



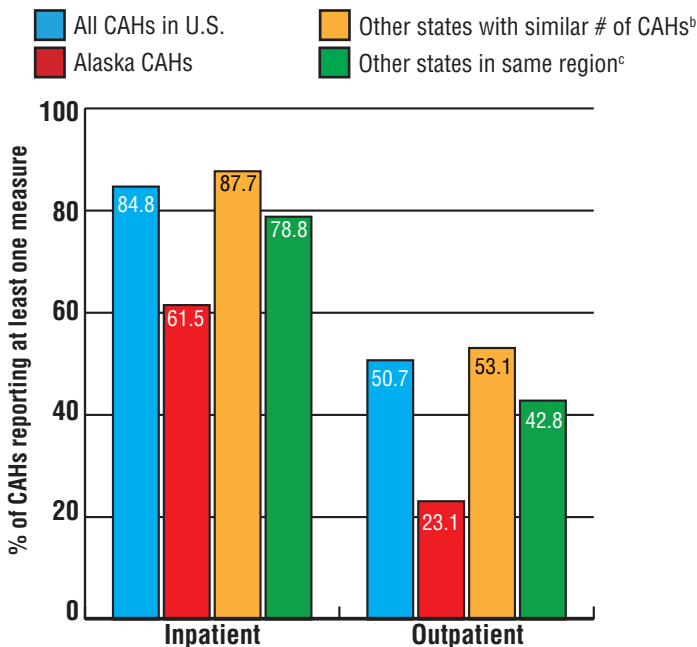
Hospital Compare Quality Measure Results for Alaska CAHs, Q2 2014 - Q1 2015

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KEY FINDINGS: ALASKA

- Compared to all other CAHs nationally, Alaska’s CAHs reported at a rate that was lower for inpatient measures (61.5% of CAHs vs. 84.8% nationally) and lower for outpatient measures (23.1% of CAHs vs. 50.7% nationally).
- Alaska’s CAHs rank #43 for inpatient measure reporting and #41 for outpatient measure reporting among the 45 states participating in the Flex Program.
- Compared to scores for all other CAHs nationally from Q2 2014 through Q1 2015, Alaska’s CAHs have significantly better scores on 0 process of care measures, significantly worse scores on 4 measures, no significant differences on 15 measures, and insufficient data to compare 19 measures.

Figure 1. CAH Participation in Hospital Compare^a, Q2 2014 -Q1 2015



^aPercentage of CAHs in each state or group of states reporting data to Hospital Compare on at least one measure.

^bGroup includes AZ (15), FL (13), ME (16), NV (11), NH (13), NY (18), PA (13), TN (16), UT (11), WY (16)

^cHRSR Region includes CO (29), ID (27), MT (48), ND (36), OR (25), SD (38), UT (11), WA (39), WY (16)

INTRODUCTION

Since 2004, acute care hospitals paid under the Medicare Prospective Payment System (PPS) have had a financial incentive to publicly report quality measure data on the Centers for Medicare & Medicaid Services’ (CMS) Hospital Compare website. Although Critical Access Hospitals (CAHs) do not face the same financial incentives as PPS hospitals to participate, the Hospital Compare initiative provides an important opportunity for CAHs to publicly report, assess and improve their performance on national standards of care.

This report is part of a series of 45 annual state-level reports that examine CAH participation in Hospital Compare, quality measure results, and trends.¹ This set of state reports focus on data for inpatient and outpatient process of care and structural measures for April 2014 through March 2015 (Q2 2014-Q1 2015). State reports on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data for the same time period were previously released.²

The report used the following data sources:

- Publicly-available Hospital Compare data down-



loaded from the CMS Hospital Compare website on inpatient and outpatient process measures for April 2014 through March 2015.

- Data for April 2014 through March 2015 on process measures for which CAHs reported ten or fewer cases, which CMS suppresses from the Hospital Compare website, but makes available to the Federal Office of Rural Health Policy for aggregate CAH analyses.

Since the last set of CAH state reports, five inpatient and two outpatient process measures were deleted due to their removal from Hospital Compare. This report includes 38 process of care measures and 6 structural measures that are potentially relevant to CAHs and for which some CAHs nationally have reported data; some states do not have any CAHs reporting some of these measures. Definitions of the measures used in the report are provided on pages 8-11.

The Hospital Compare data in this report include several measures that are also measures for the Medicare Beneficiary Quality Improvement Project (MBQIP). Although the majority of CAHs report data on these measures to both Hospital Compare and MBQIP, the data in this report may differ from MBQIP reports because some CAHs only report data to one of these programs.

