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NYSPFP Data Collection Methodology

All hospital departments or units can participate in the NYSPFP quality improvement activity. However, CMS is only interested in data from the acute care patients in medicine-surgery, and pediatrics. Please do not submit data from PPS-Exempt units such as mental health, substance abuse, subacute, long term care, swing beds, or hospice care.

Catheter-Associated Urinary Tract Infections (CAUTI)—Outcome Measures

CAUTI standardized infection ratio (SIR)

Numerator: Number of observed CAUTI infections

Denominator: Number of expected CAUTI infections

CAUTI rate per 1,000 catheter-days

Numerator: Number of observed CAUTI infections

Denominator: Number of indwelling urinary catheter days

CAUTI rate per 10,000 patient-days (population rate)¹

Numerator: Number of observed CAUTI infections

Denominator: Number of patient days

Note:

The data used to calculate these measures was submitted by the hospital to the National Healthcare Safety Network (NHSN), and retrieved by NYSPFP.

Measure Specifications:

Refer to the NHSN website,

<http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf>, for measure specifications and definitions.

Results are calculated for acute inpatient units only. NICU, outpatient, behavioral health, rehabilitation, and long term care units are excluded. For a current list of specific units that are excluded, please contact Rob O'Neil at roneil@gnyha.org.

¹ The data for this measure are extracted from NHSN and the rate is calculated by NYSPFP. Literature on this measure: Fakih, M., et. al. "Introducing a Population-Based Outcome Measure to Evaluate the Effect of Interventions to Reduce Catheter-Associated Urinary Tract Infection." American Journal of Infection Control (2011). Available at: [http://www.ajicjournal.org/article/S0196-6553\(11\)00834-0/abstract](http://www.ajicjournal.org/article/S0196-6553(11)00834-0/abstract) (accessed December 15, 2015).

CAUTI—Process Measure

Urinary catheter utilization ratio

Numerator: Number of indwelling urinary catheter days

Denominator: Number of patient days

Note:

The data used to calculate this measure was submitted by the hospital to the National Healthcare Safety Network (NHSN), and retrieved by NYSPFP.

Measure Specifications:

Refer to the NHSN website,

<http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf>, for measure specifications and definitions.

Results are calculated for acute inpatient units only. NICU, outpatient, behavioral health, rehabilitation, and long term care units are excluded. For a current list of specific units that are excluded, please contact Rob O'Neil at roneil@gnyha.org.

Central Line–Associated Blood Stream Infections (CLABSI)—Outcome Measures

CLABSI standardized infection ratio (SIR)

Numerator: Number of observed CLABSI infections

Denominator: Number of expected CLABSI infections

CLABSI rate per 1,000 central line days

Numerator: Number of observed CLABSI infections

Denominator: Number of central line days

CLABSI rate per 10,000 patient-days (population rate)²

Numerator: Number of observed CLABSI infections

Denominator: Number of patient days

Note:

The data used to calculate these measures was submitted by the hospital to the National Healthcare Safety Network (NHSN), and retrieved by NYSPFP.

Measure Specifications:

Refer to NHSN’s website, http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf, for measure specifications and definitions.

Results are calculated for acute inpatient units only. Outpatient, behavioral health, rehabilitation, and long term care units are excluded. For a current list of specific units that are excluded, please contact Rob O’Neil at roneil@gnyha.org.

² The data for this measure are extracted from NHSN and the rate is calculated by NYSPFP. Literature on this measure: Fakih, M., et. al. “Introducing a Population-Based Outcome Measure to Evaluate the Effect of Interventions to Reduce Catheter-Associated Urinary Tract Infection.” American Journal of Infection Control (2011). Available at: [http://www.ajicjournal.org/article/S0196-6553\(11\)00834-0/abstract](http://www.ajicjournal.org/article/S0196-6553(11)00834-0/abstract) (accessed December 15, 2015).

CLABSI—Process Measure

Central line utilization ratio

Numerator: Number of central line days

Denominator: Number of patient days

Note:

The data used to calculate this measure was submitted by the hospital to the National Healthcare Safety Network (NHSN), and retrieved by NYSPFP.

Measure Specifications:

Refer to NHSN's website,

http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf, for measure specifications and definitions.

Results are calculated for acute inpatient units only. Outpatient, behavioral health, rehabilitation, and long term care units are excluded. For a current list of specific units that are excluded, please contact Rob O'Neil at roneil@gnyha.org.

Surgical Site Infections (SSI)—Outcome Measures

SSI rates per 100 operative procedures (hip, CABG, colon, hysterectomy)

Numerator: Number of observed surgical site infections

Denominator: Number of operative events

SSI standardized infection ratios (SIR) (hip, CABG, colon, hysterectomy)

Numerator: Number of observed surgical site infections

Denominator: Number of expected surgical site infections

Knee prosthesis SSI rate per 100 operative procedures

Numerator: Number of observed knee prosthesis surgical site infections

Denominator: Number of knee prosthesis operative events

Knee prosthesis SSI standardized infection ratio (SIR)

Numerator: Number of observed knee prosthesis surgical site infections

Denominator: Number of expected knee prosthesis surgical site infections

Note:

The data used to calculate these measures was submitted by the hospital to the National Healthcare Safety Network (NHSN), and retrieved by NYSPFP.

Measure Specifications:

Refer to NHSN's website,

<http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf>, for measure specifications and definitions.

SSI—Process Measure

A brief NYSPFP surgical site infection assessment survey is distributed quarterly to measure hospitals' progress in implementing each of the components of the NYSPFP Advanced Colon Bundle. For more information on the NYSPFP Advanced Colon Bundle, see: https://www.nyspfp.org/Materials/Colon_Bundle_Summary.pdf.

Data Submission Method:

Hospital submits data via the NYSPFP data portal.

Data Submission Time Period:

Quarterly.

Data Submission Deadlines:

NYSPFP will announce the survey period open and close dates on a quarterly basis.

