Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

SUPERIOR HEALTH
Quality Alliance

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

**Last updated 2/24/2026**

# Contents

# Aim: Advancing Healthcare Quality Through Technology

## Sub Aim: Advancing access and use of Health IT and interoperability for improving quality and outcomes

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

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|---|---|
| **Measure Name** | Percentage of hospitals advancing AHQT Readiness tiers |
| **Measure Identifier** | ach_ahqt_advancement |
| **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 |
| **Data Availability Lag** | N/A |
| **Evaluator(s)** | QIO |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | *Acute Care Hospital and REH |

# Aim: Behavioral Health

## Sub Aim: Substance Use Disorders

### Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence*

| | |
|---|---|
| **Measure Name** | Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence |
| **Measure Identifier** | ach_ed_followup_sud |
| **Numerator** | 30-Day Follow-Up: 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).<br><br>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). |
| **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. 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** | Numerator Inclusions:<br>Include visits that occur on the date of the ED visit.<br>For both indicators, any of the following meet criteria for a follow-up visit:<br>• IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (i.e., AOD Abuse and Dependence Value Set)<br>• OUD Weekly Non-Drug Service Value Set with a principal diagnosis of AOD abuse or dependence<br>• OUD Monthly Office-Based Treatment Value Set with a principal diagnosis of AOD abuse or dependence<br>• OUD Weekly Drug Treatment Service Value Set with a principal diagnosis of AOD abuse or dependence<br>• IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence<br>• IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence |

| | |
|---|---|
| **Measure Name** | Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence |
| | • An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence<br>• A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence<br>• An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence<br><br>Denominator Exclusions:<br>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:<br>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).<br>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 |
| **Data Availability Lag** | ~90 Days |
| **Evaluator(s)** | Program Monitoring and Evaluation Contractor |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | *Acute Care Hospital and REH |

# Aim: Care Coordination

## Sub Aim: Hospital 30-Day Readmissions

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

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|---|---|
| **Measure Name** | Hospital 30-day Readmissions (HWR) All-Cause Unplanned |
| **Measure Identifier** | ach_30d_readmissions |
| **Numerator** | The number of unplanned readmissions from any cause within 30 days after discharge from the index admission. |
| **Denominator** | The total number of admissions for patients meeting the criteria outlined below. |
| **Inclusions/Exclusions** | Numerator Inclusions: 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.<br><br>Denominator Inclusions:<br>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.<br><br>Denominator Exclusions:<br>This measure excludes index admissions for patients who meet any of the following exclusion criteria:<br>1. Admitted to a PPS-exempt cancer hospital;<br>2. Without at least 30 days of post-discharge enrollment in Medicare FFS (in the case of patients who are not VA beneficiaries);<br>3. Admitted for primary psychiatric diagnosis;<br>4. Admitted for rehabilitation;<br>5. Admitted for medical treatment of cancer; or<br>6. Discharged against medical advice. |

| | |
|---|---|
| **Measure Name** | Hospital 30-day Readmissions (HWR) All-Cause Unplanned |
| **Rate calculation** | Numerator / Denominator X 100% |
| **Specifications/definitions** | 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. 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. |
| **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 |
| **Data Availability Lag** | ~90 Days |
| **Evaluator(s)** | Program Monitoring and Evaluation Contractor |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | N/A |

# Aim: Patient Safety

## Sub Aim: Adverse Drug Events

### Safe Use of Opioids - Concurrent Prescribing

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|---|---|
| **Measure Name** | Safe Use of Opioids - Concurrent Prescribing |
| **Measure Identifier** | ach_opioids_coprescribing |
| **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:<br>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 |
| **Data Availability Lag** | 2-12+ Weeks |
| **Evaluator(s)** | Submitted by Provider |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | N/A |

