

# Hospital Quality Incentive Payment (HQIP) Program 2023 Measure Details

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January 2023



**CHASE**

Colorado Healthcare Affordability and  
Sustainability Enterprise

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## I. 2023 Measures

Measures for the 2023 HQIP program are listed below. Hospitals will be requested to complete all three measure groups. Measures with an asterisk (\*) denote modified measures for the 2023 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, 2022 to December 31, 2022
Cesarean Section (PC-02)	The Joint Commission/CMS	Hospital Reported	January 1, 2022 to December 31, 2022
Perinatal Depression and Anxiety	Council on Patient Safety in Women's Health Care	Hospital Reported	In place on April 30, 2023
Maternal Emergencies	National Partnership for Maternal Safety	Hospital Reported	In place on April 30, 2023
Reproductive Life/Family Planning	Department of Health Care Finance/US Office of Population Affairs	Department/Hospital Reported	In place on April 30, 2023

### B. Patient Safety Group

Measure	Measure Basis	Source	Measurement Period
Zero Suicide*	HQIP	Hospital Reported	In place by April 30, 2023
Reduction of Racial and Ethnic Disparities*	Council on Patient Safety in Women's Health Care	Hospital Reported	In place by April 30, 2023
Clostridium difficile (C. Diff)	Center for Disease Control (CDC)	Department/Hospital Reported	October 1, 2021 to September 30, 2022
Sepsis	HQIP	Hospital Reported	In place by April 30, 2023
Antibiotics Stewardship	CPHE	Hospital Reported	In place by April 30, 2023
Adverse Event	HQIP	Hospital Reported	January 1, 2022 to December 31, 2022
Culture of Safety Survey	Agency for Healthcare Research and Quality (AHRQ)	Hospital Reported	Within the 24 months prior to data collection
Handoffs and Sign-outs	HQIP - based on Agency for Healthcare Research and Quality (AHRQ) & The Joint Commission	Hospital Reported	In place by April 30, 2023

### C. Patient Experience Group

Measure	Measure Basis	Source	Measurement Period
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	AHRQ/ Hospital Compare	Department	October 1, 2021 to September 30, 2022
Advance Care Plan*	National Committee for Quality Assurance (NCQA)	Hospital Reported	January 1, 2022 to December 31, 2022

### D. 2023 Maintenance Measures

#### 1. Incidence of Episiotomy

Measure Steward	Data Source	Measurement Period
Christiana Care Health System	Department	January 1, 2022 to December 31, 2022

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

Measure Steward	Data Source	Measurement Period
AHRQ	CHA Hospital Report Card	January 1, 2022 to December 31, 2022

#### 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, 2021 to September 30, 2022

#### 4. Early Elective Deliveries

Measure Steward	Data Source	Measurement Period
The Joint Commission	CMS	October 1, 2021 to September 30, 2022

### E. Modified Measures for 2023

#### 2A. Zero Suicide

- ✓ **Criteria Modification-** Hospitals must attend at least 9 meetings of the Zero Suicide Learning Collaborative during the measurement period.

#### 2B. Reduction of Racial & Ethnic Disparities Patient Safety Bundle

- ✓ **Criteria Modification-** Labor and delivery hospitals have the option to include in their response how they are approaching key aspects of the measure specific to peripartum patients. A separate response addressing peripartum patients is no longer mandatory.

### 3B. Advance Care Planning

- ✓ **Scoring Modification-** Advance Care Planning will be scored by setting a performance threshold for the hospital's ACP rate. Those above the performance threshold will receive the total possible points. Those below the performance threshold will receive the total possible points with the submission of a narrative summarizing: 1) The process for discussing/ initiating advance care planning when a patient does not have an ACP or when their ACP is not available to the hospital, 2) The process and systems for documenting advance care plans in the medical record, and 3) Any efforts underway to improve the hospital's ACP rate. The performance threshold for 2023 is at or above 95%.

## II. Scoring Rubric

For the FFY2022-23 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 five sub-measures:

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

### B. Patient Safety Group

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

Measure	Points Available	Scoring Method	Scoring Levels
Zero Suicide	10	Points awarded for Level 1, additional points available depending on number of Level 2- 4 elements in place	4
Reduction of Racial and Ethnic Disparities	10	Points awarded for Readiness; additional points for each additional element, up to 5	2
C. Diff infections	5	Comparison to the national benchmark - “worse, no different than, better” ranking. Points only awarded to those in “no different than” or “better” categories	3
Sepsis	7	Scoring tiered depending on number of elements in place	2
Antibiotics Stewardship	10	Points awarded for Group 1, additional points available depending on number of Group 2-4 elements in place	4
Adverse Event	5	Points awarded on an all or nothing basis	All or Nothing
Culture of Safety Survey	5	Points awarded on an all or nothing basis	All or Nothing
Handoffs and Sign-outs	7	Scoring tiered depending on number 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	Points Available	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	Points awarded based on comparison to threshold and completion of narrative response, if applicable	All or Nothing

### III. Measure Group 1: Maternal Health and Perinatal Care Measure Details

Measures for the 2023 HQIP program are listed below. Hospitals will be requested to complete all measure groups.

#### A. Exclusive Breast-Feeding (PC-05)

This measure is based on activities from January 1, 2022 to December 31, 2022 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). There is no minimum denominator for this measure.

##### 1. Measure Criteria

Hospitals will submit calendar year 2022 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.

##### 2. Scoring

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

*Exclusive Breastfeeding (PC-05) Scoring Rubric*

Total Possible
1

#### B. Cesarean Section

This measure is based on calendar year 2022 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.

##### 1. 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:

- Physician’s Cesarean Section rate.
- The individual rates (not aggregated) of other physicians’ Cesarean Section rates to provide a peer-to-peer comparison.
- 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.

**2. 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. Please note: for this measure a lower rate is better, therefore the lowest tercile is assigned the highest point value.

*Cesarean Section Scoring Rubric*

Total Possible	Above 23.6%	Upper Tercile	Middle Tercile	Lowest Tercile
5	0	1	3	5

**C. Perinatal Depression and Anxiety**

Facilities must attest that this measure has been in place since April 30, 2023 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. 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.

### *Readiness-Clinical Care Setting:*

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

### *Recognition and Prevention-Every Woman:*

- 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.
- Document the validated mental health screening provided at the hospital during patient encounters during pregnancy/immediate postpartum period.

