2023 Hospital Rate Improvement Program

Encyclopedia of Measures

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HRIPQ Encyclopedia of Measures

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2023 HRIP Quality Goal

The Hospital Rate Improvement Program (HRIP) makes it possible for Kentucky to draw down more federal funds so that Medicaid reimbursements will be closer to the average commercial rate. A portion of the funds are tied to quality metrics hospitals must meet in order to receive the improved reimbursement. During the second year of the program, each hospital is eligible for up to 10% in the quality incentive.

The table below lays out the quality measures and the applicable segment:

SFY 2023	Non-Birth Acute (Med/Lrg)	Non-Birth CAH	Low Volume	Birthing	Birthing L/V	LTACH	Rehab	Psych
Readmissions	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
Sepsis	2.0%	2.0%	2.0%	2.0%	2.0%			
CAUTI	1.0%			1.0%				
CAUTI (CAH/LV)		1.0%	1.0%		1.0%	2.0%	2.0%	
C. Diff	1.0%	1.0%	1.0%	1.0%	1.0%	2.0%	2.0%	
Social Determinants of Health	1.0%	1.0%	1.0%	1.0%	1.0%	2.0%	1.0%	2.0%
Concurrent e-Prescribing	1.0%	1.0%	1.0%	1.0%	1.0%	2.0%		2.0%
Hours of Physical Restraint								2.0%
Hours of Seclusion								2.0%
Screening for Violence Risk								2.0%
Discharge to Home/Community							2.0%	
Discharge with an Opioid Rx							1.0%	
Opioid Uncomplicated Vaginal Delivery				1.0%	1.0%			
Maternal Depression and SUD				0.5%	0.5%			
Suicide Screening in ED	1.0%	1.0%	1.0%	0.5%	0.5%			
ED Opioid Use for Acute Ankle Sprain (ALTO)	1.0%	1.0%	1.0%					
	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%

Not all measures will apply to all hospitals, e.g., certain measures won't apply to Low Volume Hospitals, Birthing hospitals or certain specialty hospitals. The definition of "Low Volume" is any hospital for whom NHSN is unable to calculate a standardized infection ratio (SIR). Once established, each incentive pool will be distributed to individual hospitals based on individual achievement level as well as the number of Medicaid discharges.

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Hospital Readmission

Title: **Readmission within 30 Days (All Cause) Rate Medicaid Only –** ***Excludes Freestanding Psych Hospitals***

Data Source: Administrative Claims Data (KY IPOP Data)

Payer: Medicaid Only

Baseline Period: Calendar Year 2019

Measure description: Align with CMS Readmission measure

Readmission measure will align with the CMS 30-day All Cause Unplanned Readmission metric. Consider quality improvement activities within the hospitals directed on discharge planning or screening. Possibly use LACE scores at discharge to help identify patients at increased risk (L=LOS, A=Acuity, C=Chronic Disease, E=ED visits in last 6 months), screen for SDOH to address economic issues that may impair health.

- **Numerator:** All patients who are readmitted within 30 days of discharge. Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, except for certain planned admissions (Note: Not all hospitals can track readmissions to other facilities. Hospitals should focus on tracking readmissions consistently across time). Count the number of patients who are readmitted within 30 days, not the number of readmissions. It is a patient-centric measure.
- **Denominator:** All patients discharged during any given month meeting the discharge inclusion/exclusion criteria:
  1. **Include:** Medicaid patients of any age
  2. **Exclude:** Patients with discharge status codes or primary admitting diagnoses as follows:
     - **a.** Expired (UB04 Code: 20)
     - **b.** Transferred to another acute care facility (UB04 Codes: 02, 05, 43, 66)
     - **c.** Against medical advice (UB04 Code: 07)
     - **d.** Transferred to a rehab facility (UB04 Code: 62)
     - **e.** Admitted for primary psychiatric diagnoses;
     - **f.** Admitted for rehabilitation; or
     - **g.** Admitted for medical treatment of cancer

