EQIC

Data Management Strategy
March 16, 2021

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Agenda

- CMS directives
- EQIC response
- Quick review of the data source logistics
- Measurement grid, discussion and timeline
- Website data entry and tour
- Culture of Safety Survey
- Q&A

CMS directives

CMS Goal I	Medication management
• Decrease opioid adverse drug events by 7%, including deaths in Medicare population • Decrease opioid prescribing by 12% • Decrease adverse drug events by 13%	• Opioids (prescribing and stewardship) • Co-occurring opioids/benzodiazepines • Insulin • Anticoagulants • Never and high-risk medications in the elderly • Other

CMS directives

Unit-Based Safety (UBS)

CMS Goal II	Patient safety across the board

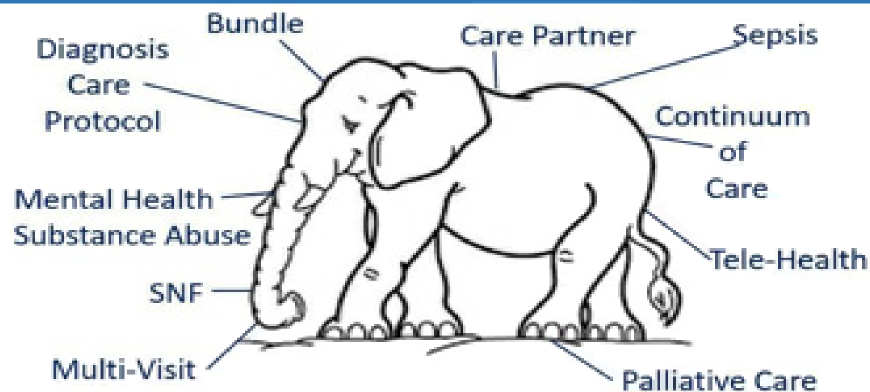
• Decrease all-cause harm by 9% or more
• Decrease the ADE and Readmissions in their goals
• Decrease *Clostridioides difficile*
	• Decrease harm in
	  • Hospital-acquired conditions (falls, PI, VTE, ADE)
	  • Hospital-associated infections (CAUTI, CLABSI, SSI, Sepsis, CDI and MRSA; antibiotic stewardship if needed
	• Decrease all-cause harm
	  • Measures (Aggregate of measures and composite measure)
	  • Programs (EQIC-wide, regional or hospital-specific)

CMS directives

Many Pieces of the Large Readmissions Elephant

Portfolio of interventions hospitals may be working on:

- Diagnosis Care Protocols
- Care Transition Bundles
- Skilled Nursing Facilities
- Tele-Health Services
- Palliative Care Services
- Mental Health
- Substance Abuse
- Multiple Visit Patients (Frequent Flyers)
- Care Partner (Patient and Family) Engagement
- Sepsis Specific Interventions



CMS Goal IV

- Decrease readmissions by 5%

Readmission prevention

- Advanced discharge planning bundle
- Care partner model (Planetree and IPFCC)
- SNF and home
- High utilizers
- Diagnosis-specific analytics and action
- Health equity analytics and action

CMS directives

- Health equity
  - REaL data collection integrity
  - Readmission
- Patient and family engagement
  - PFAC
  - Care partner model
- Culture
- COVID-19 (emergency preparedness)
- Monthly data submission to CMS
- CMS expects a full data complement for each hospital
- Information is blinded (de-identified)

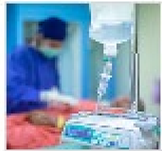
EQIC programming

Focus Areas

ADE and Opioids

ASP, *C. diff*, MRSA

CAUTI


CLABSI

Culture

Falls

Health Equity

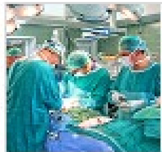
PFE

Pressure Injury

Public Health Emergencies

Readmissions

Sepsis


SSI

UBS

VTE

Next steps

- Inpatient opioid management with emphasis on prescribing practices performance improvement series
  - Medication management team and lead(s)
- Readmission prevention series (input/vote on which to start first)
  - Readmission team and lead(s)
- Monthly UBS/safety across the board education webinar

  2nd Wednesday of the month at 2 p.m.
  - New evidence, innovation or data-driven
  - Based on hospital need and priority
  - Consider a hospital champion from the staff at minimum for each area?

