EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Data Methodology Guide

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EQIC data collection methodology

All hospital departments and units can participate in EQIC quality improvement activities. However, this particular CMS contract is focused on data from acute care patients on medical-surgical units who are 18 years and older. Please *do not* submit data from PPS-exempt units, such as mental health, substance abuse, subacute, long-term care, swing beds or hospice care.

The primary automated sources of EQIC data are:

1) National Healthcare Safety Network;

2) National Database of Nursing Quality Indicators®;

3) a hospital's inpatient claims; and

4) lab and pharmacy data directly from the hospital.

Not all hospitals will have all of these data sources set up to automatically feed information into the EQIC data portal. If your hospital is not able to automate NHSN or NDNQI data, you will need to submit those manually into the EQIC data portal. Only measures with a data source that lists "EQIC data portal" under "data source" in the measure table can be manually entered into the portal. The remaining measures must come from direct electronic feeds for data validity purposes.

EQIC developed a lab and pharmacy specifications document to facilitate submission of opioid, anticoagulation and glycemic adverse drug events data. The workbook includes various drug code lists and additional details to clarify what is needed for each report.

Measure criteria

Where possible, EQIC utilizes measures from externally validated and nationally recognized sources such as NQF, NDNQI, the CDC and AHRQ. However, where measures from externally validated sources are not available, EQIC has created the category "EQIC measures." This distinction is identified under "specification/definitions" in each measure table.

The inclusion and exclusion criteria listed below **only apply to EQIC measures**, as noted in the specifications/definitions field of each measure. Measures that are created and validated by another source (such as NQF, NDNQI, the CDC and AHRQ) utilize their own inclusion and exclusion criteria, and EQIC has hyperlinked to those criteria directly in the measure sources.

EQIC measure inclusion criteria:

- Inpatient
    - Medical-surgical units
    - Critical care units (ICU, CCU, NCCU)
    - Step-down/intermediate units
- Harm events not present on admission

EQIC measure exclusion criteria:

- Outpatient
- Observation (NDNQI does not exclude observation patients on the included units)
- Emergency department (not admitted)
- PPS-exempt units (psych, rehab, SNF/swing)
- Pediatric/neonatal units (exception of CLABSI neonatal)
- Obstetric patients

Data portal specialty charts

The following charts are available on EQIC's secure data portal under the "Performance Analytics" tab.

- EQIC rate: This run chart demonstrates your hospital's performance compared to the averaged EQIC collaborative performance.
- Hospital-specific analysis:
    - Statistical process control charts utilize the mean for the central tendency analysis. The SPC upper and lower limits are set at one, two and three standard deviations away from the mean of the baseline. It is a useful quality improvement tool to be able to assess how often, when and how far the hospital data varies from the mean.
    - Distribution charts: Each hospital is grouped into one of ten bins. Each hospital will be reflected by the "yellow" bin and star. Hospitals can assess their performance relative to EQIC peers for each measure.
    - Distribution detail charts show each participating EQIC hospital along the X axis. The hospitals are then sorted by rate, providing the user hospitals with immediate specific information on where they compare or rank within the EQIC program.
- Comparison options:
    - CMS initiative goals: Each measure has a goal calculated for each hospital utilizing its hospital-specific baseline data and the CMS initiative goals. For example, one of the CMS goals is to reduce adverse drug events by 13%. The EQIC data portal has automatically calculated what your hospital-specific goal is to reduce your rate by 13% relative to your baseline. If there is no CMS goal for a particular measure, the goal line will be set at "0."
    - CMS benchmarks: CMS has provided benchmarks for a small number of measures. The benchmarks come from the CMS Quality Division and CMS evaluation contractor review of the industry practices. Benchmarks are not risk adjusted for each specific hospital.
    - Similar EQIC hospitals: EQIC provides comparison data for your hospital and similarly situated hospitals. For example, you can review your data performance compared to hospitals in your own state or hospital system (blinded). EQIC also provides comparisons among critical access hospitals, rural hospitals or large hospital systems.