For FY 2015-17, State Flex Grantees are required to work with all CAHs on all MBQIP core improvement activities in each of four quality domains: patient safety, patient engagement, care transitions, and outpatient care. States may also choose to work on additional improvement activities with CAHs based on need and relevance. This report includes Hospital Compare data reported by CAHs on several measures that are new MBQIP measures for FY 2015-17, including new outpatient measures. The tables in the report indicate if a measure is an MBQIP core or additional improvement measure in addition to being a Hospital Compare measure.

APPROACH

For this report, summary measures were calculated to compare performance on the inpatient and outpatient process of care measures for all CAHs within Alaska to

the performance of CAHs in all other states. The inpatient and outpatient measure scores were classified as: 1) insufficient data (less than 25 patients total); 2) not significantly different than CAHs in all other states; 3) significantly better than all other CAHs; or 4) significantly worse than all other CAHs. The percent of CAH patients receiving recommended care was not reported when the total number of CAH patients in a state (or nationally) with data on a measure was less than 25.

The percentages of patients that received recommended care for the inpatient and outpatient process of care quality measures were calculated by dividing the total number of patients in all CAHs in the state and all other CAHs nationally who received the recommended care by the total number of eligible patients in all CAHs in the state and all other CAHs nationally for each measure. For each inpatient and outpatient rate measure, the percent of CAH patients receiving recommended care in each state was then compared to the percent of CAH patients that received recommended care in all other states combined. Chi-square tests were used to calculate whether these differences were statistically significant ($p < .05$, which means that at least 95% of the time, the differences between CAHs in Alaska and all other CAHs nationally are equal to or more extreme than the observed differences in the data).

Median scores for the median time process measures were calculated by arranging the median times by quarter for all CAHs in the state and all other CAHs nationally from the lowest time to the highest time by hospital, and selecting the middle value based on number of patients. Wilcoxon-Mann-Whitney tests were used to compare the median times for CAHs in each state and all other CAHs.

For each structural measure, the percentages of CAHs in Alaska and all other states that reported no data, and those that reported yes or no on each measure, were calculated.

REPORTING FOR PROCESS OF CARE MEASURES IN ALASKA AND ALL OTHER STATES

As in previous years, the percent of CAHs reporting inpatient and outpatient process of care data to Hospital Compare varied considerably across states. In



Alaska, 61.5% of the 13 CAHs reported data to Hospital Compare on at least one inpatient process of care measure for Q2 2014 through Q1 2015 discharges.

Figures 2 and 3 (next page) compare the respective inpatient and outpatient reporting rates over time (2011 through Q1 2015) among CAHs in four groups: those in Alaska, all CAHs nationally, other states with a similar number of CAHs as Alaska, and other states located in the same geographic region as Alaska.

Figure 4 (page 5) compares the respective inpatient and outpatient reporting rates of CAHs in Alaska to those located in the other 44 states participating in the Flex Program as well as the rate for all CAHs nationally. The Alaska CAH inpatient reporting rate of 61.5% ranks #43 nationally; the Alaska CAH outpatient reporting rate of 23.1% ranks #41 nationally.

The number of CAHs reporting individual inpatient and outpatient process of care measures may differ by measure for several reasons. Some measures only apply to a portion of patients; others exclude patients with contraindications, or only apply to conditions not treated or procedures not performed in some CAHs.

RESULTS

Process of Care Measures

Tables 1-2 (pages 6 and 7, respectively) display the results for inpatient and outpatient process-of-care results for Q2 2014 through Q1 2015 discharges for CAHs in Alaska and all other CAHs. Table 3 (page 7) displays results for median time measures (lower scores, indicating shorter median times, are better).

Structural Measures

Nationally, more than three-fourths of CAHs did not report structural quality measure data. Table 4

(page 7) provides results for CAHs in Alaska and all other CAHs nationally that reported data between Q2 2014 and Q1 2015.

TOOLS AND RESOURCES

The Flex Monitoring Team (FMT) provides free access to all publications and presentations on our website, www.flexmonitoring.org, including a series of policy briefs on evidence-based QI programs and strategies that could be implemented by CAHs.

The [Technical Assistance and Services Center \(TASC\)](#) provides resources for State Flex Programs and CAHs on their website.

For profiles of State Flex Programs, State Contacts, and examples of Flex activities to support quality improvement, visit <http://www.ruralcenter.org/tasc/flex-profile>

For resources focused on the Medicare Beneficiary Quality Improvement Program (MBQIP), visit <https://www.ruralcenter.org/tasc/mbqip>.