### *Response-Every Case:*

- Submit documentation on the facility’s stage-based response protocol for a positive mental health screen.
- Submit documentation on the emergency referral protocol for women with suicidal/homicidal ideation or psychosis.

### *Reporting/Systems Learning-Clinical Care Setting:*

- Describe the policies and processes by which the hospital incorporates information about patient mental health into how it plans care.
- 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.

## **2. Scoring**

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

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

### *Perinatal Depression and Anxiety Scoring Rubric*

Total Possible	Three Rs	Four Rs
5	3	5

## **D. Maternal Emergencies and Preparedness**

Facilities must attest that this measure has been in place since April 30, 2023 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).

## 1. 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 (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

### *Structure Measure 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?

### *Structure Measure 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?

*Structure Measure C*

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

*Structure Measure 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:
  - a. Severe hypertension
  - b. Eclampsia, seizure prophylaxis, and magnesium over-dosage
  - c. Postpartum presentation of severe hypertension preeclampsia
2. Minimum requirements for protocol
  - a. Notification of physician or primary care provider if systolic BP  $\geq 160$   $\geq 110$  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 or 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:**

1. Establish a culture of huddles for high risks 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.

#### *Process Measure A*

How many drills on maternal safety topics were performed in the facility during the past calendar year?

#### *Process Measure 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?

#### *Process Measure 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: [https://saferbirth.org/wp-content/uploads/Updated-AIM-SMM-Code-List\\_10152021.xlsx](https://saferbirth.org/wp-content/uploads/Updated-AIM-SMM-Code-List_10152021.xlsx))

## **2. 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
5

## **E. Reproductive Life/Family Planning**

Facilities must attest that this measure has been in place since April 30, 2023 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.

### **1. 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.

## 2. 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
5

## IV. Measure Group 2: Patient Safety Group Measure Details

### A. Zero Suicide

Zero Suicide was introduced to the Patient Safety measure group in the 2021 HQIP program year. This measure is for all patients regardless of insurance status. Facilities must attest that this measure has been in place as of April 30, 2023. Hospitals will earn points for the successful completion of deliverables. In order to receive the highest points, hospitals must complete all deliverables. Deliverables and levels are not cumulative; however, hospitals must complete Level I to earn points on other deliverables. The levels are:

- Level I: Lead and Plan;
- Level II: Train;
- Level III: Identify, Treat, Engage, and
- Level IV: Transition and Improve.

#### 1. Measure Criteria

##### *Level I: Lead and Plan*

##### *Implementation Team*

Establish an implementation team to drive Zero Suicide forward. The team should aim to include representation from all areas of a health system, and may include clinical workforce, non-clinical workforce, IT/data specialist, quality improvement specialist, and at least one person with lived experience of suicidal despair or attempt, or of receiving suicide-related care in the health system

**Deliverable 1a:** Please describe your implementation team, clearly defining roles, tasks, and qualifications of team members. Please also share how many members of the implementation team have lived experience, and how frequently you will meet.

**Deliverable 1b:** Implementation team must participate in the monthly [Zero Suicide Learning Collaborative](#) hosted by the Office of Suicide Prevention (OSP). Meetings are typically held virtually the 4<sup>th</sup> Thursday of the month at 10am. For HQIP 2023 Survey hospitals must attend at least 9 meetings of the Zero Suicide Learning Collaborative during the

measurement period and follow the procedures to ensure attendance is recorded. The Department will receive a list of hospitals that have attended directly from CDPHE. Please contact [Conlin.Bass@state.co.us](mailto:Conlin.Bass@state.co.us) to get added to the list, or to reach out with any questions, ideas for session topics, focus, guests, etc.

#### *Leadership Buy-in*

Leadership drives the dramatic reduction in suicide deaths achieved by organizations implementing Zero Suicide. Leadership must both help staff see and believe that suicide can be prevented and provide tangible supports in a safe and blame-free environment — what is known as just culture. Leaders at all levels should embrace the Zero Suicide ideology, and make themselves available to listen, support, and reinforce the necessary changes to support suicide-safer care within their organization.

- Train management and executive level leadership on new initiative.
- Consider ways to link Zero Suicide to other initiatives (e.g., trauma-informed care, substance abuse).
- Encourage leadership participation in implementation team meetings, as well as various suicide prevention training opportunities, webinars, conferences, etc.

**Deliverable 1c:** Collect and submit a written commitment from CEO/leadership highlighting that suicide prevention is a core priority of the health system. A sample letter is available at this link:

<https://zerosuicide.edc.org/resources/resource-database/sample-letter-staff-announcing-adoption-zero-suicide-approach>

#### *Organizational Self-Survey*

**Deliverable 1d:** Submit the organizational Self-Study (annually)

- Resources available at the following links: [General template](#); [Inpatient Template](#); [Organization Self-Study Portal](#)

## *Reflections*

**Deliverable 1e:** After completing the Organizational Self-Study, make a plan that identifies current strengths and opportunities for improvements in suicide care, and accounts for any systemic barriers and challenges. After determining some short and long-term next steps, please identify any support/resources needed and questions about implementation.

- **Strengths & Opportunities:** In implementing the Zero Suicide framework, what are the strengths your system already has? What Opportunities do you see for furthering Zero Suicide initiatives? Any next steps?
- **Challenges & Barriers:** What are some barriers your system has faced in improving safer suicide care? What do you see as current and future challenges to overcome?
- **Support, Resources & Questions:** What support or resources from the Office of Suicide Prevention (OSP), Colorado Hospital Association (CHA), or Dept. of Health Care Policy and Financing (HCPF) are needed, if applicable? Please reach out at any point with questions.

## *Level II: Train*

### *Workforce Survey*

The Workforce Survey helps prioritize limited time and training resources, and gauges how prepared/supported staff feels providing care for patients at risk for suicide. An implementation team should use this annual survey to inform opportunities to train and support staff in the ways they need to be trained, and also address bias and stigma in suicide care.