Adverse drug events

Measure name	ADE rate per 1,000 discharges
Numerator	Number of discharges with ADEs
Denominator	Number of discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The code set for adverse drug events are located in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.
CMS goal	13%

Measure name	Anticoagulant-related ADE rate per 1,000 discharges
Numerator	Number of discharges with anticoagulant-related ADEs
Denominator	Number of discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The code set for adverse drug events are located in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.
CMS goal	13%

Measure name	Hypoglycemic-related ADE rate per 1,000 discharges
Numerator	Number of discharges with hypoglycemic ADEs
Denominator	Number of discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The code set for adverse drug events are located in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.
CMS goal	13%

Measure name	Hyperglycemic-related ADE rate per 1,000 discharges
Numerator	Number of discharges with hyperglycemic ADEs
Denominator	Number of discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The code set for adverse drug events are located in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.
CMS goal	13%

Measure name	Percentage of hyperglycemic POCT blood glucose episodes with results > 250 mg/dl
Numerator	Number of POCT blood glucose episodes with results > 250 mg/dl
Denominator	Number of POCT blood glucose episodes
Measure type	Process
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The day of admission is excluded. An episode includes any POCT blood glucose results within three hours of index result. *EQIC Laboratory and Pharmacy Specifications*

Measure name	Percentage of hyperglycemic POCT blood glucose episodes with results > 180 mg/dl
Numerator	Number of POCT blood glucose episodes with results > 180 mg/dl
Denominator	Number of POCT blood glucose episodes
Measure type	Process
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The day of admission is excluded. An episode includes any POCT blood glucose results within three hours of index result. *EQIC Laboratory and Pharmacy Specifications*

Measure name	Percentage of hypoglycemic POCT blood glucose episodes with results < 70 mg/dl
Numerator	Number of POCT blood glucose episodes with results < 70 mg/dl
Denominator	Number of POCT blood glucose episodes
Measure type	Process
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The day of admission is excluded. An episode includes any POCT blood glucose results within one hour of index result. *EQIC Laboratory and Pharmacy Specifications*

Measure name	Percentage of hypoglycemic POCT blood glucose episodes with results ≤ 40 mg/dl
Numerator	Number of POCT blood glucose episodes with results ≤ 40 mg/dl
Denominator	Number of POCT blood glucose episodes
Measure type	Process
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The day of admission is excluded. An episode includes any POCT blood glucose results within one hour of index result. *EQIC Laboratory and Pharmacy Specifications*

Measure name	Percentage of POCT blood glucose tests within normal range (70-180) during hospitalization
Numerator	Number of POCT blood glucose tests within normal range (70-180) during the hospitalization
Denominator	Number of POCT blood glucose tests
Measure type	Outcome
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. Calculated the month of the patient's discharge. The number of blood glucose tests within the normal range (70-180) / the number of POCT blood glucose tests. *EQIC Laboratory and Pharmacy Specifications*

Measure name	Percentage of supratherapeutic INR results above normal range
Numerator	Number of INR episodes with results > 5
Denominator	Number of INR episodes
Measure type	Process
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The day of admission is excluded. An episode includes any INR completed within a day. *EQIC Laboratory and Pharmacy Specifications*

Measure name	Percentage of subtherapeutic INR results below normal range
Numerator	Number of INR episodes with results < 2
Denominator	Number of INR episodes
Measure type	Process
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The day of admission is excluded. An episode includes any INR completed within a day. *EQIC Laboratory and Pharmacy Specifications*

Measure name	Opioid-related ADE rate per 1,000 discharges
Numerator	Number of opioid-related ADEs, including deaths
Denominator	Number of discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. The code set for adverse drug events are located in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.
CMS goal	7%

Measure name	Opioid-related mortality rate per 1,000 discharges
Numerator	Number of opioid-related deaths
Denominator	Number of discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure: The code set for adverse drug events is located in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*
CMS goal	7%

Measure name	Percentage of patients with daily opioid dosage of ≥ 90 MME during hospitalization
Numerator	Number of patients with daily opioid dosage of ≥ 90 MME during hospitalization
Denominator	Number of patients with an opioid prescription during hospitalization
Measure type	Process
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. Opioid codes are sourced via RxNorm and are located in the *EQIC Laboratory and Pharmacy Specifications.* They are reviewed annually for changes. MME dosage equivalent per 24 hours = (strength per unit) x (total doses) / (days' supply) x (MME conversion factor)
CMS goal	12%

Measure name	Opioid reversal agent doses administered during hospitalization per 1,000 patients on opioids
Numerator	Number of doses of naloxone administered on inpatient care units
Denominator	Number of patients with an opioid prescription during hospitalization
Measure type	Process
Data source	Pharmacy/Lab exchange
Resource	EQIC measure
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. Opioid codes are sourced via RxNorm and are located in the *EQIC Laboratory and Pharmacy Specifications.* They are reviewed annually for changes.