Ventilator-Associated Events (VAE) / Delirium—Outcome Measures

Ventilator-associated event (VAE) rate per 1,000 ventilator days

Numerator: Number of observed VAEs (VAC, IVAC, PVAP)

Denominator: Number of ventilator days

Ventilator-associated condition (VAC) rate per 1,000 ventilator days

Numerator: Number of observed VACs

Denominator: Number of ventilator days

Infection-related ventilator-associated complication (IVAC) rate per 1,000 ventilator days

Numerator: Number of observed IVACs

Denominator: Number of ventilator days

Possible ventilator-associated pneumonia (PVAP) rate per 1,000 ventilator days

Numerator: Number of observed PVAPs

Denominator: Number of ventilator days

Infection-related ventilator-associated complication and possible ventilator-associated pneumonia (IVAC+) rate per 1,000 ventilator days

Numerator: Number of observed IVACs and PVAPs

Denominator: Number of ventilator days

Ventilator-associated event (VAE) standardized infection ratio (SIR)

Numerator: Number of observed VAEs

Denominator: Number of predicted VAEs

Infection-related ventilator-associated complication and possible ventilator-associated pneumonia (IVAC+) standardized infection ratio (SIR)

Numerator: Number of observed IVACs and PVAPs

Denominator: Number of predicted IVACs and PVAPs

Note:

The data used to calculate these measures was submitted by the hospital to the National Healthcare Safety Network (NHSN), and retrieved by NYSPFP.

Measure Specifications:

Refer to the [National Healthcare Safety Network \(NHSN\) documentation](#) for VAE measure specifications and definitions.

Results are calculated for acute inpatient units only. Outpatient, behavioral health, rehabilitation, pediatric, neonatal, and long term care units are excluded. For a current list of specific units that are excluded, please contact Rob O'Neil at roneil@gnyha.org.

Delirium Prevalence Rate

Numerator: Number of ICU patients for whom delirium was assessed as present using a delirium assessment tool (e.g. CAM-ICU or ICDSC)

Denominator: Number of ICU patients assessed for delirium using a delirium assessment tool identified in the prevalence study

Measure Specifications:

Refer to [AHRQ](#) for measure specifications and related definitions.

Definitions:

Prevalence Study: A prevalence study, or a cross-sectional count of the number of cases in a population, measures the total number of persons in the ICU who were assessed positively for delirium on the day of this survey.

Note:

For NYSPFP's purposes, hospitals are encouraged to conduct a prevalence study for this measure on a monthly basis (in conjunction with the prevalence studies for the pain, agitation, and delirium [PAD] measures).

NYSPFP asks that hospital-specific data be entered into NYSPFP's data collection portal on a monthly basis within 45 days of the month's end.

VAE / Delirium—Process Measures

Ventilator Utilization Ratio

Numerator: Number of ventilator days

Denominator: Number of patient days

Note:

The data used to calculate this measure was submitted by the hospital to the National Healthcare Safety Network (NHSN), and retrieved by NYSPFP.

Measure Specifications:

Refer to the [National Healthcare Safety Network \(NHSN\) documentation](#) for VAE measure specifications and definitions.

Results are calculated for acute inpatient units only. Outpatient, behavioral health, rehabilitation, pediatric, neonatal, and long term care units are excluded. For a current list of specific units that are excluded, please contact Rob O'Neil at roneil@gnyha.org.

Pain assessment utilization rate

Numerator: Number of ICU patients identified in the prevalence study with a pain assessment completed at least once in the last 24 hours using a pain assessment tool (e.g. CPOT or BPS)

Denominator: Number of ICU patients identified in the prevalence study

Measure specifications:

Refer to the "[Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit](#)", published by the Society for Critical Care Medicine in January 2013, for more information about evidence-based protocols for preventing and treating pain, agitation, and delirium in critically ill patients.

Definitions:

Prevalence Study: A prevalence study, or a cross-sectional count of the number of cases in a population, measures the total number of persons in the ICU who had at least one assessment for pain conducted on the day of this survey.

Note:

For NYSPFP's purposes, hospitals are encouraged to conduct a prevalence study for this measure on a monthly basis (in conjunction with the prevalence studies for the pain, agitation, and delirium [PAD] measures). NYSPFP asks that hospital-specific data be entered into NYSPFP's data collection portal on a monthly basis within 45 days of the month's end.

Agitation assessment utilization rate

Numerator: Number of ICU patients identified in the prevalence study with an agitation assessment completed at least once in the last 24 hours using an agitation assessment tool (e.g. RASS or SAS)

Denominator: Number of ICU patients identified in the prevalence study

Measure Specifications:

Refer to the "[Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit](#)", published by the Society for Critical Care Medicine in January 2013, for more information about evidence-based protocols for preventing and treating pain, agitation, and delirium in critically ill patients.

Definitions:

Prevalence Study: A prevalence study, or a cross-sectional count of the number of cases in a population, measures the total number of persons in the ICU who had at least one assessment for agitation conducted on the day of this survey.

Note:

For NYSPFP's purposes, hospitals are encouraged to conduct a prevalence study for this measure on a monthly basis (in conjunction with the prevalence studies for the pain, agitation, and delirium [PAD] measures). NYSPFP asks that hospital-specific data is entered into NYSPFP's data collection portal on a monthly basis within 45 days of the month's end.

Delirium assessment utilization rate

Numerator: Number of ICU patients identified in the prevalence study with a delirium assessment completed at least once in the last 24 hours using a delirium assessment tool (e.g. CAM-ICU or ICDSC)

Denominator: Number of ICU patients identified in the prevalence study

Measure specifications:

Refer to the "[Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit](#)", published by the Society for Critical Care Medicine in January 2013, for more information about evidence-based protocols for preventing and treating pain, agitation, and delirium in critically ill patients.

Definitions:

Prevalence Study: A prevalence study, or a cross-sectional count of the number of cases in a population, measures the total number of persons on in the ICU who had at least one assessment for delirium conducted on the day of this survey.

Note:

For NYSPFP's purposes, hospitals are encouraged to conduct a prevalence study for this measure on a monthly basis (in conjunction with the prevalence studies for the pain, agitation, and delirium [PAD] measures). Hospitals are asked to enter data into the NYSPFP data collection portal on a monthly basis within 45 days of the month's end.