# Aim: Patient Safety

## Sub Aim: Infection Prevention and Control

### Catheter-Associated Urinary Tract Infection (CAUTI)

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|---|---|
| **Measure Name** | Catheter-Associated Urinary Tract Infection (CAUTI) |
| **Measure Identifier** | ach_hai_cauti |
| **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:<br>• Acute care hospitals: CDC location, facility bed size, medical school affiliation, and facility type<br>• Critical access hospitals: medical school affiliation<br>• Long-term acute hospitals: Average length of stay, setting type, and location type<br>• 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:<br>1. Suprapubic catheters<br>2. Condom catheters<br>3. "In and out" catheterizations<br>4. Nephrostomy tubes<br>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) |

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|---|---|
| **Measure Name** | Catheter-Associated Urinary Tract Infection (CAUTI) |
| **Data source(s)** | NHSN |
| **Data Availability Lag** | ~45 Days |
| **Evaluator(s)** | To Be Determined |
| **Evaluation period** | To Be Determined |

# Aim: Patient Safety

## Sub Aim: Infection Prevention and Control

### Central Line Associated Bloodstream Infection (CLABSI)

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|---|---|
| **Measure Name** | Central Line Associated Bloodstream Infection (CLABSI) |
| **Measure Identifier** | ach_hai_clabsi |
| **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:<br>- Non-lumened pacemaker wires and other non-lumened devices inserted into central blood vessels or the heart<br>- Arterial catheters<br>- Arteriovenous fistula<br>- Arteriovenous graft<br>- Extracorporeal membrane oxygenation (ECMO)<br>- Hemodialysis reliable outflow (HERO) dialysis catheters<br>- Intra-aortic balloon pump (IABP) devices<br>- Atrial catheters (also known as transthoracic intracardiac catheters, those catheters inserted directly into the right or left atrium via the heart wall)<br>- Peripheral IV or Midlines<br>- 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 |
| **Data Availability Lag** | ~45 Days |
| **Evaluator(s)** | To Be Determined |
| **Evaluation period** | To Be Determined |

# Aim: Patient Safety

## Sub Aim: Infection Prevention and Control

### Facility-Wide Inpatient Hospital-onset MRSA Bacteremia

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|---|---|
| **Measure Name** | Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia |
| **Measure Identifier** | ach_hai_mrsa |
| **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** | Denominator Exclusions:<br>• Patients who are not assigned to an inpatient bed in an applicable location<br>• Stays from inpatient rehabilitation units and inpatient psychiatric units with unique CMS Certification Numbers (CCN) than the acute care facility.<br>• Data from well-baby nurseries and NICUs |
| **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 |
| **Data Availability Lag** | ~45 Days |
| **Evaluator(s)** | To Be Determined |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | N/A |

# Aim: Patient Safety

## Sub Aim: Infection Prevention and Control

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

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|---|---|
| **Measure Name** | Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) |
| **Measure Identifier** | ach_hai_cdi |
| **Numerator** | Total number of observed hospital-onset CDI LabID events among all inpatients in the facility |
| **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** | Denominator Exclusions:<br>• Data from patients who are not assigned to an inpatient bed, such as outpatient clinics, 24-hour observation units, and emergency department visits.<br>• Inpatient rehab locations and inpatient psychiatric locations that have their own Centers for Medicare and Medicaid Services (CMS) Certification Number (CCN)<br>• Data from well-baby nurseries and NICUs |
| **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 |
| **Data Availability Lag** | ~45 Days |
| **Evaluator(s)** | To Be Determined |
| **Evaluation period** | To Be Determined |

# Aim: Patient Safety

## Sub Aim: Infection Prevention and Control

### Harmonized Procedure Specific Surgical Site Infection (SSI)

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|---|---|
| **Measure Name** | Harmonized Procedure Specific Surgical Site Infection (SSI) |
| **Measure Identifier** | ach_hai_ssi |
| **Numerator** | Deep incisional primary (DIP) and organ/space SSIs during the 30-day postoperative period among patients 18 years of age or older, 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 (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed or renovated. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab. 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). |
| **Inclusions/Exclusions** | Numerator Inclusions:<br>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.<br><br>Numerator Exclusion:<br>Otherwise eligible procedures that are assigned an American Society of Anesthesiologists (ASA) score of 6 are not eligible for NHSN SSI surveillance. 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 |

