Medicare Beneficiary Quality Improvement Program (MBQIP) Resources

TABLE OF CONTENTS

Center for Rural Health

Arizona Rural Hospital Flexibility Program (AzFLEX)

MBQIP Reminders & Updates | December, 2022

December MBQIP Data Submission Reminders

Jan 31

Emergency Department Transfer Communication (EDTC) | Due: Tuesday, January 31, 2023

- Patients Seen Q4 2022 (October, November, December)
- New Data Collection Tool and Specifications Manual

Submit data to **Jill Bullock | bullock1@arizona.edu**

Feb 1

CMS Outpatient Measures: OP-2, OP-3, OP-18 | Due: Wednesday, February 1, 2023

- Patients seen Q2 2022 (July, August, September)
- CART version 1.20.2
- CMS Hospital Outpatient Reporting Specifications Manual version 15.0b
- Submitted to the QualityNet warehouse via CART or by vendor

Core MBQIP Measures

CMS Outpatient Measures (Domain: Outpatient)

Measure	Importance	Improvement	Reported On	Available On	Best Practices/Resources
OP-2: Fibrinolytic Therapy Received Within 30 Minutes	Same as OP-1 measure	Increase in the rate (%)	QualityNet via Outpatient CART/Vendor	• Hospital Compare • MBQIP Data and FMT Reports	• Time-to-fibrinolytic therapy is a strong predictor of outcome in patients with AMI. Nearly 2 lives per 1,000 patients are lost per hour of delay. National guidelines recommend fibrinolytic therapy within 30 minutes of hospital arrival for patients with STEMI.
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention	Early use of primary angioplasty in patients w/ STEMI results in a significant reduction in mortality & morbidity. The earlier primary coronary intervention is provided, the more effective.	Decrease in median value (time)	QualityNet via Outpatient CART/Vendor	• Hospital Compare • MBQIP Data and FMT Reports	• Diagnose the patient as early in the patient flow as possible (e.g., enable emergency medical service (EMS) to diagnose STEMI patients) • Synchronize equipment and clocks in the ED • Work with EMS providers and regional centers to establish processes and protocols to expedite communication and transfer • Establish initial and backup plan for transfer or transport to a STEMI-receiving hospital • For helicopter transport, immediately activate transport during initial communication between referring hospital ED and receiving hospital regarding the need for reperfusion
OP-18: Median time from ED Arrival to ED departure for ED discharged patients	Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care, potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.	Decrease in median value (time)			• Consider implementing alternative patient flow models such as: - RN triage and preliminary registration upon arrival, with bedside registration - Provider/RN team evaluations upon arrival with bedside registration - Low acuity patients evaluated by provider upon arrival and discharged as soon as full registration is completed - Share median time patients spent in the emergency department before being sent home evaluation data with ED managers, ED staff, and providers daily • Synchronize all staff and equipment clocks in the ED • AHRQ Patient Flow Guide https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/final-reports/ptflow/ptflowguide.pdf
OP-22: Patient Left Without Being Seen	Reducing patient wait time in the ED helps improve access to care, increase capability to	Decrease in the rate (%)	QualityNet Secure Online Portal		• The best practices to reduce door to evaluation by QMP (OP 20) also are likely to reduce the number of patients left without being seen

Measure	Importance	Improvement	Reported On	Available On	Best Practices/Resources
	provide treatment, reduce ambulance refusals/diversions, reduce rushed treatment environments, reduce delays in medication administration, & reduce patient suffering.				• Implement a process to capture patients that leave without being seen • Conduct regular patient record analyses to identify and understand trends, such as a particular diagnosis or timeframe • Contact patients who leave without being seen before the end of the shift or the next day to encourage them to return to the ED or seek treatment • AHRQ Patient Flow Guide • https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/final-reports/ptflow/ptflowguide.pdf

Patient Safety (Patient Safety Domain)

Measure		Importance	Improvement	Reported On	Available On	Best Practices/Resources
IMM-3: Immunization for Influenza (Inpatient)		1 in 5 people in the U.S. get influenza each season. Combined in pneumonia, influenza is the 8th leading cause of death, two-thirds of those attributable to patients hospitalized during the flu season. Hospitalization is an underutilized opportunity to vaccinate.	Increase in the rate (%)	NHSN	• Hospital Compare • MBQIP Data and FMT Reports	• Offer influenza vaccination by October, if possible. Vaccination should continue to be offered as long as influenza viruses are circulating (generally October – March) • Incorporate influenza vaccination status into initial patient assessment and identify a process for follow-up when needed • Review influenza vaccination status in the discharge process with administration of vaccine if indicated on initial assessment and not already given during hospitalization
Antibiotic Stewardship		Improving antibiotic use in hospitals is imperative to improving patient outcomes. Antibiotic use has well known unintended consequences, including Clostridium difficile (C. difficile) diarrhea and other adverse events.3 C.	Increase in number of core elements met	National Healthcare Safety Network (NHSN)	• MBQIP Data and FMT Reports	• See Antibiotic Stewardship Core Elements at Small and Critical Access Hospitals • http://www.cdc.gov/nhsn/forms/instr/57_103-TOI.pdf

		difficile infections alone affect more than 500,000 patients and are associated with more than 15,000 deaths in the United States each year.4 Moreover, antibiotic use is an important driving factor in the growing crisis of antibiotic resistance in the United States.				

Emergency Department Transfer Communication/EDTC (Domain: Care Transitions)

Measure	Importance	Improvement	Reported To	Available On	Best Practices/Resources
All/None Composite Calculation (all 27 data elements in EDTC sub-measures 1-7 can be used as an overall evaluation of performance on this measure set.)	Timely, accurate, & direct communication facilitates the handoff to the receiving facility, provides continuity of care, & avoids medical errors & redundant tests.	Increase in the rate (%)	State Flex Office, then to FORHP	MBQIP Data Reports	• Identify and implement a standardized process for documentation and transfer of information to the next setting of care • Update paper transfer forms to ensure capture of all the required data elements and documentation that the information was communicated to the next setting of care • Implement prompts and documentation in the electronic health record (EHR) to ensure elements are captured and communicated to the receiving facility, whether electronically or via a printed-paper form
EDTC SUB 1: Home Medications					
EDTC SUB 2: Allergies and Reactions					
EDTC SUB 3: Medications Administered in ED					
EDTC SUB 4: ED Provider Note					
EDTC SUB 5: Mental Status/Orientation Assessment					
EDTC SUB 6: Reason for Transfer and/or Plan of Care					

EDTC SUB 7: Tests and/or Procedures Performed					• Initiate discussions with organizations, both hospitals and and long-term care centers that frequently receive patients from the ED, regarding opportunities for improved transfer communication and care for patients Develop standardized setting of care processes to report outstanding test or lab results to the next setting of care if not available prior to transfer
EDTC SUB 8: Tests and/or Procedures Results					

Source: MBQIP Measures Fact Sheets, Stratis Health, http://www.stratishealth.org/providers/ED_Transfer.html

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (Domain: Patient Engagement)

HCAHPS survey contains 21 patient perspective on care and patient rating items that encompass eight key topics:

Element	Reported To	Available On
Communications with Doctors	CMS Warehouse	Hospital Compare & MBQIP Data Reports
Communication with Nurses		
Responsiveness of Hospital Staff		
Communication about Medicines		
Discharge Information		
Cleanliness of the Hospital Environment		
Quietness of the Hospital Environment		
Transition of Care		
Willingness to Recommend		
Overall Rating		

Additional Measures

Measure	Importance	Reported To	Available On
HAI-1 CLABSI: a central line-associated bloodstream infections (CLABSI) in ICUs and select wards	Central line-associated bloodstream infections (CLABSIs) result in thousands of deaths each year and billions of dollars in added costs to the U.S. healthcare system, yet these infections are preventable.	CDC/NHSN	• Hospital Compare

HAI-2 CAUTI: a catheter-associated infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney; in ICUs and select wards	UTIs are the most common type of healthcare-associated infection reported to the National Healthcare Safety Network (NHSN). CAUTIs have been associated with increased morbidity, mortality, healthcare costs, and length of stay.	CDC/NHSN	• Hospital Compare
HAI-6 CDI*: Clostridium difficile* (C.diff.) a spore-forming, Gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. Laboratory-identified Events (Intestinal infections)	It is a common cause of antibiotic-associated diarrhea (AAD). It accounts for 15-25% of all episodes of AAD. It was estimated to cause almost half a million infections in the United States in 2011, and 29,000 died within 30 days of the initial diagnosis. Those most at risk are people, especially older adults, who take antibiotics and also get medical care.	CDC/NHSN	• Hospital Compare
HAI-5 MRSA: Methicillin-resistant *Staphylococcus Aureus*(MRSA), a bacteria that is resistant to many antibiotics; blood Laboratory-identified Events (Bloodstream infections)	In a healthcare setting, such as a hospital or nursing home, MRSA can cause severe problems such as bloodstream infections, pneumonia and surgical site infections. MRSA remains an important public health problem and more remains to be done to further decrease risks of developing these infections.	CDC/NHSN	• Hospital Compare
SSIs: Surgical Site Infections Colon or Hysterectomy			
Perinatal Care • PC-01: Elective Delivery • PC-05: Exclusive Breast Milk Feeding (eCQM)			
Falls	Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk		

Source: www.cdc.gov

MBQIP Measures Fact Sheets

October 2021

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How to Use MBQIP Measure Fact Sheets

These Measure Fact Sheets provide an overview of the data collection and reporting processes for current Medicare Beneficiary Quality Improvement Project (MBQIP) Core Measures and MBQIP Additional Measures with federally established means of data collection and reporting.

The intended audience for the MBQIP Measures Fact Sheets is critical access hospital personnel involved with quality improvement and/or reporting and state Flex Program personnel.

Additional detail on MBQIP and Quality Data Reporting can be found at https://www.ruralcenter.org/tasc/mbqip.

Special thanks to the Nebraska Flex Program at the Nebraska Office of Rural Health for their efforts in supporting the development of this resource.