**Deliverable 2a:** Administer a Workforce Survey, submit results, and use results to formulate training plans and other system changes (annually)

- Resources are available at the following links: [Guidelines from Zero Suicide for survey administration and for improving response rates](#), [Survey Template](#) and [Online Workforce Survey Request Form](#)

### *Non-Clinical Workforce Training*

In this context, 'non-clinical training' means training for anyone in your system who might benefit from general awareness and literacy training about mental illness and/or suicide prevention. All non-clinical staff should receive gatekeeper-level or better suicide prevention training on an annual basis. The goal of the program is to train 100% of health system staff in basic prevention: how to recognize suicide risk and suicide behavior, how to respond, and how to refer someone to a professional. Examples of acceptable evidence-based trainings include, but are not limited to:

- [Question, Persuade, Refer \(QPR\)](#): Gatekeeper Training for Suicide Prevention (60-90 minutes, in person or virtual)
- [LivingWorks Start](#) (45-60 minutes, online scroll down in link for log-in information)
- [SAVE VA](#) Sponsored gatekeeper training (75 minutes, in person or virtual scroll down in link for program information)
- [Applied Suicide Intervention Skills Training \(ASIST\)](#) (2 days, in person)
- [Mental Health First Aid](#) (8 hours, in person or virtual scroll down in link for program information)
- To learn more about available training resources in Colorado, please visit <https://cdphe.colorado.gov/suicide-prevention-training> or contact [CDPHE\\_SuicidePrevention@state.co.us](mailto:CDPHE_SuicidePrevention@state.co.us)
- Zero Suicide also has a helpful matrix of [suicide care training options](#)
- There are also online resources for [Counseling on Access to Lethal Means](#) & [Safety Planning](#)

**Deliverable 2b:** Using the results from the Workforce Survey, please describe a non-clinical training plan that includes a) what gatekeeper curricula the system will use for non-clinical staff, b) how trainings will be implemented, c) how they will be tracked, d) plans for sustainability of the training, and e) any additional resources needed to achieve the plan.

**Deliverable 2c:** Submit an annual update with the number and percentage of non-clinical staff trained (i.e. progress on non-clinical training plan. For each training report the following:

- Name of Training
- Number of non-clinical staff trained
- Percentage of non-clinical staff trained
- Who will receive the training

#### *Clinical Workforce Training*

The goal of the program is for all clinicians to receive suicide prevention training relevant to their roles within a system. Trainings should cover core competencies of screening, assessment, safety planning, and lethal means counseling. Some trainings cover more than one of these competencies. Other skills relevant to clinicians' duties, such as workflows, EHR Updates intake, discharge planning, and follow-up services should be included in training plans to meet varying needs of system clinicians. Examples of acceptable trainings include, but are not limited to:

#### Screening and Assessment Skills:

- [Assessing and Managing Suicide Risk \(AMSR\)](#)
- [Assessment of Suicidal Risk Using the Columbia Suicide Severity Rating Scale \(C-SSRS\)](#)
- [Joint Commission Podcast: "Screening"](#)
- [Joint Commission Podcast: "Assessment"](#)

#### Lethal Means Safety

- [Counseling on Access to Lethal Means \(CALM\)](#)
- [Lethal Means Counseling: A Role for Colorado Emergency Departments to Reduce Youth Suicide](#)

#### Collaborative Safety Planning

- [Collaborative Safety Planning Training](#)
- [Collaborative Safety Planning Webinar](#)
- [Safety Planning Intervention for Suicide Prevention](#)
- [Joint Commission Safety Planning Training](#)

- [Crisis Response Planning](#)
- [Stanley & Brown Safety Plan](#)

#### Brief Interventions

- [Brief Cognitive Behavioral Therapy](#)
- [Making it matter with Micro-Interventions from Dr Ursula Whiteside](#)
- [Suicide Safe Care from Dr. Ursula Whiteside](#)

#### Ongoing Clinical Care

- [Collaborative Assessment and Management of Suicidality CAMS](#)
- [Bite-size DBR Skills with Dr. Ursula Whiteside](#) (gathering confidence and momentum as DBT Skills Expert)

**Deliverable 2d:** Using the results from the Workforce Survey, please describe a clinical training plan that includes:

- What trainings are selected to meet various needs and core competencies
- How trainings will be implemented
- How they will be communicated to clinical staff
- How they will be tracked
- How trainings will be sustained,
- Any additional resources needed to achieve the plan

**Deliverable 2e:** Submit an annual update with the number and percentage of clinical staff trained (i.e., progress on clinical training plan. For each training report the following:

- Name of Training
- Number of clinical staff trained
- Percentage of clinical staff trained
- Who will receive the training

### *Level III: Identify, Treat, Engage*

#### *Screening*

As part of the aspirational goal central to Zero Suicide, ideally all persons receiving care in a system are screened for suicidal thoughts and behaviors at intake and at all subsequent appointments. Whenever a patient screens positive for suicide risk, a full risk formulation is completed for the client. A gold standard for screening would be a system where screening workflows:

- Clearly define the frequency of screening
- Identify which staff will be providing the screening after being trained in standardized screening tools and documentation
- Describe a policy and procedure for connecting patients to clinically trained staff after screening positive for suicide risk
- Ensure that staff are alerted when a patient screens positive for suicide risk
- Embed screening measures into the electronic health record (EHR) system
- Screen patients at discharge in inpatient settings

While the goal is universal screening for clients, implementation teams should identify the patient population to be screened (if not universal) and any barriers to achieving universal. There are additional [screening tool and risk assessment resources](#) available on the Zero Suicide website.

**Deliverable 3a:** Please describe your policies, procedures, and workflows for screening patients for suicide risk. In your description, please include a) what standardized tool is used for screening, b) which staff administer screening, c) when patients are screened, and d) if the process/tool is embedded in the EHR. Please also identify any future plans towards universal screening of patients, and any obstacles foreseen.

**Deliverable 3b:** On an annual basis, submit an update 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.



### *Assessment*

A gold standard for assessment would be a system where assessment procedures/policies/workflows:

- Ensure that 100% of individuals who screen positive for suicide risk are provided with full assessment for safety
- Utilize standardized assessment tool Identify staff providing the assessment
- Embed assessment protocols into the electronic health record (EHR) system

**Deliverable 3c:** Please describe your policies, procedures, and workflows for assessing patients for suicide risk. In your description, please include a) what standardized tool is used for assessment, b) which staff complete assessment, c) if the process/tool is embedded in the EHR. Please also identify any future plans towards improving assessment of patients screening positive for suicide risk, and any obstacles foreseen.