Calculation: (Numerator/Denominator) X 100

Measure of success: Decrease in the number of readmissions over time

Measure Goal for CY 2023:

In Quarter 4 of CY 2023, have performance better than Target of 10.10 OR Achieve a 10% improvement in the Gap to KY Target from hospital baseline of CY 2019 – 1.0%

In Quarter 4 of CY 2023, have performance better than Target of 10.10 OR Achieve a 15% improvement in the Gap to KY Target from hospital baseline of CY 2019 – 1.0%

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Sepsis – Screening to be performed at triage

Title: **Sepsis –** ***Excludes LTACH, Psych and Rehab Hospitals***

Data Source: Facility

Payer: All Payer

Baseline Period: July - September 2021

Measure description: Align with Sepsis Consortium

Sepsis Screening to be performed at triage – the rate of patients presenting to the emergency department who are screened for Sepsis.

- **Numerator:** Number of emergency department patients 18 years of age and older screened
- **Denominator:** Number of patients 18 years of age and older presenting to the emergency department

Calculation: (Numerator/Denominator) X 100

Specification/Definitions:

Sepsis screening to be performed at triage to include:

- Assessing for presence of 2 or more Systemic Inflammatory Response Syndrome (SIRS) criteria:
  - (tachycardia (heart rate >90 beats/min)
  - tachypnea (respiratory rate >20 breaths/min)
  - fever or hypothermia (temperature >38 or <36 °C)
  - Leukocytosis, leukopenia, or bandemia (white blood cells >1,200/mm3, <4,000/mm3 or bandemia ≥10%)
- Organ dysfunction (MAP <65 torr, Systolic BP <90, Creatinine > 2.0, Serum Lactate > 2.0
- Platelets less than 100K
- Total Bili >2.0, INR >1.5 upper limit normal
- Urine output < 5ml/kg/hr. for two hours) with documented or suspected infection

Measure of success:

Adherence to sepsis bundle

Measure Goal for CY 2023:

Screen 70% of eligible patients in the emergency department (ED) AND track bundle compliance – 0.5%

Screen 95% of eligible patients in the emergency department (ED) AND track bundle compliance – 0.5%

Screen 95% of eligible patients in the emergency department (ED) in Quarter 4 of CY 2023 AND in Quarter 4 of CY 2023 KY bundle adherence benchmark of 55% OR if below the KY benchmark improve 25% of the Gap to KY benchmark – 1.0%

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Sepsis – Screening to be performed at triage - continued

[3]CMS SIRS & OD criteria delineates between adult patients who are pregnant with gestational age 20 weeks and older:

Two or more manifestations of systemic infection according to the Systemic Inflammatory Response Syndrome (SIRS) criteria, which are:

- For SIRS criteria, use the table below.
  - Use the Non-Pregnant criteria if Value “2” was selected for the Pregnant 20 Weeks Through Day 3 Post-Delivery data element.
  - Use the Pregnant 20 weeks through Day 3 Post-delivery criteria if Value “1” was selected for the Pregnant 20 Weeks Through Day 3 Post-delivery data element..

Non-Pregnant Criteria	Pregnant 20 weeks through Day 3 Post-delivery Criteria
Temperature > 38.3 C or <36.0 C (>100.9 F or <96.8 F)	Temperature ≥ 38.3 C or <36.0 C (≥100.9 F or <96.8 F)
Heart rate (pulse) >90	Heart rate (pulse) > 110
Respiration >20 per minute	Respiration > 24 per minute
White blood cell count >12,000 or ≤4,000 or >10% bands	White blood cell count >15,000 or <4,000 or >10% bands

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Sepsis – Screening to be performed at triage - continued

Organ dysfunction, evidenced by any one of the following:

- Systolic blood pressure (SBP) <90 mmHg or mean arterial pressure <65 mmHg.
    - Use the Non-Pregnant criteria if Value “2” was selected for the Pregnant 20 Weeks Through Day 3 Post-delivery data element
    - Use the Pregnant 20 Weeks through Day 3 Post-delivery criteria if Value “1” was selected for the Pregnant 20 Weeks Through Day 3 Post-delivery date element.

