Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

SUPERIOR HEALTH
Quality Alliance

Encyclopedia of Measures (EOM)
QIN-QIO 13th Scope of Work
Settings: Hospitals

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Contents

Aim: Advancing Healthcare Quality Through Technology

Percentage of Hospitals Advancing Readiness Tiers in the Advancing Health Care Quality Through Technology (AHQT) Pilot*

Measure Name	Percentage of hospitals advancing AHQT Readiness tiers
Measure Identifier	ach_ahqt_advancement
Sub Aim	Advancing access and use of Health IT and interoperability for improving quality and outcomes
Numerator	Number of Tier 1 (Basic Technology) provider practices in the pilot advancing to Tier 2 (Interoperability Adopter)
Denominator	Number of hospitals with a baseline AHQT Readiness of tier 1
Inclusions/Exclusions	N/A
Rate calculation	Numerator / Denominator X 100%
Specifications/Definitions	As a Quality Improvement Organization (QIO), we're assessing the readiness of facilities to electronically access, share, and use data for quality improvement and reporting. This AHQT Readiness Assessment categorizes providers into one of four Technical Readiness Tiers (0–3), enabling us to tailor support based on their current systems and infrastructure. The assessment includes questions on foundational, technical, administrative, and operational topics. The QIO team will share more details.
Data source(s)	QIO AHQT Readiness Assessment
Evaluator(s)	QIO
Evaluation period	To Be Determined
Target	90% of Tier 1 (Basic Technology) provider practices in the pilot advance to Tier 2 (Interoperability Adopter)
Additional Notes	*Acute Care Hospital and REH

Aim: Behavioral Health

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*

Measure Name	Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence
Measure Identifier	ach_ed_followup_sud
Sub Aim	Substance Use Disorders
Numerator	30-Day Follow-Up
Denominator	An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year, where the beneficiary was aged 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period.
Inclusions/ Exclusions	<u>Numerator Inclusions:</u> A follow-up visit with any practitioner, with a principal diagnosis of AOD abuse or dependence, within 30 days after the ED visit (31 total days). 7-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of AOD abuse or dependence within 7 days after the ED visit (8 total days). NOTE: Include visits that occur on the date of the ED visit. For both indicators, any of the following meet criteria for a follow-up visit: • IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) • OUD Weekly Non-Drug Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) • OUD Monthly Office-Based Treatment Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) • OUD Weekly Drug Treatment Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)

	• IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) • IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) • An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) • A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) • An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) <u>Denominator Exclusions:</u> ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from occurring.
Rate calculation	Numerator / Denominator X 100%
Specifications/ Definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	264 - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) CMIT ID: 00264-02-C- MACS
Data source(s)	Medicare Fee-for-Service Claims
Evaluator(s)	Program Monitoring and Evaluation Contractor
Evaluation period	To Be Determined
Target	Increase by 70% (Relative Improvement Rate)
Additional Notes	*Acute Care Hospital and REH

Aim: Care Coordination

Hospital 30-day Readmissions (HWR) All-Cause Unplanned

Measure Name	Hospital 30-day Readmissions (HWR) All-Cause Unplanned
Measure Identifier	ach_30d_readmissions
Sub Aim	Hospital 30-Day Readmissions
Numerator	30-day, all-cause readmissions.
Denominator	The cohort includes admissions for patients that meet all of the following inclusion criteria: 1. Enrolled in Medicare FFS Part A for the 12 months before the date of admission and during the index admission. [For VA beneficiaries hospitalized in VA hospitals, there are no Medicare FFS enrollment requirements. For VA beneficiaries hospitalized in non-VA hospitals, they must be concurrently enrolled in Medicare FFS Part A at the time of the index admission, to be eligible for cohort inclusion, but the 12-month Part A enrollment before admission is not required.] 2. Aged 65 or over 3. Discharged alive from a non-federal short-term acute care hospital (or VA hospital) 4. Not transferred to another acute care facility.
Inclusions/Exclusions	Numerator Inclusions: We define readmission as an inpatient acute care admission for any cause, except for certain planned readmissions, within 30 days of discharge from the index admission for patients discharged from the hospital after an admission for any eligible condition. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only the first one is counted as a readmission. This measure looks for a dichotomous yes-or-no outcome: 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. Denominator Exclusions: This measure excludes index admissions for patients who meet any of the following exclusion criteria: 1. Admitted to a PPS-exempt cancer hospital;