**Deliverable 3d:** 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.

### *Safety Planning*

A gold standard for assessment would be a system where safety planning procedures/policies/workflows:

- Ensure 100% of individuals who screen positive for suicide risk work with a clinician to create an effective and collaborative safety plan and receive counseling on temporary lethal means safety
- Safety planning procedures and workflows are identified utilizing standardized safety planning tool
- Identify which staff will provide the collaborative tool, and provide a plan that the client takes with them
- Are embedded into the electronic health record (EHR) system

**Deliverable 3e:** Please describe your policies, procedures, and workflows for safety planning with patients at risk for suicide. In your description, please include:

- What standardized tool is used for safety planning
- Which staff make safety plans with patients
- If safety planning includes discussion of lethal means
- If the process/tool is embedded in the EHR. Please also identify any future plans towards improving safety planning practices with patients at risk, and any obstacles foreseen.

**Deliverable 3f:** On an annual basis, provide an update including the number and percentage of individuals who screened positive for suicide risk and who received a safety plan.

#### *Engagement for Health Equity*

While creating, maintaining, and evaluating suicide-related policies and practices, it is vital to solicit input from and work collaboratively with people in the communities you serve. It is particularly important to do this with those particularly affected by historical and ongoing marginalization that leads to health inequities, including but not limited to people who are Black, indigenous, people of color, LGBTIQ+, veterans, people who experience chronic mental health and substance use disorders, and people with disabilities. As part of this engagement, a hospital should hold itself accountable to such feedback and regularly incorporate it into any suicide-related policies and procedures.

**Deliverable 3g:** Please describe:

- Any ongoing outreach efforts to the above communities
- How these community members (particularly those with lived experience of mental illness, suicide, or receiving care in your system) are consistently included in Zero Suicide implementation efforts
- How input and feedback is regularly received from community members
- The specific actions that have been taken or are planned by the implementation team as a result of this collaborative effort.

## *Level IV: Transition and Improve*

### *Transition*

Care transitions are generally high-risk times for patients. Caregivers and clinicians must bridge patient transitions from inpatient, ED, or primary care to outpatient behavioral health care. It is equally important to address suicide risk at every visit within an organization, from one behavioral health clinician to another or between primary care and behavioral health staff in integrated care settings.

One aspirational goal of Zero Suicide is that all individuals who screen positive for suicide risk should receive non-demand caring follow-up contacts from health system after inpatient, outpatient, or emergency visits

**Deliverable 4a:** Please provide indication that your health system participates in the [Colorado Follow-Up Project](#) in partnership with the Office of Suicide Prevention and Rocky Mountain Crisis Partners. (The Colorado Office of Suicide Prevention can confirm participation.)

**Alternative Deliverable 4a:** Please submit a written policy and work plan for following up (via phone call, text, email, etc.) within 3 calendar days for clients who screen positive for suicide risk that includes which staff are responsible for making the non-demand caring contact and what system is used to track implementation. On an annual basis, submit a report with the number and percentage of individuals who screened positive for suicide risk who received such follow-up.

### *Improve*

Data-driven quality improvement is essential to ensure improved patient outcomes and better care for those at risk of suicide. Continuous quality improvement can only be effectively implemented in a safety-oriented, "just" culture free of blame for individual clinicians when a patient attempts or dies by suicide. A top priority of any system implementing Zero Suicide should be to develop capability to track key improvement measures and have them be built into the electronic health record system.

**Deliverable 4b:** Please describe how your hospital is using 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 identified below, adapted from the [Data Elements Worksheet](#)). Also comment on how the hospital tracks both process and outcome measures, as well as any barriers faced in collecting this information. Note: it's also encouraged that your hospital look at county level indicators, accessible via the [Colorado Suicide Data Dashboard](#).

**Deliverable 4b continued: Health Equity Data:** You should also collect and track data on screening, referral, access to care, and the above metrics among populations most affected by health inequities. Please describe your current process/plans for collecting and reporting data relevant (but not limited) to people of color, people who are indigenous, LGBTQ+, veterans, and people with disabilities.

*Measures adopted from the data elements worksheet are provided for reference:*

- Rate of Deaths by Suicide Among ALL Clients, during the last year
  - Total number of clients who died by suicide during the last year (reporting period)
  - Total number of clients seen over the reporting period
- Rate of Suicide Deaths Among Those with Identified Suicide Risk, during the last year
  - Total number of clients with suicide risk (determined by screening/assessment) who died by suicide during the last year
  - Total number of clients with suicide risk (determined by screening/assessment) during the last year
- Emergency Department Usage, during the last year
  - Total number of clients with suicide risk (determined by screening/assessment) who went to the emergency department for making a suicide attempt
  - Total number of clients with suicide risk (determined by screening/assessment)
- Suicide Attempt Rate Among ALL Clients, during the last year

- Total number of clients who made a suicide attempt during the reporting period
- Total number of clients seen over the reporting period
- Suicide Attempt Rate Among Those with Identified Risk, during the last year
  - Total number of clients with identified suicide risk (determined by screening/assessment) who made a suicide attempt during the reporting period
  - Total number of clients with suicide risk (determined by screening/assessment)

## 2. Scoring

Hospitals will earn points for the successful completion of deliverables in the four levels. To be eligible for points, hospitals must successfully complete all criteria for measure Level I. Hospitals can earn additional points by completing deliverables in Levels 2 - 4.

### *Zero Suicide Scoring Rubric*

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

### *Zero Suicide Scoring by Deliverable*

Level	Deliverables	Score
1	1a - 1e	1
2	2a	1
2	2b & 2c	1
2	2d & 2e	1
3	3a & 3b	1
3	3c & 3d	1
3	3e & 3f	1
3	3g	1
4	4a	1
4	4b	1

## B. Reduction of Racial and Ethnic Disparities Patient Safety Bundle

Hospitals must report on the current status of initiatives to identify and reduce racial and ethnic disparities on a hospital-wide basis. Scoring will be based on having specific components of each “R” in place. The measurement period should be the hospital’s experience as of the date the survey is filled out. Hospitals with labor and delivery will also have the option to include in their responses how they are approaching key aspects of the measure specifically for peripartum patients.

Facilities must attest that this measure has been in place as of April 30, 2023 and is for all patients regardless of insurance status.

