a report including the number and percentage of individuals who screened positive for suicide risk who received a safety plan.

4. Engagement for Health Equity

a. The hospital solicits input on suicide-related policies and procedures from people in the communities they serve who are affected by health inequities, including but not limited to people who are Black, indigenous, people of color, LGBTQ+, veterans, people who experience chronic mental health and substance use disorders, and people with disabilities, and holds itself accountable to that feedback.

b. **Deliverable**: The hospital must submit an annual report that documents outreach efforts, input from community members, and the specific actions that were taken by staff as a result of that information.

Level IV: Transition and Improve

1. Follow-Up

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All individuals who screen positive for suicide risk should receive follow-up contacts from health system after inpatient, outpatient, or emergency visits.

a. **Deliverable** (internal process)

   i. Submit a written policy and work plan for following up within 3 calendar days for clients who screen positive for suicide risk that includes which staff are responsible for making contact and what system is used to track implementation.

   ii. On an annual basis submit reports with number and percentage of individuals who screened positive for suicide risk who received a follow-up contact (phone call, text, email, etc.) within 3 days of discharge

b. **Alternative Deliverable**: Documentation that the health system participates in the Colorado Follow-Up Project in partnership with the Office of Suicide Prevention and Rocky Mountain Crisis Partners

2. Data Collection and Tracking

   a. **Deliverable**: The hospital must have the capability to track screening, assessment, safety planning, and lethal means counseling built into its system (electronic health record, other electronic or manual system) in order to track compliance with written policies

   b. **Deliverable**: The hospital must document utilization of a data monitoring tool to track implementation of written policies, training plans, return ED visits, suicide attempts, and suicide fatalities of clients using the measures documented in the data elements worksheet.

      i. Resource: Data Elements Worksheet

   c. **Deliverable**: The hospital must collect and track data on screening, referral, and access to care among populations most affected by health inequities, including but not limited to people who are Black, indigenous, people of color, LGBTQ+, veterans, and people with disabilities.

Scoring

Hospitals will earn points for the successful completion of four levels. To be eligible for points, hospitals must successfully complete all criteria for measure Level I and measure Level II. Levels are cumulative, for example, hospitals must complete all criteria within measure Level I, measure Level II and

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measure Level III to be eligible to earn 7 points under scoring level 2. In order to receive the highest points, hospitals must complete all four measure levels.

Zero Suicide Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
10	5	7	10	N/A

2. Reduction of Racial and Ethnic Disparities Patient Safety Bundle

Hospitals must report on the current status and future plans to identify and reduce racial and ethnic disparities on a hospital-wide basis. Scoring will be based on having particular components of each "R" in place. The measurement period should be the hospital's experience as of the date the survey is filled out. This survey is for all patients regardless of insurance status. Hospitals with labor and delivery will also have to submit responses for the Reduction of Peripartum Racial and Ethnic Disparities Patient Safety Bundle.

Hospitals will have to answer all the questions to earn any points. Each question will be answered by choosing a categorical response and providing details on the response. For example, the categories will be: yes, no but have plans to, or no and no current plans to. For each response hospitals will be required to provide additional comments, explanation and/or documentation.

1. Readiness – Every Health System
    a. Does the hospital's system accurately document self-identified race, ethnicity, and primary language?
        i. Does the hospital provide system-wide staff education and training on how to ask demographic intake questions?
        ii. How does your hospital ensure that patients understand why race, ethnicity, and language data are being collected?
        iii. Are race, ethnicity, and language data accessible in the electronic medical record?
        iv. Does the hospital evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English?
        v. Does the hospital educate all staff (e.g. inpatient, outpatient, community-based) on interpreter services available within the healthcare system?

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   b. Does the hospital provide staff-wide education on:
      i. Racial and ethnic disparities and their root causes?
      ii. Best practices for shared decision making?
   c. Does the hospital engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams?
2. Recognition & Prevention – Every patient, family and staff member
   a. Does the hospital provide staff-wide education on implicit bias?
   b. Does the hospital provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the patient, in a clear and simple format that summarizes information most pertinent to patient care and wellness?
   c. Does the hospital have a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect?
3. Response – Every Clinical Encounter
   a. Does the hospital ensure that providers and staff engage in best practices for shared decision making?
   b. Does the hospital have a process to ensure a timely and tailored response to each report of inequity or disrespect?
   c. Does the hospital have discharge navigation and coordination systems post discharge to ensure that patients have appropriate follow-up care and understand when it is necessary to return to their health care provider?
      i. Does the hospital provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern?
      ii. Does the hospital provide discharge materials that meet patients' health literacy, language, and cultural needs?
4. Reporting/Systems Learning
   a. Does the hospital have initiatives in place to build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture?
   b. Does the hospital have a process in place for the regular reporting and monitoring of metrics (process and/or outcome) stratified by race and

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ethnicity and disseminate the information internally to staff and leadership? This could take the form of a dashboard, regularly distributed reports or other reporting and monitoring tools.

c. Does the hospital implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes?

d. Does the hospital consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of morbidity and mortality, and other clinically important metrics?

   i. Does the hospital have a checkbox on the review sheet: Did race/ethnicity (i.e. implicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?