Non-Pregnant Criteria	Pregnant 20 weeks through Day 3 Post-delivery Criteria
Systolic blood pressure (SBP) <90 mmHg or mean arterial pressure <65 mmHg.	Systolic blood pressure (SBP) <85 mmHg or mean arterial pressure <65 mmHg.
Systolic blood pressure decrease of more than 40 mmHg.	Systolic blood pressure decrease of more 40 mmHg.
Acute respiratory failure as evidenced by a new need for invasive or non-invasive mechanical ventilation.	Acute respiratory failure as evidenced by a new need for invasive or non-invasive mechanical ventilation.
Creatinine >2.0 mg/dL	Creatinine > 1.2 mg/dL
Urine output <0.5 mL/kg/hour for two consecutive hours	Urine output <0.5 mL/kg/hour for two onsecutive hours
Total Bilirubin >2 mg/dL (34.2 mmol/L)	Total Bilirubin > 2 mg/dL (34.2 mmol/L)
Platelet count <100,000	Platelet count <100,000
INR > 1.5 or aPTT >60 sec	INR >1.5 or PTT >60 sec
Lactate > 2 mmol/L (18.0 mg/dL)	Lactate >2 mmol?L (18.0 mg/dL) **NOTE:** Do not use lactate obtained during active delivery defined as documentation of uterine contractions resulting in cervical change (dilation or effacement) through delivery or childbirth.

Sepsis – Bundle compliance 3 and 6 hour

Title: **Sepsis – *Excludes LTACH, Psych and Rehab Hospitals***

Data Source: Facility

Payer: All Payer

Baseline Period: July - September 2021

Measure description: Aligns with the CMS and Sepsis Consortium Bundle – 3 and 6 Hour measure

Link to the CMS 3 and 6 Hour Bundle Measure:
https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=1017

Link to the CMS Sampling Guidance:
https://qualitynet.cms.gov/inpatient/specifications-manuals

- **Bundle Compliance –** Percent of identified sepsis patients who receive all of the 3 and 6 hour bundle elements.
- **Numerator:** Patients who received ALL of the following within three hours of presentation of severe sepsis:
    - Initial lactate level measurement
    - Broad spectrum or other antibiotics administered
    - Blood cultures drawn prior to antibiotics
    - Fluid Resuscitation: Administer 30 mL/kg of crystalloid fluid** for hypotension (defined as mean arterial pressure (MAP) < 65) or lactate (> 4)*

Number of identified sepsis patients who received all of the following within six hours of presentation of severe sepsis.

The **"6-hour septic shock bundle"** contains all the therapeutic goals to be completed within 6 hours of the time of presentation with septic shock:

1. to apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a MAP ≥65 mmHg,
2. to consider measurement of CVP and ScvO2 when arterial hypotension persists despite volume resuscitation or initial lactate ≥4 mmol/L, and
3. to re-measure lactate if initial lactate was elevated

* Two low BPs (either SBP<90 or MAP<65) within 3 hours of each other, not needing to be consecutive and can be 6 hours prior to or after time zero

For Discharges Starting with July 1, 2021, Cry Crystalloid Fluid Administration for Hypotension due to Sepsis.**

Exclusion criteria for the 30 ml/kg fluid requirement for CHF & E & ESRD patients If Less than 30ml/kg are ordered and given, all the following criteria must be met: The ordering provider must document within a

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single note in the medical record:

- That administration of 30ml/kg of crystalloid fluids would be detrimental or harmful for the pt. despite having hypotension, a lactate >= 4 mmol/L, or documentation of septic shock;
- AND the pt. has one of the following conditions:
    - o Advanced or End Stage Heart Failure (with documentation of NYHA class III or symptoms with minimal exertion, OR NYHA class IV or symptoms at rest or with any activity) o Advanced or End Stage Chronic Renal Disease (with documentation of Stage IV or GFR 15-29ml/min, OR Stage V or GFR 30).
- Provider documents the IBW is used to determine target ordered volume.
- IBW is documented in the medical record. Provider orders are required for the fluids.

