NYSPFP Measurement Grid

Initiative	Measure Type	Measure Description	Numerator Definition	Denominator Definition	Measure Source/Resource	Data Submission Method	Data Submission Time Period	Data Submission Deadlines
Adverse Drug Event (ADE)	Process	Percentage of Supratherapeutic INR results	Number of INR results with values ≥ 5	Number of all INR tests resulted	NYSPFP Measure	Hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days
	Process	Percentage of hyperglycemic POCT blood glucose results ≥ 200 mg/dL	Number of POCT blood glucose results with values ≥ 200 mg/dL	Number of all POCT blood glucose tests resulted	NYSPFP Measure	Hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days
	Process	Percentage of hyperglycemic POCT blood glucose results ≥ 300 mg/dL	Number of POCT blood glucose results with values ≥ 300 mg/dL	Number of all POCT blood glucose tests resulted	NYSPFP Measure	Hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days
	Process	Percentage of hypoglycemic POCT blood glucose results ≤ 40 mg/dL	Number of POCT blood glucose results ≤ 40 mg/dL	Number of all POCT blood glucose tests resulted	NYSPFP Measure	Hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days
	Process	Percentage of hypoglycemic POCT blood glucose results ≤ 70 mg/dL	Number of POCT blood glucose results ≤ 70 mg/dL	Number of all POCT blood glucose tests resulted	NYSPFP Measure	Hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days
	Process	Rate of opioid reversal agent administration on inpatient care units per 1,000 patient days	Number of naloxone doses administered on inpatient care units	Number of total patient days	NYSPFP Measure	Hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days

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Initiative	Measure Type	Measure Description	Numerator Definition	Denominator Definition	Measure Source/Resource	Data Submission Method	Data Submission Time Period	Data Submission Deadlines
Antibiotic Stewardship Program (ASP) / *Clostridium difficile* (*C. difficile*) / Methicillin-resistant *Staphylococcus aureus* (MRSA)	Outcome	*C. difficile* infection (CDI) healthcare hospital-onset incidence rate per 10,000 patient days	Number of incident hospital-onset CDI LabID events	Number of patient days for the facility	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	CDI standardized infection ratio (SIR)	Number of incident hospital-onset CDI LabID events	Number of predicted hospital-onset CDI LabID events	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	MRSA bloodstream infection hospital-onset incidence rate per 10,000 patient days	Number of incident hospital-onset MRSA LabID events	Number of patient days for the facility	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	MRSA bloodstream infection standardized infection ratio (SIR)	Number of incident hospital-onset MRSA LabID events	Number of predicted hospital-onset MRSA LabID events	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Process	The ASP/*C. difficile* /MRSA assessment is a quarterly survey which measures each hospital's progress in implementing each of the Centers for Disease Control and Prevention's core components of antibiotic stewardship.	N/A	N/A	CDC's Core Components of Antibiotic Stewardship	Hospital data entry into NYSPFP data collection portal	Quarterly	NYSPFP will announce the survey period open and close dates on a quarterly basis.
Catheter-Associated Urinary Tract Infection (CAUTI)	Outcome	CAUTI rate per 1,000 catheter days	Number of observed CAUTI infections	Number of indwelling urinary catheter days	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	CAUTI rate per 10,000 patient days (population rate)	Number of observed CAUTI infections	Number of patient days	NHSN; American Journal of Infection Control. Fakih M.G. et al. 2011; 40(4):359-364	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	CAUTI standardized infection ratio (SIR)	Number of observed CAUTI infections	Number of expected CAUTI infections	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Process	Urinary catheter utilization ratio	Number of indwelling urinary catheter days	Number of patient days	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
Central Line-Associated Blood Stream Infection (CLABSI)	Outcome	CLABSI rate per 1,000 central line days	Numbers of observed CLABSI infections	Number of central line days	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	CLABSI rate per 10,000 patient days (population rate)	Numbers of observed CLABSI infections	Number of patient days	NHSN; American Journal of Infection Control. Fakih M.G. et al. 2011; 40(4):359-364	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	CLABSI standardized infection ratio (SIR)	Number of observed CLABSI infections	Number of expected CLABSI infections	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Process	Central line utilization ratio	Number of central line days	Number of patient days	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days