REFERENCES

1. The Flex Monitoring Team has published national Hospital Compare reports since 2006. All are available for download at <http://www.flexmonitoring.org/publications/annualhospital-compare-results/>.

2. Previous state-level reports are available on the Flex Monitoring Team website at <http://www.flexmonitoring.org/data/state-level-data>.

(Figures 2-4, Tables 1-4, and measure definitions begin on next page)



Figure 2. CAH Participation in Hospital Compare for Inpatient Discharges, 2011 - 2015

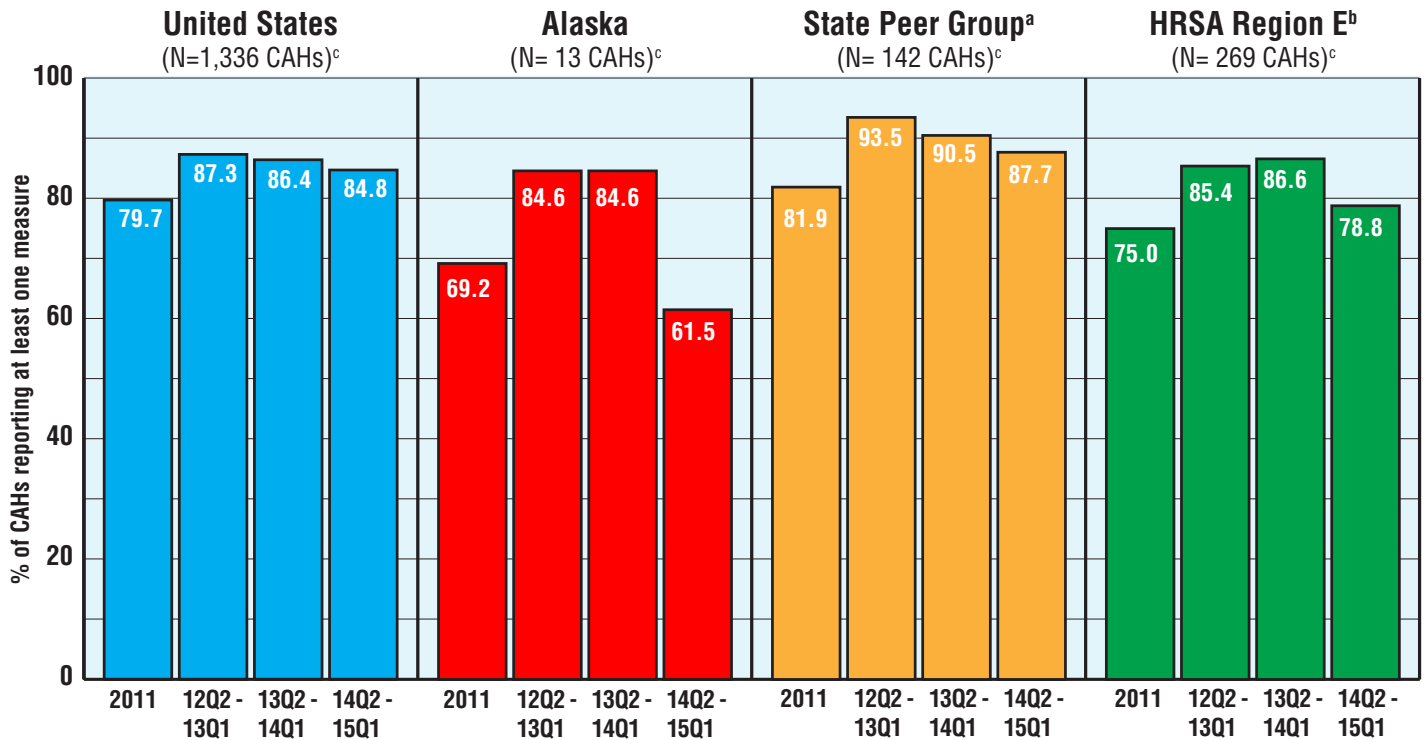
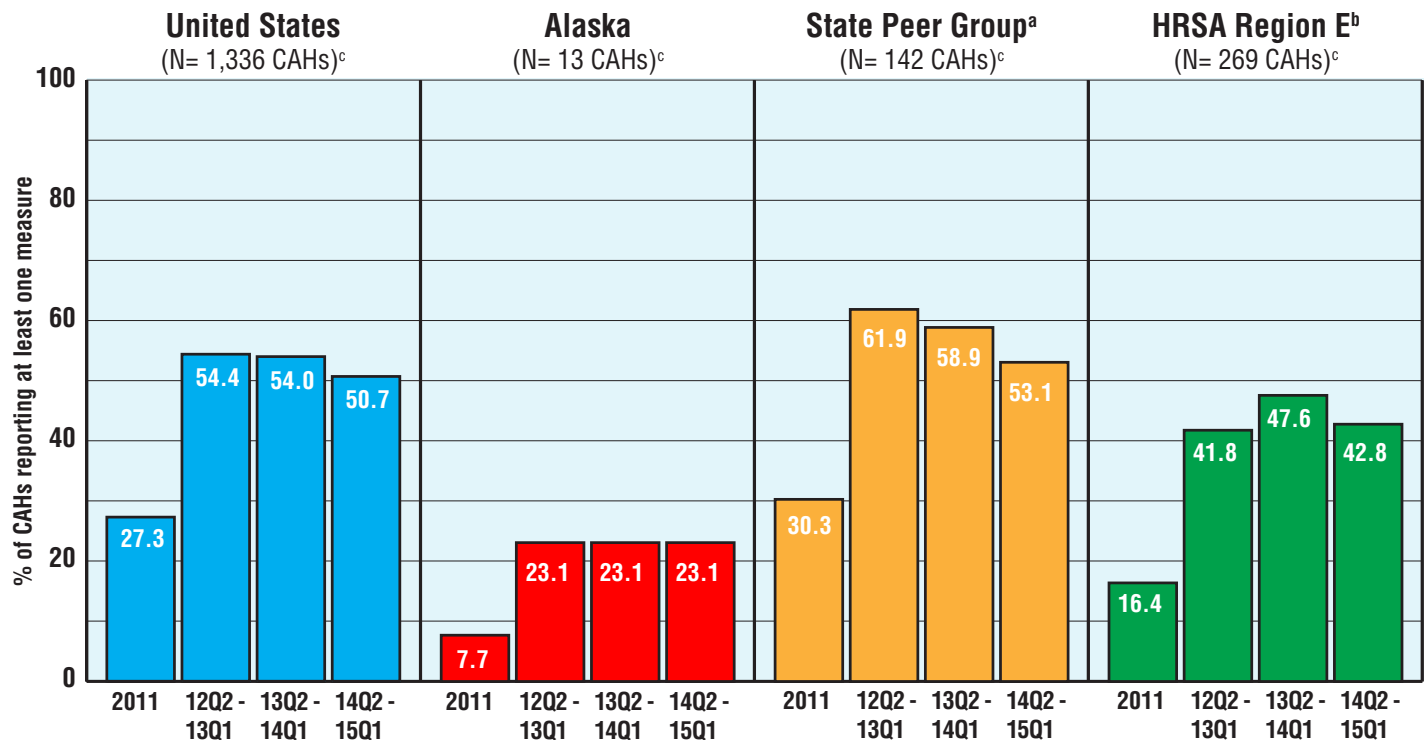