- **Denominator:** All inpatients with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis or Septic Shock

Denominator Exclusions:

The following patients are excluded from the denominator: Severe sepsis is not in present patients transferred from another acute care facility Patients receiving IV antibiotics for more than 24 hours prior to presentation of severe sepsis. Patients with a Directive for Comfort Care or Palliative Care within 3 hours of presentation of severe sepsis; Patients with an Administrative Contraindication to Care within 6 hours of presentation of severe sepsis; Patients with an Administrative Contraindication to Care within 6 hours of presentation of septic shock; Patients with a Directive for Comfort Care or Palliative Care within 6 hours of presentation of septic shock; Patients with septic shock who are discharged within 6 hours of presentation Patients with severe sepsis who are discharged within 6 hours of presentation; Patients with a Length of Stay >120 days; Patients included in a Clinical Trial

Specifications/Definitions: This measure focuses on adults 18 years and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, the measure contains several elements, including measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. As reflected in the data element and their definitions, these elements should be performed in the early management of severe sepsis and septic shock.

Measure of success: Adherence to sepsis bundle

Measure Goal for CY 2023:

Screen 70% of eligible patients in the emergency department (ED) AND track bundle compliance – 0.5%

Screen 95% of eligible patients in the emergency department (ED) AND track bundle compliance – 0.5%

Screen 95% of eligible patients in the emergency department (ED) in Quarter 4 of CY 2023 AND in Quarter 4 of CY 2023 KY bundle adherence benchmark of 55% OR if below the KY benchmark improve 25% of the Gap to KY benchmark – 1.0%

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CAUTI – Standardized Infection Ratio (SIR)

Title: **CAUTI – Based on Standardized Infection Ratio - *Excludes Psych, Rehab, LTACH, CAH, Low Volume and Low Volume Birthing hospitals.***

Data Source: NHSN

Payer: All Payer

Baseline Period: Calendar Year 2019

Measure description:

Episodes of CAUTI cause discomfort and sequelae can range from mild (fever, urethritis, and cystitis) to severe (acute pyelonephritis, renal scarring, calculus formation, and bacteremia). Left untreated, these infections can lead to urosepsis and death. CAUTIs also cause exposure to antibiotics which can lead to additional unpleasant symptoms, allergic reactions, and C difficile infections. Complications associated with CAUTI result in increased length of stay of 2-4 days, patient discomfort, and excess health care costs, and contribute to increased mortality. The estimated total U.S. cost per year for CAUTI is $340-450 million.

Measure of success:

Decrease in the number of CAUTIs

Measure progression:

- **Numerator:** Number of observed CAUTIs (catheter associated urinary tract infections)
- **Denominator:** Number of predicted CAUTIs

NHSN calculates predicted infections based on the annual survey the hospitals complete. It is based on risk factors which have proven to impact infection rates.

Measure Goal for CY 2023:

Better than the National average (.74) OR in Quarter 4 of CY 2023 improve 10% from Baseline – 0.5%

In Quarter 4 of CY 2023, improve 20% from baseline OR be 10% lower (.67) than the National average – 0.5%

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CAUTI – Low Volume Hospitals

Title: **CAUTI – Low Volume hospitals (Based on Catheter Utilization Ratio) –** ***Includes any hospital for which NHSN is unable to calculate an SIR.***

Data Source: NHSN

Payer: All Payer

Baseline Period: Calendar Year 2019

Measure description:

Episodes of CAUTI cause discomfort and sequelae can range from mild (fever, urethritis, and cystitis) to severe (acute pyelonephritis, renal scarring, calculus formation, and bacteremia). Left untreated, these infections can lead to urosepsis and death. CAUTIs also cause exposure to antibiotics which can lead to additional unpleasant symptoms, allergic reactions, and C difficile infections. Complications associated with CAUTI result in increased length of stay of 2-4 days, patient discomfort, and excess health care costs, and contribute to increased mortality. The estimated total U.S. cost per year for CAUTI is $340-450 million.