Table of Contents

OP-2 Fibrinolytic Therapy Received Within 30 Minutes	
MBQIP Domain	Outpatient
Measure Set	AMI
Measure Description	Emergency Department acute myocardial infarction (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less.
Importance/Significance	Time-to-fibrinolytic therapy is a strong predictor of outcome in patients with AMI. Nearly 2 lives per 1,000 patients are lost per hour of delay. National guidelines recommend fibrinolytic therapy within 30 minutes of hospital arrival for patients with STEMI.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	Hospital Quality Reporting (HQR) via Outpatient CART/Vendor
Data Available On	Care Compare MPQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients seen in a Hospital Emergency Department for whom all of the following are true: • Discharged/transferred to a short-term general hospital for inpatient care or to a Federal Healthcare facility • A patient age ≥ 18 years • An ICD-10-CM Principal Diagnosis Code for AMI An ICD-10-CM Principal Diagnosis Code for AMI as defined in Appendix A, OP Table1.1, of the CMS Hospital OQR Specifications Manual.
Sample Size Requirements	**Quarterly** 0-80 - submit all cases If you have more than 80 cases, see the specifications manual. **Monthly** Monthly sample size requirements for this measure are based on the anticipated quarterly patient population.
Data Collection Approach	Chart Abstracted
Data Elements	Arrival Time Birthdate Discharge Code E/M Code Fibrinolytic Administration Fibrinolytic Administration Date Fibrinolytic Administration Time ICD-10-CM Principal Diagnosis Code Outpatient Encounter Date Reason for Delay in Fibrinolytic Therapy
Encounter Periods	Q1 (January 1 - March 31) Q2 (April 1 - June 30) Q3 (July 1 - September 30) Q4 (October 1 – December 31)
Submission Deadlines	See MBQIP Data Submission Deadlines
Other Notes	Do not include direct admission from your ED to your acute care inpatient.

OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention	
MBQIP Domain	Outpatient
Measure Set	AMI
Measure Description	Median time from emergency department arrival to time of transfer to another facility for acute coronary intervention.
Importance/Significance	The early use of primary angioplasty in patients with STEMI results in a significant reduction in mortality and morbidity. The earlier primary coronary intervention (PCI) is provided, the more effective it is. Times to treatment in transfer patients undergoing primary PCI may influence the use of PCI as an intervention. Current recommendations support a door-to-balloon time of 90 minutes or less.
Improvement Noted As	Decrease in median value (time)
Data Reported To	Hospital Quality Reporting (HQR) via Outpatient CART/Vendor
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients seen in a Hospital Emergency Department for whom all of the following are true: • Discharged/transferred to a short-term general hospital for inpatient care or to a Federal Healthcare facility • A patient age ≥ 18 years • An ICD-10-CM Principal Diagnosis Code for AMI as defined in Appendix A, OP Table1.1, of the CMS Hospital OQR Specifications Manual.
Sample Size Requirements	**Quarterly** 0-80 - submit all cases If you have more than 80 cases, see the specifications manual. **Monthly** Monthly sample size requirements for this measure are based on the anticipated quarterly patient population.
Data Collection Approach	Chart Abstracted
Data Elements	Arrival Time Birthdate Discharge Code ED Departure Date ED Departure Time E/M Code Fibrinolytic Administration ICD-10-CM Principal Diagnosis Code Outpatient Encounter Date Reason for Not Administering Fibrinolytic Therapy Transfer for Acute Coronary Intervention
Encounter Period - Submission Deadline	Q1 (January 1 - March 31) Q2 (April 1 - June 30) Q3 (July 1 - September 30) Q4 (October 1 – December 31)
Submission Deadlines	See MBQIP Data Submission Deadlines
Other Notes	Do not include direct admission from your ED to your acute care inpatient.

OP-18

Median Time from ED Arrival to ED Departure for Discharged ED Patients	
MBQIP Domain	Outpatient
Measure Set	ED Throughput
Measure Description	Median time from Emergency Department (ED) arrival to time of departure from the emergency room for patients discharged from the ED.
Importance/Significance	Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care, potentially improves access to care specific to the patient condition, and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although once only a problem in large, urban, teaching hospitals, the phenomenon has spread to other suburban and rural healthcare organizations. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.
Improvement Noted As	Decrease in median value (time)
Data Reported To	Hospital Quality Reporting (HQR) via Outpatient CART/Vendor
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients seen in a Hospital Emergency Department that have an E/M code in Appendix A, OP Table 1.0 of the CMS Hospital OQR Specifications Manual.
Sample Size Requirements	**Quarterly** 0-900 - Submit 63 cases > 900 - Submit 96 cases **Monthly** Note: Monthly sample size requirements for this measure are based on the quarterly patient population. 0-900 - submit 21 cases > 900 - submit 32 cases
Data Collection Approach	Chart Abstracted
Data Elements	Arrival Time Discharge Code E/M Code ED Departure Date ED Departure Time ICD-10-CM Principal Diagnosis Code Outpatient Encounter Date
Encounter Period - Submission Deadline	Q1 (January 1 - March 31) Q2 (April 1 - June 30) Q3 (July 1 - September 30) Q4 (October 1 – December 31)
Submission Deadlines	See MBQIP Data Submission Deadlines
Other Notes	Do not include direct admission from your ED to your acute care inpatient.

OP-22 Patient Left Without Being Seen	
MBQIP Domain	Outpatient
Measure Set	ED Throughput
Measure Description	Percent of patients who leave the Emergency Department (ED) without being evaluated by a physician/advanced practice nurse/physician's assistant (physician/APN/PA.
Importance/Significance	Reducing patient wait time in the ED helps improve access to care, increase capability to provide treatment, reduce ambulance refusals/diversions, reduce rushed treatment environments, reduce delays in medication administration, and reduce patient suffering.
Improvement Noted As	Decrease in the rate (percent)
Data Reported To	Hospital Quality Reporting (HQR) via Online Tool
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	NA -This measure uses administrative data and not claims data to determine the measure's denominator population.
Sample Size Requirements	No sampling - report all cases
Data Collection Approach	Hospital tracking
Data Elements	Numerator: What was the total number of patients who left without being evaluated by a physician/APN/PA? Denominator: What was the total number of patients who presented to the ED?
Encounter Period	Calendar Year (January 1 – December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	Definition of patients who present to the ED: Patients who presented to the ED are those that signed in to be evaluated for emergency services. Definition of provider includes: • Residents/interns • Institutionally credentialed provider • APN/APRNs

HCP Influenza Vaccination Coverage Among Health Care Personnel (Single Rate for Inpatient and Outpatient Settings)	
MBQIP Domain	Patient Safety/Inpatient
Measure Set	Web-Based (Preventive Care)
Measure Description	Percentage of health care workers given influenza vaccination.
Importance/Significance	1 in 5 people in the U.S. get influenza each season. Combined in pneumonia, influenza is the 8th leading cause of death, with two-thirds of those attributed to patients hospitalized during the flu season.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	National Healthcare Safety Network (NHSN) Website
Data Available On	Care Compare (*Note*: Listed as IMM-3 in CMS data sets) MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	NA - This measure uses administrative data and not claims to determine the measure's denominator population.
Sample Size Requirements	No sampling - report all cases
Data Collection Approach	Hospital tracking
Data Elements	Three categories (all with separate denominators) of HCP working in the facility at least one day b/w 10/1-3/31: • Employees on payroll • Licensed independent practitioners • Students, trainees, and volunteers 18yo+ A fourth optional category is available for reporting other contract personnel HCP workers who: • Received vaccination at the facility • Received vaccination outside of the facility • Did not receive vaccination due to contraindication • Did not receive vaccination due to declination
Encounter Period	Q4 – Q1 (October 1 – March 31) – Aligns with the flu season
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	Each facility in a system needs to be registered separately and HCPs should be counted in the sample population for every facility at which s/he works. Facilities must complete a monthly reporting plan for each year or data reporting period. All data reporting is aggregate (whether monthly, once a season, or at a different interval).

Antibiotic Stewardship Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Annual Survey	
MBQIP Domain	Patient Safety/Inpatient
Measure Set	NA
Measure Description	Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Annual Survey
Importance/Significance	Improving antibiotic use in hospitals is imperative to improving patient outcomes, decreasing antibiotic resistance, and reducing healthcare costs. According to the Centers for Disease Control and Prevention (CDC), 20-50 percent of all antibiotics prescribed in U.S. acute care hospital are either unnecessary or inappropriate, which leads to serious side effects such as adverse drug reactions and Clostridium difficile infection. Overexposure to antibiotics also contributes to antibiotic resistance, making antibiotics less effective. In 2014, CDC released the "Core Elements of Hospital Antibiotic Stewardship Programs" that identifies key structural and functional aspects of effective programs and elements designed to be flexible enough to be feasible in hospitals of any size.
Improvement Noted As	Increase in number of core elements met
Data Reported To	National Healthcare Safety Network (NHSN) Website
Data Available On	MBQIP Data Reports (TBD)
Measure Population ***(Determines the cases to abstract/submit)***	NA - This measure uses administrative data and not claims to determine the measure's denominator population.
Sample Size Requirements	No sampling – report all information as requested
Data Collection Approach	Hospital tracking
Data Elements	Questions as answered on the Patient Safety Component Annual Hospital Survey (https://www.cdc.gov/nhsn/forms/57.103_pshospsurv_blank.pdf) inform whether the hospitals has successfully implemented the following core elements of antibiotic stewardship: • Leadership • Accountability • Drug Expertise • Action • Tracking • Reporting • Education
Encounter Period	Calendar Year (January 1 – December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

Emergency Department Transfer Communication (EDTC) All or None Composite Calculation	
MBQIP Domain	Care Transitions
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have all necessary communication made available to the receiving facility in a timely manner.
Importance/Significance	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	State Flex Office
Data Available On	MBQIP Data Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients admitted to the emergency department and transferred from the emergency department to another health care facility (e.g., other hospital, nursing home, hospice, etc.)
Sample Size Requirements	**Quarterly** 0-44 - submit all cases > 45 - submit 45 cases **Monthly** 0-15 - submit all cases > 15 - submit 15 cases
Data Collection Approach	Chart Abstracted, composite of EDTC data elements 1-8
Data Elements	Home Medications Allergies and/or Reactions Medications Administered in ED ED Provider Note Mental Status/Orientation Assessment Reason for Transfer and/or Plan of Care Tests and/or Procedures Performed Tests and/or Procedure Results
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	This measure is a composite of all 8 data elements and can be used as an overall evaluation of performance on this measure set.