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Initiative	Measure Type	Measure Description	Numerator Definition	Denominator Definition	Measure Source/Resource	Data Submission Method	Data Submission Time Period	Data Submission Deadlines
Culture and Leadership	Process	The patient and family engagement assessment is a brief quarterly survey which measures each hospital's progress in implementation of five proven best practices, as provided by CMS, which emerged as part of the PfP 1.0 model test campaign	N/A	N/A	CMS	Hospital data entry into NYSPFP data collection portal	Quarterly	NYSPFP will announce the survey period open and close dates on a quarterly basis.
	Process	The leadership assessment is a brief quarterly survey which measures each hospital's progress in implementation of four proven best practices, as provided by CMS	N/A	N/A	CMS	Hospital data entry into NYSPFP data collection portal	Quarterly	NYSPFP will announce the survey period open and close dates on a quarterly basis.
Injuries from Falls and Immobility	Outcome	Falls with moderate or greater harm per 1,000 patient days	Number falls with injury level of moderate or greater severity	Number of patient days on eligible nursing units	National Database of Nursing Quality Indicators (NDNQI)	Data waiver for NYSPFP access to hospital NDNQI data **or** hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days
	Outcome	Falls with any harm per 1,000 patient days	Number of falls with any harm (minor and greater)	Number of patient days on eligible nursing units	National Quality Forum #0202 (click "Accept" on the "Copyright Notice" dialog box)	Data waiver for NYSPFP access to hospital NDNQI data **or** hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days
	Outcome	Falls per 1,000 patient days	Number of falls	Number of patient days on eligible nursing units	National Quality Forum #0141 (click "Accept" on the "Copyright Notice" dialog box)	Data waiver for NYSPFP access to hospital NDNQI data **or** hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days
	Process	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	Number of falls with moderate or greater injury with a documented risk assessment within 24 hours prior to the fall	Number of falls with injury level of moderate or greater severity	AHRQ; NDNQI	Data waiver for NYSPFP access to hospital NDNQI data or hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days

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Initiative	Measure Type	Measure Description	Numerator Definition	Denominator Definition	Measure Source/Resource	Data Submission Method	Data Submission Time Period	Data Submission Deadlines
Pressure Injuries	Outcome	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	Number of discharged adult patients with a facility-acquired pressure injury of stage III or IV (or unstageable)	Number of medical and surgical discharges age 18 years and older	AHRQ specifications using ICD-10 codes; AHRQ specifications using ICD-9 codes	NYSPFP will calculate. No hospital submission needed.	Monthly	N/A
	Outcome	Prevalence rate of facility-acquired pressure injuries of Stage 2 or higher per 100 patients	Number of patients with a facility-acquired Stage 2 or higher pressure injury at a particular point in time	Number of patients on units being studied at a particular point in time	National Quality Forum #0201 (click "Accept" on the "Copyright Notice" dialog box)	Data waiver for NYSPFP access to hospital NDNQI data or hospital-specific data entry into NYSPFP data collection portal	Monthly prevalence study preferred; NYSPFP will accept quarterly prevalence study rates based on NDNQI guidelines	Submit data to NYSPFP within 45 days
	Process	Percent of patients with documentation of a pressure injury risk assessment within 24 hours of admission	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	Number of patients with a facility-acquired Stage 2 or higher pressure injury identified in the prevalence study (should match numerator of the pressure injury prevalence rate)	AHRQ; NDNQI	Data waiver for NYSPFP access to hospital NDNQI data **or** hospital-specific data entry into NYSPFP data collection portal	Review of cases identified on the monthly or quarterly prevalence study, as described above.	Submit data to NYSPFP within 45 days
Preventable Readmissions	Outcome	30-day potentially preventable readmission rate (PPR)	Number of PPRs in 30 days	Number of eligible admissions	SPARCS; NYSPFP Measure	N/A	N/A	N/A
	Outcome	30-day all-cause readmission rate	Number of readmissions from all causes (without regard to clinical relatedness) within 30 days of discharge	Number of eligible admissions for any condition	SPARCS; NYSPFP Measure	N/A	N/A	N/A

