PROCESS REPORT

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

HOSPITAL ENHANCED ACCESS LEADING TO HEALTH IMPROVEMENTS INITIATIVES (HEALTHII) QUALITY MEASURES, PART II

03/30/2023

HealthTech SOLUTIONS

Revision History

Initiated By / Date	Approved By / Date	Comments
Donia Watson 01/31/2023		Draft document.
Donia Watson 03/01/2023		Revised AHCCCS-02 MDC and Ungroupable Diagnosis Value Sets to APR-DRG. Revised AHCCCS-10 to include Type of Bill, Revenue Code, and Procedure Code in Hospice Value Sets. Removed references to PSI 04.
Donia Watson 03/30/2023		Finalized deliverable.

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Introduction

The HEALTHII program provides quarterly directed payments to participating hospitals from the Health Care Investment Fund (HCIF). This initiative has received Centers for Medicare and Medicaid Services (CMS) approval and requires AHCCCS to recommend and track healthcare quality measures. From December 2021 to May 2022, AHCCCS engaged provider stakeholders to review and select healthcare quality measures that would tie HEALTHII payments to performance. HealthTech has been contracted to support AHCCCS in calculating baseline and performance measure rates for 12 selected measures. Measure definitions have been modified for AHCCCS purposes, as appropriate. Measure rates will be calculated via self-reporting from the hospitals or from AHCCCS Claims data, as applicable.

Hospital self-reported measures include:

- Influenza Vaccination Coverage Among Healthcare Personnel (AHCCCS-01, NQF# 0431 modified)
- HBIPS-2 Hours of Physical Restraint Use (AHCCCS-03, NQF# 0640 modified)
- HBIPS-3 Hours of Seclusion Use (AHCCCS-04, NQF# 0641 modified)
- Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (AHCCCS-05, NQF# 0674 modified)
- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (AHCCCS-06, NQF# 1717 modified)
- Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (AHCCCS-09, NQF# 2631 modified)
- Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (AHCCCS-12, OP-18 modified)
- Successful Implementation of Antibiotic Stewardship Program

The table below identifies which measures are applicable to each HEALTHII Hospital Quality Category for self-reported measures:

HEALTHII Hospital Quality Category	Measure							
	AHCCCS-01/ NQF 0431	AHCCCS-03/ NQF 0640	AHCCCS-04/ NQF 0641	AHCCCS-05/ NQF 0674	AHCCCS-06/ NQF 1717	AHCCCS-09/ NQF 2631	AHCCCS-12/ OP-18	AHCCCS-11/ Antibiotic Stewardship
Critical Access Hospitals	✓						✓	✓
Freestanding Children's Hospitals	✓				✓			
Freestanding Rehabilitation Hospitals	✓			✓				

General Acute	✓				✓			
Long Term Acute Care Hospitals	✓			✓		✓		
Psychiatric Hospitals	✓	✓	✓					
Short Stay Hospitals	✓							

AHCCCS Claims data measures include:

- Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite (AHCCCS-02, NQF# 0531 modified)
- 30-Day Hospital-Wide All-Cause Unplanned Readmission Rate (AHCCCS-07, NQF# 1789 modified)
- Pediatric All-Condition Readmission Measure (AHCCCS-08, NQF# 2393 modified)
- Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities (IRF) (AHCCCS-10, NQF# 3479 modified)

The table below identifies which measures are applicable to each HEALTHII Hospital Quality category for AHCCCS Claims data measures:

HEALTHII Hospital Quality Category	Measure			
	AHCCCS-02/ NQF 0531	AHCCCS-07/ NQF 1789	AHCCCS-08/ NQF 2393	AHCCCS-10/ NQF 3479
Critical Access Hospitals				
Freestanding Children's Hospitals			✓	
Freestanding Rehabilitation Hospitals				✓
General Acute	✓			
Long Term Acute Care Hospitals				
Psychiatric Hospitals				
Short Stay Hospitals		✓		

Measure Details

The sections below describe each measure in detail, including:

- Brief Description
- Rationale
- Numerator Statement
- Numerator Exclusions
- Denominator Statement
- Denominator Exclusions
- Calculation
- Reporting Period
- Population

Appendices A-L contain measure-specific documentation and may be accessed in the left Portfolio panel in Adobe. Measure-specific documentation includes:

- Data Elements and Value Sets
- Measure Source Specifications
- Additional Measure Source Documentation

AHCCCS-01 (NQF 0431 Modified): Influenza Vaccination Coverage Among Healthcare Personnel

Measure Definition

Brief Description: Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

Rationale: Use of this measure to monitor influenza vaccination among HCP is envisioned to result in increased influenza vaccination uptake among HCP, because improvements in tracking and reporting HCP influenza vaccination status will allow healthcare institutions to better identify and target unvaccinated HCP. Increased influenza vaccination coverage among HCP is expected to result in reduced morbidity and mortality related to influenza virus infection among patients.