HCAHPS Composite 1 Communication with Nurses	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that their nurses "Always" communicated well.
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: During this hospital stay, how often did nurses treat you with courtesy and respect? During this hospital stay, how often did nurses listen carefully to you? During this hospital stay, how often did nurses explain things in a way you could understand?
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HCAHPS Composite 2 Communication with Doctors	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that their doctors "Always" communicated well.
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: During this hospital stay, how often did doctors treat you with courtesy and respect? During this hospital stay, how often did doctors listen carefully to you? During this hospital stay, how often did doctors explain things in a way you could understand?
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HCAHPS Composite 3 Responsiveness of Hospital Staff	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that they "Always" received help as soon as they wanted.
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use, and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HCAHPS Composite 5 Communications About Medicines	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that staff "Always" explained about medicines before giving them.
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use, and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HCAHPS Question 8 Cleanliness of Hospital Environment	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that their room and bathroom were “Always” clean.
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use, and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: During this hospital stay, how often were your room and bathroom kept clean?
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HCAHPS Question 9 Quietness of Hospital Environment	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that the area around their room was “Always” quiet at night.
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use, and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: During this hospital stay, how often was the area around your room quiet at night?
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HCAHPS Composite 6 Discharge Information	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that "Yes" they were given information about what to do during their recovery at home.
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use, and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: 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? 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?
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HCAHPS Composite 7 Care Transitions	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who “Strongly Agree” they understood their care when they left the hospital.
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use, and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: 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. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. When I left the hospital, I clearly understood the purpose for taking each of my medications.
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HCAHPS Question 21 Overall Rating of Hospital	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use, and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HCAHPS Question 22 Willingness to Recommend	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported "Yes" they would definitely recommend the hospital.
Importance/Significance	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use, and quality and safety of care.
Improvement Noted As	Increase in percent always
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: Would you recommend this hospital to your friends and family?
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Submission Deadline	See MBQIP Data Submission Deadlines
Other Notes	--

HoPC-01 Elective Delivery	
MBQIP Domain	Patient Safety/Inpatient, Additional measure
Measure Set	Pregnancy and Delivery Care/Perinatal Care
Measure Description	Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed
Importance/Significance	The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative. Almost 1/3 of all babies born in the Unites States are electively delivered with five percent delivered in a manner violating ACOG/AAP guidelines. Most are for convenience and result in significant short-term neonatal morbidity. Compared to spontaneous labor, elective inductions result in more cesarean births and longer maternal length of stay.
Improvement Noted As	Decrease in the rate
Data Reported To	Hospital Quality Reporting (HQR) via an Online Tool
Data Available On	Care Compare Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Patients admitted to the hospital for inpatient acute care are included in the PC Mother Initial sampling group if they have: ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 11.01.1 in the Specifications Manual for Joint Commission National Quality Measures a Patient Age >= 8 years and < 65 a Length of Stay (Discharge Date - Admission Date) ≤ 120 days.
Sample Size Requirements	**Quarterly** < 75 - 100% of initial pt. pop 75-375 - report 75 cases 376-1499 - 20% of initial pt. pop > 1499 - report 301 cases **Monthly** < 25 - 100% of initial pt. pop 25-125 - report 25 cases 126-500 - 20% of initial pt. pop > 500 - report 101 cases
Data Collection Approach	Hospital tracking
Data Elements	Admission Date Birthdate Discharge Date Gestational Age ICD-10-CM Other Diagnosis Codes ICD-10-CM Principal Diagnosis Code ICD-10-PCS Other Procedure Codes ICD-10-PCS Principal Procedure Code Labor Prior Uterine Surgery
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1- December 31)
Other Notes	Inpatient Web-Based Measure

CLABSI	
MBQIP Domain	Patient Safety/Inpatient, Additional Measure
Measure Set	Healthcare Acquired Infections (HAI)
Measure Description	Central line-associated bloodstream infection (CLABSI)
Importance/Significance	An estimated 30,100 central line-associated bloodstream infections (CLABSI) occur in intensive care units and wards of U.S. acute care facilities each year. These infections are usually serious infections typically causing a prolongation of hospital stay and increased cost and risk of mortality. CLABSI can be prevented through proper insertion techniques and management of the central line.
Improvement Noted As	Decrease in the ratio
Data Reported To	National Healthcare Safety Network (NHSN) Website
Data Available On	Care Compare Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Denominator: Device days and patient days - collection method may differ depending on location of patient being monitored. Numerator: Reported using the Primary Bloodstream Infection (BSI) form (CDC 57.108)
Sample Size Requirements	No sampling - report all cases
Data Collection Approach	Hospital tracking
Data Elements	Data elements include patient demographics, risk factors, event details, and organism(s) present. For details, see the 57.108 Primary Bloodstream Infection (BSI) Form and related table of instructions on the Surveillance for Central Line – associated Bloodstream Infections webpage: http://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

CAUTI	
MBQIP Domain	Patient Safety/Inpatient, Additional Measure
Measure Set	Healthcare Acquired Infections (HAI)
Measure Description	Catheter-associated urinary tract infection (CAUTI)
Importance/Significance	Complications associated with CAUTI cause discomfort to the patient, prolonged hospital stay, and increased cost and mortality. It has been estimated that each year more than 13,000 deaths are associated with UTIs. Virtually all healthcare-associated UTIs are caused by instrumentation of the urinary tract.
Improvement Noted As	Decrease in the ratio
Data Reported To	National Healthcare Safety Network (NHSN) Website
Data Available On	Care Compare Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Denominator: Device days and patient days - collection method may differ depending on location of patient being monitored. Numerator: Reported using the Urinary Tract Infection (UTI) form (CDC 57.114)
Sample Size Requirements	No sampling - report all cases
Data Collection Approach	Hospital tracking
Data Elements	Data elements include patient demographics, risk factors, event details, and organism(s) present. For details, see the http://www.cdc.gov/nhsn/forms/57.114_uti_blank.pdf and related table of instructions on the Surveillance for Urinary Tract Infections webpage: http://www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

CDI	
MBQIP Domain	Patient Safety/Inpatient, Additional Measure
Measure Set	Healthcare Acquired Infections (HAI)
Measure Description	*Clostridioides difficile* – Laboratory identified events (Intestinal infections)
Importance/Significance	*Clostridioides difficile* is responsible for a spectrum of *C. diff* infections (CDIs), which can, in some instances, lead to sepsis and even death.
Improvement Noted As	Decrease in the ratio
Data Reported To	National Healthcare Safety Network (NHSN) Website
Data Available On	Care Compare Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Denominator: Reported using the MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring form (CDC 57.127) Numerator: Reported using the Laboratory-identified MDRO or CDI Event form (CDC 57.128)
Sample Size Requirements	No sampling - report all cases
Data Collection Approach	Hospital tracking
Data Elements	Data elements include patient demographics and event details. For details see the http://www.cdc.gov/nhsn/forms/57.128_labidevent_blank.pdf and related table of instructions on the Surveillance for C. difficile, MRSA and other Drug-resistant Infections webpage: http://www.cdc.gov/nhsn/acute-care-hospital/cdiff-mrsa/index.html
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

MRSA	
MBQIP Domain	Patient Safety/Inpatient, Additional Measure
Measure Set	Healthcare Acquired Infections (HAI)
Measure Description	Methicillin-resistant Staphylococcus Aureus (MRSA) Blood Laboratory-identified events (Bloodstream infections)
Importance/Significance	A primary reason for concern about MRSA is that options for treating patients are often extremely limited, and such infections are associated with increased lengths of stay, costs, and mortality.
Improvement Noted As	Decrease in the ratio
Data Reported To	National Healthcare Safety Network (NHSN) Website
Data Available On	Care Compare Flex Monitoring Team Reports
Measure Population ***(Determines the cases to abstract/submit)***	Denominator: Reported using the MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring form (CDC 57.127) Numerator: Reported using the Laboratory-identified MDRO or CDI Event form (CDC 57.128)
Sample Size Requirements	No sampling - report all cases
Data Collection Approach	Hospital tracking
Data Elements	Data elements include patient demographics and event details. For details see the http://www.cdc.gov/nhsn/forms/57.128_labidevent_blank.pdf and related table of instructions on the Surveillance for C. difficile, MRSA and other Drug-resistant Infections webpage: http://www.cdc.gov/nhsn/acute-care-hospital/cdiff-mrsa/index.html
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

References

CMS Hospital Outpatient Quality Reporting (OQR) Specification Manual:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244

CMS Inpatient Specification Manual:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099

Emergency Department Transfer Communication Measure Data Collection Guide and Resources:
http://www.stratishealth.org/providers/ED_Transfer.html

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS):
http://www.hcahpsonline.org

National Healthcare Safety Network - Healthcare Personnel Vaccination:
https://www.cdc.gov/nhsn/acute-care-hospital/hcp-vaccination/index.html

National Healthcare Safety Network – Healthcare Acquired Infections:
http://www.cdc.gov/nhsn/acute-care-hospital/index.html

StratisHealth Rural Quality Improvement Technical Assistance

Interpreting MBQIP Hospital Core Measures Reports for Quality Improvement

Updated March 2021

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Table of Contents

Overview

About MBQIP

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Federal Office of Rural Health Policy's (FORHP) Medicare Rural Hospital Flexibility (Flex) grant program. Implemented in 2011, **the goal of MBQIP is to improve the quality of care provided in critical access hospitals** (CAHs) by increasing voluntary quality data reporting by CAHs and then driving quality improvement activities based on the data.

MBQIP provides an opportunity for individual hospitals to look at their own data, compare their results against other CAHs and partner with other hospitals around quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients. Demonstrating value by providing cost efficient, quality care is the future of health care reimbursement. MBQIP takes a proactive approach to ensure CAHs are well-prepared to meet future quality requirements.

Purpose of this Guide

This guide is intended to help CAH staff use MBQIP Hospital Core Measures Reports to support quality improvement efforts and improve patient care. The guide includes:

- Examples of how to interpret MBQIP Hospital Core Measures Reports with a focus on improvement. The examples within the text frequently reference notated sample MBQIP Hospital Core Measures Reports (which can be found in Appendix A). Hyperlinks within the text and the sample reports allow the reader to toggle back and forth on the screen. Some may find it helpful to print the sample reports for review purposes.
- A glossary of key words with definitions and external links, if applicable. Throughout the document key words are hyperlinked so the reader is able to click on the word and go directly to the glossary.
- This guide focuses on interpretation and use of the MBQIP Hospital Core Measures Reports. For information regarding best practices on MBQIP measures and quality improvement strategies, see the Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals

Measures included in the MBQIP Data Interpretation Guide
This guide focuses on how to make use of data for core measures reported for MBQIP. Recognizing the evolving nature of health care quality measures, this guide will be updated on a routine basis to align with changes made to MBQIP.

MBQIP Hospital Core Measures Reports, which include state and national CAH comparisons, are distributed to CAHs approximately quarterly. Contact your state Flex Coordinator if you are unsure who is receiving these reports at your hospital. Contact information for your state Flex Coordinator can be on the State Flex Profile page of the TASC website. There are three separate MBQIP Hospital Core Measures Reports:

- Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report
- Care Transition Core Measures/EDTC Report
- Patient Experience Core Measures/HCAHPS Report

Data Exceptions and Labels on MBQIP Hospital Core Measures Reports

The following are brief explanations of why an MBQIP Hospital Core Measures Report might display something other than a measure rate or median for some measures. Not all these data exceptions and labels are present on every type of report. The introductory pages on each type of report will outline the data exceptions and labels that are relevant.

- "N/A" indicates that data was not submitted/reported by the CAH.
- "†" indicates that the measure may not accurately reflect the true value of the data. Without access to population and sampling data, it is not possible to determine whether a CAH submitted that they had no eligible patients in the required measure population (indicated as a "0" in earlier reports) or that the CAH did not submit data or data was rejected (indicated as "N/A" in earlier reports).
- "#" indicates that the CAH did not have a signed MOU for MBQIP at the time of reporting for this time period.
- "D/E" indicates that the data was submitted but excluded because it didn't meet the measure criteria.