	2. Without at least 30 days of post-discharge enrollment in Medicare FFS (in the case of patients who are not VA beneficiaries); 3. Admitted for primary psychiatric diagnosis; 4. Admitted for rehabilitation; 5. Admitted for medical treatment of cancer; or 6. Discharged against medical advice.
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	356 - Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Groups- Active (00356-09-C- MIPS)
Data source(s)	Medicare Fee-for-Service Claims
Evaluator(s)	Program Monitoring and Evaluation Contractor
Evaluation period	To Be Determined
Target	Reduce by 8% (Relative Improvement Rate)
Additional Notes	N/A

Aim: Patient Safety

Safe Use of Opioids - Concurrent Prescribing

Measure Name	Safe Use of Opioids - Concurrent Prescribing
Measure Identifier	ach_opioids_coprescribing
Sub Aim	Adverse Drug Events
Numerator	Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge.
Denominator	Initial Population 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.
Inclusions/Exclusions	Denominator Exclusions: Inpatient hospitalizations where patients have cancer that begins before 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
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	669 - Safe Use of Opioids - Concurrent Prescribing - Active (00669-01-E-HIQR)
Data source(s)	Provider Medical Records
Evaluator(s)	Submitted by Provider
Evaluation period	To Be Determined
Target	Reduce by 10% (Relative Improvement Rate)
Additional Notes	N/A

Catheter-Associated Urinary Tract Infection (CAUTI)

Measure Name	Catheter-Associated Urinary Tract Infection (CAUTI)
Measure Identifier	ach_hai_cauti
Sub Aim	Infection Prevention and Control
Numerator	Total number of observed healthcare-associated CAUTI among patients in bedded inpatient care locations (excluding patients in Level II or III neonatal ICUs).
Denominator	Total number of predicted healthcare-associated CAUTI among inpatient care locations under surveillance for CAUTI during the data period, based on the national CAUTI baseline. Data is calculated using the facility's number of catheter days and the following significant risk factors: • Acute Care Hospitals: CDC Location, Facility bed size, Medical school affiliation, and Facility type • Critical Access Hospitals: Medical school affiliation • Long-Term Acute Hospitals: Average length of stay, Setting type, and Location type • Inpatient Rehabilitation Facilities: Setting type, Proportion of admissions with traumatic and non-traumatic spinal cord dysfunction, Proportion of admissions with stroke
Inclusions/Exclusions	The following are not considered indwelling catheters by NHSN definitions: 1. Suprapubic catheters 2. Condom catheters 3. "In and out" catheterizations 4. Nephrostomy tubes Note: if a patient has either a nephrostomy tube or a suprapubic catheter and also has an indwelling urinary catheter, the indwelling urinary catheter will be included in the CAUTI surveillance.
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	459 - National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure - Active (00459-01-C- HACRP)
Data source(s)	NHSN

Evaluator(s)	To Be Determined
Evaluation period	To Be Determined
Target	Reduce by 50% (Relative Improvement Rate)
Additional Notes	N/A

Central Line Associated Bloodstream Infection (CLABSI)

Measure Name	Central Line Associated Bloodstream Infection (CLABSI)
Measure Identifier	ach_hai_clabsi
Sub Aim	Infection Prevention and Control
Numerator	Total number of observed healthcare-associated CLABSIs among patients in bedded inpatient care locations.
Denominator	Total number of central line days for each location under surveillance for CLABSI during the data period.
Inclusions/Exclusions	The following devices are excluded as central lines: - Non-lumened pacemaker wires and other non-lumened devices inserted into central blood vessels or the heart - Arterial catheters - Arteriovenous fistula - Arteriovenous graft - Extracorporeal membrane oxygenation (ECMO) - Hemodialysis reliable outflow (HERO) dialysis catheters - Intra-aortic balloon pump (IABP) devices - Atrial catheters (also known as transthoracic intracardiac catheters, those catheters inserted directly into the right or left atrium via the heart wall) - Peripheral IV or Midlines - Ventricular Assist Device (VAD)
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	460 - National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure - Active (00460-01-C- HACRP)
Data source(s)	NHSN
Evaluator(s)	To Be Determined
Evaluation period	To Be Determined
Target	Reduce by 50% (Relative Improvement Rate)

Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia

Measure Name	Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia
Measure Identifier	ach_hai_mrsa
Sub Aim	Infection Prevention and Control
Numerator	Total number of observed hospital-onset unique blood source MRSA LabID events among all inpatients in the facility.
Denominator	The expected number of hospital-onset unique blood source MRSA LabID events is calculated using the facility's number of inpatient days, bed size, affiliation with a medical school, and community-onset MRSA bloodstream infection admission prevalence rate.
Inclusions/Exclusions	Data from patients who are not assigned to an inpatient bed in an applicable location are excluded from the denominator counts. Denominator counts exclude data from inpatient rehabilitation units and inpatient psychiatric units.
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	463 - National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure - Active (00463-01-C-HACRP)
Data source(s)	NHSN
Evaluator(s)	To Be Determined
Evaluation period	To Be Determined
Target	Reduce by 50% (Relative Improvement Rate)
Additional Notes	N/A

Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI)

Measure Name	Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI)
Measure Identifier	ach_hai_cdi
Sub Aim	Infection Prevention and Control
Numerator	Total number of observed hospital-onset CDI LabID events among all inpatients in the facility, excluding well baby nurseries and NICUs
Denominator	Total number of predicted hospital-onset CDI LabID events, calculated using the facility's number of inpatient days, facility type, CDI event reporting from Emergency Department and 24-hour observation units, bed size, ICU bed size, affiliation with medical school, microbiological test method used to identify C. difficile, and community-onset CDI admission prevalence rate.
Inclusions/Exclusions	Data from patients who are not assigned to an inpatient bed are excluded from the denominator counts, including outpatient clinics, 24-hour observation units, and emergency department visits. Inpatient rehab locations and inpatient psychiatric locations that have their own Centers for Medicare and Medicaid Services (CMS) Certification Number (CCN) are excluded. Additionally, data from well-baby nurseries and NICUs are excluded from the denominator count.
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	462 - National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure - Active (00462-01-C-HIQR);
Data source(s)	NHSN
Evaluator(s)	To Be Determined
Evaluation period	To Be Determined
Target	Reduce by 50% (Relative Improvement Rate)

Harmonized Procedure Specific Surgical Site Infection (SSI)

Measure Name	Harmonized Procedure Specific Surgical Site Infection (SSI)
Measure Identifier	ach_hai_ssi
Sub Aim	Infection Prevention and Control
Numerator	Deep incisional primary (DIP) and organ/space SSIs during the 30-day postoperative period among patients = 18 years of age, who undergo inpatient colon surgeries or abdominal hysterectomies.
Denominator	A National Healthcare Safety Network (NHSN) Operative Procedure is a procedure that is included in the ICD-10-PCS or CPT NHSN operative procedure code mapping. And takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure And takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute s (FGI) or American Institute of Architects (AIA) criteria for an operating room when it was constructed or renovated11. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab.
Inclusions/Exclusions	Numerator Inclusions: SSIs will be identified before discharge from the hospital, upon readmission to the same hospital, or during outpatient care or admission to another hospital (post-discharge surveillance). Case accrual will be guided by sampling algorithms as described below. Numerator Exclusion: SSI events with Infection Present at Time of Surgery (PATOS) field = yes. PATOS denotes that there is evidence of an infection or abscess at the start of or during the index surgical procedure (in other words, it is present preoperatively). PATOS is a YES/NO field on the SSI Event form. PATOS does not apply if there is a period of wellness between the time of a preoperative condition and surgery. The evidence of infection or abscess must be noted/documented intraoperatively in an operative note or report of surgery. Only select PATOS = YES if it applies to the depth of SSI being attributed to the procedures (e.g., if a patient has evidence of an intra-abdominal infection at the time of surgery and then later returns with an