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|---|---|
| **Measure Name** | Harmonized Procedure Specific Surgical Site Infection (SSI) |
| | index surgical procedure (in other words, it is present preoperatively). 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.<br><br>Denominator Exclusions:<br>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. |
| **Rate calculation** | Numerator / Denominator X 100% |
| **Specifications/definitions** | 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). |
| **CMS Measures Inventory Tool (CMIT) ID** | 001 - Surgical Site Infection (SSI) (00001-02-C-HIQR); |
| **Data source(s)** | NHSN |
| **Data Availability Lag** | ~45 Days |
| **Evaluator(s)** | To Be Determined |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | Both primarily closed procedures and those that are not closed primarily are included in the denominator data. |

# Aim: Patient Safety

## Sub Aim: Safety Events

### Hospital Harm Pressure Injury

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|---|---|
| **Measure Name** | Hospital Harm Pressure Injury |
| **Measure Identifier** | ach_pressure_injury |
| **Numerator** | Inpatient hospitalizations for patients with a new deep tissue pressure injury (DTPI) or stage 2, 3, 4, or unstageable pressure injury. |
| **Denominator** | Inpatient hospitalizations for patients aged 18 and older |
| **Inclusions/Exclusions** | Numerator Inclusions:<br>• A diagnosis of DTPI with the DTPI not present on admission, i.e., the diagnosis of DTPI has a Present on Admission indicator = N (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)<br>• 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)<br>• A DTPI found on exam greater than 72 hours after the start of the encounter.<br>• A stage 2, 3, 4, or unstageable pressure injury found on exam, greater than 24 hours after the start of the encounter<br><br>Denominator Exclusions:<br>• Inpatient hospitalizations for patients with a DTPI or stage 2, 3, 4 or unstageable pressure injury diagnosis present on admission, i.e., the diagnosis of pressure injury has a Present on Admission indicator = Y yes (Diagnosis was present at time of inpatient admission) or W (clinically undetermined). |

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|---|---|
| **Measure Name** | Hospital Harm Pressure Injury |
| | • Inpatient hospitalizations for patients with a DTPI found on exam 72 hours or less after the start of the encounter.<br>• Inpatient hospitalizations for patients with a stage 2, 3, 4, or unstageable pressure injury found on exam 24 hours or less after the start of the encounter.<br>• Inpatient hospitalizations for patients with a diagnosis of a COVID-19 infection during the encounter. |
| **Rate calculation** | Numerator / Denominator X 100% |
| **Specifications/definitions** | https://ecqi.healthit.gov/ecqm/eh/2025/cms0826v2 |
| **Data source(s)** | Provider Medical Records |
| **Data Availability Lag** | 2-12+ Weeks |
| **Evaluator(s)** | Submitted by Provider |
| **Evaluation period** | To Be Determined |

# Aim: Patient Safety

## Sub Aim: Safety Events

### Median Time from ED Arrival to ED Departure for Discharged ED Patients*

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|---|---|
| **Measure Name** | Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients |
| **Measure Identifier** | ach_ed_time |
| **Numerator** | Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department. |
| **Denominator** | Patients discharged from the emergency department. |
| **Inclusions/Exclusions** | Exclusions: Patients who expired in the emergency department. |
| **Rate calculation** | Median time |
| **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 (OQR) |
| **Data Availability Lag** | 3-6 Months |
| **Evaluator(s)** | Program Monitoring and Evaluation Contractor |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | *Acute Care Hospital and REH |