Numerator Statement: HCP in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year:

(a) received an influenza vaccination administered at the healthcare facility, or reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere; or

(b) were determined to have a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine, or history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination; or

(c) declined influenza vaccination

Numerator Exclusions: None

Denominator Statement: Number of HCP in groups (a)-(c) above who are working in the healthcare facility for at least 1 working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact.

Denominator Exclusions: None

Calculation: *Numerator / Denominator*

Each of the three (3) sub-measure numerators described above will be calculated and reported separately, alongside the overall numerator calculated as the aggregate of the three sub-measure numerators. Denominator is reported in the aggregate.

Reporting Period

Baseline: 10/01/2019 – 03/31/2020

Performance: 10/01/2021 – 03/31/2022

Population

Healthcare Providers

AHCCCS-02 (NQF 0531 Modified): Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite

Measure Definition

Brief Description: The PSI 90 composite measure summarizes patient safety across multiple indicators for the CMS Medicare managed care (MCO) population.

Rationale: None provided in source specification sheet.

Numerator Statement:

PSI 03: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis codes for pressure ulcer stage III or IV (or unstageable).

PSI 06: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis codes for iatrogenic pneumothorax.

PSI 08: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis codes for hip fracture.

PSI 09: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with: any secondary ICD-10-CM diagnosis codes for perioperative hemorrhage or hematoma and any-listed ICD-10-CM procedure codes for treatment of hemorrhage or hematoma (Note: The ICD-10-CM specification is limited to postoperative hemorrhage or hematoma).

PSI 10: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis codes for acute renal failure and any-listed ICD-10-CM procedure codes for dialysis.

PSI 11: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with either: any secondary ICD-10-CM diagnosis code for acute respiratory failure; or any-listed ICD-10-CM procedure codes for a mechanical ventilation for 96 consecutive hours or more that occurs zero or more days after the first major operating room procedure code (based on days from admission to procedure); or any-listed ICD-10-CM procedure codes for a mechanical ventilation for less than 96 consecutive hours (or undetermined) that occurs two or more days after the first major operating room procedure code (based on days from admission to procedure); or any listed ICD-10-CM procedure codes for a reintubation that occurs one or more days after the first major operating room procedure code (based on days from admission to procedure).

PSI 12: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with a secondary ICD-10-CM diagnosis code for proximal deep vein thrombosis or a secondary ICD-10-CM diagnosis code for pulmonary embolism.

PSI 13: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis codes for sepsis.

PSI 14: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any-listed ICD-10-PCS procedure codes for repair of the abdominal wall and any-listed ICD-10-CM diagnosis code for disruption of internal surgical wound

PSI 15: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis codes for accidental puncture or laceration during a

procedure and second abdominopelvic operation >=1 day after an index abdominopelvic operation.

Numerator Exclusions: N/A

Denominator Statement:

PSI 03: Surgical or medical discharges, for patients ages 18 years and older. Surgical and medical discharges are defined by specific MS-DRG codes.

PSI 06: Surgical and medical discharges, for patients ages 18 years and older. Surgical and medical discharges are defined by specific MS-DRG codes.

PSI 08: Discharges, for patients ages 18 years and older, in a medical DRG or in a surgical DRG, with any listed ICD-10-PCS procedure codes for an operating room procedure.

PSI 09: Surgical discharges, for patients ages 18 years and older, with any-listed ICD-10-PCS procedure codes for an operating room procedure. Surgical discharges are defined by specific MS-DRG codes.

PSI 10: Elective surgical discharges, for patients ages 18 years and older, with any-listed ICD-10-PCS procedure codes for an operating room procedure. Elective surgical discharges are defined by specific MS-DRG codes with admission type recorded as elective.

PSI 11: Elective surgical discharges, for patients ages 18 years and older, with any-listed ICD-10-PCS procedure codes for an operating room procedure. Elective surgical discharges are defined by specific MS-DRG codes with admission type recorded as elective.

PSI 12: Surgical discharges, for patients ages 18 years and older, with any-listed ICD-10-PCS procedure codes for an operating room procedure. Surgical discharges are defined by specific MS-DRG codes.

PSI 13: Elective surgical discharges, for patients ages 18 years and older, with any-listed ICD-10-PCS procedure codes for an operating room procedure. Elective surgical discharges are defined by specific MS-DRG codes with admission type recorded as elective.

PSI 14: Discharges, for patients ages 18 years and older, with any-listed ICD-10-CM procedure codes for abdominopelvic surgery, open approach, or with any-listed ICD-10-PCS procedure codes for abdominopelvic surgery, other than open approach.

PSI 15: Surgical and medical discharges, for patients ages 18 years and older, with any ICD-10-PCS procedure code for an abdominopelvic procedure.