Figure 3. CAH Participation in Hospital Compare for Outpatient Discharges, 2011 - 2015



^aGroup includes AZ (15), FL (13), ME (16), NV (11), NH (13), NY (18), PA (13), TN (16), UT (11), WY (16)

^bHRSA Region E includes CO (29), ID (27), MT (48), ND (36), OR (25), SD (38), UT (11), WA (39), WY (16)

^cListed N value refers to most recent data (Q2 2014- Q1 2015) only.



Figure 4. State Rankings of CAH Reporting Rates for Hospital Compare Inpatient and Outpatient Quality Measures, Q2 2014 - Q1 2015

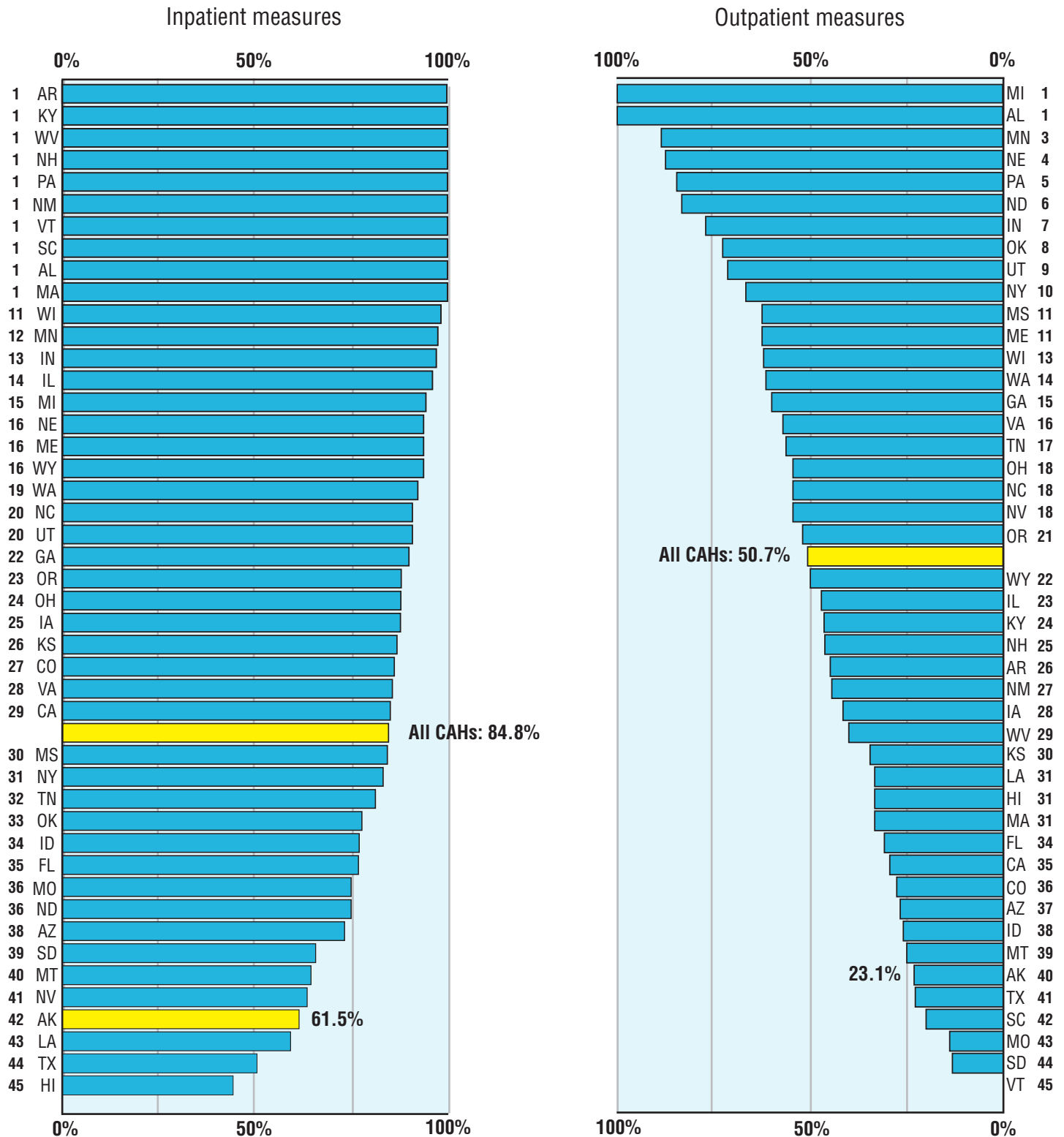




Table 1. Inpatient Process of Care Results for Patients Discharged from Reporting CAHs in Alaska and All Other States, Q2 2014 - Q1 2015

■ Significantly better than rate for all other CAHs nationally (p<.05)

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		Alaska (n=13)			All Other CAHs (n=1,323)	
		CAHs reporting		% of patients ^a	CAHs reporting	% of patient
AMI-7a	Fibrinolytic therapy received within 30 minutes of hospital arrival	1	*	*	7	22.2
HF-2	Evaluation of LVS function	8	W	78.8	1034	88.6
IMM-2 [†]	Immunization for influenza	1	NS	89.1	541	90.9
OP-27/IMM-3 [†]	Healthcare workers given influenza vaccination	2	W	78.2	371	87.6
PC-01 [‡]	Early elective delivery (lower is better)	1	*	*	134	8.9
PN-6	Initial antibiotic selection for pneumonia patient	7	NS	90.7	1062	89.7