# Aim: Patient Safety

## Sub Aim: Safety Events

### Patient Safety Index-90

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|---|---|
| **Measure Name** | Patient Safety Index-90 |
| **Measure Identifier** | ach_psi_90 |
| **Numerator** | Composite value is a weighted average of the risk- and reliability-adjusted rates of the 10 component PSI measures. |
| **Denominator** | N/A |
| **Inclusions/Exclusions** | N/A |
| **Rate calculation** | Weighted average of the 10 component PSI measures |
| **Specifications/definitions** | The 10 component PSI measures: 1. PSI 03-Pressure Ulcer Rate 2. PSI 06-Iatrogenic Pneumothorax Rate 3. PSI 08-In-Hospital Fall with Hip Fracture Rate 4. PSI 09-Postoperative Hemorrhage or Hematoma Rate 5. PSI 10-Postoperative Acute Kidney Injury Requiring Dialysis Rate 6. PSI 11-Postoperative Respiratory Failure Rate 7. PSI 12-Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate 8. PSI 13-Postoperative Sepsis Rate 9. PSI 14-Postoperative Wound Dehiscence Rate 10. PSI 15-Abdominopelvic Accidental Puncture or Laceration Rate |
| **CMS Measures Inventory Tool (CMIT) ID** | 135 - CMS Patient Safety and Adverse Events Composite (CMS PSI 90) - Active - 00135-02-C-HACRP |
| **Data source(s)** | Medicare Fee-for-Service Claims |
| **Data Availability Lag** | ~90 Days |
| **Evaluator(s)** | Program Monitoring and Evaluation Contractor |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | Limited information currently. Additional details are coming soon. |

# Aim: Prevention and Chronic Disease Management

## Sub Aim: Vaccinations

### Influenza Vaccination among Healthcare Personnel

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|---|---|
| **Measure Name** | Influenza Vaccination among Healthcare Personnel |
| **Measure Identifier** | ach_staff_influenza_vaccination |
| **Numerator** | Numerators are to be calculated separately for each of the below groups. Healthcare personnel who, during the time from October 1 (or when the vaccine became available) through March 31 of the following year:<br>(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<br>(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<br>(c) declined influenza vaccination. |
| **Denominator** | Number of healthcare personnel 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 healthcare personnel group may be calculated separately for facility-level quality improvement purposes:<br>(a) Employees: all people who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll).<br>(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.<br>(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 |

| | |
|---|---|
| **Measure Name** | Influenza Vaccination among Healthcare Personnel |
| **CMS Measures Inventory Tool (CMIT) ID** | 390 - Influenza Vaccination Coverage among Healthcare Personnel - Active 00390-01-C- HIQR |
| **Data source(s)** | NHSN |
| **Data Availability Lag** | ~45 Days |
| **Evaluator(s)** | To Be Determined |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | N/A |

# Aim: Quality Management Infrastructure

## Sub Aim: Emergency Preparedness: Inspection Deficiencies Related to Emergency Preparedness requirements

### 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 |
| **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<br><br>*Calculation of summed severity score specific to the QIO program, see Appendix A |
| **Data source(s)** | Enforcement Data |
| **Data Availability Lag** | 1-3 Months |
| **Evaluator(s)** | Program Monitoring and Evaluation Contractor |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | *Acute Care Hospital and REH |

# Aim: Quality Management Infrastructure

## Sub Aim: Inspection Deficiencies Related to the 4 Aims

**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 |
| **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<br>*Calculation of summed severity score specific to the QIO program, see Appendix A |
| **Data source(s)** | Enforcement Data |
| **Data Availability Lag** | 1-3 Months |
| **Evaluator(s)** | Program Monitoring and Evaluation Contractor |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | *Acute Care Hospital and REH |

# Aim: Quality Management Infrastructure

## Sub Aim: Inspection Deficiencies Related to the 4 Aims

**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 |
| **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<br>*Calculation of summed severity score specific to the QIO program, see Appendix A |
| **Data source(s)** | Enforcement Data |
| **Data Availability Lag** | 1-3 Months |
| **Evaluator(s)** | Program Monitoring and Evaluation Contractor |
| **Evaluation period** | To Be Determined |
| **Additional Notes** | *Acute Care Hospital and REH |

# Aim: Quality Management Infrastructure

## Sub Aim: Quality Management Infrastructure: Inspection Deficiencies Related to QAPI requirements

**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 |
| **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<br>*Calculation of summed severity specific to the QIO program, see Appendix A. |
| **Data source(s)** | Enforcement Data |
| **Data Availability Lag** | 1-3 Months |
| **Evaluator(s)** | Program Monitoring and Evaluation Contractor |
| **Evaluation period** | To Be Determined |
| **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.