Denominator Exclusions:

PSI 03

- Length of stay of less than 3 days
- Principal ICD-10-CM diagnosis code for pressure ulcer stage III or IV (or unstageable)
- All secondary ICD-10-CM diagnosis codes for pressure ulcer III or IV (or unstageable) present on admission. If more than one diagnosis of pressure ulcer is present, all diagnoses must be present on admission for the discharge to be excluded

- Any listed ICD-10-CM diagnosis code for severe burns (>20% body surface area)
- Any listed ICD-10-CM diagnosis code for exfoliative disorders of the skin (>20% body surface area)
- MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

PSI 06

- Principal ICD-10-CM diagnosis code for iatrogenic pneumothorax
- Any secondary ICD-10-CM diagnosis code for iatrogenic pneumothorax present on admission, among patients qualifying for the numerator
- Any listed ICD-10-CM diagnosis codes for specified chest trauma (rib fractures, traumatic pneumothorax and related chest wall injuries)
- Any listed ICD-10-CM diagnosis codes for pleural effusion
- Any listed ICD-10-PCS procedure codes for thoracic surgery
- Any listed ICD-10-CM procedure codes for cardiac procedure;
- MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

PSI 08

- Principal ICD-10-CM diagnosis code for hip fracture
- Any secondary ICD-10-CM diagnosis code for hip fracture present on admission, among patients otherwise qualifying for the numerator
- Principal ICD-10-CM diagnosis code for seizure
- Principal ICD-10-CM diagnosis code for syncope
- Principal ICD-10-CM diagnosis code for stroke and occlusion of arteries
- Principal ICD-10-CM diagnosis code for coma
- Principal ICD-10-CM diagnosis code for cardiac arrest
- Principal ICD-10-CM diagnosis code for poisoning
- Principal ICD-10-CM diagnosis code for trauma
- Principal ICD-10-CM diagnosis code for delirium and other psychoses
- Principal ICD-10-CM diagnosis code for anoxic brain injury
- Any listed ICD-10-CM diagnosis codes for metastatic cancer

- Any listed ICD-10-CM diagnosis codes for lymphoid malignancy
- Any listed ICD-10-CM diagnosis codes for bone malignancy
- MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

PSI 09

- Principal ICD-10-CMS diagnosis code for perioperative hemorrhage or postoperative hematoma
- Any secondary ICD-10-CM diagnosis present on admission for perioperative hemorrhage or postoperative hematoma, among discharges that otherwise qualify for the numerator
- The only operating room procedure is for treatment of perioperative hemorrhage, or hematoma and with any secondary ICD-10-CM diagnosis codes for perioperative hemorrhage or hematoma
- Treatment of postoperative hemorrhage or hematoma occurs one day or more before the first operating room procedure, and with any secondary ICD-10-CM diagnosis codes for postoperative hemorrhage or hematoma
- With any listed ICD-10-CM diagnosis codes for coagulation disorders
- MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

PSI 10

- Principal ICD-10-CM diagnosis code for acute renal failure, cardiac arrest, cardiac dysrhythmia, shock or chronic kidney failure
- Any secondary ICD-10-CM diagnosis code for acute kidney failure, cardiac arrest, cardiac dysrhythmia, shock or chronic kidney failure, present on admission, among patients otherwise qualifying for the numerator
- Any dialysis procedure that occurs before or on the same day as the first operating room procedure
- Any dialysis access procedure occurring before or on the same day as the first operating room procedure
- Principal ICD-10-CM (or secondary diagnosis present on admission) for urinary tract obstruction
- Any ICD-10-CM diagnosis code present on admission for solitary kidney disease and any ICD-10-PCS procedure code for partial nephrectomy
- MDC 14 (pregnancy, childbirth, and puerperium)

- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

PSI 11

- Principal ICD-10-CM diagnosis code for acute respiratory failure
- Any secondary ICD-10-CM diagnosis code for respiratory failure present on admission, among patients otherwise qualifying for the numerator
- Only operating room procedure is tracheostomy
- Procedure for tracheostomy occurs before the first operating room procedure
- Any listed ICD-10-CM diagnosis codes for neuromuscular disorder
- Any listed ICD-10-PCS procedure codes for laryngeal or pharyngeal, nose, mouth pharynx or facial surgery
- Any listed ICD-10-CM procedure codes for esophageal resection
- Any listed ICD-10-CM procedure codes for lung cancer
- Any listed ICD-10-CM diagnosis codes for degenerative neurological disorder
- Any listed ICD-10-CM procedure codes for lung transplant
- MDC 4 (diseases/disorders of respiratory system);
- MDC 5 (diseases/disorders of circulatory system);
- MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

PSI 12

- Principal ICD-10-CM diagnosis code for proximal deep vein thrombosis (DVT) or pulmonary embolism (PE),
- Any secondary ICD-10-CM diagnosis code for DVT or PE present on admission, among patients otherwise qualifying for the numerator
- Procedure for interruption of vena cava occurs before or on the same day as the first operating room procedure
- Only operating room procedure was interruption of vena cava
- Any listed ICD-10-CM diagnosis code for acute brain or spinal injury present on admission
- Any listed ICD-10-PCS procedure code for extracorporeal membrane oxygenation (ECMO)
- Procedure for pulmonary arterial thrombectomy occurs before or on the same day as the first operating room procedure

