NHA | NEBRASKA HOSPITALS

NEBRASKA DIRECTED PAYMENT PROGRAM QUALITY METRICS

SPECIFICATION MANUAL

JULY 2024

NEBRASKA HOSPITALS

Post-Partum Depression Screening

Measure Definition: Complete a screening for post-partum depression to include an assessment for anxiety on each mother that delivers prior to discharge from the hospital

Numerator: # of delivering mothers that are admitted for delivery that receive a depression screen after delivery and before discharge

Denominator: Total # of delivering mothers

Rate = Total number of delivered mothers that were screened for post-partum depression / Total # of delivered mothers **x 100**

*Hospitals that do not perform deliveries are excluded from this measure

DATA COLLECTION CONSIDERATIONS	- Use of a recognized screening tool that addresses depression and anxiety. - Examples: - Edinburgh Postnatal Depression Scale (EPDS) - Edinburgh Postnatal Depression Anxiety Subscale (EPDS-3A) - Patient Health Questionnaire 9 (PHQ-9) with Generalized Anxiety Disorder Screener (GAD-7)
DATA SUBMISSION CONSIDERATIONS	- Data will be self-reported by each participating organization: - Screening can occur within the Electronic Health Record or paper form - Data may come from an EHR report or manual abstraction dependent on internal systems and processes - Data will be submitted in numerator / denominator format - Progress reports will be submitted quarterly to the NHA Data Portal - Final performance report will be submitted to CMS per calendar year

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Post-Partum Depression Screening Resources

- Perinatal Mental Health Initiatives: Nebraska Perinatal Quality Improvement Collaborative (NPQIC)
- Patient Health Questionnaire (PHQ-9)
- Generalized Anxiety Disorder Screener (GAD-7)
- Edinburgh Postnatal Depression Scale (EPDS)

Data Submission Deadlines	
Quarter 1 Data Due	**May 31**
Quarter 2 Data Due	**August 31**
Quarter 3 Data Due	**November 30**
Quarter 4 Data Due	**February 29**

GOALS		
Year 1:	18-month lookback (July 1, 2024 - December 31, 2025)	**71%**
Year 2:	12-month CY lookback (January 1, 2026 - December 31, 2026)	**75%**
Year 3:	12-month CY lookback (January 1, 2027 - December 31, 2027)	**80%**

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Screening for Social Determinants of Health (SDOH)

Measure Definition: Complete a screening for five social risk drivers: food insecurity, interpersonal safety, housing insecurity, transportation needs, utilities

Numerator: # of adult patients >=18 y/o admitted inpatient to the hospital that receive an SDOH screening that includes each of the 5 health-related social needs (food insecurity, housing instability, transportation needs, utility difficulties, interpersonal safety) during each hospital stay

Denominator: Total # of inpatient admissions

Rate = $\frac{\text{Total number of completed SDOH screenings}}{\text{Total \# of inpatient admissions}}$ **x 100**

*Only fully complete screenings will be considered applicable.

DATA COLLECTION CONSIDERATIONS	

DATA COLLECTION CONSIDERATIONS	• Screening can occur any time during the hospital admission prior to discharge
	• Screening should occur during each hospital stay
	• Only unique patients should be included in any one reporting period (year)
	• If a patient has multiple admissions in the year, the most recent result (i.e., the result closest to the reporting period) should be submitted
	• Use discharge date for inclusion into the denominator
	• The following patients would be EXCLUDED from the denominator:
	  ◦ Patients who opt out of screening for any reason
	  ◦ Patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf
	  ◦ Patients who expire during the inpatient stay

DATA SUBMISSION CONSIDERATIONS	• Data will be self-reported by each participating organization:
	  ◦ Screening can occur within the Electronic Health Record or paper form
	  ◦ Data may come from an EHR report or manual abstraction dependent on internal systems and processes
	• Data will be submitted in numerator / denominator format
	• Progress reports will be submitted quarterly to the NHA Data Portal
	• Final performance report will be submitted to CMS per calendar year