## Data Source Information

| Data Source | Anticipated Data Availability Lag Time* | Frequency of Updates | Notes |
|---|---|---|---|
| **Medicare Part A Claims** | ~90 Days | Monthly | Includes ~30 days post-discharge window (e.g., readmissions) plus claims run-out and processing. Operationally, 2–3 months is standard for QIN-QIO use via CCSQ/CDR. |
| **Medicare Part B Claims** | ~90 Days | Monthly | Similar to Part A; professional claims finalize on comparable timelines. Some line items appear earlier, but completeness stabilizes ~3 months post-service. |
| **Medicare Part D Claims** | ~90 Days | Monthly | Pharmacy claims adjudicate faster, but CMS completeness expectations still align to ~3 months for analysis. Earlier use possible with caveats. |
| **NHSN** | ~45 Days | Monthly | Facilities submit continuously, but CMS/QIN access typically reflects a 1–1.5 month lag depending on reporting cadence and validation. |
| **HOQR Program** | 3-6 Months | Quarterly | Quarterly submission cycles plus validation mean usable data often trails the performance period by at least one quarter. Best treated as **r**etrospective monitoring, not near-real-time QI. |
| **Provider Medical Records** | 2-12+ Weeks (variable) | TBD | Highly metric-dependent. Includes provider response time, abstraction, and validation. Often, a slow source operationally despite being “real-time” clinically. |
| **CMS Payroll-Based Journal (PBJ)** | ~1-2 Months | Monthly/Quarterly | Facilities submit quarterly; CMS processing and release typically add several weeks. Suitable for workforce trend analysis, not rapid cycle testing. |

| Data Source | Anticipated Data Availability Lag Time* | Frequency of Updates | Notes |
|---|---|---|---|
| **Enforcement Data** | ~1-3 Months | Monthly/Quarterly | Depends on survey completion, citation finalization, and posting. Often lags events significantly but is authoritative once posted. |
| **MDS** | ~1-2 Months | Monthly | Resident assessments are frequent, but QIN-QIO-ready extracts generally stabilize after validation and submission cycles. Faster than claims, slower than EHR data. |
| **QIO AHQT Readiness Assessment** | Near Real-time | Ad Hoc | Internally controlled instrument. Lag is driven mainly by provider completion and internal processing, rather than by CMS systems. |
| **Medicare Part C (Advantage)** | ~3–6+ Months | Monthly | No standardized CMS near-real-time feed. Encounter data completeness varies widely by MAO; expect longer and less predictable lags than FFS. Actual timeline to be determined upon access and use. |
| **Beneficiary Information on the Cloud (BIC)** | 1 Month | Monthly | Estimate aligns with typical beneficiary-level refresh cycles. Often, one of the more “current” CMS-linked sources available to QIN-QIOs. |

***Data availability lag varies by source and reflects CMS processing cycles, provider submission timelines, and validation requirements. For planning purposes, Superior Health analysts assume a 1–3-month lag for most CMS administrative data, with potentially longer lags for quarterly quality programs and Medicare Advantage encounter data. These estimates are reviewed periodically and will be updated as data access processes change or as observed availability timelines are reduced or extended.***

## 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
  - Revised metric descriptions to improve clarity.
  - Added acronym definitions to each table.
- 12/4/2025
  - Removed measure “COVID-19 Vaccination Coverage among Healthcare Personnel”.
- 12/23/2025
  - Updated the definition of “Patient Safety Index-90"
- 2/24/2026
  - Added anticipated data availability lag times for metrics, based on data source(s).
  - Added Aim and Sub Aim as headers for all metrics.

This material was prepared by the Superior Health Quality Alliance, a Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 13SOW-QINQIO-R4-25-26 091125