SCIP-Card-2	Surgery patients who received perioperative beta blocker	2	*	*	416	95.4
SCIP-Inf-1	Preventative antibiotic(s) 1 hour before incision	3	NS	100.0	475	95.9
SCIP-Inf-2	Received appropriate preventative antibiotic(s)	3	NS	100.0	474	97.4
SCIP-Inf-3	Preventative antibiotic(s) stopped within 24 hours after surgery	3	NS	100.0	471	97.0
SCIP-Inf-9	Urinary catheter removed 1 st / 2 nd day after surgery	3	NS	100.0	444	97.4
SCIP-VTE-2	Surgery patients who received appropriate VTE prophylaxis	3	NS	98.4	490	99.1
STK-1 [‡]	VTE prophylaxis	1	*	*	311	89.2
STK-2	Discharged on antithrombotic therapy	1	*	*	282	94.7
STK-3	Anticoagulation therapy for atrial fibrillation/flutter	1	*	*	165	91.8
STK-4	Thrombolytic therapy	0	*	*	105	10.9
STK-5	Antithrombotic therapy by end of hospital day 2	1	*	*	279	93.2
STK-6	Discharged on statin medication	1	*	*	293	79.3
STK-8 [‡]	Stroke education	1	*	*	237	81.2
STK-10	Assessed for rehabilitation	1	*	*	293	95.4
VTE-1 [‡]	Venous thromboembolism prophylaxis	1	NS	93.9	363	89.4
VTE-2 [‡]	ICU venous thromboembolism prophylaxis	1	W	82.4	164	93.2
VTE-3 [‡]	Anticoagulation overlap therapy	1	*	*	312	90.4
VTE-4	Unfractionated heparin with dosages/platelet count monitoring	1	*	*	144	98.2
VTE-5	Warfarin therapy discharge instructions	1	*	*	287	88.9
VTE-6	Incidence of potentially-preventable VTE (lower is better)	1	*	*	90	10.2