Interpreting Reports to Support Improvement

Below are broad examples of how to analyze data reports and identify opportunities for improvement.

Lack of Consistent Process

Measures that are routinely at low performance may indicate that there is not a consistent process for completion and documentation of that best practice of care. Hospitals in this situation are encouraged to develop and implement standardized processes to ensure evidence-based care is being provided and documented.

Process May Need Adjustment

A measure routinely at high performance, but not at 100 percent, may indicate that processes for best practices are in place, but there is opportunity to ensure they are consistently followed. In this situation, a hospital may want to consider reviewing records for the patient stays that did not meet the measure. They can help the hospital to understand why those individual patients did not receive the evidence-based best practice. This can help identify opportunities to improve processes and documentation or may identify the need for staff education or reminders to follow the processes and procedures in place.

Understanding Variation

Measures showing a wide variation on timing measures should be reviewed to understand the cause(s) of that variation. There are two causes of variation:

- If the variation is common cause, such as the time to run and interpret test results, that may indicate an opportunity to improve the testing process.
- If the variation is special cause, due to an unusual case or situation that impacted the results, it is important to understand that cause; however, rather than changing processes, it may lead to the need for development of a back-up plan.

Considerations for Timing Measures

To identify areas of improvement for timing measures (such as OP-18), look at your own hospital's variation to understand opportunities. For example, if the median time from ED arrival to discharge is steadily increasing, a hospital might want to investigate any possible reasons for that increase in time. In addition to looking at variation each quarter within the hospital, it can also be helpful to compare against the median and 90th percentiles for both the state and the nation to identify areas of improvement and identify

benchmarking targets. If a hospital has a consistently larger median time than both the state and national averages, this suggests that the hospital might want to look at opportunities for decreasing that time.

Using MBQIP Patient Safety/Inpatient and Outpatient MBQIP Core Measures Reports

The MBQIP Patient Safety/Inpatient and Outpatient MBQIP Core Measures Reports include data from CMS Care Compare measures that are relevant for CAHs under the MBQIP domains of patient safety/inpatient and outpatient care. The reports include data from all CAHs that have signed a MBQIP Memorandum of Understanding (MOU) and have submitted data. Thus, the reports include data from CAHs that have not agreed to publicly report on CMS Care Compare, in addition to data from CAHs that don't have enough cases to be publicly reported on CMS Care Compare, providing a more complete picture of performance across CAHs nationally.

Organization of the Report

- **Introduction:** Pages one, two, and three provide detailed information about the measures included in the report, what the values mean, and notes about changes and footnotes.
- **Quarterly Measures:** Page four summarizes the quality measures submitted to CMS on a quarterly basis. Measures are grouped by set, including AMI/Cardiac Care and Emergency Department (ED), which includes both inpatient and outpatient ED measures.
- **Annual Measures:** Page five of the report summarizes quality measures reported on an annual basis, including OP-22 and HCP/IMM-3.
- **Antibiotic Stewardship Program – NHSN Annual Facility Survey:** Page six of the report summarizes performance on each of the seven core elements of an antibiotic stewardship program, as collected via the NHSN Annual Facility Survey.

Data Exceptions and Labels on Patient Safety/Inpatient and Outpatient MBQIP Core Measures Reports

See the "Overview" section of this resource for brief explanations of why an MBQIP Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report might display something other than a measure rate or median for some measures beginning with data reports reflecting Q4 2019. (For reports summarizing Patient Safety/Inpatient and Outpatient data through Q3 2019, see the archived version of this resource.)

Using Comparison Data for Patient Safety/Inpatient and Outpatient Measures

MBQIP Patient Safety/Inpatient and Outpatient MBQIP Core Measures Reports include comparison data for all reporting CAHs by state (under the column header State Current Quarter) as well as nationally (under the column header National Current Quarter). The measures on these reports are process-based quality measures, which evaluate implementation of clinically proven best practices of care. Hospitals should strive to provide these best practices in clinical care to *every patient, 100 percent of the time*.

State and national comparison data are averages. In your reports, the state and national median measures (OP-18b, OP-3b) are calculated by taking the medians of those hospital-level medians for CAHs in the state and CAHs in the nation. To calculate such an average for a given measure, the medians of all hospitals reporting that measure would be arranged smallest to largest, and the middle median would be displayed on the report. Averages of the state and national percentage measures (OP-2, ED-2b, etc.) are averages in the more usual sense of the term. To calculate the state and national averages for a given measure, the sum of all numerators for

that measure is divided by the sum of all denominators. State and national median measures are medians of the median, while state and national percentage measures are averages in the usual use of the term.

Although it can be helpful to understand your comparison to those norms, averages represent the middle ground for performance and *everyone* should strive to achieve at least the 90th percentile for each measure. Therefore, for quality improvement purposes, such data benchmarks are more useful than average comparison data. (*Note*: Benchmarks for the top 10 percent by state and for the nation are included in your Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report. Your state Flex Coordinator may be able to provide additional state specific information.)

Interpreting Patient Safety/Inpatient and Outpatient MBQIP Core Measures Reports to Support Improvement

Examples of how to interpret the data for use in quality improvement efforts are listed below. Each example is hyperlinked to the corresponding example in the sample report found in Appendix A.

Example A: Swings in performance are reflective of low patient volume. However, this is an every patient/every time measure and even with low patient volume this variation in performance highlights opportunities to improve processes.

Example B: For OP-22, strive for the lowest number possible – lower is better in terms of performance.

Example C: Look for variation your hospital may have between survey years for any of the core elements of antibiotic stewardship programs. If your hospital met a core element for one year, but did not meet it for the next, consider why. Did something change about your hospital's antibiotic stewardship program? Or, did the person/people completing the Annual Facility Survey differ between the survey years? In addition, compare your hospital's performance to that of the state or nation. Are there areas where your hospital has not implemented a core element, but most other hospitals have? You may also consider asking your state Flex program for more detail about this data as they have access to the more granular survey responses.

Using Patient Experience Core Measures/HCAHPS Reports

Patient Experience Core Measures/HCAHPS Reports summarize Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data reported by hospitals, which provides hospitals the opportunity to understand care provided from the patient's point of view. In addition to three screening and seven demographic questions, the survey includes 19 questions that ask patients for their feedback on a variety of aspects related to their experience as an inpatient in the hospital. The 19 substantive questions are broken into six composite areas, two individual topic areas and two global topic areas. The full survey is available on the HCAHPS survey website. It is not expected that hospitals will perform at 100 percent on any individual measure because, unlike process measures, data from the HCAHPS is based on patient perception.

Using Comparison Data for HCAHPS Measures

- There is typically more variation in this type of survey data than in process measures. Therefore, you should look for trends that indicate consistent decline or improvement over time.
- Looking at comparison data on the Patient Experience Core Measures/HCAHPS Reports can help provide a better understanding of how your hospital compares to other like facilities in your state and nationally. State and national data are available on these reports, which can be helpful for setting targets

for improvement goals. If your hospital is below the state or national average in an area, that also indicates an improvement opportunity. While benchmark data from top performers (such as the top 10 percent) is not available on these reports, you might see if it is available from other sources in your state to help in setting targets for improvement goals, particularly if your hospital is already above the state and national averages.

    - Note: Beginning with data reports reflecting Q1 2019 - Q4 2019 HCAHPS data, state and national rates in the Patient Experience Core Measures/HCAHPS Reports represent just CAHs in the state and nation. CMS Care Compare is the best source for state and national rates that include PPS hospitals as well, but data may be a bit older than what is included in Patient Experience Core Measures/HCAHPS Reports.

- HCAHPS data are presented as a rolling four quarters (see the sample Patient Experience Core Measures/HCAHPS Report in Appendix A) and each report represents the most recent rolling four quarters available, so it will take time to see improvements/changes in the data. To look at HCAHPS performance over time, you can compare Patient Experience Core Measures/HCAHPS Reports from different time periods. If quarterly reports are available from the survey vendor (or through the internal processes if a vendor is not used) those reports may be more useful for evaluating changes resulting from specific initiatives or efforts that have been launched. Always use caution when interpreting data from individual quarters, as the number of surveys completed in any individual quarter may be small.
- Not all hospitals will be given an HCAHPS Star Rating. Hospitals must have 100 completed surveys in a rolling four quarter period to have an HCAHPS Star Rating calculated. Hospitals that generally have near 100 completed surveys in such a time period may have no Star Rating for some time periods that dip slightly below 100 completed surveys.
- The data publicly reported on Hospital Compare includes percentage of "Always", "Yes", "Yes Definitely" and "9" or "10" ratings depending on the type of question for the most recent rolling four quarters. These are known as the top box scores.

Interpreting Patient Experience Core Measures/HCAHPS Reports to Support Improvement

Examples of how to interpret the data for use in quality improvement efforts are listed below. Each example is hyperlinked to the corresponding example in the sample report found in Appendix A.

Example D: Opportunity for Improvement

In this example of the HCAHPS composite scores for Composites 1 through 3:

- The hospital's percent "Always" response rate is consistently lower than the state and national CAH averages for all these composite indicators as shown on page two of the report.
- The hospital could revisit earlier HCAHPS reports to see if any similar trends in these composite scores are noticeable.

Example E: Calculating the Number of Patients

- For many, talking about percentages of responses on a survey can be difficult to translate into impact on individual patients. One strategy in using HCAHPS data to help staff understand the need for improvement is to translate the percentages into numbers of actual patients. Considering the number of patients may help make a more compelling appeal to staff to improve in this area.

By using information provided on the report we can compute how many patients answered a question in a certain way. In this case, we want to know how many patients answered "Definitely" to the questions asking if they would recommend the hospital. We know that 85 percent of patients said "Definitely"; this is represented as 85 divided by 100. We also know that 21 people completed the survey (as listed at the top of the report). So, we are solving for X where 85 divided by 100 equals X divided by 21.

$$\frac{85}{100} = \frac{X}{21} \qquad \frac{85 * 21}{100} = 18 \text{ Patients}$$

We find that, in this example, 85 percent is equal to 18 patients. To calculate the number of patients who did not answer "Definitely," subtract 18 from 21: 21 – 18 = 3 patients.

Note: Survey respondents can opt out of answering questions on the HCAHPS. If using a HCAHPS vendor, CAHs can also identify the exact number of patients with specific responses by looking for that additional information in their vendor reports.

Using Care Transition Core Measures/EDTC Reports

A fundamental role of CAHs in the health care safety net for rural communities is stabilization and transfer of patients in emergency situations. The Emergency Department Transfer Communication (EDTC) measure allows CAHs to evaluate and demonstrate the effectiveness of that important role.

The EDTC measure evaluates the process of transfer communication through documentation of key information (data elements) and the timeliness in which that information is communicated to the next setting of care.

