Measures Under Consideration for MBQIP (2023)

Request for feedback: January 13-February 28, 2023

Background

The Measures Under Consideration for MBQIP (2023) is a list of quality measures the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) is considering adopting for use in the Medicare Beneficiary Quality Improvement Program (MBQIP) within the Medicare Rural Hospital Flexibility Program. All measures currently under consideration align with other federal programs.

This resource and related opportunity for feedback is a vehicle to hear from invested parties regarding consideration of ten (10) measures for potential adoption in MBQIP. Inclusion of a measure on this list does not require FORHP to propose to adopt or finalize the adoption of the measure for MBQIP. Therefore, this list may include a larger number of measures than the number of measures FORHP will decide to propose for adoption.

FORHP must balance competing goals of establishing a condensed, rural relevant measure set that aligns with other federal quality reporting programs, while including sufficient measures to facilitate critical access hospital participation in MBQIP.

Request for Feedback

The public is invited to provide feedback on the measures under consideration no later than 5:00 p.m. Eastern Standard Time on **Tuesday, February 28, 2023.** State Flex Coordinators, subcontractors, hospital quality staff, and other interested parties are encouraged to provide input. Feedback must be submitted via this electronic form: https://survey.alchemer.com/s3/7175573/2023-MBQIP-Measures-Under-Consideration. The feedback form includes the following fields:

- Input regarding each of the individual measures under consideration
- General feedback regarding potential addition of eCQMs to MBQIP
- General feedback regarding the measures under consideration
- Name and contact information (optional)

Included in this Resource

For each of the measures under consideration, the following information is provided:

- Measure Description
- Measure Rationale
- Improvement Noted As
- Measure Program Alignment
- Measure Submission and Reporting Channel
- Additional Information, References, and Resources (includes links to sources utilized for measure summaries)

Measures Under Consideration

- Antimicrobial Use and Resistance (AUR) Options
- Electronic Clinical Quality Measure (eCQM) – Outpatient
    - ST-Segment Elevation Myocardial Infarction (STEMI) (OP-40)
- Electronic Clinical Quality Measures (eCQMs) - Inpatient
    - Global Malnutrition Composite Score (GMCS)
    - Safe Use of Opioids – Concurrent Prescribing (Safe Use of Opioids)
    - Venous Thromboembolism Prophylaxis (VTE-1)
- Hospital Commitment to Health Equity
- Hybrid Hospital-Wide All Cause Readmissions (Hybrid HWR)
- Screening for Social Drivers of Health
- Screen Positive for Social Drivers of Health
- Sepsis (SEP-1)

Antimicrobial Use and Resistance (AUR) Options

Measure Description

The **Antimicrobial Use and Resistance (AUR) module** through the National Healthcare Safety Network (NHSN) provides a mechanism for facilities to report and to analyze antimicrobial use and/or resistance data to inform benchmarking, reduce antimicrobial resistant infections through antimicrobial stewardship, and interrupt transmission of resistant pathogens at facilities.

Measure Rationale

Antimicrobial resistance rates continue to increase in hospitals across the United States. One of the five Centers for Disease Control & Prevention (CDC) core actions to combat the spread of antimicrobial resistance is improving the use of antimicrobials. Studies show that providing timely and reliable feedback of information to clinicians regarding their prescribing practices, such as through antimicrobial usage reports, can improve appropriateness of antimicrobial use. The primary objective of the **Antimicrobial Use (AU) option** (measure) is to facilitate risk-adjusted inter- and intra-facility antimicrobial use benchmarking. A secondary objective is to evaluate antimicrobial use trends over time at the facility and national levels.

The misuse and overuse of antimicrobials both facilitates the emergence of drug-resistant pathogens and exposes patients to needless risk for adverse effects. Antibiotic resistant infections can also complicate the response to and recovery from other serious health risks, such as COVID-19. With timely and complete reporting through the **Antimicrobial Resistance (AR) option** (measure), data can aid in clinical decision making (hospital cumulative antibiograms), direct transmission prevention, antimicrobial stewardship efforts, as well as facilitate rapid identification and control of potential outbreaks and longer-term assessment of progression or improvement to guide public health response efforts.

Improvement Noted As

AU and AR are not performance measures. Rather, the measurement of AU and AR provide quantitative data on antibiotic use and resistance, respectively, and are critical to identify opportunities for improvement and to assess the impact of interventions. They do not assess the appropriateness of antibiotic use or resistance.