### 1. Measure Criteria

#### *Readiness*

##### *Collection of Demographic Data*

- a. Does the hospital’s system accurately document self-identified race, ethnicity, and primary language?

**Deliverable:** Provide a brief narrative describing how your hospital’s systems collect and document self-identified race, ethnicity, and primary language.

- b. Does the hospital provide staff education and training on how to ask demographic intake questions for staff in all settings where someone is registering patients or adding demographic information to a patient’s record?

**Deliverable:** Provide a brief narrative describing how your hospital provides staff education and training on how to ask demographic intake questions for staff in all settings where someone is registering patients or adding demographic information to a patient’s record.

- c. Does your hospital provide information to patients on why race, ethnic and language data are being collected?

**Deliverable:** Provide a brief narrative describing how your hospital provides education on why race, ethnic and language data are being collected.

- d. Are race, ethnicity, and language data accessible in the electronic medical record?

**Deliverable:** Please submit documentation showing how race, ethnicity, and language data are accessible in the electronic medical record.

*Support for non-English Speakers*

- e. Does the hospital ensure that communications with patients about their medical care in languages other than English meet non-English language proficiency (e.g., Spanish proficiency) requirements?

**Deliverable:** Indicate from the selections below and provide a brief narrative describing how your hospital ensures that communications with patients about their medical care in languages other than English meet non-English language proficiency requirements. Check all that apply electronic translation services/language line/iPads, certified interpreters, language proficiency assessment of staff who are communicating with patients regarding their medical care.

- f. Does the hospital educate all staff responsible for communicating with patients regarding their medical care on interpreter services available within the healthcare system?

**Deliverable:** Provide a brief narrative describing how your hospital educates all staff responsible for communicating with patients regarding their medical care on interpreter services available within the healthcare system.

*Hospital Education*

- g. Does the hospital provide education on racial and ethnic disparities and their root causes?

**Deliverable:** Provide a brief narrative describing how your hospital provides staff-wide education on racial and ethnic disparities and their root causes.

(Optional for labor and delivery hospitals) Please describe any staff-wide education your hospital provides on racial and ethnic disparities that is specific to the peripartum population.

- h. Does the hospital provide education on best practices for shared decision making?

**Deliverable:** Provide a brief narrative describing how your hospital provides education to providers on best practices for shared decision making.

(Optional for labor and delivery hospitals) Please describe how your hospital provides education to providers on best practices for shared decision making specific to the peripartum population.

#### *Community Engagement*

- i. Does the hospital engage diverse populations within its community regarding issues of equity in quality and safety to inform the decisions made by quality and safety leadership teams?

**Deliverable:** Provide a brief narrative describing how your hospital engages diverse populations within your community regarding issues of equity in quality and safety. Describe how input and information from your engagement is communicated to and informs the decisions made by quality and safety leadership teams.

(Optional for labor and delivery hospitals) Does your hospital include stakeholders representing peripartum concerns? Please describe or provide information about these stakeholders and how they are engaged regarding issues of equity in quality and safety for peripartum patients.

#### *Recognition & Prevention - Every patient, family, and staff member*

- a. Does the hospital provide staff-wide education on implicit bias?

**Deliverable:** Provide a brief narrative describing how your hospital provides 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?

**Deliverable:** Provide a brief narrative describing how your hospital provides 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?

**Deliverable:** Provide a brief narrative describing your hospital's mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect.

*Response - Every Clinical Encounter*

- a. Does the hospital ensure that providers and staff engage in best practices for shared decision making?

**Deliverable:** Provide a brief narrative describing how your hospital ensures that providers and staff engage in best practices for shared decision making.

(Optional for labor and delivery hospitals) Please describe how your hospital engages in best practices for shared decision making specific to peripartum patients.

- b. Does the hospital have a process to ensure a timely and tailored response to each report of inequity or disrespect?

**Deliverable:** Provide a brief narrative describing your hospital's process to ensure a timely and tailored response to each report of inequity or disrespect.

*Discharge Navigation and Coordination Systems*

- c.i 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?

**Deliverable:** Provide a brief narrative describing your hospital's discharge navigation and coordination systems to ensure that patients have appropriate follow-up care and understand when it is necessary to return to their health care provider?

(Optional for labor and delivery hospitals) Please describe your hospital's discharge navigation and coordination systems post childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider.

- c.ii 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?

**Deliverable:** Provide a brief narrative describing how your hospital provides 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.

- c.iii Does the hospital provide discharge materials that meet patients' health literacy, language, and cultural needs?

**Deliverable:** Provide a brief narrative describing how your hospital provides discharge materials that meet patients' health literacy, language, and cultural needs.

### *Reporting/Systems Learning*

- a. Does the hospital have initiatives in place to build a culture of equity, including systems for reporting, response, and learning?

**Deliverable:** Provide a brief narrative describing the initiatives in place to build a culture of equity, including systems for reporting, response, and learning.

- 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 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.

**Deliverable:** Provide a brief narrative describing your hospital's process for the regular reporting and monitoring of metrics (process and/or outcome) stratified by race and ethnicity and disseminate the information internally to staff and leadership.

(Optional for labor and delivery hospitals) Please outline your hospital's process for the regular reporting of metrics stratified by race and ethnicity specific to the peripartum population. Describe the peripartum specific metrics in your response.

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

**Deliverable:** Provide a brief narrative description how your hospital implements quality improvement projects that target disparities in healthcare access, treatment, and outcomes.

(Optional for labor and delivery hospitals) Please describe how your hospital implements quality improvement projects that target disparities in healthcare access, treatment, and outcomes specific to peripartum patients.

- d. Does the hospital consider and document 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? For example, does the hospital have a checkbox on the review sheet that asks: 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?

**Deliverable:** Please upload supporting documentation showing how you document whether race/ethnicity (i.e., implicit bias), language barrier, or specific social determinants of health contributed to the morbidity and mortality. Please describe how you review and disseminate this information as part of your hospital's efforts around continuous learning and quality improvement.

**Note:** Additional resources for this measure can be found in the Appendices.

## 2. Scoring

To earn points for this measure, hospital must have all elements of Readiness in place. Additional points can be earned for this measure based on having additional elements of the bundle in place.

(Recognition/Prevention, Response, Reporting/Systems Learning).