Using Comparison Data for the EDTC Measure

Like the other reports, Care Transition Core Measures/EDTC Reports also include state and national comparison data for all reporting CAHs. State and national comparison data are averages. Although it can be helpful to understand your comparison to those norms, averages represent the middle ground for performance. EDTC is a process measure with a demonstrably achievable 100% benchmark. Strive to achieve at least the 90th percentile for EDTC. For quality improvement purposes, such data benchmarks are more useful than average comparison data. (Note: Benchmarks for the top 10 percent by state and for the nation are included in your EDTC reports, but your state Flex Coordinator may be able to provide additional state specific information)

Although the EDTC measure has been utilized sporadically across the country for over 10 years, inclusion of the measures in MBQIP is the first systematic nationwide implementation of the EDTC measure. A Technical Expert Panel reviewed the measure in 2018 and recommended changes to the EDTC measure. These changes were implemented starting with Q1 2020 data collection and included adjustments to help streamline and modernize the measure, including a reduction in the total number of data elements from 27 to 8 and clarifications to specific definitions of individual data elements. Because these changes were substantial, comparison data for prior to Q1 2020 are not included in these reports.

Interpreting Care Transition Core Measures/EDTC Reports to Support Improvement

Examples of how to interpret the data for use in quality improvement efforts are listed below. Each example is hyperlinked to the corresponding example in the Care Transition Core Measures/EDTC Reports found in Appendix A.

Example F: Opportunity for Improvement

Home Medications is lower-performing among the EDTC categories for this hospital, although performance is improving (Q1 2020 indicates 37 percent, and Q2 2020 indicated 64 percent). It is also lower than the state and national averages (89 percent and 95 percent respectively) and 90th percentiles (both at 100 percent). Therefore, it may be a target for improvement efforts such as updating documentation fields and processes to help ensure the data is captured and communicated.

Example G: Documentation or Process?

In general, this hospital has room for improvement in all areas, with an aggregate performance thus far at 34 percent. The hospital may choose to evaluate whether the lower scores are a result of failure to document or an issue with the process. CAHs participating in an eight-state pilot on this measure found that one common area for improvement was to ensure documentation of a plan for how tests results would be communicated to the next setting of care if they were not available at the time of transfer.

Additional Resources

CAHMPAS (Critical Access Hospital Measurement and Performance Assessment System)

Online data query tool from the Flex Monitoring Team which can be used to compare and visualize CAH performance on financial, quality, and community-benefit measures between groups of hospitals defined by users. Data are available at state and national levels for all to view.

Emergency Department Transfer Communication Measure Resources

Data specifications manual, Excel-based data collection tool, recorded trainings, quality improvement toolkit

MBQIP Measures Fact Sheets

One-measure-per-page-overview of the data collection and reporting processes for the required MBQIP measures.

MBQIP Reporting Guide

This guide is intended to help Flex Coordinators, critical access hospital staff and others involved with MBQIP understand the measure reporting process. For each reporting channel, information is included on how to register for the site, which measures are reported to the site and how to submit those measures to the site.

Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals

Offers strategies and resources to help critical access hospital (CAH) staff organize and support efforts to implement best practices for quality improvement. It includes:

- A quality improvement implementation model for small, rural hospital settings
- A 10-step guide to leading quality improvement efforts
- Summaries of key national quality initiatives that align with MBQIP priorities
- Best practices for improvement for current MBQIP measures
- Simple, Excel-based tool to assist CAHs with tracking and displaying real time data for MBQIP and other quality and patient safety measures to support internal improvement efforts
- CAH quality prioritization tool

Appendix A – Sample MBQIP Hospital Data Reports

Flex Monitoring Team
University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Hospital-Level
Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report

Quarter 4 - 2019

MBQIP Hospital Example

The Medicare Beneficiary Quality Improvement Program (MBQIP) focuses on quality improvement efforts in the 45 states that participate in the Medicare Rural Hospital Flexibility (Flex) Program. Through Flex, MBQIP supports more than 1,350 small hospitals certified as rural Critical Access Hospitals (CAHs) in voluntarily reporting quality measures that are aligned with those collected by the Centers for Medicare and Medicaid Services (CMS).

The Federal Office of Rural Health Policy (FORHP) tasked the Flex Monitoring Team with producing a set of hospital-level reports for the core MBQIP measures.

This report contains the following core MBQIP measures:

Patient Safety/Inpatient Measures

- HCP/IMM-3: Influenza Vaccination Coverage Among Health Care Personnel (annual measure, updated in quarter 1 only)
- Antibiotic Stewardship (annual measure, updated in quarter 4 only)
  - Element 1: Leadership
  - Element 2: Accountability
  - Element 3: Drug Expertise
  - Element 4: Action
  - Element 5: Tracking
  - Element 6: Reporting
  - Element 7: Education

1

  - All Elements Met
- ED-2b: Admit Decision Time to ED Departure Time for Admitted Patients

Outpatient Measures

- OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- OP-3b: Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- OP-22: Patient Left Without Being Seen (annual measure, updated in quarter 4 only)

General Report Information

For the measures in this report, hospital-level data are included for previous reporting periods and the current reporting period. State-level data and national data are also included for the current quarter, including:

- The number of CAHs reporting
- Median values
- 90th percentile values

These data may be useful in understanding how your hospital's performance compares to other hospitals.

The data for state and national values in this report only include CAHs with a signed MBQIP Memorandum of Understanding (MOU). The data used for this report are reported to the Centers for Medicare and Medicaid Services (CMS) and extracted from QualityNet, or to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) annual survey.

Specific information on how data elements were calculated for inclusion in this report is outlined below. Please direct questions regarding your MBQIP data reports to the Flex Coordinator in your state. You can find contact information for your Flex Coordinator at: https://www.ruralcenter.org/tasc/flexprofile.

Percentage Values

Percentages are calculated using the number of patients (or healthcare workers for the measure HCP/IMM-3) who meet the measure criteria, divided by the number of patients or workers in the measure population, which are specifically defined for each measure. Values are rounded to the nearest whole number.

Time Values

Median time includes the median number of minutes until the specified event occurs among patients who meet certain criteria, which are specifically defined for each measure.

Percentiles

Some measures include state and national values for 90th percentile. The 90th percentile is the level of performance required to be in the top 10% of CAHs for a given measure (i.e., 10% of CAHs perform at or better than the 90th percentile).

Binary Responses (Y/N)

For antibiotic stewardship measures, data include a yes (Y) or no (N) for each of the seven core elements, indicating if the CAH fulfilled that element or not. The report also includes a Y or N for whether the CAH met requirements for all seven elements.

Reporting Periods for Annual Measures

Measure OP-22 is reported annually, with data due May 15 of each year reflecting the prior calendar year. Measure HCP/IMM-3 is also reported annually, with data due May 15 of each year reflecting the prior Flu season (quarter 4 of the previous year through quarter 1 of the current year). Antibiotic Stewardship is also reported annually, with data reflecting NHSN survey answers from the previous year.

Measure Aggregation

State measures aggregate all CAHs in the state and national measures aggregate all CAHs nationwide.

Data Exceptions & Labels

- "N/A" indicates that the CAH did not submit any data for this measure.
- "†" This measure may not accurately reflect the true value of the data. Without access to population and sampling data, we cannot determine whether a CAH submitted that they had no eligible patients in the required measure population (indicated as a "0" in earlier reports) or that the CAH did not submit data or data was rejected (indicated as "N/A" in earlier reports).
- "#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.
- "D/E" indicates that the data was submitted but excluded because it didn't meet the measure criteria

999999: MBQIP Hospital Example

City, ST, 00000

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report
Quarter 4 - 2019

Generated on 10/23/20

[Example A]

	AMI Cardiac Care Measures	Your Hospital's Performance by Quarter				State Current Quarter			National Current Quarter		
		Q1 2019	Q2 2019	Q3 2019	Q4 2019	# CAHs Reporting	Median Time/ Overall Rate	90th Percentile	# CAHs Reporting	Median Time/ Overall Rate	90th Percentile
OP-2	Fibrinolytic Therapy Received within 30 Minutes of ED Arrival	100%	N/A†	0%	100%	16	47%	100%	186	56%	100%
	Number of Patients (N)	N=1	N/A	N=1	N=1						
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention	N/A†	N/A†	N/A†	110 min	6	96 min	78 min	277	66 min	32 min
	Number of Patients (N)	N/A	N/A	N/A	N=1						

	Emergency Department – Quarterly Measures	Your Hospital's Performance by Quarter				State Current Quarter			National Current Quarter		
		Q1 2019	Q2 2019	Q3 2019	Q4 2019	# CAHs Reporting	Median Time/ Overall Rate	90th Percentile	# CAHs Reporting	Median Time/ Overall Rate	90th Percentile
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	112 min	104 min	103 min	102 min	66	101 min	76 min	960	106 min	78 min
	Number of Patients (N)	N=48	N=71	N=57	N=79						
ED-2b	Admit Decision Time to ED Departure for Admitted Patients	46 min	54 min	50 min	46 min	66	17 min	5 min	904	43 min	9 min
	Number of Patients (N)	N=120	N=109	N=72	N=77						

"N/A" indicates that the CAH did not submit any data for this measure.
"†" This measure may not accurately reflect the true value of the data. Without access to population and sampling data, we cannot determine whether a CAH submitted that they had no eligible patients in the required measure population (indicated as a "0" in earlier reports) or that the CAH did not submit data or data was rejected (indicated as "N/A" in earlier reports).
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.
"D/E" indicates that the data was submitted but excluded because it did not meet the measure criteria.

4

Example B

999999: MBQIP Hospital Example

City, ST, 00000

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report

Quarter 4 - 2019

Generated on 10/23/20

		Your Hospital's Performance by Calendar Year			State Current Year			National Current Year		
	Emergency Department – Annual Measure	CY 2017	CY 2018	CY 2019	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	90th Percentile
OP-22	Patient Left Without Being Seen	1%	1%	1%	44	0%	0%	665	1%	0%
	Number of Patients (N)	N=10,145	N=9,827	N=9,401						

		Your Hospital's Reported Adherence Percentage			State Current Flu Season			National Current Flu Season		
	NHSN Immunization Measure	4Q16 - 1Q17	4Q17 - 1Q18	4Q18 - 1Q19	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	90th Percentile
HCP/IMM-3	Healthcare Provider Influenza Vaccination	100%	100%	100%	73	89%	100%	981	90%	99%

"N/A" indicates that the CAH did not submit any data for this measure.
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

5

Example C

999999: MBQIP Hospital Example

City, ST, 00000

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report
Quarter 4 - 2019

Generated on 10/23/20

	Your Hospital's Performance by Survey Year		State Percentage for Current Survey Year		National Percentage for Current Survey Year	
Antibiotic Stewardship Measure – CDC Core Elements	Survey Year 2018	Survey Year 2019	# CAHs Reporting	Percentage of CAHs Meeting Elements	# CAHs Reporting	Percentage of CAHs Meeting Elements
All Elements Met	5	6	82	68%	1,073	80%
Element 1: Leadership	Y	Y	82	99%	1,073	98%
Element 2: Accountability	Y	Y	82	87%	1,073	95%
Element 3: Drug Expertise	Y	Y	82	78%	1,073	92%
Element 4: Action	Y	Y	82	98%	1,073	98%
Element 5: Tracking	Y	Y	82	95%	1,073	95%
Element 6: Reporting	N	N	82	83%	1,073	89%
Element 7: Education	N	Y	82	87%	1,073	89%

"N/A" indicates that the CAH did not submit any data for this measure.
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

6

Flex Monitoring Team
University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Hospital-Level
Patient Experience Core Measures/HCAHPS Report

Current Reporting Period: Q1 2019 - Q4 2019

MBQIP Hospital Example

The Medicare Beneficiary Quality Improvement Program (MBQIP) focuses on quality improvement efforts in the 45 states that participate in the Medicare Rural Hospital Flexibility (Flex) Program. Through Flex, MBQIP supports more than 1,350 small hospitals certified as rural Critical Access Hospitals (CAHs) in voluntarily reporting quality measures that are aligned with those collected by the Centers for Medicare and Medicaid Services (CMS) and other Federal programs.