Measure Program Alignment

Currently available to report through the CDC's NHSN. Starting with calendar year 2024, AUR will be incorporated into the Medicare Promoting Interoperability Program. Submission of AUR data will be one of five measures required under the Public Health and Clinical Data Exchange Objective. Eligible hospitals, including critical access hospitals (CAHs) must report a "yes" response or an exclusion of all five measures to receive credit for the 25 points associated with the Public Health and Clinical Data Exchange Objective. Eligible hospitals, including CAHs, must score least 60 points (out of 100) in the performance-based scoring methodology for the CMS program to avoid a downward Medicare payment adjustment.

Exclusions for the AUR reporting for the Medicare Promoting Interoperability Program include:

1. Does not have any patients in any patient care location for which data are collected by NHSN during the EHR reporting period;
2. Does not have electronic medication administration records (eMAR)/barcoded medication administration (BCMA) records or an electronic admission discharge transfer (ADT) system during the EHR reporting period; or
3. Does not have an electronic laboratory information system (LIS) or electronic ADT system during the EHR reporting period.

Measure Submission and Reporting Channel

Monthly pharmacy and/or laboratory information software derived data submitted via HL7 Clinical Document Architecture to NHSN. The CDC maintains lists of validated AU vendors and AR vendors.

Additional Information, References, and Resources

- National Healthcare Safety Network | Antimicrobial Use & Resistance
- NHSN Antimicrobial Use and Resistance (AUR) Module Protocol (cdc.gov)
- NHSN AUR Promoting Interoperability Guidance (cdc.gov)
- 2023 Final IPPS Rule (pages 1596 – 1605; note, there is a known error in the rule regarding the number of CAHs voluntarily reporting AUR – the number is less than 300 and applies only to those reporting to the AU option)
- Promoting Interoperability Programs | CMS
- FY2023FinalRuleIPPS (qualityreportingcenter.com) (see slides 52 – 54)

ST-Segment Elevation Myocardial Infarction (STEMI) (OP-40)

Outpatient Electronic Clinical Quality Measure (eCQM)

Measure Description

Percentage of emergency department (ED) encounters for patients 18 and older with diagnosis of ST-Segment Elevation Myocardial Infarction (STEMI) that received appropriate treatment:

- Fibrinolytic therapy within 30 minutes of ED arrival; OR
- Percutaneous coronary intervention (PCI) within 90 minutes of ED arrival; OR
- Transfer within 45 minutes of arrival

Denominator: All ED encounters for patients 18 years or older at the start of the encounter with a diagnosis of STEMI during the measurement period

Numerator: ED encounters with a diagnosis of STEMI that received appropriate treatment

Measure Rationale

Primary percutaneous coronary intervention (PCI) is the preferred approach for revascularization. For patients presenting to hospitals with on-site PCI capabilities, guidelines recommend PCI be performed within 90 minutes of arrival. In situations where a patient arrives at a non-PCI capable hospital, but can be transferred for primary PCI, guidelines recommend primary PCI be performed within 120 minutes of arrival.

In situations where it is unlikely or impossible for a patient to receive primary PCI within 120 minutes, guidelines recommend that fibrinolytic therapy be used for reperfusion, and should be rapidly administered (within 30 minutes of arrival) to reduce mortality and minimize morbidity.

Improvement Noted As

Increase in the rate.

Measure Program Alignment

New CMS Outpatient Quality Reporting (OQR) program measure. First available reporting period is calendar year (CY) 2023, with data due May 15, 2024.

Measure Submission and Reporting Channel

Annual, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.

Additional Information, References, and Resources

- Clinically similar to current chart-abstracted OP-2 and OP-3, which will retire after Q1 2023 encounters. See the related MBQIP Measure Change Summary for more information.
- For Prospective Payment System (PPS) hospitals the first reporting period required to meet OQR program requirements and avoid a negative payment adjustment is CY 2024 encounters. Critical access hospitals are not held to OQR program requirements but will be able to voluntarily report starting with CY 2023 data.
- NQF: Quality Positioning System ™ (qualityforum.org)
- Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED) | eCQI Resource Center (healthit.gov)
- CY 2022 OPPS Final Rule: How to Succeed in Outpatient Quality Reporting (qualityreportingcenter.com) (OP-40 measure information starts on slide 16)

Global Malnutrition Composite Score (GMCS)

Inpatient Electronic Clinical Quality Measure (eCQM)

Measure Description

Assesses adults 65 years of age and older admitted to inpatient hospital service who received care appropriate to their level of malnutrition risk and malnutrition diagnosis.