Measure of success:

Decrease in the number of CAUTIs

Measure progression:

Catheter Utilization Rate is calculated by dividing:

- **Numerator:** Number of catheter days in a given time period
- **Denominator:** The number of patient days in the same time period

Measure Goal for CY 2023:

In Quarter 4 of CY 2023, better than KY baseline average OR in Quarter 4 of CY 2023 improve 25% from Gap to KY baseline average from CY 2022 – 1.0%

For LTACH and Rehab Hospitals – 2.0%

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Clostridioides Difficile – Standardized Infection Ratio (SIR)

Title: **Clostridioides Difficile –** ***Excludes Freestanding Psych Hospitals and Low Volume Hospitals***

Data Source: NHSN

Payer: All Payer

Baseline Period: Calendar Year 2019

Clostridioides Difficile (C. diff) is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. Illness from C. difficile most commonly affects older adults in hospitals or in long-term care facilities and typically occurs after use of antibiotic medications. It's estimated to cause almost half a million infections in the United States each year. About 1 in 6 patients who get C. diff will get it again in the subsequent 2-8 weeks. One in 11 people over age 65 diagnosed with a healthcare-associated C. diff infection die within one month.

Kentucky has a higher incidence of C. diff than the national incidence. Since inappropriate antibiotic use is associated with higher incidence of C. diff and since Kentucky has a considerably higher rate of antibiotic prescribing than the national rate, this measure has much room for impactful improvement.

Measure description:

C difficile SIR is calculated by dividing:

- **Numerator:** Total number of observed hospital-onset C. difficile lab identified events among all inpatients facility-wide, excluding well-baby nurseries and NICUs
- **Denominator:** Number of Predicted cases of patients with C. difficile.

Calculation: Numerator/Denominator

Measure of success:

Decrease in rate of Clostridioides Difficile infections

Measure Goal for CY 2023:

In Quarter 4 of CY 2023, improve 10% OR be lower than the KY baseline average (.62) – 0.5%

In Quarter 4 of CY 2023, improve 20% OR be 10% lower (.56) than the KY baseline average (.62) – 0.5%

For LTACH and Rehab Hospitals – 2.0%

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Clostridioides Difficile – Low Volume Hospitals

Title: **Clostridioides Difficile (C. diff) – Low Volume hospitals (Based on C. diff Rate) – C. diff Rate will be used for hospitals that are unable to calculate a SIR due to volume – *Excludes Freestanding Psych Hospitals***

Data Source: NHSN

Payer: All Payer

Baseline Period: Calendar Year 2019

Clostridioides Difficile (C. diff) is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. Illness from C. difficile most commonly affects older adults in hospitals or in long-term care facilities and typically occurs after use of antibiotic medications. It's estimated to cause almost half a million infections in the United States each year. About 1 in 6 patients who get C. diff will get it again in the subsequent 2-8 weeks. One in 11 people over age 65 diagnosed with a healthcare-associated C. diff infection die within one month.

Kentucky has a higher incidence of C. diff than the national incidence. Since inappropriate antibiotic use is associated with higher incidence of C. diff and since Kentucky has a considerably higher rate of antibiotic prescribing than the national rate, this measure has much room for impactful improvement.

Measure description:

C. difficile Rate is calculated by dividing:

- **Numerator:** Total number of observed hospital-onset C. difficile lab identified events among all inpatients facility-wide, excluding well-baby nurseries and NICUs
- **Denominator:** Patient days (facility-wide)

Rate Calculation: (Numerator/Denominator) X 10,000

Measure of success:

Decrease in rate of Clostridioides Difficile infections

Measure Goal for CY 2023:

In Quarter 4 of CY 2023, better than the KY baseline average OR in Quarter 4 of CY 2023 improve 25% from Gap to KY baseline average from CY 2022 – 1.0%

For LTACH and Rehab Hospitals – 2.0%

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Safe Use of Opioids – Concurrent e-Prescribing – Opioid Rx

Title: **Safe Use of Opioids – Concurrent e-Prescribing – Opioid Rx – *Excludes Rehab Hospitals***

Data Source: Facility

Payer: All Payer

Measure description: Align with KY SOS Metric 2b

Patients, age 18 years or older, prescribed via electronic means (unless exempt per KRS 218A.182) two or more schedule II opioids (such as fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, tapentadol) or a schedule II opioid and benzodiazepine concurrently at discharge from a hospital-based encounter (e.g., inpatient or emergency department, including observation stays).