The Federal Office of Rural Health Policy (FORHP) tasked the Flex Monitoring Team with producing a set of hospital-level reports for the core MBQIP measures.

This report contains the following core MBQIP measures:

- HCAHPS Composite 1: Q1 to Q3, Communication with Nurses
- HCAHPS Composite 2: Q5 to Q7, Communication with Doctors
- HCAHPS Composite 3: Q4 & Q11, Responsiveness of Hospital Staff
- HCAHPS Composite 5: Q16 & Q17, Communication about Medicines
- HCAHPS Composite 6: Q19 & Q20, Discharge Information
- HCAHPS Composite 7: Q23 to Q25, Care Transition
- HCAHPS Q-8: Cleanliness of Hospital Environment
- HCAHPS Q-9: Quietness of Hospital Environment
- HCAHPS Q-21: Overall Rating of Hospital
- HCAHPS Q-22: Willingness to Recommend This Hospital

General Report Information

For the measures in this report, hospital-level data are included for the current reporting period consisting of a rolling four quarters. Hospital-level data include:

- The number of completed surveys - the number of participants who returned the survey in the specified timeframe.
- The survey response rate - the percentage of participants sampled who returned the survey.
- HCAHPS summary of Star Ratings - calculated using mean scores for each HCAHPS measure which was then categorized into a rating of 1, 2, 3, 4, or 5 using a statistical clustering algorithm. All measures are eligible to receive a star rating. Hospitals with fewer than 100 completed HCAHPS surveys within the current reporting period consisting of a rolling four quarters are not eligible to receive star ratings.

This report also includes state and national averages for each measure. These data may be useful in understanding how your hospital's performance compares to other hospitals.

The data for state and national values in this report only include CAHs with a signed MBQIP Memorandum of Understanding (MOU). The data used for this report are reported to the Centers for Medicare and Medicaid Services (CMS) and extracted from QualityNet.

Specific information on how data elements were calculated for inclusion in this report is outlined below. Please direct questions regarding your MBQIP data reports to the Flex Coordinator in your state. You can find contact information for your Flex Coordinator at: https://www.ruralcenter.org/tasc/flexprofile.

Measure Adjustment & Aggregation

For each measure (composite or individual question), your hospital has a reported "adjusted score", where data has been adjusted by CMS for the mix of patients and the mode by which the survey was administered. Adjusted scores show the percentage of survey respondents who selected certain responses to the survey questions, and is completed to reduce the bias in comparisons between hospitals. State measures aggregate all CAHs in the state and national measures aggregate all CAHs nationwide (not all hospitals, as was the case in the MBQIP reports previously produced by Telligen). Values for state and national data may not always add to 100% due to rounding.

Response Categories

Response categories vary by question. For example, some questions use "Yes" or "No" as response options, where others have scales ranging from "Never" to "Always" or "Strongly disagree" to "Strongly agree". For this report, some responses are combined into one category, for example "Sometimes to Never," compared to "Usually" or "Always".

Data Exceptions & Labels

- "N/A" indicates that a CAH did not report data for each of the four quarters included in the current reporting period.
- "N/C" indicates that less than 100 surveys were returned in the current reporting period so a Star Rating was not able to be calculated.
- "#" indicates that the CAH did not have a signed MOU at the time of reporting for this period.

999999: MBQIP Hospital Example

City, ST, 00000

Hospital-Level Patient Experience Core Measures/HCAHPS Report
Current Reporting Period: Q1 2019 - Q4 2019

Generated on 10/23/20

Number of Completed Surveys: 21
Survey Response Rate: 21%
HCAHPS Summary Star Rating: N/C

Example D

	HCAHPS Star Rating	Your Hospital's Adjusted Score			Your State's CAH Data			National CAH Data		
HCAHPS Composites	Star Rating (0-5)	Sometimes to Never	Usually	Always	Sometimes to Never	Usually	Always	Sometimes to Never	Usually	Always
Composite 1 (Q1 to Q3) Communication with Nurses	N/C	12%	8%	80%	2%	13%	85%	3%	13%	85%
Composite 2 (Q5 to Q7) Communication with Doctors	N/C	6%	14%	80%	2%	10%	87%	3%	12%	85%
Composite 3 (Q4 & Q11) Responsiveness of Hospital Staff	N/C	7%	22%	71%	3%	19%	77%	5%	18%	77%
Composite 5 (Q16 & Q17) Communication about Medicines	N/C	0%	12%	88%	13%	17%	70%	13%	17%	70%

	HCAHPS Star Rating	Your Hospital's Adjusted Score			Your State's CAH Data			National CAH Data		
Hospital Environment Items	Star Rating (0-5)	Sometimes to Never	Usually	Always	Sometimes to Never	Usually	Always	Sometimes to Never	Usually	Always
Q8 Cleanliness of Hospital	N/C	4%	1%	95%	4%	12%	84%	5%	14%	82%
Q9 Quietness of Hospital	N/C	9%	15%	76%	5%	26%	69%	6%	27%	66%

"N/A" indicates that a CAH did not report data for each of the four quarters included in the reporting period.
"N/C" indicates that less than 100 surveys were returned in the reporting period so a Star Rating was not able to be calculated.
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this period.

3

999999: MBQIP Hospital Example

City, ST, 00000

Hospital-Level Patient Experience Core Measures/HCAHPS Report

Current Reporting Period: Q1 2019 - Q4 2019

Generated on 10/23/20

	HCAHPS Star Rating	Your Hospital's Adjusted Score		Your State's CAH Data		National CAH Data	
Discharge Information Composite	Star Rating (0-5)	No	Yes	No	Yes	No	Yes
Composite 6 (Q19 & Q20) Discharge Information	N/C	15%	85%	12%	88%	11%	89%

	HCAHPS Star Rating	Your Hospital's Adjusted Score			Your State's CAH Data			National CAH Data		
Care Transition Composite	Star Rating (0-5)	Disagree to Strongly Disagree	Agree	Strongly Agree	Disagree to Strongly Disagree	Agree	Strongly Agree	Disagree to Strongly Disagree	Agree	Strongly Agree
Composite 7 (Q23 to Q25) Care Transition	N/C	1%	32%	67%	3%	38%	59%	4%	39%	57%

	HCAHPS Star Rating	Your Hospital's Adjusted Score			Your State's CAH Data			National CAH Data		
HCAHPS Global Items	Star Rating (0-5)	0-6 rating	7-8 rating	9-10 rating	0-6 rating	7-8 rating	9-10 rating	0-6 rating	7-8 rating	9-10 rating
Q21 Overall Rating of Hospital (0 = worst hospital, 10 = best hospital)	N/C	5%	17%	78%	4%	16%	80%	5%	17%	78%
	Star Rating (0-5)	Definitely Not or Probably Not	Probably	Definitely	Definitely Not or Probably Not	Probably	Definitely	Definitely Not or Probably Not	Probably	Definitely
Q22 Willingness to Recommend This Hospital	N/C	1%	14%	85%	2%	18%	80%	3%	21%	76%

Example E

"N/A" indicates that a CAH did not report data for each of the four quarters included in the reporting period.
"N/C" indicates that less than 100 surveys were returned in the reporting period so a Star Rating was not able to be calculated.
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this period.

4

Flex Monitoring Team
University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Hospital-Level
Care Transition Core Measures/EDTC Report

Quarter 2 - 2020

MBQIP Hospital Example

The Medicare Beneficiary Quality Improvement Program (MBQIP) focuses on quality improvement efforts in the 45 states that participate in the Medicare Rural Hospital Flexibility (Flex) Program. Through Flex, MBQIP supports more than 1,350 small hospitals certified as rural Critical Access Hospitals (CAHs) in voluntarily reporting quality measures that are aligned with those collected by the Centers for Medicare and Medicaid Services (CMS).

The Federal Office of Rural Health Policy (FORHP) tasked the Flex Monitoring Team with producing a set of hospital-level reports for the core MBQIP measures.

This report contains the following core MBQIP measures:

- EDTC-All
  - Home Medications
  - Allergies and/or Reactions
  - Medications Administered in Emergency Department
  - Emergency Department Provider Note
  - Mental Status/Orientation Assessment
  - Reason For Transfer and/or Plan Of Care
  - Tests and/or Procedures Performed
  - Tests and/or Procedures Results

1

General Report Information

For the measures in this report, hospital-level data are included for previous reporting periods and the current reporting period. State-level data and national data are also included for the current quarter, including:

- The number of CAHs reporting
- Average values
- 90th percentile

The number of records reviewed are reported at the hospital, state, and national level.

These data may be useful in understanding how your hospital's performance compares to other hospitals.

The data for state and national values in this report only include CAHs with a signed MBQIP Memorandum of Understanding (MOU). The data used for this report are from the Federal Office of Rural Health Policy as reported by CAHs to State Flex Programs.

Specific information on how data elements were calculated for inclusion in this report is outlined below. Please direct questions regarding your MBQIP data reports to the Flex Coordinator in your state. You can find contact information for your Flex Coordinator at: https://www.ruralcenter.org/tasc/flexprofile.

Percentage Values

The EDTC measure is calculated as the percentage of patients that met all of the eight data elements nationwide.

Percentiles

The 90th percentile is the level of performance needed to be in the top 10% of CAHs for a given measure (i.e., 10% of CAHs perform at or better than the 90th percentile).

Measure Aggregation

State measures aggregate all CAHs in the state and national measures aggregate all CAHs.

Data Exceptions

- * The EDTC measure was revised starting January 1, 2020, so comparable data for previous quarters are not available.
- "N/A" indicates that the CAH did not submit any data.
- "#" indicates that the CAH did not have a signed MOU at the time of reporting for this period.