Data management

NYSPFP measurement strategy

- Most meaningful, standardized, NQF-endorsed outcome measures possible
- Directional and actionable
- Comparable
- Minimal to no burden on hospitals for data submission
- Robust hospital-facing reports
- Special reports
- New/innovative
- Opioid and medications measures
- Relationship with CMS STAR and other measures
- Ask!!!

Source data

- NHSN
- NDNQI
- Hospital claims
- Lab and pharmacy exchange

If your hospital does not participate in NDNQI or NHSN, EQIC has a website portal to enter the data

There maybe occasional surveys and evaluations to complete

Tentative timeline

EQIC data steps	Qtr. I – 2021	Qtr. II – 2021	Qtr. III – 2021	Qtr. IV– 2021
Set up source data and complete exchanges	X	X		
Begin displaying measurement run charts and tables		X		
Begin adding SPC and distribution chart analytics with the run charts			X	
Begin to make various comparable data available				X
Begin to provide special reports				X

Hospital (state) data steps	Qtr. I – 2021	Qtr. II – 2021	Qtr. III – 2021	Qtr. IV– 2021
Ensure data exchanges are set up for pharmacy/lab and claims	X →	→		
Confer rights (NHSN); sign waiver (NDNQI)	X			
Submit portal measures as needed ▪ September 2020 to present		By April 30 X		

Portal data

Who needs to use this method?

- Non NDNQI hospitals
- NHSN: CAHs who do not use or only use partially

Measures

- See falls and pressure injuries on EQIC measurement gird
- See infection measures (except sepsis) on EQIC measurement grid

There may be state-specific differences based on data collection and management. In those states; ask your project manager.

Improvement Area	Measure Name	Numerator	Denominator	Measure Type	Source/ Collection Strategy	Resource	Data Submission Time Period	Data Submission Deadline
ADE	ADE	Number of patients with ADEs	Total number of patient days	Outcome	Claims	EQIC Measure	Monthly	Submit within 45 days of close of month
	High-risk medications in the elderly	High-risk (see list in data dictionary) medications prescribed in patients ≥ 65 y/o	Total patients ≥ 65 y/o discharges	Outcome	Portal/ Pharmacy	NQF 0022	Monthly	Submit within 45 days of close of month
	Percentage of hyperglycemic POCT blood glucose results > 180 mg/dL	Number of episodes with POCT blood glucose results with values > 180 mg/dL	Number of episodes where POCT blood glucose tests resulted	Process	Portal/Lab	ADA Measure	Monthly	Submit within 45 days of close of month
	Percentage of hyperglycemic POCT blood glucose results > 250 mg/dL	Number of episodes with POCT blood glucose results with values > 250 mg/dL	Number of episodes where POCT blood glucose tests resulted	Process	Portal/Lab	ADA Measure	Monthly	Submit within 45 days of close of month
	Percentage of hypoglycemic POCT blood glucose results < 56 mg/dL	Number of episodes with POCT blood glucose results < 56 mg/dL	Number of episodes where POCT blood glucose tests resulted	Process	Portal/Lab	ADA Measure	Monthly	Submit within 45 days of close of month
	Percentage of hypoglycemic POCT blood glucose results < 70 mg/dL	Number of episodes with POCT blood glucose results < 70 mg/dL	Number of episodes where POCT blood glucose tests resulted	Process	Portal/Lab	ADA Measure	Monthly	Submit within 45 days of close of month