Measure of success:

- **Numerator:** Patients, age 18 years or older, prescribed via electronic means (unless exempt per KRS 218A.182) two or more schedule II opioids or a schedule II opioid and benzodiazepine at discharge.
- **Denominator:** Patients, age 18 years or older, prescribed via electronic means (unless exempt per KRS 218A.182) a schedule II opioid or a benzodiazepine at discharge from a hospital-based encounter (inpatient stay less than or equal to 120 days or emergency department encounters, including observation stays) during the measurement period.

Denominator Inclusions:

- Patients with ICD codes for personal history of cancer (Z85 codes) should be included in the analysis (do not exclude).

Denominator Exclusions:

- Encounters for patients with an active diagnosis of cancer during the encounter. This should be identified using patients with active cancer ICD codes (Codes C00-D49).
- Encounters for patients, who are ordered for palliative care during the encounter, as identified by the reporting institution.
- Encounters for patients with a length of stay greater than 120 days.
- Continued home medications

Applies to a facility that prescribes opioids and/or benzodiazepines
Measure considered met if facility has obtained a waiver from the Cabinet pursuant to KRS 218A.182

Measure Goal for CY 2023:

Hospital to improve during Quarter 4 of CY 2023 5% from hospital baseline OR achieve KY baseline average or better – 0.5%

Hospital to improve during Quarter 4 of CY 2023 10% from hospital baseline OR achieve KY baseline average or better – 0.5%

For LTACH and Rehab Hospitals – 2.0%

*Hospitals will receive credit if waiver was obtained from the Cabinet for Health and Family Services per KRS 218A.182.

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Social Determinants of Health
– Health-Related Social Needs Screening Tool

Title: **Health-Related Social Needs Screening Tool**

Data Source: Facility

Payer: Medicaid Only

Measure description:

To further develop health and well-being in individuals and communities in Kentucky, the utilization of Social Health Determinant Screening will prioritize healthcare access and quality of health services.

https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-So-cial-Needs-in-Clinical-Settings.pdf

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Measure of success:

Utilizing effective SHD screening can be accomplished in a short period of time while offering valuable information that will assist in providing improved quality of care.

- **Numerator =** Number of Medicaid (traditional and all Medicaid Managed Care) Inpatients screened with HRSN OR Kynect screening tool
- **Denominator =** Number of Medicaid (traditional and all Medicaid Managed Care) Inpatients hospitalizations

Exclusions:

- Patients under full Palliative Care
- Patients under full Hospice Care
- Newborns
- Incarcerated patients
- Patient readmitted within 5 days of discharge if screen was performed during first admission
- Patients admitted from nursing home who will be discharged back to nursing home
- Patient screened in Outpatient/Ambulatory Care Setting (using the same hospital screening tool) if admitted to Inpatient within 72 hours of outpatient visit

Hospital Rate Improvement Program Social Determinants of Health Screening Questions
(Must complete the following questions)

1. Housing (CMS Question #1)
2. Utilities (CMS Question #6)
3. Employment (CMS #12)
4. Income (CMS Question #11)
5. Food (CMS Question #3)
6. Physical Activity (CMS #17)
7. Education (CMS #15)
8. Transportation (CMS #5)
9. Mental Health (CMS #23)
10. Substance Use (CMS #19)
11. Safety (CMS #7)
12. Care of Elderly and/or the Disabled (CMS #25)
13. Basic Daily Needs (CMS Question #2)
14. Social Connections and Friendships (CMS #13)