### *Reduction of Racial and Ethnic Disparities Patient Safety Bundle Scoring Rubric*

Total Possible	Readiness	One Point for Each Additional Element
10	5	Up to 5

## C. Hospital Acquired Clostridium Difficile (C. diff) Infections

### 1. Measure Criteria

Hospitals must submit data for this measure to National Healthcare Safety Network (NHSN); this allows for risk adjusting and calculation of an SIR rate. The Department will pull hospital data from CMS.

### 2. Scoring

For Hospital Acquired Clostridium Difficile infections points will be earned based on hospital performance compared to the national benchmark. The comparison is scored as better, no different, or worse than the benchmark, and points are associated with those scores.

### *Hospital Acquired Clostridium Difficile (C. diff) Scoring Rubric*

Total Possible	Worse	No Different	Better
5	0	3	5

## D. Sepsis

This process measure focuses on systems in place for improving the early identification and treatment of sepsis. Facilities must attest that this measure has been in place as of April 30, 2023 and is for all patients regardless of insurance status.

### 1. Measure Criteria

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.

## 2. Scoring

In 2023, 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	Process Measure Only	Process Measure w/ Documented Improvement
7	5	7

## E. Antibiotics Stewardship

This measure is based on the elements of the Centers for Disease Control and Prevention's (CDC) Core Elements for Hospital Antibiotic Stewardship Programs: 2019 (<https://www.cdc.gov/antibiotic-use/core-elements/hospital.html>) and emphasizes priority activities. This measure has four individual groups (i.e., they are not cumulative). To receive points for a group, all level criteria must be met.

Facilities must attest that this measure has been in place as of April 30, 2023 and is for all patients regardless of insurance status.

### 1. Measure Criteria

#### *Group 1: Commitment, Accountability and Pharmacy Expertise*

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

- Does your hospital have formal, written support from leadership (e.g., an active policy, active program charter, or annual letter) that supports and prioritizes the implementation and/or administration of an antibiotic stewardship program?
- Does your facility have physician and pharmacist co-leaders responsible for program management, implementation, and outcomes of stewardship activities?
- Is there an antibiotic stewardship committee that meets at least quarterly and provides feedback to leadership or the Board at least annually?

#### *Deliverables*

To receive point(s) on this section hospitals must:

- **Deliverable 1a:** Provide an updated letter from a senior-level leader with oversight over the antibiotic stewardship program or documentation of an active formal policy statement/charter indicating support and prioritization for the implementation and/or administration of an antibiotic stewardship program.
- **Deliverable 1b:** Provide names, titles, and roles of physician and pharmacist co-leaders.
- **Deliverable 1c:** Dates of antibiotic stewardship committee meetings; names and titles or roles of attendees (e.g., “physician leader”).
- **Deliverable 1d:** Documentation of committee feedback to leadership or hospital board of directors (e.g., PowerPoint, report, etc.)

#### *Group 2: Action and Tracking*

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

- Does your hospital have facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilities (e.g., antibiogram) to assist with

antibiotic selection for the following common conditions: pneumonia, urinary tract infection, and skin and soft-tissue infection?

- Does your hospital conduct any of the following broad interventions to improve antibiotic use (must answer yes to at least one)?
  - Does your facility perform preauthorization for specific antibiotic agents? (Preauthorization requires prescribers to gain approval prior to the use of certain antibiotics. The antibiotic stewardship team selects antibiotics for preauthorization based on characteristics such as broad spectrum of activity, toxicity, and potential for misuse or overuse in order to improve patient care and prevent antibiotic resistance)
  - Does your facility perform prospective audit and feedback for specific antibiotic agents? (Prospective audit and feedback is an external review of antibiotic therapy by an expert in antibiotic use, accompanied by suggestions to optimize use, at some point after the agent has been prescribed.)
  - Does your stewardship program include at least one member of the stewardship team conducting regular stewardship rounds that include real-time discussions with prescribers (also called “handshake stewardship”)?
- Does your hospital monitor antibiotic use (consumption) at the unit and/or hospital-wide level by one of the following metrics (must answer yes to at least one)?
  - 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). This may include manual counts or counts

through submission to the National Healthcare Safety Network (NHSN).

- 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).

### *Deliverables*

To receive point(s) for this section hospitals must:

- **Deliverable 2a:** Upload evidence of facility-specific treatment recommendations based on national guidelines for pneumonia, urinary tract infection, and skin and soft-tissue infection.
- **Deliverable 2b:** Provide a thorough description of at least one of the processes for the above intervention(s) (pre-authorization, prospective audit with feedback, or stewardship rounds), including Who, What, Where, When and How, as appropriate, or upload associated policy/procedure if available (preferred).
- **Deliverable 2c:** Provide a complete description of how DOT or DDD are measured or upload an example of measurement (an uploaded example is preferred).

### *Group 3, Education and Reporting:*

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

- Does your stewardship program provide written or in-person education to prescribers on improving antibiotic prescribing at least annually?
- Does your hospital produce an antibiogram (cumulative antibiotic susceptibility report) and distribute the antibiogram to prescribers annually or every other year?



- Does your antibiotic stewardship program share facility and/or individual prescriber-specific reports on antibiotic use with prescribers?

#### *Deliverables*

To receive point(s) for this section hospitals must:

- **Deliverable 3a:** Provide dates and topics of education to prescribers, include any supporting materials (PowerPoints, handouts, flyers). Must include at least one (1) education session during the measurement period.
- **Deliverable 3b:** Provide a copy of the hospital's latest antibiogram. Antibiograms must be dated within two (2) years of the end of the measurement period (May 2021-April 2023).
- **Deliverable 3c:** Upload example(s) of how antibiotic utilization information is reported to prescribers. Examples could include: antibiotic utilization reports, screenshots of antibiotic use dashboards, de-identified examples of report cards or e-mails sent to individual prescribers, or summaries of antibiotic prescribing. Examples must be dated from within the measurement period. (Jan.,1 2022 - April 30, 2023)

#### *Group 4, NHSN Reporting:*

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 Jan.1, 2022 - April 30, 2023)?

#### *Deliverable*

To receive point(s) for this section hospitals must:

- **Deliverable 4a:** Provide the dates of reporting antibiotic use data to NHSN, as well as evidence of at least three months reporting (e.g., sample SAAR report or line listing).

## **2. Scoring**

Hospitals will earn points for the successful completion of the four groups. To be eligible for points, hospitals must successfully complete all

criteria for measure Group 1. Hospitals can earn additional points by completing Groups 2 - 4.