Sepsis—Outcome Measure

AHRQ Patient Safety Indicator (PSI) 13: Post-operative sepsis rate per 1,000 elective surgical discharges for patients ages 18 years and older

Numerator: Number of hospital-acquired sepsis cases in the defined surgical populations

Denominator: Elective surgical discharges age 18 and older

Note:

No data collection is required for this measure; it will be calculated from claims data on a quarterly basis.

Measure Specifications:

On October 1, 2015 the US health care industry implemented the International Classification of Diseases, 10th Revision (ICD-10). Prior this date, the data used for this PSI measure was coded using the International Classification of Diseases, 9th Revision (ICD-9). This change in methodology has resulted in PSI measure data that is not comparable before and after the implementation of ICD-10. In order to account for this, NYSPFP reports PSI-13 separately for data reported before and after October 1, 2015.

For AHRQ's PSI-13 measure specifications, please see the following references:

[AHRQ measure specifications using ICD-10 codes](#)

[AHRQ measure specifications using ICD-9 codes](#)

Sepsis—Process Measures

Measures examine adherence to the following individual components of the three-hour and composite bundles:

- Timely Lactate Level
- Timely Blood Cultures Prior To Antibiotics
- Timely Administration of Broad Spectrum Antibiotics
- Timely Crystalloid Administration
- Timely Vasopressor Administration
- Timely Re-measurement of Lactate
- Timely Fluid Assessment

Measure Specifications:

Data reported prior to 2017 is not comparable to data reported from Q1 2017 onward due to revisions in the methodology.

Please refer to the NYS Department of Health's (DOH's) / IPRO's measure specifications:

- [2017 Sepsis Measure Specifications](#)
- [2015-16 Sepsis Measure Specifications](#)

Refer to the [DOH's Data Dictionary for Severe Sepsis or Septic Shock](#) for information on specific data elements.

Note:

No additional data collection or submission is required. NYSPFP has aligned with the NYS DOH and its contractor IPRO for data collection and analysis to streamline and reduce the burden of redundant data collection for NYSPFP-participating hospitals. DOH will provide NYSPFP with hospital-level aggregate severe sepsis and septic shock data.

Antibiotic Stewardship Program (ASP) / Clostridium difficile (C. difficile) / Methicillin-resistant Staphylococcus aureus (MRSA)—Outcome Measures

C. difficile infection (CDI) standardized infection ratio (SIR)

Numerator: Number of incident hospital-onset CDI LabID events

Denominator: Number of predicted hospital-onset CDI LabID events

CDI healthcare hospital-onset incidence rate per 10,000 patient days

Numerator: Number of incident hospital-onset CDI LabID events

Denominator: Number of patient days for the facility

MRSA bloodstream infection standardized infection ratio (SIR)

Numerator: Number of incident hospital-onset MRSA LabID events

Denominator: Number of predicted hospital-onset MRSA LabID events

MRSA bloodstream infection hospital-onset incidence rate per 10,000 patient days

Numerator: Number of incident hospital-onset MRSA LabID events

Denominator: Number of patient days for the facility

Note:

The data used to calculate these measures was submitted by the hospital to the National Healthcare Safety Network (NHSN), and retrieved by NYSPFP.

Measure Specifications:

Refer to the [National Healthcare Safety Network \(NHSN\) website](#) for measure specifications and definitions.

ASP / *C. difficile* / MRSA—Process Measure

The ASP / *C. difficile* / MRSA assessment is a quarterly survey which measures each hospital's progress in implementing each of the CDC's Core Components of Antibiotic Stewardship. For more information on the CDC's Core Components of Antibiotic Stewardship, see: <https://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html>.

Data Submission Method:

Hospital submits data via the NYSPFP data portal.

Data Submission Time Period:

Quarterly.

Data Submission Deadlines:

NYSPFP will announce the survey period open and close dates on a quarterly basis.

Potential Adverse Drug Events (ADEs)–Process Measures

Percentage of Supratherapeutic INR results

Numerator: Number of INR results with values ≥ 5

Denominator: Number of all INR tests resulted

Notes:

Inclusion Criteria:

- Samples drawn and resulted from the following units:
 - Inpatient
 - Intensive Care Unit (ICU)
 - Medical/Surgical
 - Step-Down/Intermediate
 - Critical Care Unit (CCU)
 - Obstetrics
 - Pediatrics
 - Neonatal

Exclusion Criteria:

- Samples drawn and resulted from the following units:
 - Outpatient
 - Emergency Department
 - PPS-exempt units (Psych, Rehab)
 - All procedural and perioperative areas (i.e. - OR, PACU, Radiology, Cath Lab, Endoscopy, etc.)
- Samples not resulted

Percentage of hyperglycemic POCT blood glucose results \geq 200 mg/dL

Numerator: Number of POCT blood glucose results with values \geq 200 mg/dL

Denominator: Number of all POCT blood glucose tests resulted

Notes:

Inclusion Criteria:

- Samples drawn and resulted from the following units:
 - Inpatient
 - Intensive Care Unit (ICU)
 - Medical/Surgical
 - Step-Down/Intermediate
 - Critical Care Unit (CCU)
 - Obstetrics

Exclusion Criteria:

- Samples drawn and resulted from the following units:
 - Outpatient
 - Emergency Department
 - Pediatrics
 - Neonatal
 - PPS-exempt units (Psych, Rehab)
 - All procedural and perioperative areas (i.e. - OR, PACU, Radiology, Cath Lab, Endoscopy, etc.)
- Samples not resulted

Percentage of hyperglycemic POCT blood glucose results \geq 300 mg/dL

Numerator: Number of POCT blood glucose results with values \geq 300 mg/dL

Denominator: Number of all POCT blood glucose tests resulted

Notes:

Inclusion Criteria:

- Samples drawn and resulted from the following units:
 - Inpatient
 - Intensive Care Unit (ICU)
 - Medical/Surgical
 - Step-Down/Intermediate
 - Critical Care Unit (CCU)
 - Obstetrics

Exclusion Criteria:

- Samples drawn and resulted from the following units:
 - Outpatient
 - Emergency Department
 - Pediatrics
 - Neonatal
 - PPS-exempt units (Psych, Rehab)
 - All procedural and perioperative areas (i.e. - OR, PACU, Radiology, Cath Lab, Endoscopy, etc.)
- Samples not resulted

Percentage of hypoglycemic POCT blood glucose results \leq 40 mg/dL

Numerator: Number of POCT blood glucose results with values \leq 40 mg/dL

Denominator: Number of all POCT blood glucose tests resulted

Notes:

Inclusion Criteria:

- Samples drawn and resulted from the following units:
 - Inpatient
 - Intensive Care Unit (ICU)
 - Medical/Surgical
 - Step-Down/Intermediate
 - Critical Care Unit (CCU)
 - Obstetrics

Exclusion Criteria:

- Samples drawn and resulted from the following units:
 - Outpatient
 - Emergency Department
 - Pediatrics
 - Neonatal
 - PPS-exempt units (Psych, Rehab)
 - All procedural and perioperative areas (i.e. - OR, PACU, Radiology, Cath Lab, Endoscopy, etc.)
- Samples not resulted

Percentage of hypoglycemic POCT blood glucose results \leq 70 mg/dL

Numerator: Number of POCT blood glucose results with values \leq 70 mg/dL

Denominator: Number of all POCT blood glucose tests resulted

Notes:

Inclusion Criteria:

- Samples drawn and resulted from the following units:
 - Inpatient
 - Intensive Care Unit (ICU)
 - Medical/Surgical
 - Step-Down/Intermediate
 - Critical Care Unit (CCU)
 - Obstetrics

Exclusion Criteria:

- Samples drawn and resulted from the following units:
 - Outpatient
 - Emergency Department
 - Pediatrics
 - Neonatal
 - PPS-exempt units (Psych, Rehab)
 - All procedural and perioperative areas (i.e. - OR, PACU, Radiology, Cath Lab, Endoscopy, etc.)
- Samples not resulted

Rate of opioid reversal agent administration on inpatient care units per 1,000 patient days

Numerator: Number of naloxone doses administered on inpatient care units

Denominator: Number of total patient days

Notes:

Inclusion Criteria:

- Inpatient
- Intensive Care Unit (ICU)
- Medical/Surgical
- Step-Down/Intermediate
- Critical Care Unit (CCU)
- Obstetrics
- Pediatrics
- Neonatal

Exclusion Criteria:

- Outpatient
- Emergency Department
- PPS-exempt units (Psych, Rehab)
- All procedural and perioperative areas (i.e. - OR, PACU, Radiology, Cath Lab, Endoscopy, etc.)
- Low-dose, continuous infusions of naloxone

Injuries from Falls and Immobility—Outcome Measures

Falls with moderate or greater harm per 1,000 patient days

Numerator: Number of falls with injury level of moderate or greater severity

Denominator: Number of patient days on eligible nursing units

Falls with any harm per 1,000 patient days

Numerator: Number of falls with any harm (minor and greater)

Denominator: Number of patient days on eligible nursing units

Falls per 1,000 patient days

Numerator: Number of falls

Denominator: Number of patient days on eligible nursing units

Notes:

Hospitals that participate in the National Database of Nursing Quality Indicators (NDNQI) may sign a data waiver for NYSPFP to access data for these measures **or** hospitals may choose to enter this data manually into the NYSPFP data collection portal.

Definitions:

Fall: A patient fall is an unplanned descent to the floor with or without injury to the patient, and occurs on an eligible reporting nursing unit. All unassisted and assisted falls are to be included in the data set whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). Hospitals should include patients who roll off a low bed onto a mat in the data set as a fall, as well.

Exclude falls by:

- Visitors
- Students
- Staff members
- Falls on other units not eligible for reporting

If a patient from an eligible reporting unit was not on the unit at the time of the fall, then it should be excluded (e.g., patient falls in radiology department).

Assisted Fall: A fall in which any staff member was with the patient and attempted to minimize the fall's impact by easing the patient's descent to the floor, or in some manner attempting to break the patient's fall (e.g., when a patient who is ambulating becomes weak and the staff lowers the patient to the floor). In this scenario, the staff was using professional judgment to prevent injury to the patient. A fall that is reported to have been assisted by a family member or a visitor counts as a fall, but does not count as an assisted fall. Assisting the patient back into a bed or chair after a fall is not an assisted fall.³

Injury Level: When nursing staff write the initial fall report, the extent of the injury may not yet be known. Hospitals have 24 hours to determine the injury level (e.g., hospitals may be waiting for diagnostic test results or consultation reports). When the patient is discharged within 24 hours from the fall, determine injury level at the time of discharge.

- None: Patient had no injuries (no signs or symptoms) resulting from the fall, or if an x-ray, CT scan, or other post-fall evaluation results in a finding of no injury.
- Minor: Resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, pain, bruise or abrasion.
- Moderate: Resulted in suturing, applying steri-strips/skin glue, splinting, or muscle/joint strain.
- Major: Resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of a fall.
- Death: The patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall).⁴

Patient Days: Conceptually, a patient day is 24 hours, beginning the hour of admission. The total number of patient days for each unit is reported for each calendar month in the quarter.

³ National Database of Nursing Quality Indicators (NDNQI) Guidelines for Data Collection and Submission on Quarterly Indicators. Version 9.4 (February 2012).

⁴ See note 4.

Eligible Inpatient Units:

- Critical Care-Adult
- Step Down
- Medical
- Surgical
- Med-Surg Combined
- Bone Marrow Transplant
- Burn
- Critical Access Unit
- High Acuity
- Moderate Acuity
- Blended Acuity

Suggested Data Sources:

- Incident, variance or occurrence report
- Nurses notes
- Progress notes
- Radiology report after time of fall
- Census reports
- Other electronic administrative or medical record reports

Injuries from Falls and Immobility—Process Measure

Percent of falls with moderate or greater severity in which the patient had a fall risk assessment performed and documented within 24 hours of the fall

Numerator: Number of falls with moderate or greater injury with a documented risk assessment within 24 hours prior to the fall

Denominator: Number of falls with injury level of moderate or greater severity

Notes:

Hospitals that participate in the National Database of Nursing Quality Indicators (NDNQI) may sign a data waiver for NYSPFP to access data for this measure or hospitals may choose to enter this data manually into the NYSPFP data collection portal.