	organ/space SSI, the PATOS field would be selected as YES. If the patient returned with a superficial or deep incisional SSI, the PATOS field would be selected as a NO). The patient does not have to meet the NHSN definition of an SSI at the time of the primary procedure; however, there must be a notation indicating that evidence of an infection or abscess was present at the time of surgery. PATOS is not necessarily diagnosis-driven. Denominator Exclusions: Otherwise eligible procedures that are assigned an American Society of Anesthesiologists (ASA) score of 6 are not eligible for NHSN SSI surveillance. Using multivariable logistic regression models for colon surgeries and abdominal hysterectomies, the expected number of SSIs is obtained. These expected numbers are summed by facility and surgical procedure and used as the denominator of this measure (see also 2a.8). Denominator exclusions: Persons under the age of 18, those having a procedure performed on an outpatient basis, procedures associated with SSI events where the PATOS = yes, those with ASA Class VI (6) are excluded. Note: Both primarily closed procedures and those that are not closed primarily are included in the denominator data.
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	001 - Surgical Site Infection (SSI) (00001-02-C-HIQR);
Data source(s)	NHSN
Evaluator(s)	To Be Determined
Evaluation period	To Be Determined
Target	Reduce by 50% (Relative Improvement Rate)
Additional Notes	N/A

Hospital Harm Pressure Injury

Measure Name	Hospital Harm Pressure Injury
Measure Identifier	ach_pressure_injury
Sub Aim	Safety Events
Numerator	Inpatient hospitalizations for patients with a new deep tissue pressure injury (DTPI) or stage 2, 3, 4, or unstageable pressure injury.
Denominator	Equals Initial Population
Inclusions/Exclusions	Numerator Inclusions: Any of the following: A diagnosis of DTPI with the DTPI not present on admission, i.e., the diagnosis of DTPI has a Present on Admission indicator = N no (Diagnosis was not present at the time of inpatient admission) or U (documentation insufficient to determine if the condition was present at the time of inpatient admission) A diagnosis of stage 2, 3, 4 or unstageable pressure injury with the pressure injury diagnosis not present on admission, i.e., the diagnosis of pressure injury has a Present on Admission indicator = N no (Diagnosis was not present at the time of inpatient admission) or U (documentation insufficient to determine if the condition was present at the time of inpatient admission) A DTPI found on exam greater than 72 hours after the start of the encounter. A stage 2, 3, 4, or unstageable pressure injury found on exam, greater than 24 hours after the start of the encounter
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	https://ecqi.healthit.gov/ecqm/eh/2025/cms0826v2
Data source(s)	Provider Medical Records
Evaluator(s)	Submitted by Provider
Evaluation period	To Be Determined
Target	Reduce by 10% (Relative Improvement Rate)

Median Time from ED Arrival to Emergency Department (ED) Departure for Discharged ED Patients*

Measure Name	Median Time from ED Arrival to Emergency Department (ED) Departure for Discharged ED Patients
Measure Identifier	ach_ed_time
Sub Aim	Safety Events
Numerator	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.
Denominator	This measure is reported as a continuous variable statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.
Inclusions/Exclusions	Exclusions: Patients who expired in the emergency department.
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	427 - Median time from ED Arrival to ED Departure for Discharged ED patients - Active (00427- 01-C-HOQR)
Data source(s)	Hospital Outpatient Quality Reporting Program (HOQR)
Evaluator(s)	Program Monitoring and Evaluation Contractor
Evaluation period	To Be Determined
Target	Reduce by 20% (Relative Improvement Rate)
Additional Notes	*Acute Care Hospital and REH

Patient Safety Index-90

Measure Name	Patient Safety Index-90
Measure Identifier	ach_psi_90
Sub Aim	Safety Events
Numerator	To Be Determined
Denominator	To Be Determined
Inclusions/Exclusions	To Be Determined
Rate calculation	To Be Determined
Specifications/definitions	To Be Determined
Data source(s)	Medicare Fee-for-Service Claims
Evaluator(s)	Program Monitoring and Evaluation Contractor
Evaluation period	To Be Determined
Target	Reduce by 15%
Additional Notes	Limited information currently. Additional details are coming soon.