Scoring

To earn points for this measure, hospital must have all elements of Readiness and Recognition/Prevention in place. Additional points can be earned for this measure based on having additional elements of the bundle in place. (Response, Reporting/Systems Learning).

Reduction of Peripartum Racial and Ethnic Disparities Patient Safety Bundle Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
10	5	One point for each additional bullet	N/A	N/A

3. <u>Hospital Acquired Clostridium Difficile (C. diff) Infections</u>

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

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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

4. Sepsis

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

1. Describe the protocols and alerts your facility has in place for identifying sepsis and for treating sepsis. If the protocols are different for different levels of care (e.g. ED vs inpatient), please describe the protocols and their differences.
2. Describe and provide evidence of the training that your facility has in place for orienting new providers and staff to your facility's systems and protocols for addressing suspected sepsis cases
3. Describe and provide evidence of the process of providing regular feedback to providers on sepsis identification and treatment results.
4. Provide process measures and/or outcome measures your facility uses for tracking sepsis identification and treatment as well as any results for the purposes of quality improvement.

Scoring

In 2022, hospitals earn points for reporting the measure and additional points for any improvement hospitals can document on self-reported process or outcome measures.

Sepsis Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
7	5	7	N/A	N/A

5. Antibiotics Stewardship

This measure is based on the work that the Colorado Department of Public Health and Environment (CDPHE), the Colorado Hospital Association (CHA), Colorado Health Care Association (CHCA), and Telligen have done on antibiotic stewardship working towards developing an Antibiotic Stewardship Honor Roll. This measure

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has four levels which will correspond to a tiered point structure. The levels are cumulative, e.g. a hospital must achieve Level I to potentially achieve Level II. As proposed will have four levels as shown below.

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

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

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

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

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

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

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

Measure Details

Each level is cumulative, a hospital has to meet the conditions and provide documentation and supporting evidence for the highest level it wishes to obtain

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as well as those below it. (e.g. to achieve level 3 hospitals must meet the criteria and submit documentation that meets levels 1 – 3).

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

1. Does your hospital have formal, written support from leadership (e.g., a policy statement) that supports efforts to improve antibiotic use (antibiotic stewardship)?
2. Is there a physician leader responsible for program outcomes of stewardship activities at your hospital?
3. Is there a pharmacist leader responsible for working to improve antibiotic use at your hospital?
4. Is there an antibiotic stewardship committee that meets at least quarterly?

Documentation:

1. Documentation should include dates of antibiotic stewardship committee meetings and include the names and position descriptions of attendees (e.g., “physician leader”).
2. *Letter of support*: The letter must indicate support for improving antibiotic stewardship and attest that there is an antibiotic stewardship committee that includes physician and pharmacist leaders and meets at least quarterly.

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

1. Community-acquired pneumonia
2. Urinary tract infection
3. Skin and soft-tissue infection
4. Does your hospital produce an antibiogram (cumulative antibiotic susceptibility report) and distribute the antibiogram to prescribers annually or every other year?
5. Does your stewardship program provide education to clinicians and other relevant staff on improving antibiotic prescribing at least annually?

Documentation:

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

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2. Indicate general references to the national guidelines upon which facility-specific guidelines are based (e.g., Infectious Diseases Society of America).
3. Dates and topics of education to clinicians and staff, must include at least 1 training during the measurement period,
4. Provide the date of the hospital's latest antibiogram
5. *Letter of support*: including the information outlined in Level I as well as an attestation to the availability of facility-specific treatment guidelines based on national guidelines and attest to the education of clinicians and staff on antibiotic stewardship at least annually.

Level 3:

1. Does your hospital conduct any of the following broad interventions to improve antibiotic use? (yes to one or more)
   a. Do specified antibiotic agents need to be approved by a designated physician or pharmacist prior to dispensing (i.e., pre-authorization) at your hospital?
   b. Does a designated physician or pharmacist routinely review courses of therapy for specified antibiotic agents and provide verbal or written feedback to prescribers with 72 hours after the initial orders (i.e., prospective audit with feedback) at your hospital?
   c. Is there a formal antibiotic time-out procedure during which clinicians review the appropriateness of antibiotics within 72 hours after the initial orders?
   d. Pharmacy-driven interventions for antibiotic stewardship including at least one of the following:
   e. automatic alerts and de-escalation of therapy in situations where therapy might be unnecessarily duplicative,
   f. or time-sensitive automatic stop orders for specified antibiotic prescriptions?
2. Does your hospital monitor antibiotic use (consumption) at the unit and/or hospital-wide level by one of the following metrics? (yes to one or more)
   a. By counts of antibiotic(s) administered to patients per day (Days of Therapy; DOT). DOT is defined as an aggregate sum of days for which any amount of a specified antimicrobial agent is administered or dispensed to a particular patient (numerator) divided by a standardized denominator (e.g., patient-days, days present, or admissions).