^aRates without highlights were not significantly different from comparable rates in all CAHs nationally.

*Insufficient data to calculate rate (<25 patients).

[†]MBQIP core measure (this table shows Hospital Compare data)

[‡]MBQIP additional improvement measure (this table shows Hospital Compare data)



Table 2. Outpatient Process of Care Results for Patients Discharged from Reporting CAHs in Alaska and All Other States, Q2 2014 - Q1 2015

■ Significantly better than rate for all other CAHs nationally (p<.05)
 ■ Significantly worse than rate for all other CAHs nationally (p<.05)

		Alaska (n=13)			All Other CAHs (n=1,323)	
		CAHs reporting		% of patients ^a	CAHs reporting	% of patient
OP-2 [†]	Fibrinolytic therapy received within 30 minutes	2	*	*	288	52.2
OP-4 [†]	Aspirin at arrival	2	NS	100.0	642	96.1
OP-22 [†]	Patient left without being seen (lower is better)	2	W	2.0	164	1
OP-23 [‡]	Received head CT scan interpretation within 45 minutes of arrival	2	*	*	301	58.0

^aRates without highlights were not significantly different from comparable rates in all CAHs nationally.

*Insufficient data to calculate rate (<25 patients).

[†]MBQIP core measure (this table shows Hospital Compare data)

[‡]MBQIP additional improvement measure (this table shows Hospital Compare data)

Table 3. Median Time to Patients Receiving Recommended Care at CAHs in Alaska and All Other States, Q2 2014 - Q1 2015

■ Significantly better than rate for all other CAHs nationally (p<.05)
 ■ Significantly worse than rate for all other CAHs nationally (p<.05)

Note: Lower scores are better for all median time measures		Median Minutes to Receiving Care (Lower Is Better)				
		Alaska (n=13)			All Other CAHs (n=1,323)	
		CAHs reporting		Minutes ^a	CAHs reporting	Minute
ED-1b [‡]	Median time from ED admission to ED departure for admitted patients	1	NS	269	510	217
ED-2b [‡]	Admit decision time to ED departure time for admitted patients	1	NS	170	508	55
OP-1 [†]	Median time to fibrinolysis	2	*	*	239	29
OP-3b [†]	Median time to transfer to another facility for acute coronary intervention	1	*	*	367	67
OP-5 [†]	Median time to ECG	2	NS	5	643	7
OP-18b [†]	Median time from ED arrival to ED departure for discharged patients	1	NS	148	335	104
OP-20 [†]	Median time from door to diagnostic evaluation	1	NS	33	340	18
OP-21 [†]	Median time to pain management for long bone fracture	1	NS	59	338	44

^aRates without highlights were not significantly different from comparable rates in all CAHs nationally.

*Insufficient data to calculate rate (<25 patients).