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SDOH Resources

- MIPS Clinical Quality Measures (CQMS)
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- CMS Framework for Health Equity

Data Submission Deadlines	
Quarter 1 Data Due	**May 31**
Quarter 2 Data Due	**August 31**
Quarter 3 Data Due	**November 30**
Quarter 4 Data Due	**February 29**

GOALS		
Year 1:	18-month lookback (July 1, 2024 - December 31, 2025)	**35%**
Year 2:	12-month CY lookback (January 1, 2026 - December 31, 2026)	**55%**
Year 3:	12-month CY lookback (January 1, 2027 - December 31, 2027)	**80%**

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Catheter-Associated Urinary Tract Infection (CAUTI)

Measure Definition: Rate of UTI where an indwelling urinary catheter (IUC) was in place for more than two consecutive days in an inpatient location on the date of event or the day before

Numerator: # of CAUTI infections acquired in the hospital

Denominator: Total # of urinary catheter days

Rate = $\frac{\text{Total number of CAUTI that were acquired while in hospital care}}{\text{Total \# urinary catheter days}}$ **x 1000**

**NOTE: Assessing data analysis process from DHHS regarding those low volume facilities that do not generate a SIR to assure that SIR should be the standard of measurement to best reflect CAUTI infections in the state

DATA COLLECTION CONSIDERATIONS	- NHSN or self-reported data - Follow CDC / NHSN Definitions for CAUTI - For those with designated ICU – ICU CAUTI and Med/Surg CAUTI will be reported separately
DATA SUBMISSION CONSIDERATIONS	- Data will be self-reported by each participating organization: - Screening can occur within the Electronic Health Record or paper form - Data may come from an EHR report or manual abstraction dependent on internal systems and processes - Data will be submitted in numerator / denominator format - Progress reports will be submitted quarterly to the NHA Data Portal - Final performance report will be submitted to CMS per calendar year

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CAUTI Resources

- NHSN CAUTI Definition
- NHSN CAUTI Checklist
- CDC Infection Control Recommendations

Q. What is a "urinary catheter day" and how do I measure it?

Each day a patient has a urinary catheter in place is a "urinary catheter day". To be most accurate, the number of patients with a urinary catheter should be counted at the same time each day.

The number of urinary catheter days is important when calculating CAUTI rate - the number of urinary catheter days defines the population that is "at risk" for developing a CAUTI.

Data Submission Deadlines	
Quarter 1 Data Due	**August 15**
Quarter 2 Data Due	**November 15**
Quarter 3 Data Due	**February 15**
Quarter 4 Data Due	**May 15**

GOALS		
Year 1:	18-month lookback (July 1, 2024 - December 31, 2025)	**0.7 SIR**
Year 2:	12-month CY lookback (January 1, 2026 - December 31, 2026)	**0.7 SIR**
Year 3:	12-month CY lookback (January 1, 2027 - December 31, 2027)	**0.7 SIR**

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SUPPLEMENTAL QUALITY METRICS

Rate of ED Use for Primary Dx of Behavioral Health

Numerator: Patients of all ages that are seen in an Emergency Department for a primary diagnosis of behavioral health based on the ICD-10 codes noted

Denominator: Total # of all Emergency Department visits

GOAL
Track BH ED use over time and analyze data to understand needs

BH CONSIDERATIONS

- All age groups will be collected and data will be stratified by age group
- Data will be stratified by payer-mix
- Further investigation into national rates will be completed by the NHA team
- The NHA team will create a BH focus group with subject matter experts from Nebraska to discuss noted gaps

Age-Friendly Health Systems

This will not be a rate - simply an aggregate number of NHA members that are engaged in AF.

Currently there are 26 organizations - many with multiple sites that are engaged in AF. NHA continues its work across the state to spread the framework including work towards creating AF communities.

GOAL	
2025	39 organizations
2026	49 organizations
2027	61 organizations