Measure name	Percentage of patients prescribed co-occurring opioid and benzodiazepine during hospitalization
Numerator	Number of patients prescribed co-occurring opioid and benzodiazepine during hospitalization
Denominator	Number of patients with an opioid prescription during hospitalization
Measure type	Process
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. Opioid and benzodiazepine codes are sourced via RxNorm and are located in the *EQIC Laboratory and Pharmacy Specifications*. They are reviewed annually for changes.
CMS goal	12%

Measure name	Percentage of patients prescribed two or more opioids during hospitalization
Numerator	Number of patients prescribed two or more opioids during hospitalization
Denominator	Number of patients with an opioid prescription during hospitalization
Measure type	Process
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. Opioid codes are sourced via RxNorm and are located in the *EQIC Laboratory and Pharmacy Specifications*. They are reviewed annually for changes.
CMS goal	12%

Clostridioides difficile

Measure name	***C. difficile* rate per 10,000 patient days**
Numerator	Number of hospital-onset *C. difficile* LabID events
Denominator	Number of patient days (inpatient facility-wide)
Measure type	Outcome
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC guidelines

Measure name	***C. difficile* SIR**
Numerator	Number of hospital-onset *C. difficile* LabID events
Denominator	Number of expected hospital-onset *C. difficile* LabID events
Measure type	Outcome
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC guidelines
CMS goal	9%
CMS benchmark	0.7930

Measure name	**Percentage of patients with a prescription of a high-risk antibiotic during hospitalization**
Numerator	Number of patients with a prescription of a high-risk antibiotic during hospitalization
Denominator	Number of patients with a prescription during hospitalization
Measure type	Outcome
Data source	Pharmacy/Lab exchange
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	EQIC measure. The code set for high-risk drugs is located in the *EQIC Laboratory and Pharmacy Specifications*

Methicillin-resistant *Staphylococcus aureus*

Measure name	MRSA rate per 10,000 patient days
Numerator	Number of hospital-onset MRSA LabID events
Denominator	Number of patient days (inpatient facility-wide)
Measure type	Outcome
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC guidelines

Measure name	MRSA SIR
Numerator	Number of hospital-onset MRSA LabID events
Denominator	Number of expected hospital-onset MRSA LabID events
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC guidelines
CMS goal	9%
CMS benchmark	0.7880

Catheter-associated urinary tract infections

Measure name	CAUTI rate per 1,000 catheter days
Numerator	Number of observed CAUTI infections
Denominator	Number of catheter days
Measure type	Outcome
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CAUTI guidelines
CMS goal	9%

Measure name	CAUTI rate per 1,000 catheter days for ICU patients
Numerator	Number of observed CAUTI infections for ICU patients
Denominator	Number of catheter days for ICU patients
Measure type	Process
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CAUTI guidelines
CMS benchmark	0.3400

Measure name	CAUTI rate per 1,000 catheter days for non-ICU patients
Numerator	Number of observed CAUTI infections for non-ICU patients
Denominator	Number of catheter days for non-ICU patients
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CAUTI guidelines

Measure name	CAUTI rate per 10,000 patient days (population rate)
Numerator	Number of observed CAUTI infections
Denominator	Number of patient days
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	EQIC measure. Number of observed CAUTI infections/ Number of patient days
CMS goal	9%

Measure name	CAUTI SIR
Numerator	Number of observed CAUTI infections
Denominator	Number of expected CAUTI infections
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CAUTI guidelines
CMS goal	9%

Measure name	CAUTI SIR for ICU patients
Numerator	Number of observed CAUTI infections for ICU patients
Denominator	Number of expected CAUTI infections for ICU patients
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CAUTI guidelines
CMS benchmark	0.7900

Measure name	CAUTI SIR for non-ICU patients
Numerator	Number of observed CAUTI infections for non-ICU patients
Denominator	Number of expected CAUTI infections for non-ICU patients
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CAUTI guidelines

Measure name	CAUTI utilization ratio
Numerator	Number of catheter days
Denominator	Number of patient days
Measure type	Process
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CAUTI guidelines
CMS goal	9%

Measure name	CAUTI utilization ratio for ICU patients
Numerator	Number of catheter days for ICU patients
Denominator	Number of patient days for ICU patients
Measure type	Process
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CAUTI guidelines
CMS goal	9%

Measure name	CAUTI utilization ratio for non-ICU patients
Numerator	Number of catheter days for non-ICU patients
Denominator	Number of patient days for non-ICU patients
Measure type	Process
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CAUTI guidelines
CMS goal	9%