999999: MBQIP Hospital Example

City, ST, 00000

Hospital-Level Care Transition Core Measures/EDTC Report
Quarter 2 - 2020

Generated on 10/23/20

		Your Hospital's Performance by Quarter					State Current Quarter			National Current Quarter		
	MBQIP Quality Measure	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Aggregate for All Four Quarters	# CAHs Reporting	Average Current Quarter	90th Percentile	# CAHs Reporting	Average Current Quarter	90th Percentile
EDTC-All	Composite	*	*	30%	43%	34%	79	78%	98%	1,037	90%	100%
	Home Medications	*	*	37%	64%	46%	79	89%	100%	1,037	95%	100%
	Allergies and/or Reactions	*	*	52%	93%	66%	79	95%	100%	1,037	97%	100%
	Medications Administered in ED	*	*	85%	71%	80%	79	95%	100%	1,037	97%	100%
	ED Provider Note	*	*	30%	57%	39%	79	89%	100%	1,037	95%	100%
	Mental Status/Orientation Assessment	*	*	59%	71%	63%	79	92%	100%	1,037	96%	100%
	Reason for Transfer and/or Plan of Care	*	*	63%	71%	66%	79	95%	100%	1,037	97%	100%
	Tests and/or Procedures Performed	*	*	52%	86%	63%	79	94%	100%	1,037	97%	100%
	Tests and/or Procedures Results	*	*	78%	86%	80%	79	91%	100%	1,037	96%	100%
	Total Medical Records Reviewed (N)	*	*	N=27	N=14	N=41	N=2,104			N=40,759		

Example F

Example G

* The EDTC measure was revised starting January 1, 2020, so comparable data for previous quarters are not available.
"N/A" indicates that the CAH did not submit any data.
# indicates that the CAH did not have a signed MOU at the time of reporting for this period.

3

Appendix B – Glossary

This glossary includes a list of commonly used terms and their explanations as they apply to the Medicare Beneficiary Quality Improvement Project (MBQIP) and quality data reporting.

- **Aggregate**: Sum; total combined.
- **Average**: State and national averages are calculated by adding up all the numerators and denominators of every reporting critical access hospital then dividing to get the percentage.
- **CMS Care Compare**: A website developed by the Centers for Medicare & Medicaid Services (CMS) that compiles information about hospitals and their reported quality measures and allows consumers to compare hospitals to assist in making a decision about where to seek care. For more information visit the Care Compare website.
- **CMS Clinical Warehouse**: The Centers for Medicare & Medicaid Services (CMS) Clinical Warehouse is the national data repository for health care quality data. Hospitals participating in the Centers for Medicare & Medicaid Services (CMS) quality improvement initiatives must submit specified data in the prescribed format to the CMS Clinical Warehouse.
- **Common cause variation**: Arises from factors inherent in the process; 'usual' differences in a standard process but can be an opportunity for improvement if a reduction in variation is desired.
- **Composite**: A composite measure combines more than one item in order to measure a concept that is too complex to be measured with one item. In reference to Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a composite measure is a grouping of related questions.
- **Denominator**: The bottom term in a fraction; the total number of parts created from the whole.
- **Excluded**: Individual case(s) accepted into the CMS Clinical Warehouse that did not meet the criteria to be included in a specific quality indicator; not included in the denominator.
- **Median**: The middle number in a set of values; half the numbers are less, and half the numbers are greater.
- **Numerator**: The top term in a fraction; how many parts of the whole being considered.
- **QualityNet**: Established by the Centers for Medicare & Medicaid Services (CMS), QualityNet provides health care quality improvement news, resources and data reporting tools and applications used by health care providers and others. QualityNet is a CMS-approved website for secure communications and health care quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, data vendors and end stage renal disease (ESRD) networks and facilities. For more information visit the QualityNet website.
- **Rejected**: Individual case(s) submitted, but for some reason not accepted into the CMS Clinical Warehouse.
- **Rolling quarters**: Inclusion of a certain number of the most recent quarters.
- **Special cause variation**: Arises from factors outside the process; outside the ordinary; requires a need to understand what happened, but not typically the focus of improvement. May lead to planning for specific circumstances.

- **Submit**: Transmission of data via the secure QualityNet website. Hospitals may transmit data themselves if using the CART tool for data collection or have a vendor transmit the data on their behalf if they are using a vendor supported data collection process.
- **Top box**: The most positive answer choice; in reference to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) this means the answers: "Always" for those questions with options always, usually, sometimes or never; "Yes" for those questions with the options yes or no; "Yes Definitely" for those with the options yes definitely, yes somewhat or no; and "9" or "10" for those with the options of a number 0 through 10.

Medicare Beneficiary Quality Improvement Project (MBQIP) Quality Reporting Guide

April 2022

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Table of Contents

Overview

About MBQIP

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Federal Office of Rural Health Policy's (FORHP) Medicare Rural Hospital Flexibility (Flex) grant program. Implemented in 2011, the goal of MBQIP is to improve the quality of care provided in critical access hospitals (CAHs) by increasing quality data reporting among CAHs and then driving quality improvement activities based on the data.

CAHs have historically been exempt from national quality improvement reporting programs due to challenges related to measuring improvement in low volume settings and limited resources. It is clear, however, that some CAHs are not only participating in national quality improvement reporting programs but are excelling across multiple rural relevant topic areas. For example, small rural hospitals that participate in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey often outperform prospective payment system (PPS) hospitals on survey scores. MBQIP provides an opportunity for individual hospitals to look at their own data, compare their results against other CAHs, and partner with other hospitals around quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients.

As the U.S. moves rapidly toward a health care system that pays for value versus volume of care provided, it is crucial for CAHs to participate in federal, public quality reporting programs to demonstrate the quality of the care they are providing. Low numbers are not a valid reason for CAHs to not report quality data. It is important to provide evidence-based care for every patient, 100 percent of the time. MBQIP takes a proactive approach to ensure CAHs are well-prepared to meet future quality requirements.

Current MBQIP Measures

This guide focuses on measures reported for MBQIP as part of the Flex grant program. Recognizing the evolving nature of health care quality measures, this guide will be updated on a routine basis to align with changes made to MBQIP. The current list of MBQIP measures is also updated on a routine basis.

Purpose of This Guide

This guide is intended to help Flex Coordinators, CAH staff, and others involved with the MBQIP program understand the measure reporting process. For each reporting channel, information is included on how to register for the site, which measures are reported to the site, and how to submit those measures to the site.

Key Resources

Below is an alphabetical list of key resources that are referenced throughout this guide.

Emergency Department Transfer Communication Resources
Links to the Emergency Department Transfer Communication (EDTC) Specifications Manual and a free Excel data entry tool.

HARP Account
Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) account login page for submitting measure data to the CMS Hospital Quality Reporting (HQR) platform.

MBQIP Acronyms
A list of acronyms commonly used in reference to MBQIP.

MBQIP Data Submission Deadlines
Chart of data submission deadlines for reporting the MBQIP measures.

MBQIP Measures
Overview of current MBQIP measures

National Healthcare Safety Network (NHSN)
The Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network is a healthcare-associated infection tracking system.

Online MBQIP Data Abstraction Training Series
Recorded sessions on YouTube on how to locate the CMS Specification Manuals, CART tool, and the process to identify each MBQIP measure population and abstract the required data elements.

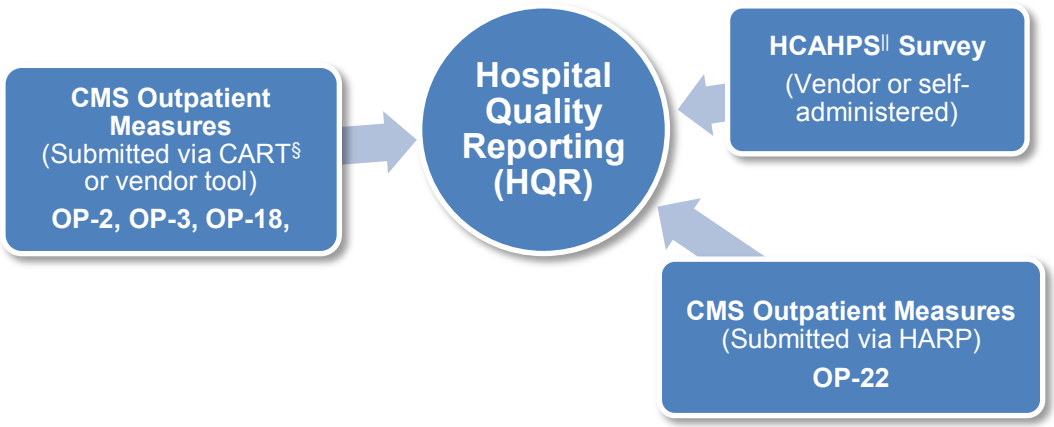
QualityNet Home Page
Specifications Manuals and Centers for Medicare & Medicaid Services (CMS) Abstraction and Reporting Tools (CART) for inpatient and outpatient measures.

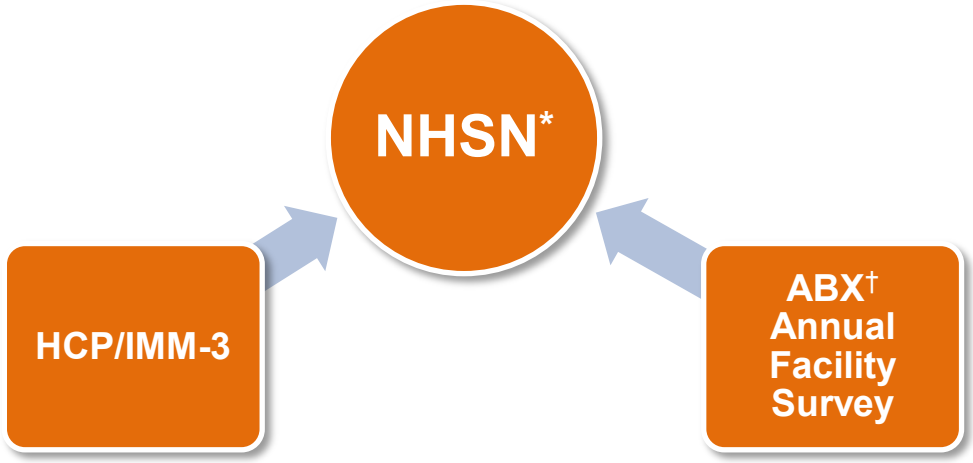
Quality Reporting Center
This site contains inpatient and outpatient educational materials/resources developed by CMS. The instructional material can be very helpful. Just remember that it is based on requirements for the CMS Inpatient and Outpatient Reporting Programs, and MBQIP Program requirements may differ.

