Core Measures

- Joint Commission and CMS
  - Created to measure processes and outcomes when using evidence based practices
  - Compared nationally to all hospitals
  - Posted on CMS (Hospital Compare) and Joint Commission websites

Congestive Heart Failure (CHF)

- Documented LVEF assessment

  Or

  Documented rationale for not assessing
  - provider deferral of LVSF assessment to another provider is not accepted as a valid reason for no LVEF assessment

Community Acquired Pneumonia (CAP)

- Antibiotic selection according to clinical practice guidelines
  - See order set *Community Acquired Pneumonia*

Medications ***Antibiotics***

<u>Inpatient, Non-ICU:</u> Not for hospital-acquired pneumonia, nursing home patients, or other healthcare associated pneumonia.

- ☐ azithromycin 500 mg IV every 24 hours **plus (select one below)**
  - ☐ ampicillin-sulbactam 3 gm IV every 6 hours
  - ☐ cefTRIAXone 1 gm IV every 24 hours
- ☐ levofloxacin 750 mg IV every 24 hours

Suspected Pseudomonas

- ☐ piperacillin-tazobactam 4.5 gm IV every 6 hours **plus (select one below)**
  - ☐ ciprofloxacin 400 mg IV every 8 hours
  - ☐ levofloxacin 750 mg IV every 24 hours
- ☐ imipenem-cilastatin 500 mg IV every 6 hours **plus (select one below)**
  - ☐ ciprofloxacin 400 mg IV every 8 hours
  - ☐ levofloxacin 750 mg IV every 24 hours
- ☐ aztreonam 2 gm IV every 8 hours **plus** levofloxacin 750 mg IV every 24 hours

Surgical Care Improvement (SCIP)

1. Antibiotic Prophylaxis :

- Selection according to clinical practice guidelines (next slide)
- Administered within 1H of incision (120 minutes for Vancomycin)
- DC within 24H of surgery end time

**Must document explicit rationale for any requirement not met*

SCIP Antibiotic Selection

**Recommended Antibiotic Prophylaxis for Common Surgical Procedures* – Anna Online

Type of Surgery	Recommended Antibiotics	Options with β-lactam allergy	Notes
Colorectal	Cefotetan or (cefazolin + metronidazole)	Clindamycin + gentamicin	Including non-perforated appendectomy
Hepatobiliary / cholecystectomy or ERCP	Cefazolin	Clindamycin + gentamicin	High-risk only: age > 70, acute cholecystitis, non-functioning gallbladder, obstructive jaundice, common duct stones
Thoracic or pacemaker placement	Cefazolin	Vancomycin or Clindamycin	Use Vanco when evidence of MRSA
Orthopedic / Arthroplasty	Cefazolin	Vancomycin or Clindamycin	Complete infusion prior to tourniquet inflation. Vanco when evidence of MRSA
Lower limb amputation (ischemic)	Cefotetan	Clindamycin + gentamicin	
Hysterectomy / C-section	Cefazolin or cefotetan	Clindamycin + gentamicin	
Head/neck (clean-contaminated, except tonsillectomy)	Cefazolin + metronidazole	Clindamycin	No prophylaxis needed for tonsillectomy, functional endoscopic sinus surgery
Esophageal, gastroduodenal	Cefazolin	Clindamycin + gentamicin	
PEG placement	Cefazolin	Clindamycin + gentamicin	
Vascular	Cefazolin	Vancomycin or Clindamycin	Use Vanco when evidence MRSA
Urologic procedures (transurethral procedures, transrectal prostate biopsy)	Levofloxacin	N/A	If urine culture is positive or unavailable, or for transrectal prostate biopsy
Urologic procedures (radical prostatectomy, nephrectomy)	Cefazolin	Clindamycin + gentamicin	

SCIP (continued)

2. VTE prevention
   - VTE prevention received within 24H of surgery end time
3. Urinary catheter DC by POD2
   - Provider documented rationale for catheter in place past POD2
   - RN documentation accepted only if ordered Nurse Driven Protocol
4. Beta Blocker
   - If pt on home BB must receive on POD 0,1,2

**Must document explicit rationale for any requirement not met*

STROKE

- VTE Prophylaxis (teds alone are not sufficient)
- For Ischemic Stroke:
  - Rehab eval
  - Anticoagulation for afib/aflutter
  - Antithrombotic by end of day 2 & at discharge
  - Statin at discharge

    (unless LDL<100 in 1st 48hrs, or within 30D of admission)