Central line-associated bloodstream infection

Measure name	CLABSI rate per 1,000 central line days
Numerator	Number of observed CLABSI infections
Denominator	Number of central line days
Measure type	Outcome
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CLABSI guidelines
CMS goal	9%
CMS benchmark	0.2100

Measure name	CLABSI rate per 1,000 central line days for ICU patients
Numerator	Number of observed CLABSI infections for ICU patients
Denominator	Number of central line days for ICU patients
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CLABSI guidelines
CMS benchmark	0.5700

Measure name	CLABSI rate per 1,000 central line days for non-ICU patients
Numerator	Number of observed CLABSI infections for non-ICU patients
Denominator	Number of central line days for non-ICU patients
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CLABSI guidelines

Measure name	CLABSI rate per 10,000 patient days (population rate)
Numerator	Number of observed CLABSI infections
Denominator	Number of patient days
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	EQIC measure. Number of observed CLABSI infections/Number of patient days
CMS goal	9%

Measure name	CLABSI SIR
Numerator	Number of observed CLABSI infections
Denominator	Number of expected CLABSI infections
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CLABSI guidelines
CMS goal	9%

Measure name	CLABSI SIR for ICU patients
Numerator	Number of observed CLABSI infections for ICU patients
Denominator	Number of expected CLABSI infections for ICU patients
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CLABSI guidelines
CMS benchmark	0.7900

Measure name	CLABSI SIR for non-ICU patients
Numerator	Number of observed CLABSI infections for non-ICU patients
Denominator	Number of expected CLABSI infections for non-ICU patients
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CLABSI guidelines

Measure name	CLABSI utilization ratio
Numerator	Number of central line days
Denominator	Number of patient days
Measure type	Process
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CLABSI guidelines
CMS goal	9%

Measure name	CLABSI utilization ratio for ICU patients
Numerator	Number of central line days for ICU patients
Denominator	Number of patient days for ICU patients
Measure type	Process
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CLABSI guidelines
CMS goal	9%

Measure name	CLABSI utilization ratio for non-ICU patients
Numerator	Number of central line days for non-ICU patients
Denominator	Number of patient days for non-ICU patients
Measure type	Process
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC CLABSI guidelines
CMS goal	9%

Falls

Measure name	Falls rate per 1,000 patient days
Numerator	Number of falls
Denominator	Number of patient days
Measure type	Outcome
Data source	NDNQI/EQIC data portal
Data submission frequency	Monthly [Data received quarterly from NDNQI]
Data submission deadline	Within 45 days of the close of the month for portal data
Specifications/definitions	NQF #0141
CMS goal	9%
CMS benchmark	2.1500

Measure name	Falls with any injury rate per 1,000 patient days
Numerator	Number of falls with any injury
Denominator	Number of patient days
Measure type	Outcome
Data source	NDNQI/EQIC data portal
Data submission frequency	Monthly [Data received quarterly from NDNQI]
Data submission deadline	Within 45 days of the close of the month for portal data
Specifications/definitions	NQF #0202
CMS goal	9%
CMS benchmark	0.5200

Measure name	Percentage of falls with any injury in which the patient had a fall risk assessment performed and documented within 24 hours of the fall
Numerator	Number of falls with any injury in which the patient had a fall risk assessment performed and documented within 24 hours of the fall
Denominator	Number of falls with any injury
Measure type	Process
Data source	EQIC data portal
Data submission frequency	Monthly [Data received quarterly from NDNQI]
Data submission deadline	Within 45 days of the close of the month for portal data
Specifications/definitions	NDNQI, Hospital determines the validated risk assessment tool.

Measure name	Percentage of falls with moderate or greater injury in which the patient had a fall risk assessment performed and documented within 24 hours of the fall
Numerator	Number of falls with moderate or greater injury in which the patient had a fall risk assessment performed and documented within 24 hours of the fall
Denominator	Number of falls with moderate or greater injury severity
Measure type	Process
Data source	NDNQI
Data submission frequency	Monthly [Data received quarterly from NDNQI]
Data submission deadline	Within 45 days of the close of the month for portal data
Specifications/definitions	NDNQI. Hospital determines the validated risk assessment tool.

Measure name	Falls HAC rate per 1,000 patient discharges
Numerator	Number of falls
Denominator	Number of discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. Falls HAC rate codes are available in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.
CMS goal	9%

Pressure injuries

A prevalence study, or a cross-sectional count of the number of cases in a population, measures the total number of persons with a pressure injury in a hospital/hospital unit on the day of the pressure injury survey. Choose one day every month or every quarter to sample your population. For further information, please reference EQIC's pressure injury prevalence study instructions.