The malnutrition composite measure includes four component measures, which are first scored separately, and then integrated into an overall composite score. The overall composite score is derived from averaging the individual performance scores of the following four component measures:

- Screening for malnutrition risk at admission
- Completing a nutrition assessment for patients who screened for risk of malnutrition
- Appropriate documentation of malnutrition diagnosis in the patient's medical record if indicated by the assessment findings
- Development of a nutrition care plan for malnourished patients including recommended treatment plan

Measure Rationale

Malnutrition care best practices recommend that for each hospitalization, adult inpatients are screened for malnutrition risk, assed to confirm findings, and if identified with a "moderate" or "severe" malnutrition status, receive a diagnosis and have a current nutrition plan performed.

Improvement Noted As

An increase in final composite score.

Measure Program Alignment

Critical access hospitals must meet Medicare Promoting Interoperability Program requirements on an annual basis to avoid a downward payment. One of the program requirements is submission of eCQM data from certified electronic health record technology (CEHRT). Calendar year (CY) 2024 eCQM reporting requirements (the first year GMCS will be available for reporting) will be data reflecting all four quarters of CY 2024 for:

- Three self-selected measures of the available eCQMs for each quarter (GMCS will be one of the options)
- Three required measures:
    - Safe Use of Opioid Measure
    - ePC-02 Cesarean Birth (except hospitals that do not have OB or perform deliveries)
    - ePC-07 Severe Obstetric Complications (except hospitals that do not have OB or perform deliveries)

Measure Submission and Reporting Channel

Annual, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.

Additional Information, References, and Resources

- Global Malnutrition Composite Score | eCQI Resource Center (healthit.gov)
- GMCS for IQR - MQii (malnutritionquality.org)
- More information about eCQMs and Promoting Interoperability:
    - Critical Access Hospital eCQM Resource List | National Rural Health Resource Center (ruralcenter.org)
    - Promoting Interoperability Programs | CMS

Safe Use of Opioids – Concurrent Prescribing (Safe Use of Opioids)

Inpatient Electronic Clinical Quality Measure (eCQM)

Measure Description

Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on two or more opioids, or an opioid and benzodiazepine concurrently at discharge.

> **Denominator:** Inpatient hospitalizations (inpatient stay less than or equal to 120 days) that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge. Exclusions include patients with cancer that begin prior to or during the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay.
>
> **Numerator:** Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge.

Measure Rationale

Unintentional opioid overdose fatalities have become an epidemic and major public health concern in the United States. Concurrent prescriptions of opioids, or opioids and benzodiazepines, places patients at a greater risk of unintentional overdose due to increased risk of respiratory depression. Patients who have multiple opioid prescriptions have an increased risk for overdose, and rates of fatal overdose are ten (10) times higher in patients who are co-dispensed opioid analgesics and benzodiazepines than opioids alone. A measure that calculates the proportion of patients with two or more opioids or opioids and benzodiazepines concurrently has the potential to reduce preventable mortality and reduce costs associated with adverse events related to opioids.

Improvement Noted As

Improvement noted as a decrease in the rate.

Clinician judgement, clinical appropriateness, or both may indicate concurrent prescribing of two unique opioids or an opioid and benzodiazepine is medically necessary. Therefore, the measure is not expected to have a zero rate.

Measure Program Alignment

Safe Use of Opioids is a current measure of the Medicare Promoting Interoperability (PI) Program. Critical access hospitals must meet PI Program requirements on an annual basis to avoid a downward payment. One of the program requirements is submission of eCQM data from certified electronic health record technology (CEHRT).

Calendar year (CY) 2023 eCQM reporting requirements for PI include data reflecting all four quarters of CY 2023 for:

- Three self-Selected measures of the thirteen available eCQMs for each quarter
- One required measure: Safe Use of Opioid Measure

Measure Submission and Reporting Channel

Annual, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.

Additional Information, References, and Resources

- NQF: Quality Positioning System ™ (qualityforum.org)
- Safe Use of Opioids - Concurrent Prescribing | eCQI Resource Center (healthit.gov)
- More information about eCQMs and Promoting Interoperability:
    - Critical Access Hospital eCQM Resource List | National Rural Health Resource Center (ruralcenter.org)
    - Promoting Interoperability Programs | CMS

Venous Thromboembolism Prophylaxis (VTE-1)

Inpatient Electronic Clinical Quality Measure (eCQM)

Measure Description

This measure assesses the number of patients who received VTE prophylaxis or have documentation addressing why no VTE prophylaxis was given the day of, or the day after hospital admission, or surgery end date for surgeries that start the day of or the day after hospital admission.