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

3. Does your hospital report information to staff on improving antibiotic use and resistance? (yes to one or more)
   a. Does your stewardship program share facility-specific reports on antibiotic use with prescribers at least once every 6 months?
   b. Do prescribers receive direct, personalized communication about how they can improve their antibiotic prescribing at least once every 6 months?

Documentation:

1. Provide a description of the process for the above intervention(s) (pre-authorization, prospective audit with feedback, antibiotic time-out, or pharmacy-driven intervention), including:
   a. What antimicrobial agents are targeted by the intervention,
   b. Who implements the intervention,
   c. How the intervention is implemented, AND
   d. When the intervention is implemented (during the course of patient care).
2. Provide a description of how DOT or DDD are measured, and
3. What antibiotic utilization information is reported to prescribers and how. Include examples of antibiotic utilization reports.
4. Letter of support including the information outlined in Levels I and 2 as well as:
   a. The letter must attest to facility practice of one or more of the above broad interventions to improve antibiotic use (antibiotic pre-authorization, prospective audit with feedback, antibiotic time-out, or pharmacy interventions), the tracking of antibiotic days of therapy or defined daily doses, and the report of antibiotic use data to prescribers at least once every six months.

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

1. Has your hospital collaborated with one or more facilities, such as other hospitals or long-term care facilities, to implement coordinated antibiotic stewardship?
    a. Examples include shared infectious diseases physician or pharmacy oversight of antibiotic stewardship activities among multiple facilities, implementation of broad interventions to improve antibiotic use as defined for Level 3, Guidance, to multiple facilities, multi-facility efforts to track and report antibiotic use, or participation in a state or national public health collaborative.
2. Does your hospital regularly report antibiotic use data to NHSN via the Antibiotic Use and Resistance Module (3 or more months during the measurement period)?

Documentation:

1. Description and evidence of the dates of collaboration, the name and facility type of collaborating facilities, and a description of the coordinated intervention.
2. Provide the dates of reporting antibiotic use data to NHSN, as well as evidence of the reporting.
3. Letter of support to include all of the information in Levels 1-3 and letter must attest to hospital participation in collaborative antibiotic stewardship efforts with other healthcare facilities and report of ≥3 months of antibiotic use data to NHSN.

Scoring

This measure will use a pay for reporting method; points will be awarded on based on the number of elements in place.

Antibiotic Stewardship Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
10	3	5	7	10

6. <u>Adverse Event Reporting</u>
    1. Must allow anonymous reporting.
    2. Reports should be received from a broad range of personnel.

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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.