[†]MBQIP core measure (this table shows Hospital Compare data)

[‡]MBQIP additional improvement measure (this table shows Hospital Compare data)



Table 4. Structural Quality Measures Reported by CAHs in Alaska and All Other CAHs Nationally, Q2 2014 - Q1 2015

		Alaska CAHs (n= 13)			All Other CAHs (n= 1,323)		
		No data	No	Yes	No data	No	Yes
OP-12	Ability to receive lab data directly to certified EHR	84.6	0.0	15.4	85.9	2.0	12.1
OP-17	Ability to track clinical results between visits	84.6	0.0	15.4	86.2	2.9	10.9
OP-25 [†]	Use of safe surgery checklist: outpatient	84.6	0.0	15.4	86.5	1.1	12.4
SM-3	Nursing care registry	92.3	7.7	0.0	84.0	11.8	4.2
SM-4	General surgery registry	92.3	7.7	0.0	84.1	14.9	1.0
SM-5	Use of safe surgery checklist: inpatient	92.3	0.0	7.7	84.1	2.0	13.9

[†]MBQIP additional improvement measure (this table shows Hospital Compare data)

DEFINITIONS OF MEASURES

Note: higher numbers reflect better performance, except where indicated below.

- **AMI-7a:** Fibrinolytic therapy received within 30 minutes of arrival – Acute Myocardial Infarction (AMI) patients receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less.
- **ED-1b:** Admit Decision Time to Emergency Department (ED) Departure Time for Admitted Patients - median time from admit decision time to time of departure from the ED for patients admitted to inpatient status. (A lower number is better.)
- **ED-2b:** Median Time from Emergency Department (ED) Arrival to ED Departure for Admitted Patients - median time from ED arrival to time of departure from the ED for patients admitted to the facility from the ED (A lower number is better.)
- **HF-2:** Evaluation of Left Ventricular Systolic (LVS) Function – heart failure patients with documentation in the hospital record that an evaluation of the LVS function was performed before arrival, during hospitalization, or is planned for after discharge.

- **IMM-2:** Influenza Vaccination – This prevention measure addresses acute care hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The numerator captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine, and patients who received the vaccine during the current year’s influenza season but prior to the current hospitalization are captured as numerator events.
- **OP-1:** Median Time to Fibrinolysis - median time from arrival to fibrinolysis for patients that received fibrinolysis. (A lower number is better.)
- **OP-2:** Fibrinolytic therapy received within 30 minutes of arrival – Acute Myocardial Infarction (AMI) patients receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less.
- **OP-3b:** Median Time to Transfer to Another Facility for Acute Coronary Intervention – Median number of minutes before outpatients with heart attack who needed specialized care were transferred to another hospital. (A lower number is better.)



- **OP-4:** Aspirin at arrival – Acute Myocardial Infarction (AMI) patients without aspirin contraindications who received aspirin within 24 hours before or after hospital arrival.
- **OP-5:** Median Time to echocardiogram (ECG) – median number of minutes before outpatients with heart attack (or with chest pain that suggests a possible heart attack) got an ECG. (A lower number is better).
- **OP-12:** Ability to Receive Lab Data Directly to Electronic Health Record (EHR) – the ability for providers with Health Information Technology (HIT) to receive laboratory data directly into their ONC-certified EHR system as discrete searchable data.
- **OP-17:** Ability to Track Clinical Results between Visits – the ability for a facility to track pending laboratory tests, diagnostic studies, or patient referrals through the ONC-certified Electronic Health Record (EHR) system.
- **OP-18b:** Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged Patients - median time from ED arrival to time of departure from the ED for patients discharged from the ED (a lower number is better).
- **OP-20:** Door to Diagnostic Evaluation by Qualified Medical Personnel - median time from Emergency Department (ED) arrival to provider contact for ED patients (a lower number is better).
- **OP-21:** Median Time to Pain Management for Long Bone Fracture - median time from Emergency Department (ED) arrival to time of initial oral or parenteral pain medication administration for ED patients with a principal diagnosis of long bone fracture (a lower number is better).
- **OP-22:** Left Without Being Seen - percent of patients who leave the Emergency Department (ED) without being evaluated by a physician, advanced practice nurse (APN), or physician's assistant (PA). (A lower number is better).
- **OP-23:** Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Emergency Department (ED) Arrival - percentage of acute ischemic stroke or hemorrhagic stroke patients who arrive at the ED within 2 hours of the onset of symptoms who have a head CT or MRI scan performed during the stay and have interpretation of the CT or MRI scan within 45 minutes of arrival.
- **OP-25:** Use of Safe Surgery Checklist (Outpatient) – whether or not a facility used a checklist for outpatient surgical procedures during each of the three critical perioperative periods (prior to administration of anesthesia, prior to skin incision, and closure of incision / prior to patient leaving the operating room).
- **OP-27 / HMM-3:** Health Care Workers Given Influenza Vaccination – Facilities must report vaccination data for three categories of Healthcare Personnel (HCP): employees on payroll; licensed independent practitioners (who are physicians, advanced practice nurses, and physician assistants affiliated with the hospital and not on payroll); and students, trainees, and volunteers aged 18 or older. Only HCP physically working in the facility for at least one day or more between October 1 and March 31 should be counted. Data on vaccinations received at the facility, vaccinations received outside of the facility, medical contraindications, and declinations are reported for the three categories of HCP.
- **PC-01:** Elective Delivery - patients with elective vaginal deliveries or elective cesarean sections at greater than or equal to 37 and less than 39 weeks of gestation completed (a lower number is better).
- **PN-6:** Most Appropriate Initial Antibiotics – immunocompetent patients with pneumonia who receive an initial antibiotic regimen that is consistent with current guidelines.
- **SCIP-Inf-1:** Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision – surgical patients who received prophylactic