Aim: Prevention and Chronic Disease Management

COVID-19 Vaccination Coverage among Healthcare Personnel

Measure Name	COVID-19 Vaccination Coverage among Healthcare Personnel
Measure Identifier	ach_staff_covid19_vaccination
Sub Aim	Vaccinations
Numerator	The numerator for this measure consists of the cumulative number of healthcare personnel (HCP) in the denominator population who are considered up to date with recommended COVID-19 vaccines. Facilities should refer to the definition of up-to-date as of the first day of the quarter.
Denominator	The target population consists of the number of HCP eligible to work in the healthcare facility for at least one day during the one-week data collection reporting period, excluding individuals with contraindications to COVID-19 vaccination.
Inclusions/Exclusions	Numerator Inclusions: https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-May2022-508.pdf As of April 1, 2022, up to date includes: Individuals who received their second dose in a two-shot primary vaccination series (Pfizer-BioNTech or Moderna vaccines) less than 5 months ago, Individuals who received a J&J/Janssen as their primary vaccination less than 2 months ago, Individuals who have received a primary series and one booster dose when recommended. Denominator Inclusions: This measure includes at least one week of data collection a month for each of the 3 months in a quarter. The denominators are reported by aggregating the categories below: There are four categories of HCP: 1. Employees: includes all people who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll). 2. Licensed independent practitioners (LIPs): This includes physicians (MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility and do not receive a direct paycheck from the reporting facility. 3. Adult students/trainees and volunteers: This includes all students/trainees and volunteers aged 18 or over who do not receive a direct paycheck from the reporting facility.

	4. Other contract personnel: Facilities may also report on individuals who are contract personnel. However, reporting for this category is optional. Contract personnel are defined as individuals providing care, treatment, or services at the facility through a contract who do not fall into any of the aforementioned denominator categories. Denominator Exclusions: Denominator-eligible individuals with contraindications to COVID-19 vaccination. Medical contraindications are listed in a vaccine's FDA authorization or labeling and include severe allergic reaction. The current list of contraindications as well as exclusions may be found at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid- 19-vaccines-us.html and includes: 1. Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine. 2. Known diagnosed allergy to a component of the COVID-19 vaccine.
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	180 - COVID–19 Vaccination Coverage among Healthcare Personnel – Active 00180-02-C-HIQR
Data source(s)	NHSN
Evaluator(s)	To Be Determined
Evaluation period	To Be Determined
Target	Increase to 90% absolute rate
Additional Notes	N/A

Influenza Vaccination among Healthcare Personnel

Measure Name	Influenza Vaccination among Healthcare Personnel
Measure Identifier	ach_staff_influenza_vaccination
Sub Aim	Vaccinations
Numerator	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 an 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. Numerators are to be calculated separately for each of the above groups.
Denominator	Number of HCP in groups(a)-(c) below 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 is reported in the aggregate; rates for each HCP group may be calculated separately for facility-level quality improvement purposes: (a) Employees: all people who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll). (b) Licensed independent practitioners: include physicians (MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility and do not receive a direct paycheck from the reporting facility. (c) Adult students/trainees and volunteers: include all students/trainees and volunteers aged 18 or over who do not receive a direct paycheck from the reporting facility.
Inclusions/Exclusions	None
Rate calculation	Numerator / Denominator X 100%
Specifications/definitions	N/A
CMS Measures Inventory Tool (CMIT) ID	390 - Influenza Vaccination Coverage among Healthcare Personnel - Active 00390-01-C- HIQR

Data source(s)	NHSN
Evaluator(s)	To Be Determined
Evaluation period	To Be Determined
Target	Increase to 90% absolute rate
Additional Notes	N/A

Aim: Quality Management Infrastructure

Number of Hospitals with a Summed Severity Score >7 Related to Emergency Preparedness Requirements*

Measure Name	Number of hospitals with a summed severity score >7 related to emergency preparedness requirements
Measure Identifier	ach_inspections_ep_high_severity
Sub Aim	Emergency Preparedness: Inspection Deficiencies Related to emergency preparedness requirements
Numerator	Number of hospitals with a summed severity score >7 related to emergency preparedness requirements
Denominator	N/A
Inclusions/Exclusions	N/A
Rate calculation	N/A
Specifications/definitions	Inspection Deficiencies Resulting from emergency preparedness requirements used the following deficiency tags for hospitals: E0001, E0002, E0004, E0005, E0006, E0007, E0009, E0012, E0013, E0014, E0015, E0018, E0020, E0022, E0023, E0024, E0025, E0026, E0029, E0030, E0031, E0032, E0033, E0034, E0036, E0037, E0039, E0041, E0042, E0043 *Calculation of summed severity score specific to the QIO program, see Appendix A
Data source(s)	Enforcement Data
Evaluator(s)	Program Monitoring and Evaluation Contractor
Evaluation period	To Be Determined
Target	0
Additional Notes	*Acute Care Hospital and REH