Measure name	**Percentage of patients with documentation of a pressure injury risk assessment within 24 hours of admission**
Numerator	Number of patients identified in the prevalence study with a facility-acquired stage II or greater pressure injury who had a risk assessment within 24 hours of admission
Denominator	Number of patients identified in the prevalence study with a facility-acquired stage II or greater pressure injury
Measure type	Process
Data source	NDNQI/EQIC data portal
Data submission frequency	Quarterly (Monthly optional)
Data submission deadline	Within 45 days of the close of the month for portal data
Specifications/definitions	NDNQI. Hospital determines the validated risk assessment tool.

Measure name	**Prevalence rate of facility-acquired pressure injuries of stage II or greater per 100 patients**
Numerator	Number of patients identified in the prevalence study with a facility-acquired stage II or greater pressure injury
Denominator	Number of patients identified in the prevalence study
Measure type	Outcome
Data source	NDNQI/EQIC data portal
Data submission frequency	Quarterly (Monthly optional)
Data submission deadline	Within 45 days of the close of the month for portal data
Specifications/definitions	NQF #0201
CMS goal	9%
CMS benchmark	1.3700

Measure name	AHRQ PSI 3: Stage III or IV pressure injuries per 1,000 discharges
Numerator	Number of discharges with a facility-acquired pressure injury of stage III, IV or unstageable
Denominator	Number of discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	AHRQ PSI specifications
CMS goal	9%
CMS benchmark	0.4500

Readmissions

Measure name	30-day all-cause readmission rate back to the same facility
Numerator	Number of readmissions within 30 days of discharge
Denominator	Number of eligible discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	This measure closely follows the specifications of NQF #1789 minus the risk adjustment. However, the measure is tailored to analyze *all* patients over the age of 18, not just Medicare patients.
CMS goal	5%
CMS benchmark	15.2600

Measure name	Average inpatient medical-surgical length of stay, including ICU
Numerator	Number of total medical-surgical patient days, including ICU
Denominator	Number of total medical-surgical discharges, including ICU
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. Number of total medical-surgical patient days, including ICU/ Number of total medical-surgical discharges, including ICU.

Measure name	Disease-specific readmission rate
Numerator	Number of readmissions for "a patient population with a specific disease state" within 30 days of discharge
Denominator	Number of eligible "patients in population with a specific disease state" discharges
Measure type	Process
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	N/A
Specifications/definitions	EQIC measure. Number of readmissions for a patient population with [a specific disease state]* within 30 days of discharge / Number of eligible patients in population with [a specific disease state]* discharges. Based on the CMS methodology but modified for diabetes and sepsis disease states. *Note: This measure is calculated for patient populations with each of the following disease states: sepsis and diabetes.

Sepsis

Measure name	AHRQ PSI 13: Post-operative sepsis rate per 1,000 elective surgical discharges
Numerator	Number of hospital-acquired sepsis cases in the defined surgical population
Denominator	Number of elective surgical discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	AHRQ PSI specifications
CMS goal	9%
CMS benchmark	3.1920

Measure name	Mortality rate per 100 sepsis discharges
Numerator	Number of deaths among patients with a primary or secondary diagnosis of sepsis or septic shock
Denominator	Number of discharges with a primary or secondary diagnosis of sepsis or septic shock
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. Number of deaths among patients diagnosed with sepsis or septic shock / Number of discharges with a diagnosis of sepsis or septic shock. Sepsis codes are available in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.
CMS goal	9%

Surgical site infections

Measure name	Colon surgery: SSI rate per 100 procedures
Numerator	Number of observed SSIs for colon surgery procedures
Denominator	Number of colon surgery procedures
Measure type	Outcome
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC SSI guidelines
CMS goal	9%

Measure name	Colon surgery: SSI SIR
Numerator	Number of observed SSIs for colon surgery procedures
Denominator	Number of expected SSIs for colon surgery procedures
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC SSI guidelines
CMS goal	9%
CMS benchmark	0.8020

Measure name	Hip prosthesis: SSI rate per 100 procedures
Numerator	Number of observed SSIs for hip prosthesis procedures
Denominator	Number of hip prosthesis procedures
Measure type	Outcome
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC SSI guidelines
CMS goal	9%

Measure name	Hip prosthesis: SSI SIR
Numerator	Number of observed SSIs for hip prosthesis procedures
Denominator	Number of expected SSIs for hip prosthesis procedures
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC SSI guidelines
CMS goal	9%
CMS benchmark	0.8200