Definitions:

Risk Assessment: Fall risk assessments (screenings) occur on admission and may be repeated periodically throughout the patient's stay. Facilities can use any published instrument (e.g., The Hendrich II,⁵ Morse,⁶ and Schmid⁷ Scales); or create or modify any risk assessment instrument. Different scales can be used within a facility depending upon the population needs of the units.

⁵ Hendrich, A.L., Bender, P.S. & Nyhuis, A. "Validation of the Hendrich II Fall Risk Model: A Large Concurrent Case/Control Study of Hospitalized Patients." *Applied Nursing Research* (2003) 16 (1): 9–21.

⁶ Morse, J. M., R. Morse, et al. "Development of a Scale to Identify the Fall-Prone Patient." *Canadian Journal of Aging* (1989) (8): 366–377.

⁷ Schmid, N. A. "1989 Federal Nursing Service Award Winner. Reducing Patient Falls: A Research-Based Comprehensive Fall Prevention Program." *Military Medicine* (1990) 155 (5): 202–207.

Eligible Inpatient Units:

- Critical Care-Adult
- Step Down
- Medical
- Surgical
- Med-Surg Combined
- Bone Marrow Transplant
- Burn
- Critical Access Unit
- High Acuity
- Moderate Acuity
- Blended Acuity

Sampling: A traditional sampling methodology does not apply to this measure.

Pressure Injuries—Outcome Measures

AHRQ Patient Safety Indicator (PSI) 3—Stage III or IV pressure injuries (secondary diagnosis) per 1,000 discharges among patients ages 18 years and older

Numerator: Number of discharged adult patients with a facility-acquired pressure injury of stage III or IV (or unstageable)

Denominator: Number of medical and surgical discharges age 18 years and older

Note:

No data collection is required for this measure; it will be calculated from claims data on a quarterly basis.

Measure Specifications:

On October 1, 2015 the US health care industry implemented the International Classification of Diseases, 10th Revision (ICD-10). Prior this date, the data used for this PSI measure was coded using the International Classification of Diseases, 9th Revision (ICD-9). This change in methodology has resulted in PSI measure data that is not comparable before and after the implementation of ICD-10. In order to account for this, NYSPFP reports PSI-3 separately for data reported before and after October 1, 2015.

For AHRQ's PSI-3 measure specifications, please see the following references:

[AHRQ measure specifications using ICD-10 codes](#)

[AHRQ measure specifications using ICD-9 codes](#)

Prevalence rate of facility-acquired pressure injuries of Stage 2 or higher per 100 patients

Numerator: Number of patients with a facility-acquired Stage 2 or higher pressure injury at a particular point in time

Denominator: Number of patients on units being studied at a particular point in time

Notes:

Hospitals that participate in the National Database of Nursing Quality Indicators (NDNQI) may sign a data waiver for NYSPFP to access data for the prevalence rate of pressure injuries stage 2 or higher measure **or** hospitals may choose to enter this data manually into the NYSPFP data collection portal. Refer to the below definition of prevalence study for more information about the data submission time periods.

Definitions:

Pressure Injury:⁸ A pressure injury is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.

- Pressure: The force that is applied vertically or perpendicularly to the skin's surface. Pressure compresses underlying tissue and small blood vessels, hindering blood flow and nutrient supply. Tissues become ischemic and are damaged or die.
- Shear: Occurs when one layer of tissue slides horizontally over another, deforming adipose and muscle tissue, and disrupting blood flow (e.g., when the head of the bed is raised > 30 degrees). Both require pressure exerted by body against bed/chair surface to create the tissue injury.
- Other locations: Pressure injuries can develop on any skin surface subject to excess pressure such as under oxygen tubing, drainage tubing, casts, cervical collars, or other medical devices.

Hospital-Acquired Pressure Injury: Those discovered or documented after the first 24 hours from the time of inpatient admission.

⁸ The Joint Commission. "Implementation Guide for the NQF Endorsed Nursing-Sensitive Care Measure Set" (2009). Retrieved from: <http://www.jointcommission.org/assets/1/6/NSC%20Manual.pdf>, and adapted from ANA NDNQI.

Category and Stages of Observed Pressure Injuries:

- Category/stage I: Non-blanchable erythema
- Category/stage II: Partial thickness
- Category/stage III: Full thickness skin loss
- Category/stage IV: Full thickness tissue loss
- Unstageable/Unclassified: Full thickness skin or tissue loss—depth unknown
- Suspected deep tissue injury—depth unknown

Suggested Data Sources:

- Nurses notes
- Pressure injury prevalence study worksheet or data collection tool
- Progress notes

Sampling/Prevalence Study: A prevalence study, or a cross-sectional count of the number of cases in a population, measures the total number of persons with a pressure injury in a hospital/hospital unit on the day of the pressure injury survey. A traditional sampling methodology does not apply to this measure.

Eligible Inpatient Units:

- Critical Care-Adult
- Step Down
- Medical
- Surgical
- Med-Surg Combined
- Bone Marrow Transplant
- Burn
- Critical Access Unit
- High Acuity
- Moderate Acuity
- Blended Acuity

Pressure Injuries—Process Measure

Percent of patients with documentation of a pressure injury risk assessment within 24 hours of admission

Numerator: Number of patients identified in the prevalence study with a Stage 2 or higher facility-acquired pressure injury who had a risk assessment within 24 hours of admission

Denominator: Number of patients with a facility-acquired Stage 2 or higher pressure injury identified in the prevalence study

Notes:

Hospitals that participate in the National Database of Nursing Quality Indicators (NDNQI) may sign a data waiver for NYSPFP to access data for this measure or hospitals may choose to enter this data manually into the NYSPFP data collection portal.