- Only operating room procedure was for pulmonary arterial thrombectomy
- MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

PSI 13

- Principal ICD-10-CM diagnosis code for sepsis or infection
- Any secondary ICD-10-CM diagnosis code for sepsis or infection present on admission, among patients otherwise qualifying for the numerator
- MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

PSI 14

- Procedure for abdominal wall reclosure occurs on or before the day of the first open abdominopelvic surgery procedure, if any, and the day of the first laparoscopic abdominopelvic surgery procedure, if any
- Any listed ICD-10-CM diagnosis codes or any-listed ICD-10-PCS procedure codes for immunocompromised state
- Principal ICD-10-CM diagnosis code for disruption of internal operation wound
- Any secondary ICD-10-CM diagnosis code for disruption of internal operation wound present on admission
- Length of stay less than two (2) days-MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

PSI 15

- Principal ICD-10-CM diagnosis code for accidental puncture or lacerations during a procedure
- Any secondary ICD-10-CM diagnosis code for accidental puncture or laceration during a procedure, among patients otherwise qualifying for the numerator
- MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

Calculation: Rates per 1,000 Discharges

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

Medicaid MCO

AHCCCS-03 (NQF 0640 Modified): HBIPS-2 Hours of Physical Restraint Use

Measure Definition

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

Rationale: Mental health providers that value and respect an individual´s autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is 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 (Donat, 2003).

The literature supports a reduction in the use of physical restraint and seclusion. A reduction in the use of physical restraint and seclusion will improve patient safety, reduce overall organizational costs, leading to a decrease in staff and patient injuries and an increase in staff productivity. And finally, focusing on behavioral interventions to defuse aggressive and violent behaviors will result in less retraumatization for patients with trauma histories leading to shortened and improved recovery.

The measure will assist health care organizations (HCOs) to track physical restraint use to determine patterns and trends to aid the organization in efforts to decrease use.

Numerator Statement: The total number of hours that all psychiatric inpatients were maintained in physical restraint.

Numerator Exclusions: None

Denominator Statement: Number of psychiatric inpatient days

Denominator Exclusions: Total leave days

Calculation: *Numerator / Denominator*

The numerator evaluates the number of hours of physical restraint; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. HealthTech will convert the minutes to hours when analyzing and reporting this measure.

The denominator is per 1,000 hours. To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

Medicaid MCO

AHCCCS-04 (NQF 0641 Modified): HBIPS-3 Hours of Seclusion Use

Measure Definition

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

Rationale: Mental health providers that value and respect an individual´s autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is 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 (Donat, 2003).

The literature supports a reduction in the use of physical restraint and seclusion. A reduction in the use of physical restraint and seclusion will improve patient safety, reduce overall organizational costs, leading to a decrease in staff and patient injuries and an increase in staff productivity. And finally, focusing on behavioral interventions to defuse aggressive and violent behaviors will result in less retraumatization for patients with trauma histories leading to shortened and improved recovery.

The measure will assist health care organizations (HCOs) to track seclusion use to determine patterns and trends to aid the organization in efforts to decrease use.

Numerator Statement: The total number of hours that all psychiatric inpatients were held in seclusion.

Numerator Exclusions: None

Denominator Statement: Number of psychiatric inpatient days

Denominator Exclusions: Total leave days

Calculation: *Numerator / Denominator*

The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. HealthTech will convert the minutes to hours when analyzing and reporting this measure.

The denominator is per 1,000 hours. To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

Medicaid MCO

AHCCCS-05 (NQF 0674 Modified): Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

Measure Definition

Brief Description: This measure reports the percentage of long-stay residents in a Long-Term Acute Care Hospitals or a Freestanding Rehabilitation Hospitals who have experienced one or more falls resulting in major injury reported in the look-back period no more than 275 days prior to the target assessment.

Rationale: This outcome-based quality measure reports the percentage of long-stay nursing home residents who have experienced one or more falls resulting in major injury, which include bone fractures, joint dislocations, and closed-head injuries. Injurious falls are important to monitor in the nursing home population because of their impacts on health outcomes, as research has demonstrated injurious falls are the leading causes of disability and death for nursing home residents. Falls with major injury also impact resident quality of life by introducing new functional limitations and psychosocial distress, while potentially influencing providers to increase the use of unwanted physical or chemical restraints. Studies have shown that risk for falling is associated with a variety of resident characteristics, including but not limited to, increasing age, being female, and cognitive decline. Falls are also associated with inappropriate or changing prescriptions. The capacity of nursing homes to provide residents appropriate living accommodations/amenities and sufficient support by appropriately qualified staff around-the-clock to serve the medical needs of residents can mitigate fall risks and prevent or reduce falls.

Numerator Statement: Number of long-stay patients with one or more look-back scan assessments that indicate one or more falls that resulted in major injury.