Measure name	Abdominal hysterectomy: SSI rate per 100 procedures
Numerator	Number of observed SSIs for abdominal hysterectomy procedures
Denominator	Number of abdominal hysterectomy procedures
Measure type	Outcome
Data source	NHSN/EQIC data portal
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC SSI guidelines
CMS goal	9%

Measure name	Abdominal hysterectomy: SSI SIR
Numerator	Number of observed SSIs for abdominal hysterectomy procedures
Denominator	Number of expected SSIs for abdominal hysterectomy procedures
Measure type	Outcome
Data source	NHSN
Data submission frequency	Monthly
Data submission deadline	Within 45 days of the close of the month
Specifications/definitions	CDC SSI guidelines
CMS goal	9%
CMS benchmark	0.8000

Measure name	MRSA rate per 100 discharges: Colon Surgery, hip prosthesis and abdominal hysterectomy
Numerator	Number of colon surgery, hip prosthesis and abdominal hysterectomy discharges with MRSA
Denominator	Number of colon surgery, hip prosthesis and abdominal hysterectomy discharges
Measure type	Process
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	CDC guidelines sorted by colon surgery, hip prosthesis and abdominal hysterectomy

Venous thromboembolism

Measure name	AHRQ PSI 12: Perioperative pulmonary embolism or deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges
Numerator	Number of surgical patients with hospital-acquired deep vein thrombosis or pulmonary embolism
Denominator	Number of surgical discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	AHRQ PSI specifications
CMS goal	9%
CMS benchmark	3.1620

Measure name	VTE rate per 1,000 medical discharges
Numerator	Number of medical discharges with facility-acquired VTE
Denominator	Number of medical discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. VTE med-surg codes are available in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.

Measure name	VTE rate per 1,000 surgical discharges
Numerator	Number of surgical discharges with facility-acquired VTE
Denominator	Number of surgical discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. VTE med-surg codes are available in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.

Measure name	VTE rate per 1,000 discharges
Numerator	Number of discharges with facility-acquired VTE
Denominator	Number of discharges
Measure type	Outcome
Data source	Administrative claims data
Data submission frequency	Monthly
Data submission deadline	Less than three-month claim submission lag
Specifications/definitions	EQIC measure. Number of discharges with facility-acquired VTE / Number of discharges. VTE med-surg codes are available in the *EQIC Data Methodology Guide Code Lists for Measurement Specifications*.
CMS goal	9%

Glossary

ADE	Adverse drug event
AHRQ	Agency for Healthcare Research and Quality
CAUTI	Catheter-associated urinary tract infection
CDC	Centers for Disease Control and Prevention
CLABSI	Central line-associated bloodstream infection
CMS	Centers for Medicare and Medicaid Services
HAC	Hospital-acquired condition
HAI	Hospital-acquired infection
INR	International normalized ratio
LabID	Laboratory-identified events
MME	Morphine milligram equivalents
MRSA	Methicillin-resistant Staphylococcus aureus
NDNQI	National Database of Nursing Quality Indicators
NHSN	The CDC's National Healthcare Safety Network
NQF	National Quality Forum
POCT	Point of care testing
PSI	Patient safety indicator
SIR	Standardized infection ratio, which is a summary statistic used in NHSN to track HAIs
SNF	Skilled nursing facility
SSI	Surgical site infection
VTE	Venous thromboembolism

Appendix: Medicare Fee-for-Service Measures

EQIC is analyzing and displaying a select group of Medicare FFS measures from Medicare SAS Viya data. Due to small-cell data Medicare rules, which prevent displaying incidents less than 10, the measures must be presented differently from the all-payer measures in the Performance Analytics tab. As a result, certain data points might be suppressed from the data. These measures are displayed on a rolling quarterly basis, each encompassing a year's worth of data. For example, a data point with a date range of April 2022 to March 2023 would include the entire count of events during that range. The next data point would then move forward one quarter and include all the data from July 2022 to June 2023.

The following is a list of the Medicare FFS measures on the portal:

- Average inpatient medical-surgical length of stay, including ICU
- 30-day all-cause readmission rate
- Health equity readmission rate (White)
- Disease-specific readmission rate: Dual eligible
- Disease-specific readmission rate: Sepsis
- Percentage of discharges with prescription of a high-risk antibiotic
- Percentage of patients with daily opioid dosage of > or = 90 MME at discharge
- Percentage of patients prescribed two or more opioids at discharge

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