Definitions:

Risk Assessment:⁹ The evaluation of patient risk for pressure injury development. Use of a validated instrument (scale) for assessing pressure injury risk is recommended by AHRQ and the Wound Ostomy & Continence Nurses Society (WOCN). Both the Braden and Norton Scales for assessing pressure injury risk have been validated for adults in research studies. Facilities should assess patient pressure injury risk on admission. The Institute for Healthcare Improvement (IHI) recommends that a pressure injury risk assessment be conducted within four hours of admission.¹⁰

Sampling/Prevalence Study: See [Pressure Injuries—Outcome Measure](#) section for more details. The number of patients with pressure injury risk assessment on admission can be collected in conjunction with the prevalence study. All patients with facility-acquired pressure injury stage 2 or higher should be included. A traditional sampling methodology does not apply to this measure.

⁹ See note 10.

¹⁰ Institute for Healthcare Improvement. “How-to Guide: Prevent Pressure Ulcers” (2011); Cambridge, MA. (Available at <http://www.ihl.org/resources/Pages/Tools/HowtoGuidePreventPressureUlcers.aspx>).

Venous Thromboembolism (VTE)—Outcome Measures

VTE rate per 100 adult inpatient discharges

Numerator: Number of facility-acquired VTEs among adult inpatient discharges

Denominator: Number of medical and surgical adult inpatient discharges

Note:

No data collection is required for this measure; it will be calculated from claims data on a quarterly basis.

Measure Specifications:

Patients under 18 years of age are excluded.

For VTE ICD-10 codes, see Tables 7.03 and 7.04 of Appendix_A.1.pdf within the [Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures](#).

For VTE ICD-9 codes, see:

<https://www.cms.gov/medicare/coding/ICD9providerdiagnosticcodes/codes.html>

VTE rate for medical adult inpatient discharges

Numerator: Number of facility-acquired VTEs among medical adult inpatient discharges

Denominator: Number of adult inpatient medical discharges

Note:

No data collection is required for this measure; it will be calculated from SPARCS claims data on a quarterly basis.

Measure Specifications:

Patients under 18 years of age are excluded.

For medical categories, see Table 5 in the CMS Acute IPPS MS-DRGs:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>

For VTE ICD-10 codes, see Tables 7.03 and 7.04 of Appendix_A.1.pdf within the [Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures](#).

For VTE ICD-9 codes, see:

<https://www.cms.gov/medicare/coding/ICD9providerdiagnosticcodes/codes.html>

VTE rate for surgical adult inpatient discharges

Numerator: Number of facility-acquired VTEs among surgical adult inpatient discharges

Denominator: Number of adult inpatient surgical discharges

Note:

No data collection is required for this measure; it will be calculated from claims data on a quarterly basis.

Measure Specifications:

Patients under 18 years of age are excluded.

For surgical categories see Table 5 in CMS Acute IPPS MS-DRGs:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>

For VTE ICD-10 codes, see Tables 7.03 and 7.04 of Appendix_A.1.pdf within the [Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures](#).

For VTE ICD-9 codes, see:

<https://www.cms.gov/medicare/coding/ICD9providerdiagnosticcodes/codes.html>

Perioperative pulmonary embolism or deep vein thrombosis (secondary diagnosis as defined by AHRQ) per 1,000 surgical discharges for patients ages 18 years and older (AHRQ PSI-12)

Numerator: Number of surgical patients with hospital-acquired deep vein thrombosis or pulmonary embolism

Denominator: Number of surgical discharges

Notes:

No data collection is required for this measure; it will be calculated from claims data on a quarterly basis.

Measure Specifications:

Patients under 18 years of age are excluded.

On October 1, 2015 the US health care industry implemented the International Classification of Diseases, 10th Revision (ICD-10). Prior this date, the data used for this PSI measure was coded using the International Classification of Diseases, 9th Revision (ICD-9). This change in methodology has resulted in PSI measure data that is not comparable before and after the implementation of ICD-10. In order to account for this, NYSPFP reports PSI-12 separately for data reported before and after October 1, 2015.

For AHRQ's PSI-12 measure specifications, please see the following references:

[AHRQ measure specifications using ICD-10 codes](#)

[AHRQ measure specifications using ICD-9 codes](#)

Venous Thromboembolism (VTE)—Process Measure

VTE-1: Venous Thromboembolism Prophylaxis

Numerator:

Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given:

- the day of or the day after hospital admission
- the day of or the day after surgery end date for surgeries that start the day of or the day after hospital admission

Denominator: All adult patients meeting inclusion criteria (as specified in the Specifications Manual for National Hospital IQR)

Note:

Excluded Populations Include:

- Patients less than 18 years of age
- Patients who have a length of stay (LOS) less than two days and greater than 120 days
- Patients with *Comfort Measures Only* documented on day of or day after hospital arrival
- Patients enrolled in clinical trials
- Patients who are direct admits to intensive care unit (ICU), or transferred to ICU the day of or the day after hospital admission with ICU LOS greater than or equal to one day
- Patients with *ICD-10-CM Principal Diagnosis Code* of Mental Disorders or Stroke as defined in Appendix A, Table 7.01, 8.1 or 8.2

Measure Specifications:

Specifications for VTE-1 are located in 2j_VTE1.pdf within the [Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures](#).

Preventable Readmissions—Outcome Measures

30-day potentially preventable readmission rate (PPR)

Numerator: Number of PPRs in 30 days

Denominator: Number of eligible admissions

30-day all-cause readmission rate

Numerator: Number of readmissions from all causes (without regard to clinical relatedness) within 30 days of discharge

Denominator: Number of eligible admissions for any condition

Notes:

No data collection is required for this measure; it will be calculated from claims data on a quarterly basis.

NYSPFP Resources:

NYSPFP Readmissions Diagnostic Reports, available at <https://www.nyspfp.org/Members/myData.aspx> (NYSPFP log in required to view hospital-specific readmission reports).

Webconference on NYSPFP Hospital-Specific Readmission Report (March 21, 2012), available at <https://www.nyspfp.org/Members/Initiatives/Readmissions/MeetingMaterials.aspx>.