Number of Hospitals with a Summed Severity Score >5 Related to the 4 Aims*

Measure Name	Number of hospitals with a summed severity score >5 related to the 4 aims
Measure Identifier	ach_inspections_4aims_high_severity
Sub Aim	Inspection Deficiencies Related to the 4 Aims
Numerator	Number of hospitals with a summed severity score >5 related to the 4 aims
Denominator	N/A
Inclusions/Exclusions	N/A
Rate calculation	N/A
Specifications/definitions	Inspection Deficiencies Resulting from 4 aims used the following tags for hospitals: C0812, C0886, C1018, C1204, C1206, C1208, C1400 *Calculation of summed severity score specific to the QIO program, see Appendix A
Data source(s)	Enforcement Data
Evaluator(s)	Program Monitoring and Evaluation Contractor
Evaluation period	To Be Determined
Target	0
Additional Notes	*Acute Care Hospital and REH

Median Summed Severity Score Related to the 4 Aims Among Acute Care Hospitals*

Measure Name	Median summed severity score related to the 4 aims among acute care hospitals
Measure Identifier	ach_inspections_4aims_median
Sub Aim	Inspection Deficiencies Related to the 4 Aims
Numerator	Median summed severity score related to the 4 Aims among acute care hospitals
Denominator	N/A
Inclusions/Exclusions	N/A
Rate calculation	N/A
Specifications/definitions	Inspection Deficiencies Resulting from the 4 aims used the following tags for hospitals: C0812, C0886, C1018, C1204, C1206, C1208, C1400 *Calculation of summed severity score specific to the QIO program, see Appendix A
Data source(s)	Enforcement Data
Evaluator(s)	Program Monitoring and Evaluation Contractor
Evaluation period	To Be Determined
Target	0
Additional Notes	*Acute Care Hospital and REH

Number of Hospitals with a Summed Severity Score >11 Related to Quality Assessment and Performance Improvement (QAPI) Requirements*

Measure Name	Number of hospitals with a summed severity score >11 related to QAPI requirements
Measure Identifier	ach_inspections_qapi_high_severity
Sub Aim	Quality Management Infrastructure: Inspection Deficiencies Related to QAPI requirements
Numerator	Number of hospitals with a summed severity score >11 for QAPI requirements
Denominator	N/A
Inclusions/Exclusions	N/A
Rate calculation	N/A
Specifications/definitions	Inspection Deficiencies Resulting from QAPI requirements used the following tags for acute care hospitals: A0286, A0309, A0321, A0535, C0336, C0338, C0339, C0340, C0341, C0342, C0343, C1300, C1306, C1311, C1315 *Calculation of summed severity specific to the QIO program, see Appendix A.
Data source(s)	Enforcement Data
Evaluator(s)	Program Monitoring and Evaluation Contractor
Evaluation period	To Be Determined
Target	0
Additional Notes	*Acute Care Hospital and REH

Appendix A

Severity-Score-Related Measures

The severity score uses deficiency tags in datasets provided by CMS's Quality, Safety & Oversight Group. The goal was to aggregate scores to account for both the severity and number of citations received by the same provider. These methods varied slightly between hospitals and nursing homes.

For hospitals, the "deficiency tag type" variable was used to create a severity variable. There are three ranks for deficiency tag type: standard, condition, and immediate jeopardy. These levels were converted into a numeric severity scale of 1, 5, and 10, respectively. Severity thresholds were then established to categorize providers into three groups: low concern, medium concern, and high concern. For hospitals, the cutoffs correspond to the severity scale: 1 represents low concern, 5 represents medium concern, and 10 represents high concern. This means that if a hospital had ten standard deficiencies, it would be ranked the same as a hospital with a single immediate jeopardy.

Summary of Updates

- 8/7/2025:
  - Initial template created
  - Measure names and information based on 13 SOW Appendix 5 – Measure Definitions and Specifications
- 10/7/2025
  - Measures applicable to Rural Emergency Hospitals (REH) are now marked with an asterisk (*) in their titles
  - Evaluator(s) for applicable measures updated to reflect ‘Program Monitoring and Evaluation Contractor’ exclusively, replacing the previous designation of ‘PMEC or CMS’.
- 10/29/2025
  - Edited to improve clarity in metric descriptions and include acronym descriptions for each table.

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