Numerator Exclusions: None

Denominator Statement: All long-stay Long-Term Acute Care Hospitals or Freestanding Rehabilitation Hospitals patients with one or more look-back scan assessments except those who meet the exclusion criteria.

Denominator Exclusions: A patient is excluded from the denominator of this quality measure if all look-back scan assessments indicate that data is missing from the data element assessing falls resulting in major injury during the look-back period preceding the target assessment.

Calculation: *Numerator / Denominator*

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

Medicaid MCO

AHCCCS-06 (NQF 1717 Modified): National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

Measure Definition

Brief Description: Standardized infection ratio (SIR) and Adjusted Ranking Metric (ARM) of hospital-onset CDI Laboratory-identified events (LabID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs).

Rationale: Measure can be used to drive prevention practices that will lead to improved outcomes, including the reduction of patient morbidity and mortality.

Numerator Statement: Total number of observed hospital-onset incident CDI LabID events among all inpatients in the facility, excluding NICU, Special Care Nursery, babies in LDRP, well-baby nurseries, or well-baby clinics.

Numerator Exclusions: N/A

Denominator Statement: Total number of Medicaid MCO discharges for a 12-month period and the total number of Medicaid MCO inpatient days for the 12- month period.

Denominator Exclusions: Well-baby nurseries and neonatal intensive care units (NICUs).

Calculation: *Numerator / Denominator*

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

Medicaid MCO

AHCCCS-07 (NQF 1789 Modified): 30-Day Hospital-Wide All-Cause Unplanned Readmission Rate

Measure Definition

Brief Description: This measure estimates a hospital-level, risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission within 30 days of discharge from an index admission with an eligible condition or procedure. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology. The measure also indicates the hospital-level standardized readmission ratios (SRR) for each of these five specialty cohorts. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date from the index admission (the admission included in the measure cohort). A specified set of readmissions are planned and do not count in the readmission outcome.

Rationale: The goal of this measure is to improve patient outcomes by providing patients, physicians, hospitals, and policy makers with information about risk-standardized all-cause unplanned readmission rates among Medicaid MCO beneficiaries 65 years and older admitted to Arizona short stay hospitals. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Complex and critical aspects of care, such as communication between providers, prevention of and response to complications, patient safety, and coordinated transitions to the outpatient environment, all contribute to patient outcomes but are difficult to measure by individual process measures. The goal of outcomes measurement is to risk adjust for patients' conditions at the time of hospital admission and then evaluate patient outcomes. This measure was developed to identify institutions' whose performance is better or worse than would be expected based on their patient case mix and hospital service mix, and therefore promote hospital quality improvement and better inform consumers about care quality.

Hospital-wide readmission is a priority area for outcomes measure development as it is an outcome that is likely attributable to care processes and is an important outcome for patients. Measuring and reporting readmission rates will inform healthcare providers and facilities about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care received by Medicaid MCO patients. The measure will also provide patients with information that could guide their choices, as well as increase transparency for consumers.

Numerator Statement: The outcome is 30-day readmission. We define readmission as an inpatient admission for any cause, except for certain planned readmissions, within 30 days from the date of discharge from an eligible index admission. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission.

Numerator Exclusions: N/A

Denominator Statement: The measure includes admissions for Medicaid MCO beneficiaries who are 65 years and older and are discharged from Arizona short stay hospitals with a complete claims history for the 12 months prior to admission.

Denominator Exclusions: Exclude index admissions for patients:

1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals;
2. Without at least 30 days post-discharge enrollment in Medicaid MCO;
3. Discharged against medical advice;
4. Admitted for primary psychiatric diagnoses;
5. Admitted for rehabilitation; or
6. Admitted for medical treatment of cancer.

Calculation: $\frac{Number\ of\ index\ admissions\ with\ one\ (1)\ or\ more\ readmissions\ within\ 30\ days}{Total\ Number\ of\ index\ admissions}$

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

Medicaid MCO

AHCCCS-08 (NQF 2393 Modified): Pediatric All-Condition Readmission Measure

Measure Definition

Brief Description: This measure calculates case-mix-adjusted readmission rates, defined as the percentage of admissions followed by 1 or more readmissions within 30 days, for patients less than 18 years old. The measure covers patients discharged from general acute care hospitals, including children's hospitals.

Rationale: Readmissions have become a major focus for improving the quality of health systems. Hospitals, payers, states, and the federal government are seeking to improve the quality of care by measuring and reducing readmissions.

In many cases, readmissions signal how well disease is managed, indicating a worsening of health status that may have been prevented, and can reflect the quality of key processes, including discharge planning and education, care transitions, and follow-up care. The number of children who experience readmissions is substantial, and readmission rates for some conditions are high. Disparities in pediatric readmission exist based on race/ethnicity, socioeconomic status, and special health care needs. Readmission rates vary among hospitals, and effective interventions to reduce readmissions have suggested potential for improvement.