Preventable Readmissions—Process Measures

NYSPFP will collect and report on the results of the following questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS):

- During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
 - Response options: Yes, No
- During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? [
 - Response options: Yes, No
- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
 - Response options: Strongly disagree, Disagree, Agree, Strongly agree
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
 - Response options: Strongly disagree, Disagree, Agree, Strongly agree
- When I left the hospital, I clearly understood the purpose for taking each of my medications.
 - Response options: Strongly disagree, Disagree, Agree, Strongly agree

Notes:

No data collection is required for this measure; it will be calculated from existing databases. The exact data source is pending.

Measure Specifications:

For more information regarding the HCAHPS Survey, see:
<http://www.hcahpsonline.org/home.aspx>.

For the HCAHPS survey instrument, see:
<http://www.hcahpsonline.org/surveyinstrument.aspx>

Culture and Leadership—Process Measures

Patient and Family Engagement Assessment

The patient and family engagement assessment is a brief quarterly survey which measures each hospital's progress in implementation of proven best practices provided by CMS that emerged as part of the PfP 1.0 model test campaign. It includes five areas:

1. Implementation of a planning check list for patients known to have a planned admission to the hospital;
2. Conducting shift change huddles and bedside reporting with patients and families;
3. Designation of an accountable leader in the hospital who is responsible for patient and family engagement;
4. Hospitals have an active patient and family engagement committee or other committees where patients are represented;
5. One or more patient representatives serving on the hospital Board of Directors.

Data Submission Method:

Hospital submits data via the NYSPFP data portal.

Data Submission Time Period:

Quarterly.

Data Submission Deadlines:

NYSPFP will announce the survey period open and close dates on a quarterly basis.

Leadership Assessment

The leadership assessment is a brief quarterly survey which measures each hospital's progress in implementation of proven best practices, as provided by CMS. It includes four areas:

1. Hospital has regular quality review aligned with the Partnership for Patients goals;
2. Hospital has a public commitment to safety improvement with transparency in sharing more than core measurement data with the public;
3. Hospital staff, all or nearly all, have a role or perceived goal in patient safety;
4. Hospital board of trustees has a quality committee established with regular review of patient safety data, including review and analysis of risk events.

Data Submission Method:

Hospital submits data via the NYSPFP data portal.

Data Submission Time Period:

Quarterly.

Data Submission Deadlines:

NYSPFP will announce the survey period open and close dates on a quarterly basis.

Worker Safety / Safe Patient Handling (SPH)—Outcome Measure

Musculoskeletal injuries from patient handling activity per 100 direct care providers

Numerator: Number of musculoskeletal injuries from patient handling activities among direct care providers

Denominator: Total hours worked by direct care providers

Measure Specifications:

Measure Source: [OSHA Form 300, Column F](#).

Note: Public hospitals are required to use [New York State Department of Labor Form SH-900](#) instead of the OSHA Form 300. The SH-900 is identical to the OSHA Form 300.

Calculating Numerator:

- Review all entries in OSHA Form 300 or SH-900 for selected time period.
- Review Column F to determine if the entry is a musculoskeletal injury that occurred during patient handling activities.
- Add up all entries that meet the above criteria.
- Note: To standardize data collection, NYSPFP recommends that hospitals use a specific code in Column F (e.g., MS-PH) to denote a musculoskeletal injury that occurred during patient handling activities.

Calculating Denominator:

- Work with Human Resources or Payroll to obtain data.
- Include hours worked by salaried, hourly, part-time and seasonal direct care providers, as well as hours worked by other direct care providers subject to day to day supervision by your establishment (e.g., temporary help services workers).
- Do not include vacation, sick leave, holidays, or any other non-work time, even if employees were paid for it.
- If your establishment keeps records of only the hours paid or if you have employees who are not paid by the hour, please estimate the hours that the employees actually worked.

Calculating Rate:

NYSPFP calculates the rate of musculoskeletal injuries from patient handling activity per 100 direct care providers using the following formula:

$$(\text{Numerator} * 200,000) / \text{Denominator}$$

For more information about this calculation, please refer to page 5 of [OSHA's Forms for Recording Work-Related Injuries and Illnesses](#) (Form 300).

Definitions:

Direct Care Provider: A healthcare provider that as a regular part of the job class duties is required to lift, move or handle a patient, or is credentialed by the hospital for direct patient contact. Job classes included in this measure are: RN, LPN, Aides, OT, PT, Radiology Technicians/Nurses, and Transporters.

Musculoskeletal Injury: Include cases where the nature of the injury or illness is pinched nerve; herniated disc; meniscus tear; sprains, strains, tears; hernia (traumatic and nontraumatic); pain, swelling, and numbness; carpal or tarsal tunnel syndrome; Raynaud's syndrome or phenomenon; musculoskeletal system and connective tissue diseases and disorders, when the event or exposure leading to the injury or illness is overexertion and bodily reaction, unspecified; overexertion involving outside sources; repetitive motion involving microtasks; other and multiple exertions or bodily reactions; and rubbed, abraded, or jarred by vibration.

Patient Handling Activities: This includes any acts of lifting, transferring, or repositioning health care patients.

Data Submission:

Data Submission Method:

Hospital-specific data entry into NYSPFP data collection portal.

Data Submission Time Period:

Monthly.

Data Submission Deadline:

Submit data to NYSPFP within 45 days.

Retired Measures

Adverse Drug Events (ADEs)—Outcome Measure

Rate of ADEs that resulted in patient harm from high-alert drugs per 1,000 patient days

Numerator: Number of total ADEs that resulted in patient harm (NCC MERP Index: Category E through Category I) from anticoagulants, insulin, and opioids

Denominator: Number of total patient days

(NOTE: Collection of this measure by NYSPFP has been discontinued as of August 2017)

Definitions:

ADE: An occurrence/incident that results in an injury from the use of a drug. For purposes of NYSPFP, this includes *adverse drug reactions, errors in medication preparation, administration, prescribing, dosing, or the discontinuation of drug therapy that results in harm.*¹¹

High-Alert Medications:¹²

- Anticoagulants
- Insulin
- Opioids

Harm: For the purposes of NYSPFP, harm is defined under Category E through Category I of the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) guidance.