Denominator: Inpatient hospitalizations for patients age 18 and older, discharged from hospital inpatient acute care without a diagnosis of venous thromboembolism (VTE) or obstetrics with a length of stay less than or equal to 120 days that ends during the measurement period. Exclusions apply; see measure specifications for details.

Numerator:

Patients in the denominator who received VTE prophylaxis:

- Between the day of arrival and the day after hospital admission
- The day of or the day after surgery end date for surgeries that end the day of or the day after hospital admission

Patients in the denominator with documented reason why VTE prophylaxis was not given:

- Between the day of arrival and the day after hospital admission
- The day of or the day after surgery end date (for surgeries that end the day of or the day after hospital admission)

Measure Rationale

Venous thromboembolism (VTE) is a major patient safety concern for hospitalized patients. VTE has been identified as the most common preventable cause of hospital death. In a review of evidence-based patient safety practices, the Agency for Healthcare Research and Quality defined thromboprophylaxis against VTE as the "number one patient safety practice" for hospitalized patients. Updated “safe practices” published by the National Quality Forum (NQF) recommend routine evaluation of hospitalized patients for risk of VTE and use of appropriate prophylaxis. It is also well known that despite the publication and widespread dissemination of multiple guidelines for the prevention and management of VTE, clinical practices in hospitals have not changed at an acceptable pace and multiple studies that have included the audit of hospital records of medical and surgical patients continue to show underuse of VTE prophylaxis.

Improvement Noted As

Improvement noted as an increase in rate.

Measure Program Alignment

VTE-1 is a current measure of the Medicare Promoting Interoperability (PI) Program. Critical access hospitals must meet PI Program requirements on an annual basis to avoid a downward payment. One of the program requirements is submission of eCQM data from certified electronic health record technology (CEHRT).

Calendar year (CY) 2023 eCQM reporting requirements for PI include data reflecting all four quarters of CY 2023 for:

- Three self-Selected measures of the thirteen available eCQMs for each quarter (VTE-1 is one of the options)
- One required measure: Safe Use of Opioid Measure

Measure Submission and Reporting Channel

Annual, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.

Additional Information, References, and Resources

- NQF: Quality Positioning System ™ (qualityforum.org) - Note, although this eCQM is not endorsed by the National Quality Form (NQF), it is based on the previous chart-abstracted measure that was NQF endorsed. The measure importance description provided here was taken from the developer rationale as posted on the NQF site.
- Venous Thromboembolism Prophylaxis | eCQI Resource Center (healthit.gov)
- More information about eCQMs and Promoting Interoperability:
    - Critical Access Hospital eCQM Resource List | National Rural Health Resource Center (ruralcenter.org)
    - Promoting Interoperability Programs | CMS

Hospital Commitment to Health Equity

Measure Description

This structural measure assesses hospital commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below poverty level.

Hospitals will receive points for responding to questions in five (5) different domains of commitment to advancing health equity:

- Domain 1 – Equity is a Strategic Priority
- Domain 2 – Data Collection
- Domain 3 – Data Analysis
- Domain 4 – Quality Improvement
- Domain 5 – Leadership Engagement

Hospital score can be a total of zero (0) to five (5) points (one point for each domain, must attest "yes" to all sub-questions in each domain, no partial-credit). For more details see the draft specifications.

Measure Rationale

The recognition of health disparities and inequities has been heightened in recent years and it is particularly relevant in rural areas. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to health care specialists and subspecialists, and limited job opportunities. Rural residents are also less likely to have employer-provided health insurance coverage, and if they are poor, often are not covered by Medicaid. The intent of this measure is to help ensure hospitals are considering and addressing equity in the care they provide to their community.

Improvement Noted As

Increase in the total score (up to 5 points).

Measure Program Alignment

New CMS Inpatient Quality Reporting (IQR) program measure. First available reporting timeline is Spring 2024 (reflecting calendar year 2023 activity).

Measure Submission and Reporting Channel

Annual attestation via Hospital Quality Reporting (HQR) platform.