Improvement Area	Measure Name	Numerator	Denominator	Measure Type	Source/ Collection Strategy	Resource	Data Submission Time Period	Data Submission Deadline
ADE	Percentage of Supratherapeutic INR results below normal	Number of episodes per calendar day with INR results with values ≤ 2	Number of episodes per calendar day where INR tests resulted	Process	Portal/Lab	EQIC Measure	Monthly	Submit within 45 days of close of month
	Percentage of Supratherapeutic INR results above normal	Number of episodes per calendar day with INR results with values ≥ 5	Number of episodes per calendar day where INR tests resulted	Process	Portal/Lab	EQIC Measure	Monthly	Submit within 45 days of close of month
Opioids	Opioid reversal agent use	Number of naloxone doses administered on inpatient care units	Total number of patient discharges	Process	Portal/ Pharmacy	EQIC Measure	Monthly	Submit within 45 days of close of month
	Opioid mortality FFS	Number of Medicare FFS opioid-related deaths (include opioid toxicity in primary or secondary diagnosis)	Total number of Medicare FFS patient days	Outcome	Claims	EQIC Measure	Monthly	Submit within 45 days of close of month
	Opioid mortality All payer	Number of opioid-related deaths (include opioid toxicity in a primary or secondary diagnosis)	Total number of patient days	Outcome	Claims	EQIC Measure	Monthly	Submit within 45 days of close of month
	Inpatient opioid dosing	Number of inpatients with average daily opioid dosage of ≥ 90 MME dosing per day	Total number of opioid prescriptions	Outcome	CMS Data/Portal/ Pharmacy	EQIC Measure	Monthly	Submit within 45 days of close of month

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Improvement Area	Measure Name	Numerator	Denominator	Measure Type	Source/ Collection Strategy	Resource	Data Submission Time Period	Data Submission Deadline
Opioids	Opioid prescriptions	Number of patients concurrently prescribed an opioid and benzodiazepine during hospitalization	Total number of patient discharges	Process	Portal/Pharmacy	EQIC Measure	Monthly	Submit within 45 days of close of month
	Opioid ADE	Number of opioid-related ADEs, including deaths	Total number of patient days	Outcome	Claims	EQIC Measure	Monthly	Submit within 45 days of close of month
CAUTI	CAUTI SIR	Number of observed CAUTI infections	Number of expected CAUTI infections	Outcome	NHSN	CDC Guidelines	Monthly	**Submit within 45 days of close of month**
	Catheter utilization ratio	Number of indwelling urinary catheter days	Number of patient days	Process	NHSN/ Portal	CDC Guidelines	Monthly	Submit within 45 days of close of month
	CAUTI rate per 1,000 catheter days	Number of observed CAUTI infections	Number of indwelling urinary catheter days	Outcome	NHSN/ Portal	CDC Guidelines	Monthly	Submit within 45 days of close of month
	CAUTI rate per 10,000 patient days (population rate)	Number of observed CAUTI infections	Number of patient days	Outcome	NHSN/ Portal	AHRQ	Monthly	Submit within 45 days of close of month
CLABSI	CLABSI SIR	Number of observed CLABSI infections	Number of expected CLABSI infections	Outcome	NHSN	NHSN per CDC Guidelines	Monthly	Submit within 45 days of close of month
	Central line utilization ratio	Number of central line days	Number of patient days	Process	NHSN/ Portal	NHSN per CDC Guidelines	Monthly	Submit within 45 days of close of month

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Improvement Area	Measure Name	Numerator	Denominator	Measure Type	Source/ Collection Strategy	Resource	Data Submission Time Period	Data Submission Deadline
CLABSI	CLABSI rate per 1,000 central line days	Numbers of observed CLABSI infections	Number of central line days	Outcome	NHSN/ Portal	NHSN per CDC Guidelines	Monthly	Submit within 45 days of close of month
	CLABSI rate per 10,000 patient days (population rate)	Numbers of observed CLABSI infections	Number of patient days	Outcome	NHSN/ Portal	American Journal of Infection Control. Fakih M.G. et al. 2011; 40(4):359-364	Monthly	Submit within 45 days of close of month
C. *difficile* Infection	*C. diff* SIR	Number of incident hospital-onset CDI LabID events	Number of predicted hospital-onset CDI LabID events	Outcome	NHSN	CDC Guidelines	Monthly	Submit within 45 days of close of month
	C. diff rate	Number of incident hospital-onset CDI LabID events	Number of patient days for the facility	Outcome	NHSN/ Portal	CDC Guidelines	Monthly	Submit within 45 days of close of month
Culture	Percent of hospitals that have implemented each of the five PFE metrics	Number of hospitals that have implemented each of the metrics	Number of hospitals	Process	Portal	CMS	Measured upon enrollment and updated as changes occur	N/A
	The leadership assessment is a brief quarterly survey that measures each hospital's progress in implementation of four proven best practices, as provided by CMS	Number of hospitals that have implemented each of the elements	Number of hospitals	Process	Portal	CMS	Measured upon enrollment and updated as changes occur	N/A
Falls	Falls with any harm per 1,000 patient days	Number of falls with any harm (minor and greater)	Number of patient days on eligible nursing units	Outcome	NDNQI/Portal	National Quality Forum #0202 (click "Accept" on the "Copyright Notice" dialog box)	Monthly	Submit within 45 days of close of month