Our candidate measure fills gaps in pediatric quality measurement. It addresses the current dearth of measures that assess inpatient care. It also meets the need for readmission measures developed for use in children. It estimates readmission rates following hospitalization for almost all pediatric conditions. Our measure focuses on patients less than 18 years old, thus complementing adult readmission measures, including the CMS all-cause and condition-specific measures and the NCQA all-cause measure. It uses a casemix adjustment model specifically developed for pediatric patients, allowing for comparisons among health systems whose patient populations differ in their demographic characteristics or chronic condition status.

An inherent limitation of readmission rates is that they do not indicate which factors most influence readmissions for a given population and are thus most important to address. Gaining these insights requires looking further to identify patterns in why patients were readmitted and which contributing factors could be modified to prevent future readmissions. Measuring readmission rates, however, is an essential first step to gauge the magnitude of the problem and to motivate investigations to understand the causes of readmission, including those that health systems can remedy.

Numerator Statement: The numerator consists of hospitalizations at general acute care hospitals for patients less than 18 years old that are followed by 1 or more readmissions to general acute care hospitals within 30 days.

Numerator Exclusions: Readmissions are excluded from the numerator if the readmission was for a planned procedure, obstetric care or for chemotherapy.

Denominator Statement: Hospitalizations at general acute care hospitals for patients less than 18 years old.

Denominator Exclusions: We apply exclusions to the denominator only (i.e., these hospitalizations are excluded from index hospitalizations but could still meet criteria for

readmissions). Hospitalizations are excluded from the denominator only if they meet any of the following criteria:

1. The patient was 18 years old or older at the time of discharge.
2. The discharge disposition was death.
3. The discharge disposition was leaving the hospital against medical advice.
4. The hospital has less than 80% of records with complete patient identifier, admission date, and discharge date or less than 80% of records with complete primary ICD-9 or principal ICD-10 diagnosis codes. (Records for these hospitals are still assessed as possible readmissions, but readmission rates are not calculated for these hospitals due to their lack of complete data.)
5. The hospital is in a state not being analyzed.
6. Thirty days of follow-up data are not available for assessing readmissions.

Additional Exclusions: We exclude certain hospitalizations from the measure entirely (i.e., from the numerator and denominator) based on clinical criteria or for issues of data completeness or quality that could prevent assessment of eligibility for the measure cohort or compromise the accuracy of readmission rates. Hospitalizations are excluded from the measure if they meet any of the following criteria:

1. The hospitalization was at a specialty or non-acute care hospital.
2. Records for the hospitalization contain incomplete data for variables needed to assess eligibility for the measure or calculate readmission rates, including hospital type, patient identifier, admission date, discharge date, disposition status, date of birth, primary ICD-9 or principal ICD-10 diagnosis codes, or gender.
3. Records for the hospitalization contain data of questionable quality for calculating readmission rates, including
    a. Inconsistent date of birth across records for a patient.
    b. Discharge date prior to admission date.
    c. Admission or discharge date prior to date of birth.
    d. Admission date after a disposition status of death during a prior hospitalization.
4. Codes other than ICD-9 or ICD-10 codes are used for the primary procedure.
5. The patient was older than 18 years, 29 days at the time of admission.
6. The hospitalization was for obstetric care, including labor and delivery.
7. The primary ICD-9 or principal ICD-10 diagnosis code was for a mental health condition.

8. The hospitalization was for birth of a healthy newborn.

Calculation: $\frac{Number\ of\ index\ admissions\ with\ one\ (1)\ or\ more\ readmissions\ within\ 30\ days}{Total\ Number\ of\ index\ admissions}$

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

- Medicaid FFS
- Medicaid MCO

AHCCCS-09 (NQF 2631 Modified): Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Measure Definition

Brief Description: This quality measure reports the percentage of all Long-Term Care Hospital (LTCH) patients with an admission and discharge functional assessment and a care plan that addresses function.

Rationale: Many Long-Term Care Hospital (LTCH) patients have functional limitations and are at high risk for functional decline during the hospital stay; therefore, this measure addresses the assessment of functional status on admission and discharge and the inclusion of function in the patient's care plan, as evidenced by a goal for at least one of the self-care or mobility function assessment items.

The importance of using standardized functional assessment items in LTCH populations is supported by the high prevalence of therapy services provided in this setting, and the need for good care coordination. Whether an LTCH patient is discharged home or to another care setting for continuing healthcare, the patient's functional status is an important aspect of a person's health status to document at the time of the transition.

This quality measure will inform LTCH providers about opportunities to improve care in the area of function and strengthen incentives for quality improvement related to patient function.

Numerator Statement: Number of Long-Term Care Hospital (LTCH) patients with complete functional assessment data and at least one self-care or mobility goal.

Numerator Exclusions: Patients who have incomplete stays are defined as those patients (1) with incomplete stays due to a medical emergency, including LTCH length of stay less than 3 days, (2) who leave the LTCH against medical advice, or (3) who die while in the LTCH. Discharge functional status data are not required for these patients because these data may be difficult to collect at the time of the medical emergency, if the patient dies or if the patient leaves against medical advice.