Additional Information, References, and Resources

- Draft specifications
- IPPS Final Rule 2022-16472.pdf (federalregister.gov)
- Rural Health Disparities Overview - Rural Health Information Hub
- For Prospective Payment System (PPS) hospitals reporting is mandatory for CY 2023 with data submission open from April 1, 2024-May 15, 2024. CY 2023 data is required for PPS hospitals to meet IQR program requirements and avoid a negative payment adjustment. Critical access hospitals are not held to IQR program requirements but will be able to voluntarily report starting with CY 2023 data.

Hybrid Hospital-Wide All Cause Readmissions (Hybrid HWR)

Measure Description

Hybrid measures differ from the claims-only measures in that they merge electronic health record (EHR) data elements with claims-data to calculate the risk-standardized readmission rate. The Hybrid HWR was developed to address complex and critical aspects of care that cannot be derived through claims data alone. The Hybrid HWR uses EHR data including clinical variables and linking elements for each patient:

- **Clinical variables (13):** Heart Rate, Systolic Blood Pressure, Respiratory Rate, Temperature, Oxygen Saturation, Weight, Hematocrit, White Blood Cell Count, Potassium, Sodium, Bicarbonate, Creatinine, Glucose
- **Linking elements (6):** CMS Certification Number (CCN), Health Insurance Claims Number or Medicare Beneficiary Identifier, Date of birth, Sex, Admission date, Discharge date

Measure Rationale

Returning to the hospital for unplanned care disrupts patients' lives, increases risk of harmful events like healthcare-associated infections, and results in higher costs absorbed by the health care system. High readmission rates of patients with clinically manageable conditions in primary care settings, such as diabetes and bronchial asthma, may identify quality-of-care problems in hospital settings. A measure of readmissions encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions and costs.

Improvement Noted As

Decrease in the rate.

Measure Program Alignment

CMS Inpatient Quality Reporting (IQR) program measure. Currently available for reporting.

Measure Submission and Reporting Channel

Annual, patient-level file in QRDA 1 format to Hospital Quality Reporting portal.

Additional Information, References, and Resources

- Reporting the Hybrid Hospital-Wide Readmission Measure to the Hospital IQR Program (qualityreportingcenter.com)
- Core Clinical Data Elements for the Hybrid Hospital-Wide Readmission (HWR) Measure with Claims and Electronic Health Record Data | eCQI Resource Center (healthit.gov)
- Hybrid Measure Overview (cms.gov)
- Unplanned hospital visits | Provider Data Catalog (cms.gov)
- Next available reporting deadline is October 2, 2023 for July 1, 2022, through June 30, 2023 hospitalizations.
- 1,113 CAHs met the threshold to have the *claims-based* HWR measure calculated for July 1, 2020 - June 30, 2021. Beginning with 2023-2024 data, CAHs that are not reporting hybrid HWR data elements will no longer have a readmissions rate calculated.
- For Prospective Payment System (PPS) hospitals the first reporting period required in order to meet IQR program requirements and avoid a negative payment adjustment is for encounters from July 1, 2023 – June 30, 2024 with data due October 1, 2024. Critical access hospitals (CAHs) are not held to IQR program requirements and are able to voluntarily report each year.
- Hybrid HWR will be publicly reported starting with the July 2025 refresh of *Care Compare* (replacing the claims-based HWR measure)

Screening for Social Drivers of Health

Measure Description

Percent of patients 18 and older admitted for an inpatient stay that are screened for all of the following health-related social needs (HRSNs):

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

Measure Rationale

The recognition of health disparities and impact of health-related social needs (HRSN) has been heightened in recent years. Economic and social factors, known as drivers of health, are known to affect health outcomes and costs, and exacerbate health inequities. This measure is derived from the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.

Improvement Noted As

Increase in the rate.

Measure Program Alignment

New CMS Inpatient Quality Reporting (IQR) program measure. First available reporting period is May 15, 2024 for calendar year (CY) 2023 data.

Measure Submission and Reporting Channel

Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.

Additional Information, References, and Resources

- QualityNet Home (cms.gov) (draft specifications)
- Rural Health Disparities Overview - Rural Health Information Hub
- Guide to social needs screening (aafp.org)
- Hospitals are allowed to select their own screening tool, given it captures the five required areas.
- For Prospective Payment System (PPS) hospitals reporting is voluntary for CY 2023 with data submission open from April 1, 2024-May 15, 2024. CY 2024 data is required for PPS hospitals to meet IQR program requirements and avoid a negative payment adjustment. CAHs are not held to IQR program requirements but will be able to voluntarily report starting with CY 2023 data.