Improvement Area	Measure Name	Numerator	Denominator	Measure Type	Source/ Collection Strategy	Resource	Data Submission Time Period	Data Submission Deadline
Falls	Falls per 1,000 patient days	Number of falls	Number of patient days on eligible nursing units	Outcome	NDNQI/Portal	National Quality Forum #0141 (click “Accept” on the “Copyright Notice” dialog box)	Monthly	Submit within 45 days of close of month
	Percent of falls in which the patient had a fall risk assessment performed and documented within 24 hours of the fall	Number of fall events with moderate or greater injury that received a risk assessment within 24 hours of the fall event	Number of falls with injury level of moderate or greater severity	Process	NDNQI/Portal	NDNQI	Monthly	Submit within 45 days of close of month
MRSA	MRSA bloodstream infection hospital-onset incidence rate per 10,000 patient days	Number of incident hospital-onset MRSA LabID events	Number of patient days for the facility	Outcome	NHSN/ Portal	CDC Guidelines	Monthly	Submit within 45 days of close of month
	MRSA bloodstream infection SIR	Number of incident hospital-onset MRSA LabID events	Number of predicted hospital-onset MRSA LabID events	Outcome	NHSN	CDC Guidelines	Monthly	Submit within 45 days of close of month
Pressure Injury	AHRQ Patient Safety Indicator (PSI) 3 - Stage III or IV pressure injuries (secondary diagnosis) per 1,000 discharges among patients ages 18 years and older	Number of discharged adult patients with a facility-acquired pressure injury of stage III or IV (or unstageable)	Number of medical and surgical discharges age 18 years and older	Outcome	Claims	AHRQ specifications using ICD-10 codes	Monthly	Submit within 45 days of close of month
	Prevalence rate of facility-acquired pressure injuries of Stage 2 or higher per 100 patients	Number of patients with a facility-acquired Stage 2 or higher pressure injury at a particular point in time	Number of patients on units being studied at a particular point in time	Outcome	NDNQI/Portal	National Quality Forum #0201 (click “Accept” on the “Copyright Notice” dialog box)	Monthly	Submit within 45 days of close of month

Improvement Area	Measure Name	Numerator	Denominator	Measure Type	Source/ Collection Strategy	Resource	Data Submission Time Period	Data Submission Deadline
Pressure Injury	Percent of patients with documentation of a pressure injury risk assessment within 24 hours of admission	Number of patients identified in the prevalence study with a stage 2 or higher facility-acquired pressure injury who had a risk assessment within 24 hours of admission	Number of patients with a facility-acquired Stage 2 or higher pressure injury identified in the prevalence study (should match numerator of the pressure injury prevalence rate)	Process	NDNQI/Portal	AHRQ NDNQI	Monthly	Submit within 45 days of close of month
Readmissions	All-cause readmission rate	Number of readmissions within 30 days of discharge	Number of eligible discharges	Outcome	Claims	EQIC Measure	Monthly	Submit within 45 days of close of month
	All-cause readmission rate, Medicare FFS	Number of readmissions within 30 days of discharge	Number of eligible Medicare FFS discharges	Outcome	Claims	EQIC Measure	Monthly	Submit within 45 days of close of month
	Diagnosis or issue-driven readmission rate (e.g., health disparities, diagnosis, SNF admission)	Number of readmissions within 30 days of discharge	Number of eligible discharges for specific conditions (i.e., sepsis, health disparities, SNF, COPD, etc.)	Process	Claims	EQIC Measure	Monthly, quarterly, ad hoc	Submit within 45 days of close of month
Sepsis	AHRQ Patient Safety Indictor (PSI) 13: Post-operative sepsis rate per 1,000 elective surgical discharges for patients ages 18 years and older	Number of hospital-acquired sepsis cases in the defined surgical populations	Elective surgical discharges age 18 years and older	Process	Claims	AHRQ specifications using ICD-10 codes	Monthly	Submit within 45 days of close of month
	Sepsis Mortality	Number of deaths among patients diagnosed with sepsis or septic shock	Patients with diagnosis of sepsis or septic shock	Outcome	Claims	EQIC Measure	Monthly	Submit within 45 days of close of month