Denominator Statement: Number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period.

Denominator Exclusions: Incomplete stays less than 3 days, AMA or dies in LTCH

Calculation: *Numerator / Denominator*

For patients with a complete stay, all three of the following are required for the patient to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment; and (3) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the discharge assessment.

For patients who have an incomplete stay, discharge data are not required. It can be challenging to gather accurate discharge functional assessment data for patients who experience incomplete stays. The following are required for the patients who have an incomplete stay to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; and (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment.

Patients who have incomplete stays are defined as those patients (1) with incomplete stays due to a medical emergency, including LTCH length of stay less than 3 days, (2) who leave the LTCH against medical advice, or (3) who die while in the LTCH. Discharge functional status data are not required for these patients because these data may be difficult to collect at the time of the medical emergency, if the patient dies or if the patient leaves against medical advice.

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

Medicaid MCO

AHCCCS-10 (NQF 3479 Modified): Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities (IRF)

Measure Definition

Brief Description: The Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities (DTC-PAC IRF) was developed to address the resource use and other measures domain of Discharge to the Community mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). This outcome measure assesses successful discharge to community from an IRF, with successful discharge to community including no unplanned rehospitalizations and no death in the 31 days following IRF discharge. The measure reports an IRF's risk-standardized rate of Medicaid fee-for-service (FFS) and managed care (MCO) patients who are discharged to the community following an IRF stay, and do not have an unplanned readmission to an acute care hospital or long-term care hospital (LTCH) in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community. The measure is calculated using two consecutive years of Medicaid FFS/MCO claims data.

Rationale: Successful discharge to community from IRF is widely recognized as an important outcome for patients and their families and an indicator of IRF quality of care. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act of 2014) mandated the specification of a measure to address the domain of discharge to community across post-acute care (PAC) settings. Discharge to community is an important goal for both patients with potential for functional improvement, and patients who may not be expected to make functional gains given their clinical condition or disease. IRFs frequently track their discharge to community outcomes for internal quality improvement purposes; however, this tracking commonly assesses discharge destination alone and not post-discharge readmissions or death. By assessing whether patients successfully remain in the community without acute complications for 31 days following discharge, the DTC-PAC IRF measure is a more meaningful, patient and family-centered measure of successful community discharge. Discharge to community is an actionable health care outcome as targeted interventions have been shown to successfully increase discharge to community rates in a variety of post-acute settings, including IRFs. The effectiveness of these interventions suggests that improvement in discharge to community rates among IRF patients is possible through modifying provider-led processes and interventions. In addition to being important from a patient and family perspective, avoiding institutionalization and promoting discharge to community when appropriate are also important from a cost and resource use perspective. Patients discharged to community settings, on average, incur lower costs over the recovery episode, compared with patients discharged to institutional settings.

Measuring and publicly reporting the DTC-PAC IRF measure is expected to help differentiate IRFs based on quality of care, and drive improvement in this outcome. The DTC-PAC IRF measure would impact a large number of Medicaid beneficiaries and the overall Medicaid program. There are no NQF-endorsed measures assessing successful discharge to community from IRFs.

Numerator Statement: The measure numerator is the risk-adjusted predicted estimate of the number of patients who are discharged to the community, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window.

This estimate starts with the observed number of discharges to community, defined as:

(i) discharges to home or self-care with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, or 86 on the Medicaid FFS/MCO claim; and

(ii) no unplanned acute or LTCH hospitalizations in the 31-day post-discharge window; and

(iii) no death in the 31-day post-discharge window.

The discharge to community outcome is risk-adjusted for patient characteristics and a statistical estimate of the facility effect beyond case-mix (described below).

Numerator Exclusions: N/A

Denominator Statement: The target population for the measure is the group of Medicaid FFS/MCO beneficiaries who are discharged from an IRF during the measurement period and are not excluded based on the measure exclusion criteria (see S.8. and S.9.). The measure denominator is the risk-adjusted expected number of discharges to community. This estimate includes risk-adjustment for patient characteristics with the facility effect removed. The "expected" number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients were treated at the average facility. The logistic regression model used to calculate the denominator is developed using all non-excluded facility stays in the national data. The denominator is computed in the same way as the numerator, but the facility effect is set at the average.

Denominator Exclusions: Measure exclusion criteria are based on administrative data from Medicaid claims and eligibility files. Exclusion criteria were selected to maintain clinical validity of the measure by excluding stays for which discharge to community would not be appropriate, to ensure data availability and completeness, to exclude stays with problematic claims data, and to maintain relevance to the IRF QRP (e.g., excluding IRFs not included in the IRF QRP based on regional location). Only IRF stays that are preceded by a short-term acute care stay in the 30 days prior to the IRF admission date are included in the measure; this is because risk-adjustment variables come from the short-term acute care stay in the 30 days prior to IRF admission. Stays ending in transfers to the same level of care (i.e., IRF-to-IRF discharge) are excluded, because the IRF episode of care had not ended. We also excluded certain discharge status codes on the IRF FFS claim that indicated that the patient was not appropriate for community discharge (e.g., discharges against medical advice). See section S.9 for detailed rationale and data sources for each exclusion.