Screen Positive for Social Drivers of Health

Measure Description

The Screen Positive for Social Drivers of Health Measure is not a performance measure. The measure is calculated as five separate rates corresponding to each of the HRSNs captured:

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

Denominator: Total number of patients 18 or older screened for an HRSN

Numerators: Number that screen positive for each of the five HRSNs captured in the Screening for Social Drivers of Health measure.

Measure Rationale

The recognition of health disparities and impact of health-related social needs (HRSN) has been heightened in recent years. Economic and social factors, known as drivers of health, are known to affect health outcomes and costs, and exacerbate health inequities. This measure is derived from the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure in is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.

Improvement Noted As

This measure is not an indication of performance.

Measure Program Alignment

New CMS Inpatient Quality Reporting (IQR) program measure. First available reporting period is May 15, 2024 for calendar year (CY) 2023 data.

Measure Submission and Reporting Channel

Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.

Additional Information, References, and Resources

- QualityNet Home (cms.gov) (draft specifications)
- Rural Health Disparities Overview - Rural Health Information Hub
- Guide to social needs screening (aafp.org)
- Hospitals are allowed to select their own screening tool, given it captures the five required areas.
- For Prospective Payment System (PPS) hospitals reporting is voluntary for CY 2023 with data submission open from April 1, 2024-May 15, 2024. CY 2024 data is required for PPS hospitals to meet IQR program requirements and avoid a negative payment adjustment. Critical access hospitals are not held to IQR program requirements but will be able to voluntarily report starting with CY 2023 data.

Sepsis (SEP-1)

Measure Rationale

Sepsis is a complication that occurs when your body has an extreme response to an infection. It causes damage to organs in the body and can be life-threatening if not treated. According to the Centers for Disease Control & Prevention, in a typical year, at least 350,000 adults who develop sepsis die during their hospitalization. Sepsis can sometimes turn into septic shock, which has a higher risk of death. Identifying sepsis early and starting appropriate care quickly, are shown to increase the chances of survival. The SEP-1 measure reflects the percentage of patients that received appropriate care for severe sepsis and/or septic shock. Early recognition and rapid implementation of the sepsis bundle has led to reductions in hospital length of stay, readmission rates, and patient mortality.

Measure Description

Sepsis (SEP-1) measures the percentage of patients that received appropriate care for severe sepsis and/or septic shock.

Denominator: Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis, or Septic Shock and not equal to U07.1 (COVID-19).

Numerator Statement: Patients who received ALL of the following:

- Within three hours of presentation of severe sepsis:
    - Initial lactate level measurement
    - Broad spectrum or other antibiotics administered
    - Blood cultures drawn prior to antibiotics
- AND received within six hours of presentation of severe sepsis. ONLY if the initial lactate is elevated:
    - Repeat lactate level measurement
- AND within three hours of initial hypotension:
    - Resuscitation with 30 mL/kg crystalloid fluids

  OR within three hours of septic shock:
    - Resuscitation with 30 mL/kg crystalloid fluids
- AND within six hours of septic shock presentation, ONLY if hypotension persists after fluid administration:
    - Vasopressors are administered
- AND within six hours of septic shock presentation, if hypotension persists after fluid administration or initial lactate >= 4 mmol/L:
    - Repeat volume status and tissue perfusion assessment is performed

Improvement Noted As

An increase in the rate.

Measure Program Alignment

SEP-1 is a current Inpatient Quality Reporting (IQR) program measure.

Measure Submission and Reporting Channel

Chart-abstracted and submitted quarterly via CART (CMS Abstraction Reporting Tool) or a vendor tool via the Hospital Quality Reporting (HQR) platform.

Additional Information, References, and Resources

- QualityNet Home (cms.gov) (current measure specifications)
- What is Sepsis? | Sepsis | CDC
- Clinical guidance is updated regularly resulting in regular updates to the measure specifications and abstraction guidance
- Many critical access hospitals (CAHs) have been focused on sepsis as part of their work with Hospital Quality Innovation Networks (formerly HIIN/HEN) or as part of statewide initiatives or requirements.
- 440 CAHs reported SEP-1 in Quarter 1, 2022.
- Currently a required measure for Prospective Payment System (PPS) hospitals in order to meet IQR program requirements and avoid a negative payment adjustment. CAHs are not held to IQR program requirements but are able to voluntarily report.