*Antibiotic Stewardship Scoring Rubric*

Total Possible	Group 1	Group 2	Group 3	Group 4
10	2	5	2	1

## F. Adverse Event Reporting

This measure is based on activities from January 1, 2022 to December 31, 2022 and is for all patients regardless of insurance coverage.

### 1. Measure Criteria

To be eligible for points in this measure:

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

### 2. 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
5

## G. 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

## 1. Measure Criteria

To be eligible for points in this measure:

- 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.

## 2. 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
5

## H. Handoffs and Sign-outs

Facilities must attest that this measure has been in place as of April 30, 2023 and is for all patients regardless of insurance status.

### 1. Measure Criteria

#### *Step 1*

Hospitals must identify the areas of handoffs and sign-outs 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 sign-outs can be between different levels of care, between departments, or other areas where providers transition care between themselves or other hospital staff.

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:

- Operating room to intensive care unit
- Emergency department to inpatient
- Intensive care unit to floor
- Perioperative services to next level of care
- Intraoperative: provider to provider
- Postoperative: OR to Post Anesthesia Care Unit (PACU)

### *Step 2*

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

- Identify the leader of the initiative.
- Describe the actions being taken to improve handoffs and sign-outs.
- Document any standardized methodologies or mnemonics being implemented (e.g., IPASS, SBAR, etc.)
- 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:

- Describe how it plans to measure progress on this initiative in HQIP 2023
  - Potential measurement strategies include:
    - Tracking how many times a handoff or sign-out uses the appropriate protocol.
    - Reviewing incident reports and documenting the times there are handoff issues pre intervention vs post intervention.
    - Assess the extent of communication issues during handoffs.

- Note which types of communication issues are attributed to handoffs based on information in incident reports.
  - Handoff direct observation (pre-intervention and post-intervention)
  - Record presence or absence of key elements
  - Analyze quality (presence of distractions, attentiveness of speaker and recipient, asking important clinical questions etc.)
  - Surveys to providers and staff about their perceptions of handoff process/perceived barriers to improvements in the handoff process
- Hospitals must document the process of communicating feedback on Handoffs and Sign-outs to hospital staff to facilitate continuous improvement.

**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

## 2. Scoring

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

### *Handoffs and Sign-outs Scoring Rubric*

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

## V. Measure Group 3: Patient Experience Group Measure Details

### A. Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS)

#### 1. Measure Criteria

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

##### *Composite 5: Communication About Medicines*

*(HCAHPS V14 Questions 13, 14)*

- How often did staff explain about medicines before giving them to patients? Before giving you any new medicine
  - How often did hospital staff tell you what the medicine was for?
  - How often did hospital staff describe possible side effects in a way you could understand?

##### *Composite 6: Discharge Information*

*(HCAHPS V14 Questions 16,17)*

- Were patients given information about what to do during their recovery at home? During this hospital stay
  - Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?
  - Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

##### *Composite 7: Care Transition*

*(HCAHPS V14 Questions 20, 21, 22)*

- 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.
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- When I left the hospital, I clearly understood the purpose for taking each of my medications.

## 2. 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; quartile 4 being the highest will receive 5 points, quartile 3 will receive 3 points, quartile 2 will receive 1, and the lowest quartile will receive no point.

### *HCAHPS Composite 5-7 Scoring Rubric*

Total Possible	Quartile 1	Quartile 2	Quartile 3	Quartile 4
5	0	1	3	5

## B. Advance Care Planning (ACP)

### 1. Measure Criteria

The Advance Care Planning measure evaluates the number of patients, regardless of payer, 65 years of age or older who have an advance care plan documented in the medical record or a record indicating that they did not wish to provide an advance care plan. This measure includes initial hospital observation care services, inpatient services, and critical care services, but excludes the emergency department. Hospitals will be required to submit data from calendar year 2022 to the Department. Sampling is allowed. There is no minimum denominator for this measure.

Hospitals with rates under the performance threshold will be required to summarize:

1. The process for discussing/ initiating advance care planning when a patient does not have an ACP or when their ACP is not available to the hospital
2. The process and systems for documenting advance care plans in the medical record
3. Any efforts underway to improve the hospital’s ACP rate

### 2. Scoring

Advance Care Planning will be scored by setting a performance threshold for the hospital’s ACP rate. Those above the performance threshold will receive the total possible points (5). Those below the performance



threshold will receive the total possible points (5) with the submission of a narrative summarizing:

1. The process for discussing/ initiating advance care planning when a patient does not have an ACP or when their ACP is not available to the hospital
2. The process and systems for documenting advance care plans in the medical record
3. Any efforts underway to improve the hospital's ACP rate

The performance threshold for 2023 is at or above 95%.

*Advance Care Planning Scoring Rubric*

Total Possible	ACP Rate $\geq$ 95% or ACP Rate < 95% and Completion of Narrative
5	5

## VI. 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.

## VII. 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"
$\geq 1551$	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 advance 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 advance care planning is 401 patients for the year. Using the above table, the required sample size is 80 cases ( $401 \times .20 = 80$ ) for the year.

## VIII. Appendices

The appendices below provide resources for the Reduction of Racial and Ethnic Disparities Patient Safety Bundle.

### A. Appendix A: Resources on Practices for Collecting Racial, Ethnic and Language Data

American Hospital Association Institute for Diversity and Health Equity (IFDHE) Why Collect Race, Ethnicity and Primary Language. See link: <https://ifdhe.aha.org/hretdisparities/why-collect-race-ethnicity-language>

Centers for Medicare and Medicaid Services (CMS): Building an Organizational Response to Health Disparities: Inventory of Resources for Standardized Demographic and Language Data Collection. Available at the link <https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/hcps-and-researchers/data-tools>

Agency for Health Care Research and Quality (AHRQ): Race and Ethnicity Data Improvement Toolkit See link: [https://www.hcup-us.ahrq.gov/datainnovations/raceethnicitytoolkit/data\\_improve\\_edu.jsp](https://www.hcup-us.ahrq.gov/datainnovations/raceethnicitytoolkit/data_improve_edu.jsp)

American Medical Association (AMA) Collecting Patient Data: Improving Health Equity in Your Practice See link: <https://edhub.ama-assn.org/interactive/17579528>

Northwest Safety and Quality Partnership: Race, Ethnicity and Language Resources. See link: [http://www.wsha.org/wp-content/uploads/REaL-Data-Collection-Resources\\_WSHA-2021.pdf](http://www.wsha.org/wp-content/uploads/REaL-Data-Collection-Resources_WSHA-2021.pdf)

## **B. Appendix B: Information and Resources for Language Proficiency**

Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, National Standards on Culturally and Linguistically Appropriate Services, Americans with Disabilities Act, and the Hill Burton Act.