Measure Goal for CY 2023:

Screen 50% of hospital Medicaid Inpatients during CY 2023 using the CMS or Kynect screening tool and make referrals according to the hospital's plan – 1.0%

For LTACH, Psych and Hospitals – 2.0%

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Hours of Physical Restraint

Title: **Hours of Physical Restraint –** ***Freestanding Psychiatric Hospitals Only***

Data Source: Facility

Payer: All Payer

Measure description: Align with Joint Commission HBIPS-2

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

Mental health providers that value and respect an individual's autonomy, independence, and safety seek to avoid the use of dangerous or restrictive interventions. The use of seclusion and restraint are limited to situations deemed objectively to meet the threshold of imminent danger and when used are rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base.

Measure of success:

- **Numerator:** The total number of hours that all psychiatric inpatients were maintained in physical restraint. The numerator evaluates the number of hours of events; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure. This measure includes all psychiatric inpatient days.

- **Denominator:** Number of psychiatric inpatient days; Denominator Basis: per 1,000 hours

Included Populations:

All psychiatric inpatient days

Excluded Populations:

Total leave days

Measure Goal for CY 2023:

In Quarter 4 of CY 2023 have performance better than KY average OR achieve a 5% improvement in the hospital's Gap to KY Average – 2.0%

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Hours of Seclusion

Title: **Hours of Seclusion – *Freestanding Psychiatric Hospitals Only***

Data Source: Facility

Payor: All Payer

Measure description: Align with Joint Commission HBIPS-3

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.

Mental health providers that value and respect an individual's autonomy, independence, and safety seek to avoid the use of dangerous or restrictive interventions. The use of seclusion and restraint are limited to situations deemed objectively to meet the threshold of imminent danger and when used are rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base.

Measure of success:

- **Numerator:** The total number of hours that all psychiatric inpatients were maintained in seclusion. The numerator evaluates the number of hours of events; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure. This measure includes all psychiatric inpatient days.
- **Denominator:** Number of psychiatric inpatient days; Denominator Basis: per 1,000 hours

Included Populations:

All psychiatric inpatient days

Excluded Populations:

Total leave days

Measure Goal for CY 2023:

In Quarter 4 of CY 2023 have performance better than KY average OR achieve a 5% improvement in the hospital's Gap to KY Average – 2.0%

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Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths

Title: **Screen for Violence Risk, Substance Use, Psychological Trauma and Patient Strengths –** ***Freestanding Psychiatric Hospitals Only***

Data Source: Facility

Payer: All Payer

Measure description: Align with Joint Commission HBIPS-1

Description:

Patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of admission for all of the following: risk of violence to self or others, substance use, psychological trauma history, and patient strengths.

Substantial evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment. Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment. In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.

The ACES scale would be a suggested tool for trauma history.

Measure of success:

- **Numerator:** Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths.
- **Denominator:** Psychiatric inpatient discharges

Included Populations:

Patients with ICD-10-CM Principal or other diagnosis codes for mental disorders as defined in Appendix A, Table 10.01. **Appendix A** can be found at: **https://www.kyha.com/assets/docs/DataDocs/CQIHBIPSandIPFQRCoreMeasureUsersManualJan2020.pdf**

- Admissions Screening continued -

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Excluded Populations:

- Patients for whom there is an inability to complete admission screening for violence risk, substance use, psychological trauma history, and patient strengths within the first three days of admission
- Patients with a length of stay ≤ 3 days or ≥ 365 days.