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Initiative	Measure Type	Measure Description	Numerator Definition	Denominator Definition	Measure Source/Resource	Data Submission Method	Data Submission Time Period	Data Submission Deadlines
Sepsis	Outcome	Agency for Healthcare Research & Quality (AHRQ) Patient Safety Indictor (PSI) 13: Post-operative sepsis rate per 1,000 elective surgical discharges for patients ages 18 years and older	Number of hospital-acquired sepsis cases in the defined surgical populations	Elective surgical discharges age 18 and older	AHRQ specifications using ICD-10 codes; AHRQ specifications using ICD-9 codes	NYSPFP will calculate. No hospital submission needed.	Monthly	N/A
	Process	Three-Hour Bundle (adherence to Timely Lactate Level, Timely Blood Cultures Prior to Antibiotics, and Timely Administration of Broad Spectrum Antibiotics)	See DOH/IPRO specification documents		NYS Department of Health (DOH)/IPRO: 2017 Sepsis Measure Specifications; 2015-16 Sepsis Measure Specifications	NYSPFP will obtain from DOH/IPRO; no hospital submission needed	Quarterly	N/A
	Process	Composite Bundle (adherence to all applicable bundle elements)			NYS Department of Health (DOH)/IPRO: 2017 Sepsis Measure Specifications; 2015-16 Sepsis Measure Specifications	NYSPFP will obtain from DOH/IPRO; no hospital submission needed	Quarterly	N/A
	Process	Timely Lactate Level			NYS Department of Health (DOH)/IPRO: 2017 Sepsis Measure Specifications; 2015-16 Sepsis Measure Specifications	NYSPFP will obtain from DOH/IPRO; no hospital submission needed	Quarterly	N/A
	Process	Timely Blood Cultures Prior To Antibiotics			NYS Department of Health (DOH)/IPRO: 2017 Sepsis Measure Specifications; 2015-16 Sepsis Measure Specifications	NYSPFP will obtain from DOH/IPRO; no hospital submission needed	Quarterly	N/A
	Process	Timely Administration of Broad Spectrum Antibiotics			NYS Department of Health (DOH)/IPRO: 2017 Sepsis Measure Specifications; 2015-16 Sepsis Measure Specifications	NYSPFP will obtain from DOH/IPRO; no hospital submission needed	Quarterly	N/A
	Process	Timely Crystalloid Administration			NYS Department of Health (DOH)/IPRO: 2017 Sepsis Measure Specifications; 2015-16 Sepsis Measure Specifications	NYSPFP will obtain from DOH/IPRO; no hospital submission needed	Quarterly	N/A
	Process	Timely Vasopressor Administration			NYS Department of Health (DOH)/IPRO: 2017 Sepsis Measure Specifications; 2015-16 Sepsis Measure Specifications	NYSPFP will obtain from DOH/IPRO; no hospital submission needed	Quarterly	N/A
	Process	Timely Re-measurement of Lactate			NYS Department of Health (DOH)/IPRO: 2017 Sepsis Measure Specifications; 2015-16 Sepsis Measure Specifications	NYSPFP will obtain from DOH/IPRO; no hospital submission needed	Quarterly	N/A
	Process	Timely Fluid Assessment			NYS Department of Health (DOH)/IPRO: 2017 Sepsis Measure Specifications	NYSPFP will obtain from DOH/IPRO; no hospital submission needed	Quarterly	N/A

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Initiative	Measure Type	Measure Description	Numerator Definition	Denominator Definition	Measure Source/Resource	Data Submission Method	Data Submission Time Period	Data Submission Deadlines
Surgical Site Infection (SSI)	Outcome	SSI rates per 100 operative procedures (hip, CABG, colon, hysterectomy)	Number of observed surgical site infections	Number of operative events	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	SSI standardized infection ratios (SIRs) (hip, CABG, colon, hysterectomy)	Number of observed surgical site infections	Number of expected surgical site infections	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	Knee prosthesis SSI rate per 100 operative procedures	Number of observed knee prosthesis surgical site infections	Number of knee prosthesis operative events	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	Knee prosthesis SSI standardized infection ratio (SIR)	Number of observed knee prosthesis surgical site infections	Number of expected knee prosthesis surgical site infections	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Process	The surgical site infection survey is a brief quarterly survey which measures each hospital's progress in implementing each of the components of the NYSPFP Advanced Colon Bundle	N/A	N/A	NYSPFP Advanced Colon Bundle	Hospital data entry into NYSPFP data collection portal	Quarterly	NYSPFP will announce the survey period open and close dates on a quarterly basis.
Venous thromboembolism (VTE)	Outcome	VTE rate per 100 adult inpatient discharges	Number of facility-acquired VTEs among adult inpatient discharges	Number of medical and surgical adult inpatient discharges	Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures (VTE ICD-10 codes are located in Tables 7.03 and 7.04 in Appendix_A.1.pdf within the zip file containing the Specifications Manual)	N/A	N/A	N/A
	Outcome	VTE rate per 100 medical adult inpatient discharges	Number of facility-acquired VTEs among medical adult inpatient discharges	Number of adult inpatient medical discharges	Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures (VTE ICD-10 codes are located in Tables 7.03 and 7.04 in Appendix_A.1.pdf within the zip file containing the Specifications Manual)	N/A	N/A	N/A
	Outcome	VTE rate per 100 surgical adult inpatient discharges	Number of facility-acquired VTEs among surgical adult inpatient discharges	Number of adult inpatient surgical discharges	Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures (VTE ICD-10 codes are located in Tables 7.03 and 7.04 in Appendix_A.1.pdf within the zip file containing the Specifications Manual)	N/A	N/A	N/A
	Outcome	AHRQ PSI 12 – Perioperative pulmonary embolism or deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges for patients ages 18 years and older	Number of surgical patients with hospital-acquired deep vein thrombosis or pulmonary embolism	Number of adult surgical discharges	AHRQ specifications using ICD-10 codes; AHRQ specifications using ICD-9 codes	N/A	N/A	N/A
	Process	VTE-1: Venous Thromboembolism Prophylaxis	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	All adult patients meeting inclusion criteria (as specified in the Specifications Manual for National Hospital IQR)	Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures (Specifications for VTE-1 are located in 2j_VTE1.pdf within the zip file containing the Specifications Manual)	Hospital data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days