Scoring

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

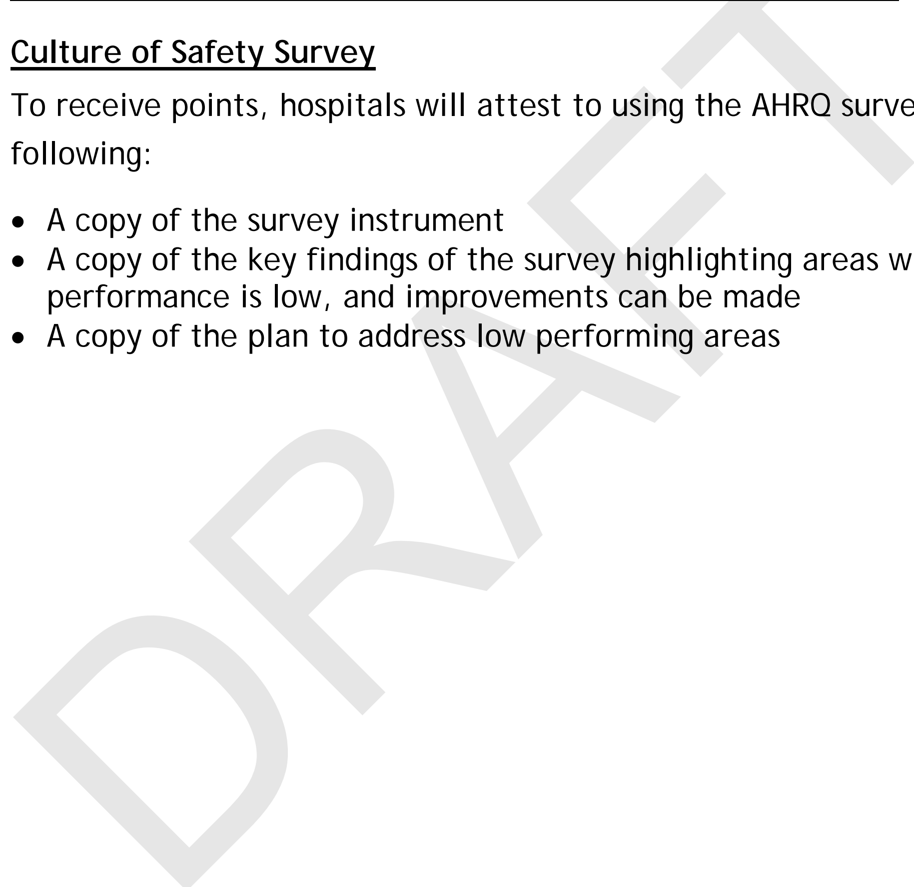
Adverse Event Reporting Scoring Rubric

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

7. <u>Culture of Safety Survey</u>

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

8. Handoffs and Signouts

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

1. Hospitals must provide a narrative description of the area they are addressing. They should provide evidence that quality needs to be improved in this area. Examples of transitions include:
   a. Operating room to intensive care unit
   b. Emergency department to inpatient
   c. Intensive care unit to floor
   d. Perioperative services to next level of care
   e. Intraoperative: provider to provider
   f. Postoperative: OR to Post Anesthesia Care Unit (PACU)

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

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

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

1. Describe how it plans to measure progress on this initiative in HQIP 2022
2. Potential measurement strategies include:
    a. Tracking how many times a handoff or signout uses the appropriate protocol
    b. Reviewing incident reports and documenting the times there are handoff issues pre intervention vs post intervention
        i. Assess the extent of communication issues during handoffs
        ii. Note which types of communication issues are attributed to handoffs based on information in incident reports
    c. Handoff direct observation (pre-intervention and post-intervention)
        i. Record presence or absence of key elements
        ii. Analyze quality (presence of distractions, attentiveness of speaker and recipient, asking important clinical questions etc.)
    d. Surveys to providers and staff about their perceptions of handoff process/perceived barriers to improvements in the handoff process

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Examples based on care settings:

Operating Room (OR) to Intensive Care Unit (ICU):

1. Review handoffs using the following:
    1. Handoff assessment tool (checklist of items essential to reports from the transmitting OR team to the receiving ICU team)
    2. Past medical history, reason for ICU admission, allergies, airway, breathing/ventilation, circulation/hemodynamics, inputs, outputs, drains/lines, complications, plan, team contact information, and family information
    3. Score the quality of hand off delivery (concise, clear, and organized hand-offs receive higher scores)
    4. Score the recipient based on eye contact, affirmatory statements, head nodding, note taking, and question asking.

Transfer to ICU:

1. Analyze critical messages (CM) for the following information:
2. Time till Rapid Response Team (RRT) activation
3. Message quality
4. Presence of vitals
5. Quality/timeliness of physician response

3. Hospitals must document the process of communicating feedback on Handoffs and Signouts to hospital staff to facilitate continuous improvement.

Scoring

Hospitals can earn Level 4 points by reporting measurement results from previous year. For Handoffs and Signouts points will be earned in in tiers by completing the requirements for each of the three steps of the measure.

Handoffs and Signouts Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
7	3	4	5	7

C. Patient Experience Group

1. <u>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)</u>

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

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1. Composite 5: Communication About Medicines
   (HCAHPS V14 questions 13, 14)
   a. How often did staff explain about medicines before giving them to patients? Before giving you any new medicine
      i. How often did hospital staff tell you what the medicine was for?
      ii. How often did hospital staff describe possible side effects in a way you could understand?
2. Composite 6: Discharge Information
   (HCAHPS V14 questions 16,17)
   a. Were patients given information about what to do during their recovery at home? During this hospital stay
      i. Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?
      ii. Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
3. Complex 7: Care transition
   (HCAHPS V14 questions 20, 21, 22)
   a. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
   b. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
   c. When I left the hospital, I clearly understood the purpose for taking each of my medications.

Scoring

Each HCAHPS Composite measure will be evaluated independently using a ranking method. Scoring for each composite will be based on "top-box", or the most positive, responses. 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

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2. <u>Advance Care Planning (ACP)</u>

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 2020 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

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

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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.

MM#4: Incidence of Episiotomy (no points). Hospitals do not need to submit data for this measure. 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.

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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.

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