Measure Goal for CY 2023:

In Quarter 4 of CY 2023 have performance better than KY average OR achieve a 5% improvement in the hospital's Gap to KY Average – 2.0%

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Discharge to Community

Title: **Discharge to Home/Community – *Freestanding Rehabilitation Hospitals Only***

Data Source: Facility

Payor: All Payer

Measure description:

- **Numerator:** Patients discharged with a Discharge Status of
  - 01 – Home (private home/apartment, board/care, assisted living, transitional living)
  - 06 – Home under care of organized home health service organization
  - 50 – Hospital (home)
- **Denominator:** total discharges

Measure Goal for CY 2023:

In Quarter 4 of CY 2023 have performance better than KY average OR achieve a 5% improvement in the hospital's Gap to KY Average – 2.0%

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Discharge with an Opioid Prescription

TITLE: **Discharge with an Opioid Prescription – *Freestanding Rehabilitation Hospitals Only***

Data Source: Facility

Payor: All Payer

Measure description:

- **Numerator:** Total patients discharged with an opioid prescription
- **Denominator:** Total patients discharged

Measure Goal for CY 2023:

Hospitals to report monthly data on percentage of patients discharged with an opioid prescription – 1.0%

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Opioids for Uncomplicated Vaginal Deliveries

Title: **Opioids for Uncomplicated Vaginal Deliveries – *All Birthing Hospitals***

Data source: Facility

Payor: All Payer

Measure description:

Align with KY SOS Metric 4b – Opioid Use for Select Procedures (zero days)

Description:

Patients, 18 years or older, prescribed no schedule II opioid after select surgical procedures.

- **Numerator:** Patients, 18 years or older, undergoing the selected procedure who are not prescribed via electronic means (e.g., e-prescribed or electronically generated and printed) a schedule II opioid.
- **Denominator:** Patients, 18 years or older, undergoing the selected procedure.
- **Denominator Exclusions:** None

Frequency of reporting: Monthly

Procedure applicable codes:

Uncomplicated vaginal delivery ICD-10 O80

Measure Goal for CY 2023:

Hospital to improve during Quarter 4 of CY 2023 5% from baseline OR achieve KY baseline average or better – 1.0%

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Emergency Department Opioid Use for Acute Ankle Sprains (ALTO)

Title: **Emergency Department Opioid Use for Acute Ankle Sprains (ALTO) –** ***Excludes Birthing, LTACH, Rehab, and Psych Hospitals***

Data source: Facility

Payor: All Payer

Measure description:

Align with KY SOS Metric 3a – Emergency Department Opioids Use for Acute Ankle Sprain

Description:

Patients, age 18 years or older, prescribed no opioids during an emergency department encounter for a specific pain-related condition.

- **Numerator:** Patients, age 18 years or older, who receive no opioids prior to discharge from the emergency department after initial encounter for dislocation or sprain of the ankle (ICD-10 Code S93.0xx, S93.4xx).
- **Denominator:** Patients, age 18 years or older, discharged from the emergency department after initial encounter for dislocation or sprain of the ankle (ICD-10 Code S93.0xx, S93.4xx).
- **Denominator Exclusions:** The following encounters should be excluded from the denominator: Encounters for patients with a 7th character modifier of D or S (e.g. S93.401D).

Frequency of reporting: Monthly

Measure Goal for CY 2023:

Hospital to improve during Quarter 4 of CY 2023 5% from hospital baseline OR achieve KY baseline average or better – 0.5%

Hospital to improve during Quarter 4 of CY 2023 10% from hospital baseline OR achieve KY baseline average or better – 0.5%

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Suicide Screening

Title: **Suicide Screening in the Emergency Department –** ***Excludes LTACH, Rehab, and Psych Hospitals***

Data source: Facility

Payor: All Payer

Measure Goal for CY 2023:

Develop a process for hospitals to conduct standardized screening for suicide in the ED and a process for hospitals to report data – 1.0%

Total for Birthing Hospitals – 0.5%

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Maternal Depression and Substance Use Disorder (SUD) Screening

Title: **Maternal Depression and Substance Use Disorder (SUD) Screening – *All Birthing Hospitals***

Data source: Facility

Payor: All Payer

Measure Goal for CY 2023:

Develop a process for hospitals to conduct standardized depression and substance use disorder (SUD) screening 1 - 2 weeks postpartum with an attempt of 3 times and develop a process to collect and report data; educate hospitals on system change needed to implement screening – 0.5%

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