Measure exclusion criteria are as follows:

- Age under 18 years;
- No short-term acute care hospital discharge within the thirty days preceding an IRF admission;
- Discharges to a psychiatric hospital;

- Discharges against medical advice;
- Discharges to disaster alternative care site or a federal hospital;
- Discharges to court/law enforcement;
- Discharges to hospice or patient stays with a hospice benefit in the 31-day post-discharge window;
- Planned discharges to an acute or LTCH setting;
- Stays for patients without continuous Medicaid FFS/MCO enrollment during the 12 months prior to the IRF admission date
- and the 31 days after the IRF discharge;
- IRF stays preceded by a short-term acute care stay for non-surgical treatment of cancer;
- Stays ending in transfer to an IRF;
- Stays with problematic claims data (e.g. anomalous records for stays that overlap wholly or in part or are otherwise
- erroneous or contradictory; claims not paid);
- Exhaustion of Medicaid benefit during the IRF stay; and
- IRF stays in facilities outside of the United States, Puerto Rico, or another U.S. territory.

Calculation: $\frac{Number\ of\ patients\ with\ no\ unplanned\ readmissions\ within\ 31\ day\ post\ discharge\ window}{Total\ Number\ of\ discharges}$

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

- Medicaid FFS
- Medicaid MCO

AHCCCS-11: Successful Implementation of Antibiotic Stewardship Program

Measure Definition

Brief Description: Program has seven (7) core elements. Hospitals to attest to which elements were met in the reporting period:

1. Hospital Leadership Commitment. Dedicate necessary human, financial, and information technology resources.

2. Accountability. Appoint a leader or co-leaders, such as a physician and pharmacist, responsible for program management and outcomes.

3. Pharmacy Expertise (previously "Drug Expertise"). Appoint a pharmacist, ideally as the co-leader of the stewardship program, to help lead implementation efforts to improve antibiotic use.

4. Action. Implement interventions, such as prospective audit and feedback or preauthorization, to improve antibiotic use.

5. Tracking. Monitor antibiotic prescribing, impact of interventions, and other important outcomes, like C. difficile infections and resistance patterns.

6. Reporting. Regularly report information on antibiotic use and resistance to prescribers, pharmacists, nurses, and hospital leadership.

7. Education. Educate prescribers, pharmacists, nurses, and patients about adverse reactions from antibiotics, antibiotic resistance, and optimal prescribing.

Rationale: In 2014, CDC called on all hospitals in the United States to implement antibiotic stewardship programs and released the *Core Elements of Hospital Antibiotic Stewardship Programs* (Core Elements) to help hospitals achieve this goal. The Core Elements outlines structural and procedural components that are associated with successful stewardship programs. In 2015, The United States National Action Plan for Combating Antibiotic Resistant Bacteria set a goal for implementation of the Core Elements in all hospitals that receive federal funding.

The Core Elements form the foundation for antibiotic stewardship accreditation standards from the Joint Commission and DNV-GL. The 2019 hospital Conditions of Participation from the Centers for Medicare and Medicaid Services (CMS) created a federal regulation for hospital antibiotic stewardship programs and also reference the Core Elements.

Excerpted from: CDC. Core Elements of Hospital Antibiotic Stewardship Programs. Atlanta, GA: US Department of Health and Human Services, CDC; 2019.

Numerator Statement: Number of core elements met

Numerator Exclusions: None

Denominator Statement: Total number of core elements

Denominator Exclusions: None

Calculation: *Numerator / Denominator*

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

Critical Access Hospitals

AHCCCS-12 (OP-18 Modified): Median Time from ED Arrival to ED Departure for Discharged ED Patients

Measure Definition

Brief Description: Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department.

Rationale: Empirical evidence demonstrates that emergency department (ED) throughput is an indicator of hospital quality of care and shows that shorter lengths of stay in the ED lead to improved clinical outcomes. Significant ED overcrowding has numerous downstream effects, including prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes (Gardner, 2018). Quality improvement efforts aimed at reducing ED overcrowding and length of stay have been associated with an increase in ED patient volume, decrease in number of patients who leave without being seen, reduction in costs, and increase in patient satisfaction (Bucci, 2016; Chang, 2017; Zocchi, 2015).

Recent peer-reviewed studies also demonstrate the need for dedicated emergency mental health services, supplying evidence that the clinical needs for these patients substantively differ from the non-psychiatric population (ACEP, 2017; Lester, 2018).

Exclusions: Patients who expired in the emergency department

Calculation: *Median*

Reporting Period

Baseline: 10/01/2018 – 09/30/2019

Performance: 10/01/2020 – 09/30/2021

Population

Medicaid MCO