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Improvement Area	Measure Name	Numerator	Denominator	Measure Type	Source/ Collection Strategy	Resource	Data Submission Time Period	Data Submission Deadline
Surgical Site Infections	SSI SIR: Abdominal Hysterectomy	Number of observed surgical site infections	Number of expected SSIs	Outcome	NHSN	CDC Guidelines	Monthly	Submit within 45 days of close of month
	SSI SIR: Hip Prosthesis	Number of observed SSIs	Number of expected SSIs	Outcome	NHSN	CDC Guidelines	Monthly	Submit within 45 days of close of month
	SSI SIR: Colon Surgery	Number of observed SSIs	Number of expected SSIs	Outcome	NHSN	CDC Guidelines	Monthly	Submit within 45 days of close of month
	SSI rates per 100 operative procedures: Abdominal Hysterectomy	Number of observed SSIs	Number of operative events	Outcome	NHSN/ Portal	CDC Guidelines	Monthly	Submit within 45 days of close of month
	SSI rates per 100 operative procedures: Hip Prosthesis	Number of observed SSIs	Number of operative events	Outcome	NHSN/ Portal	CDC Guidelines	Monthly	Submit within 45 days of close of month
	SSI rates per 100 operative procedures: Colon Surgery	Number of observed SSIs	Number of operative events	Outcome	NHSN/ Portal	CDC Guidelines	Monthly	Submit within 45 days of close of month
	AHRQ Patient Safety Indictor 13: Post-operative sepsis rate per 1,000 elective surgical discharges for patients ages 18 years and older	Number of hospital-acquired sepsis cases in the defined surgical populations	Elective surgical discharges age 18 years and older	Process	Claims	AHRQ specifications using ICD-10 codes	Monthly	Submit within 45 days of close of month

Improvement Area	Measure Name	Numerator	Denominator	Measure Type	Source/ Collection Strategy	Resource	Data Submission Time Period	Data Submission Deadline
Venous Thromboem-bolism	VTE rate per 100 adult inpatient discharges	Number of discharges with facility-acquired VTEs	Number of discharges	Outcome	Claims	Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures	Monthly	Submit within 45 days of close of month
	VTE rate per 100 adult surgical inpatient discharges	Number of surgical discharges with facility-acquired VTEs	Number of surgical discharges	Outcome	Claims	Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures	Monthly	Submit within 45 days of close of month
	VTE rate per 100 adult medical inpatient discharges	Number of medical discharges with facility-acquired VTEs	Number of medical discharges	Outcome	Claims	Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures	Monthly	Submit within 45 days of close of month
	Percentage of Supratherapeutic INR results below normal	Number of episodes per calendar day with INR results with values ≤ 2	Number of episodes per calendar day where INR tests resulted	Process	Portal/Lab	EQIC Measure	Monthly	Submit within 45 days of close of month
	AHRQ PSI 12 – Perioperative pulmonary embolism or deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges for patients ages 18 years and older	Number of surgical patients with hospital-acquired deep vein thrombosis or pulmonary embolism	Number of adult surgical discharges	Outcome	Claims	AHRQ specifications using ICD-10 codes	Monthly	Submit within 45 days of close of month

EQIC website

Let’s tour the Data Section!

AHRQ Culture of Safety Survey

Features

- Offered at no cost to EQIC hospitals
- Twice during the four-year EQIC program
- Onboarding and registration support
  - Promotional materials

- Dashboards
  - Password protected
  - real-time
  - unit-specific participation rates
- Detailed reports
- Automated tools
  - Action planning
  - Debriefing

Survey poll

- Select the best time for you organization to take the COS survey

[ ] May-June 2021

[ ] September-October 2021

Comment:

Q&A

Any questions or clarifications?

Thank you.

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