**Must document explicit rationale for any requirement not met*

VTE Prevention

- Either mechanical or pharmacological by hospital day 2 for all patients 18+

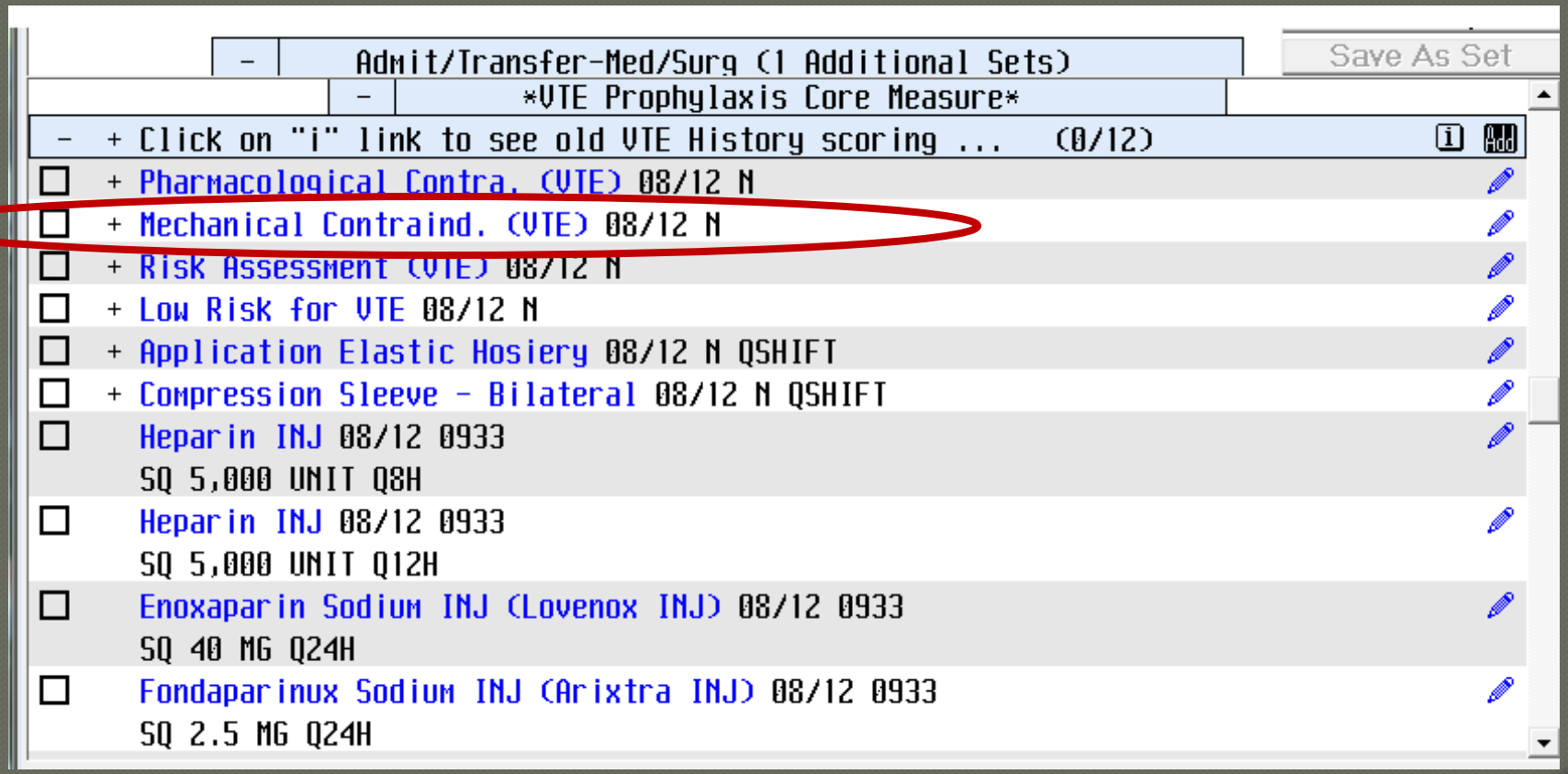
**Must document explicit rationale for any requirement not met including:*

- *low VTE risk (use CPOE risk assessment, order set)*
- *bleeding risk (must still order or address mechanical)*
- *therapeutic INR*

i.e. "no VTE prophylaxis required due to therapeutic INR"

VTE Prevention – Using CPOE

Remember – the literature shows that most patients are at risk for VTE,
so even if the patient is a bleeding risk they will likely benefit from mechanical prevention.
If not, the contraindication must be documented.



VTE Confirmed

- Overlap of enteral & parenteral anticoagulation for at least 5 days

**Must document explicit rationale for any requirement not met including:*

- *Lovenox/heparin bridge DC'd due to therapeutic INR before day 5 (INR value on chart is not enough)*

Tobacco

- Cessation medication for smokers on admission & at discharge

**Must document explicit rationale for any requirement not met including:*

  - *Patient refusal*

Fallouts at AJH – Watch Out For…

- VTE - no mechanical prevention /rationale in patient who can't be anticoagulated
- STROKE- no explicit rationale for no statin on DC
- VTE overlap therapy- no explicit rationale to DC lovenox bridge before day 5
- SCIP foley - no explicit rationale to continue foley past POD2
- SCIP abx - no explicit rationale for abx choice outside of guidelines, including Vanco in absence of MRSA hx