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Initiative	Measure Type	Measure Description	Numerator Definition	Denominator Definition	Measure Source/Resource	Data Submission Method	Data Submission Time Period	Data Submission Deadlines
Ventilator-Associated Event (VAE) / Delirium	Outcome	Ventilator-associated event (VAE) rate per 1,000 ventilator days	Number of observed VAEs (VAC, IVAC, PVAP)	Number of ventilator days	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data within 45 days
	Outcome	Ventilator-associated condition (VAC) rate per 1,000 ventilator days	Number of observed VACs	Number of ventilator days	NHSN per CDC Guidelines (see page 19)	Confer rights to NYSPFP group	Monthly	Submit data within 45 days
	Outcome	Infection-related ventilator-associated complication (IVAC) rate per 1,000 ventilator days	Number of observed IVACs	Number of ventilator days	NHSN per CDC Guidelines (see page 20)	Confer rights to NYSPFP group	Monthly	Submit data within 45 days
	Outcome	Possible ventilator-associated pneumonia (PVAP) rate per 1,000 ventilator days	Number of observed PVAPs	Number of ventilator days	NHSN per CDC Guidelines (see page 21)	Confer rights to NYSPFP group	Monthly	Submit data within 45 days
	Outcome	Infection-related ventilator-associated complication and possible ventilator-associated pneumonia (IVAC+) rate per 1,000 ventilator days	Number of observed IVACs and PVAPs	Number of ventilator days	NHSN per CDC Guidelines (see pages 20-21)	Confer rights to NYSPFP group	Monthly	Submit data within 45 days
	Outcome	Ventilator-associated event (VAE) standardized infection ratio (SIR)	Number of observed VAEs	Number of predicted VAEs	NHSN per CDC Guidelines (see page 20)	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	Infection-related ventilator-associated complication and possible ventilator-associated pneumonia (IVAC+) standardized infection ratio (SIR)	Number of observed IVACs and PVAPs	Number of predicted IVACs and PVAPs	NHSN per CDC Guidelines (see page 20)	Confer rights to NYSPFP group	Monthly	Submit data to NHSN within 45 days
	Outcome	Delirium Prevalence Rate	Number of ICU patients for whom delirium was assessed as present using a delirium assessment tool (e.g. CAM-ICU or ICDSC)	Number of ICU patients assessed for delirium using a delirium assessment tool identified in the prevalence study	NYSPFP Measure	Hospital data entry into NYSPFP data collection portal	Monthly prevalence study	Submit data within 45 days
	Process	Pain Assessment Utilization Rate	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)	Number of ICU patients identified in the prevalence study	NYSPFP Measure	Hospital data entry into NYSPFP data collection portal	Monthly prevalence study	Submit data within 45 days
	Process	Agitation Assessment Utilization Rate	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)	Number of ICU patients identified in the prevalence study	NYSPFP Measure	Hospital data entry into NYSPFP data collection portal	Monthly prevalence study	Submit data within 45 days
	Process	Delirium Assessment Utilization Rate	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)	Number of ICU patients identified in the prevalence study	NYSPFP Measure	Hospital data entry into NYSPFP data collection portal	Monthly prevalence study	Submit data within 45 days
	Process	Ventilator Utilization Ratio	Number of ventilator days	Number of patient days	NHSN per CDC Guidelines	Confer rights to NYSPFP group	Monthly	Submit data within 45 days
Worker Safety/ Safe Patient Handling (SPH)	Outcome	Musculoskeletal injuries from patient handling activity per 100 direct care providers	Number of musculoskeletal injuries from patient handling activities among direct care providers	Total hours worked by direct care providers	OSHA Form 300, Column F; Public hospitals, use: New York State Department of Labor Form SH-900	Hospital-specific data entry into NYSPFP data collection portal	Monthly	Submit data to NYSPFP within 45 days