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA).

On May 13, 2016, the HHS Office for Civil Rights issued the final rule implementing Section 1557. The latest ruling emphasizes the importance of using a qualified medical interpreter and expressly prohibits the use of ad-hoc interpreters, including family members and other untrained bilingual individuals, barring extreme circumstances.

A rights-based framework. Access to health care services is a human right, as defined in numerous international health rights covenants. The United Nations Committee on Economic, Social and Cultural Rights' General Comment 14 states, "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity". The right to health care should be an organizing principle in our health systems. The use of appropriate language services and the right of a patient with LEP to access health care are inextricably linked. For patients with LEP, the only way to meaningfully access health services is by clearly communicating with health care professionals using their preferred language of care.

In the United States, patients with LEP have a legal right to access health care in their preferred language. The foundation of this right is established in Title VI of the landmark Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. In health care, Title VI—as enforced by Executive Order 13166, entitled "Improving Access to Services for Persons with Limited English Proficiency"—is a cornerstone for the provision of oral interpretation and written translation services to patients with LEP.

Health care institutions can provide appropriate language services to their patients with LEP by hiring qualified bilingual staff [4]. However, since it is not always possible to hire qualified bilingual staff in all patients' preferred languages, it is essential to have systems for accessing professional language assistance services in place rather than relying on ad hoc interpreters. One solution is for hospitals to employ qualified medical interpreters in the major languages of their patient populations and contract with telephonic or videoconference services for access to additional languages on demand

Standards of practice for medical interpreting. A concern of clinical and ethical importance relates specifically to the risk of errors during a verbal consent process for a patient with LEP that does not involve a qualified medical interpreter [6]. In the United States, the Department of Health and Human Services (HHS) establishes competencies required of a "qualified interpreter" [7]. These competencies include the knowledge of specialized terminology and interpreter ethics and the skills to interpret accurately, effectively, and impartially. HHS requires that hospitals conduct an assessment of individuals claiming to have competencies prior to designating an individual as a qualified interpreter. HHS does not require that hospital staff serving as interpreters possess national certification, which is currently available in just a handful of spoken languages [8]. However, HHS clarifies that "the fact that an individual has above average familiarity with speaking or understanding a language other than English does not suffice to make that individual a qualified interpreter for an individual with limited English proficiency" [9].

Health care professionals should use extreme caution when using ad hoc interpreters. The use of ad hoc interpreters—a broad category that includes a patient's friends or family members and unqualified bilingual staff—can significantly increase medical errors [6]. Health care professionals face potential civil liability when they fail to provide qualified interpreters, if such failure leads to a tort cause of action, such as lack of informed consent, breach of duty to warn, or improper medical care [10]. In contrast, the use of professional interpreters while providing medical care for patients with LEP improves comprehension, service utilization, clinical outcomes, and patient satisfaction [11]

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7. Nondiscrimination in health programs and activities: final rule. Fed Regist. 2016;81(96):31375-31473. <https://www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf>. Accessed January 26, 2016.
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9. Nondiscrimination in health programs and activities, 31390-31391.

10. DeCola A. Making language access to health care meaningful: the need for a federal health care interpreters' statute. *J Law Health.* 2010;58(151):151-182. Accessed January 26, 2016.
11. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Ser Res.* 2007;42(2):727-754. See the following links for the article and citations: [View Article](#) [PubMed](#) [Google Scholar](#)
12. National Council on Interpreting in Health Care. National standards of practice for interpreters in health care. Published September 2005. Accessed October 18, 2016.  
<https://www.ncihc.org/assets/z2021images/NCIHC%20National%20Standards%20of%20Practice.pdf>
13. See the link:  
<https://www.ncihc.org/assets/documents/workingpapers/NCIHC%20Working%20Paper%20-%20Linguistically%20Appropriate%20Access%20and%20Services.pdf>
14. See the link:  
[https://www.coloradotrust.org/sites/default/files/CT\\_LanguageAccessBrief\\_final-1.pdf](https://www.coloradotrust.org/sites/default/files/CT_LanguageAccessBrief_final-1.pdf)

#### *Language Proficiency Assessment*

1. [https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/california/pdf/providers/Language\\_Proficiency\\_Assessment-Resources\\_9.25.18.pdf](https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/california/pdf/providers/Language_Proficiency_Assessment-Resources_9.25.18.pdf)
2. <https://www.coloradolanguageconnection.org/bridging-the-gap>
3. <http://www.palsforhealth.org/language-assessment.html>



## C. Appendix C: Additional resources on Racial and Ethnic Disparities, Implicit Bias, Shared Decision Making

### *Implicit Bias*

- Project Implicit see the link:  
<https://implicit.harvard.edu/implicit/education.html>
- Training Health Professionals to Understand Implicit Bias linked to Racial and Ethnicity-Based Discrimination, and the Implications for Health Equity: see the link:  
[https://cdn.who.int/media/docs/default-source/world-health-day-2021/4-wonca-presentation-webinat-25march2021.pdf?sfvrsn=75bc4c69\\_7](https://cdn.who.int/media/docs/default-source/world-health-day-2021/4-wonca-presentation-webinat-25march2021.pdf?sfvrsn=75bc4c69_7)

### *Resources from Massachusetts General Hospital Disparities Solutions Center*

- See the link: <https://www.mghdisparitiessolutions.org/guides->

### *The Commonwealth Fund*

- The Commonwealth Fund: In Focus: Reducing Racial Disparities in Health Care by Confronting Racism. See the link:  
<https://www.commonwealthfund.org/publications/2018/sep/focus-reducing-racial-disparities-health-care-confronting-racism>

### *Shared Decision Making*

- Agency for Health Care Research and Quality (AHRQ) The SHARE Approach. See the link: <https://www.ahrq.gov/health-literacy/professional-training/shared-decision/index.html>