antibiotics within 1 hour prior to surgical incision.

- **SCIP-Inf-2:** Prophylactic Antibiotic Selection for Surgical Patients – surgical patients who received the recommended antibiotics for their particular type of surgery.
- **SCIP-Inf-3:** Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time – surgical patients whose prophylactic antibiotics were discontinued within 24 hours after surgery end time.
- **SCIP-Card-2:** Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period – surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.
- **SCIP-VTE-2:** Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis within 24 Hours Prior to Surgery to 24 Hours After Surgery – surgery patients who received appropriate VTE prophylaxis within 24 hours prior to surgical incision time to 24 hours after surgery end time.
- **SM-3:** Nursing Care Registry – participation in a systematic clinical database for nursing-sensitive care
- **SM-4:** General Surgery Registry – participation in a systematic clinical database for general surgery
- **SM-5:** Use of Safe Surgery Checklist (inpatient) – whether or not a facility used a checklist for inpatient surgical procedures during each of the three critical perioperative periods (prior to administration of anesthesia, prior to skin incision, and closure of incision / prior to patient leaving the operating room).
- **STK-1:** Venous Thromboembolism (VTE) Prophylaxis - ischemic and hemorrhagic stroke patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given

the day of or the day after hospital admission.

- **STK-2:** Discharged on Antithrombotic Therapy - ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.
- **STK-3:** Anticoagulation Therapy for Atrial Fibrillation/Flutter - ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.
- **STK-4:** Thrombolytic Therapy - acute ischemic stroke patients who arrive at this hospital within two hours of time last known well and for whom intravenous tissue plasminogen activator (IV tPA) was initiated at this hospital within three hours of time last known well.
- **STK-5:** Antithrombotic Therapy By End of Hospital Day 2 - ischemic stroke patients administered antithrombotic therapy by the end of hospital day two.
- **STK-6:** Discharged on Statin Medication - ischemic stroke patients with low-density lipoprotein (LDL) cholesterol levels greater than or equal to 100 mg/dL, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.
- **STK-8:** Stroke Education - ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.
- **STK-10:** Assessed for Rehabilitation - ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.
- **VTE-1:** Venous Thromboembolism (VTE) Prophylaxis - the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date



for surgeries that start the day of or the day after hospital admission.

- **VTE-2:** Intensive Care Unit (ICU) Venous Thromboembolism (VTE) Prophylaxis - number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the ICU or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).
- **VTE-3:** Venous Thromboembolism (VTE) Patients with Anticoagulation Overlap Therapy - the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous or subcutaneous) anticoagulation and warfarin therapy. Patients who received less than five days of overlap therapy should be discharged on both medications or have a reason for discontinuation of parenteral therapy. Overlap therapy should be administered for at least five days with an international normalized ratio (INR) greater than or equal to two prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications, or have a reason for discontinuation of parenteral therapy.
- **VTE-4:** Venous Thromboembolism (VTE) Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol or Nomogram - the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages and had their platelet counts monitored using defined parameters such as

a nomogram or protocol.

- **VTE-5:** Venous Thromboembolism (VTE) Warfarin Therapy Discharge Instructions - the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.
- **VTE-6:** Hospital Acquired Potentially-Preventable Venous Thromboembolism (VTE) - the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date (a lower number is better).

For detailed measure specifications:

- [Specifications Manual for National Hospital Inpatient Quality Measures](http://bit.ly/InpManual) <http://bit.ly/InpManual>, accessed March 3, 2015
- [Specifications Manual for National Hospital Outpatient Quality Measures](http://bit.ly/OutpManual) <http://bit.ly/OutpManual>, accessed March 3, 2015
- [Prenatal measure specifications](http://bit.ly/PrenatalSpecs) <http://bit.ly/PrenatalSpecs>, accessed March 3, 2015

For more information on this study, please contact Michelle Casey at mcasey@umn.edu



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