Sampling:

Sampling does not apply to these measures.

Suggested Data Sources:

- Pharmacy records

¹¹ The definition of an adverse drug event was adapted from Veterans' Administration Center for Medication Safety.

¹² High-alert drugs were adapted from [ISMP's high-alert medication list](#).

- Medical Records
- Adverse incident Logs/Reports
- NYPORTS

Obstetric Adverse Events: Early Elective Deliveries—Outcome Measures

(NOTE: Collection of all Obstetrics measures has been discontinued for NYSPFP, as of November 2016)

Patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed (PC-01)*

Numerator: Elective deliveries ≥ 37 and < 39 completed weeks of gestation (includes medical induction or C-section while not in labor or experiencing spontaneous ROM)

Denominator: Deliveries ≥ 37 and < 39 completed weeks of gestation (includes planned C-sections in labor)

Notes:

*Some exclusions apply. Please see the Specifications Manual for Joint Commission National Quality Measures for more detail.

Submit data to NYSPFP Data Portal.

Measure Specifications:

Refer to the Specifications Manual for Joint Commission National Quality Measures at <https://manual.jointcommission.org/releases/TJC2015B/MIF0166.html> and <https://manual.jointcommission.org/releases/TJC2015B/PerinatalCare.html> for measure specifications and definitions.

Data Sources:

Reports from hospitals' Core Measures Vendor(s):

- Press Ganey: Rate Report
- Midas: Standard Core Measure Summary
- Premier: Hospital Comparative Report
- QuadraMed: Measure Outcomes Reports

Obstetric Adverse Events: Maternal Emergencies—Outcome Measures

(NOTE: Collection of all Obstetrics measures has been discontinued for NYSPFP, as of November 2016)

Maternal Hemorrhage Outcome Measure: Percent of maternity patients who have given birth (vaginal and cesarean deliveries; live and still birth) ≥ 20 weeks completed gestation that received ≥ 4 units of packed red cells for maternal hemorrhage

Numerator: Number of maternity patients who have given birth (vaginal and cesarean deliveries; live and still birth) ≥ 20 weeks completed gestation receiving ≥ 4 units of packed red cells

Denominator: All maternity patients who have given birth (vaginal and cesarean deliveries; live and still birth) ≥ 20 weeks completed gestation discharged following the birth hospitalization

Notes:

Submit data to NYSPFP Data Portal. Data elements for collection:

- Number of maternity patients who have given birth (vaginal and cesarean deliveries; live and still birth) ≥ 20 weeks completed gestation with a diagnosis of hemorrhage receiving ≥ 4 units of packed red cells for maternal hemorrhage.
- Number of maternity patients ≥ 20 weeks completed gestation who have given birth (vaginal and cesarean deliveries; live and still birth) discharged following the birth hospitalization.
- Cases are included in the measure based on the month of discharge.
- Discharge for this measure should include discharge from the hospital or patient expiration.

Persistent Hypertension in Pregnancy Outcome Measure: Percentage of maternity patients who have given birth ≥ 20 weeks completed gestation with persistent hypertension admitted to the ICU (or similar unit)

Numerator: Number of maternity patients ≥ 20 weeks completed gestation with persistent hypertension admitted to the ICU or similar unit

Denominator: Number of maternity patients ≥ 20 weeks completed gestation with persistent hypertension who have given birth (vaginal and cesarean deliveries; live and still birth) discharged following the birth hospitalization

Notes:

Submit data to NYSPFP Data Portal. Data elements for collection:

- Number of maternity patients with a diagnosis of severe hypertension who have given birth (vaginal and cesarean deliveries; live or still birth) ≥ 20 weeks completed gestation.
- Cases are included in the measures based on the month of discharge.

Obstetric Adverse Events: Maternal Emergencies—Process Measures

(NOTE: Collection of all Obstetrics measures has been discontinued for NYSPFP, as of November 2016)

Maternal Hemorrhage Process Measure: Percent of maternity patients who have given birth \geq 20 weeks completed gestation with a documented risk assessment for maternal hemorrhage completed on admission for the birth hospitalization.

Numerator: Number of maternity patients \geq 20 weeks completed gestation with documented risk assessment for maternal hemorrhage completed upon admission for the birth hospitalization

Denominator: All maternity patients who have given birth (vaginal and cesarean deliveries; live and still birth) \geq 20 weeks completed gestation discharged following the birth hospitalization

Notes:

Submit data to NYSPFP Data Portal. Data elements for collection:

- Number of maternity patients \geq 20 weeks completed gestation with a documented risk assessment for maternal hemorrhage completed on admission for the birth hospitalization.
- Number of maternity patients \geq 20 weeks completed gestation who have given birth (vaginal and cesarean deliveries; live and still birth) discharged following the birth hospitalization.
- Cases are included in the measure based on the month of their discharge.
- Discharge for this measure should include discharge from the hospital or patient expiration.

Sampling: Hospitals may employ a sampling methodology for submitting data on this measure.

Severe Hypertension in Pregnancy Process Measure: Patients with persistent hypertension receiving treatment within one hour of second elevated blood pressure reading

Numerator: Number of maternity patients with persistent hypertension receiving treatment within one hour of the second elevated blood pressure

Denominator: Number of maternity patients \geq 20 weeks completed gestation with persistent hypertension who have given birth (vaginal and cesarean deliveries; live and still birth) discharged following the birth hospitalizations

Notes:

Submit data to NYSPFP Data Portal. Data elements for collection:

- Number of maternity patients with a diagnosis of severe hypertension who have given birth (vaginal and cesarean deliveries; live and still birth) ≥ 20 weeks completed gestation following the birth hospitalization.
- Cases are included in the measures based on the month of discharge.

Definitions:

- **Persistent hypertension:** Two severe blood pressure values taken within 15–60 minutes apart. Severe blood pressure values do not need to be consecutive.
- **Severe hypertension:** Abnormal blood pressure value of systolic ≥ 160 mmHg or diastolic blood pressure ≥ 110 mmHg.
- **Treatment:** Includes labetalol, hydralazine, or oral nifedipine.