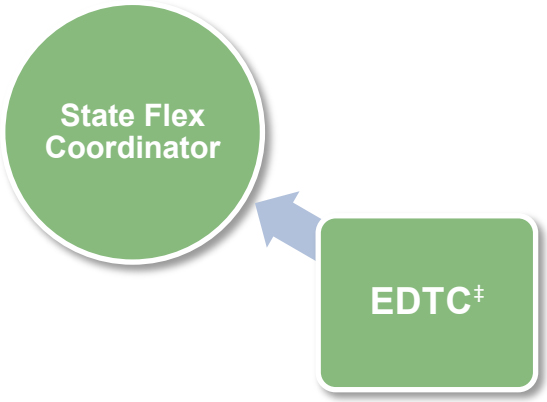
How This Guide is Organized

MBQIP measures are generally referred to by domain: Patient Safety/Inpatient, Patient Experience, Care Transitions, and Outpatient. However, since this guide focuses on reporting, the measures are grouped by how and where the data is to be reported.

Quality Data Reporting Channels for MBQIP Required Measures







§CMS Abstraction and Reporting Tool ‖Hospital Consumer Assessment of Healthcare Providers and Systems
*National Healthcare Safety Network †Antibiotic Stewardship ‡Emergency Department Transfer Communication

Getting Started

MBQIP Training Video: Data Abstraction Training Series Session 1 – QualityNet. This video shows how to locate and navigate the CMS QualityNet website. (12-minute video)

1. **Become Familiar with QualityNet**
   QualityNet provides health care quality improvement news, resources, and data reporting tools and applications used by health care providers and others. This site is where you will find the Hospital Quality Reporting Specifications Manuals, which contain the measure instructions for reporting, and the CART tool, the free CMS software tool for data submission.

The QualityNet Service Center offers technical support for issues with data submission.

2. **Register for a HARP Account**
   To submit data to the Hospital Quality Reporting (HQR) platform, you must create a HARP account. HARP is a secure identity management portal provided by the CMS. Creating a HARP account provides you with a user ID and password to sign in to submit data to HQR.
   - Watch this CMS HARP Registration video, then follow the steps below, listed under Scenario #2 on the HARP – Getting Started page.
     1. Go to https://harp.cms.gov/register.
     2. Enter your profile information (please use your corporate email address) and select **Next**.
     3. Choose your user ID, password, and challenge question and select **Next**
     4. If remote proofing questions were successfully generated, answer the five identity proofing questions to verify your identity and select **Next**.
     5. Your account has been created, and you will receive a confirmation email
     6. For security reasons, all HARP accounts are required to have two-factor authentication. Select **Login** to Complete Setup to log into HARP and set up two-factor authentication. Once you have set up two-factor authentication, you are able to log into your respective CMS application. Follow your application's instructions for how to request a role.

   To register as a Basic User or Security Administrator/Official in the Hospital Quality Reporting (HQR) System:
     1. Log into hqr.cms.gov with your HARP User ID and Password.
     2. Go to **My Profile**. (Under your **User Name** in the upper right)
        - From this page, you can Request Access or View Current Access.
     3. Select either **Basic User** or **Security Administrator/Official** when prompted to **Choose Your User Type**.
     4. **Select** your required permissions, **Review** them, and click **Submit** when ready.
     5. You will be notified by email when your request has been approved.

The Security Administrator/Official role gives you access to all the functions of submitting data in HQR. Hospitals are required to maintain an active SA. To stay active, SAs should log into their account at least once per month. It is recommended that all hospitals have at least two staff with that role.

CMS Training Videos – Check out these resources from CMS for information on creating a HARP account and navigating HQR.

CMS Outpatient Measures

MBQIP Measures

Required
OP-2: Fibrinolytic Therapy Received within 30 minutes
OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
OP-22: Patient Left Without Being Seen

1. **Identify Measure Population**
   Hospitals need to identify which outpatient cases fit in the measure population for reporting. The information on how to determine the initial patient population for each measure is found in the related Measurement Information section of the Hospital Outpatient Quality Reporting Specifications Manual on QualityNet.

   Be sure to reference the manual for the encounter time period you are currently abstracting.

MBQIP Training Video: Data Abstraction Training Series Session 2 - Locating CMS Data Specifications Manuals. This video shows how to locate the CMS Reporting Manuals. (13-minute video)

2. **Enter Outpatient Population and Sampling Counts**
   Hospitals are encouraged to submit aggregate population and sample size counts for Medicare and non-Medicare discharges for each chart-abstracted measure quarterly. Information on how to determine the clinical measure population and sampling requirements are found in the Measurement Information sections and the Population and Sampling Specification section of the Hospital Outpatient Quality Reporting Specifications Manual on QualityNet.

   Be sure to reference the manual for the discharge time period you are currently abstracting.

   Population and Sample size counts are submitted via the HQR Secure Portal.
   a. Log in to HQR via your HARP account.
   b. Under **Dashboard** on the left-hand side of the screen, select **Data Submissions**.
   c. Click on the **Population and Sampling** tab.
   d. Choose **Data Form** and then **OQR** for Outpatient Quality Reporting.
   e. Make sure the Reporting Period box contains the correct quarter for which you are submitting data.
   f. Click on **Start Measure** for the measure set where you want to submit data.
   g. Select your sampling option.
      - Choose **Sampled** if you are not doing all the cases that meet the measure set population requirements and you are only doing a sample.
      - Choose **Not Sampled** if you are doing all the cases that meet the measure set population requirements.
      - Choose **N/A Submission** not required if you are not submitting any data for the measure set.

   If you have no cases that meet the measure population requirements for a quarter, choose **Not Sampled** and enter zero for your population.

h. Enter your numbers in the grids. Under **Population**, enter the total number of cases that meet the measure set requirements for the quarter in the boxes. Under Sampling, enter the number of cases you are planning to submit to the warehouse.
i. Click on **Save and Return** to get back to the measure selection screen.
j. When you have finished submitting data for each measure, in a green banner towards the top of the page you should see a check mark and the notice "Hospital Outpatient: Population and Sampling Measure Sets Successfully Submitted."

Each measure must have a reply. If you are not submitting on a measure set, choose **N/A** for the sampling option. If you have a measure set that you would be submitting cases for but there are none that meet the measure requirements for the quarter, select **Not Sampled** and record zero in the population and sampling boxes.

3. **Abstract CMS Outpatient Measure Data using CART or a vendor tool**
Hospitals must chart abstract and submit data quarterly for the core clinical process measure sets AMI (OP-2, OP-3) and ED-Throughput (OP-18). For further information on how to collect this data, reference the Hospital Outpatient Quality Reporting Specifications Manual on QualityNet.

Be sure you reference the manual for the discharge time period you are currently abstracting.

MBQIP Training Videos: Data Abstraction Training Series Session 4, Outpatient AMI Measures (OP-2, OP-3) (23-minute video) and Session 5, Outpatient ED Throughput Measures (OP-18, OP-22) (25-minute video) provide further guidance on abstracting the MBQIP core outpatient measures.

The Outpatient CART application is available at no charge. Instructions on CART downloading and information, including the CART User's Guide are found here: CART Downloads & Info.

Always check to make sure you have installed the most current version of CART available before you start abstracting for the quarter.

MBQIP Training Video: Data Abstraction Training Series Session 3 Locating CART. This video shows how to locate the CMS abstraction reporting tool, CART. (16-minute video)

CMS Training Video: CART Basics. This video reviews the basic steps needed to use CART including how to download the application, log in, create a provider and user set up and navigate through the application. (30-minute video)
Presentation Slides.

CMS Training Video: CART Outpatient Quality Reporting (OQR): Knowing the Basics.
This video reviews the steps required for entering abstractions into CART. Stop viewing at 38:00 – the rest of the video describes the outdated QualityNet submission method.

4. **Submit CMS Outpatient Web-Based Measures**
ED Throughput measure OP-22 is collected using administrative data to determine the measures' population; there is no individual chart abstraction. Data is collected on a yearly, not quarterly basis.

Data is submitted the year following the encounter period, through the Hospital Quality Reporting (HQR)Secure Portal. For further information on how to collect this data, reference the Hospital Outpatient Quality Reporting Specifications Manual on QualityNet.

CMS Training Video: System Updates: Hospital Outpatient Quality Reporting (OQR) Program.
This video demonstrates the important features and key steps for submitting outpatient measures to the CMS Hospital Quality Reporting (HQR) platform. (54-minute video) Presentation Slides.

5. **Submit Data to Hospital Quality Reporting**
   Measure data must be submitted via the HQR Secure Portal either by the hospital or a vendor of their choice. Clinical data submission is accomplished in one of two ways: uploading from Outpatient CART or by a third-party vendor.

CMS Training Videos: HQR Tutorials.
The 24 videos in this playlist contain tips on using Hospital Quality Reporting, including instructions on submitting data to CMS.


Data submissions must be timely. Refer to the MBQIP Data Submission Deadlines for timeframes.

6. **Check Submitted Cases**
   After your data is submitted you should get confirmation that the data was received. To check and make sure the data was accepted and not rejected, run the Case Status Summary Report. This report is run from the HQR portal.

   To Run the Case Status Summary Report:
   a. Log in to HQR via your HARP account.
   b. Under the **Dashboard** on the left-hand side of the screen, select **Data Results** and **Chart Abstracted**.
   c. Select the **File Accuracy** tab.
   d. Under **Program** chose **OQR** (Outpatient Quality Reporting).
   e. Under **Report** select **Case Status Summary**.
   f. Under Encounter Quarter select the quarter for the data you have just submitted.
   g. Click on **Export CSV**. Your report will appear in an Excel format showing the number of cases that made it to the warehouse for each measure submitted and the number accepted and/or rejected.

If your Case Status Summary Report shows that cases have been rejected, run the Submission Detail Report. This report will show you why your cases have been rejected. Correct the errors and resubmit those cases. Follow the above steps but select **Submission Detail** as your report.

If your Case Status Summary Report shows no data fits the criteria, then the data you submitted did not make it to the warehouse. Something must have gone wrong with your submission so try again.


Do not wait until right before the data due date to submit and check on your data. If you have rejected cases, you will want to have time to correct the errors and resubmit. Once the due date has passed, no further data will be accepted for the quarter.

CMS Inpatient Measures

MBQIP Measures

Additional
PC-01: Elective Delivery

Submitting Web-Based Measures[1]

The inpatient web-based measure PC-01: Elective Delivery is reported quarterly through the Hospital Quality Reporting Secure Portal.

The Initial Patient Population, numerator, denominator, and total exclusions are to be determined using the specifications developed by the Joint Commission for this measure. Full definitions and other relevant information can be found at https://manual.jointcommission.org/bin/view/Manual/WebHome

More information on how to submit this measure can be found at the Quality Reporting Center.

[1] At this time there are no MBQIP core measures that are web-based inpatient measures.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

MBQIP Measures

Required
HCAHPS Survey

1. **Decide Process for HCAHPS Survey Implementation**
   HCAHPS is a standardized survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. Either the hospital or a vendor representing the hospital can implement the survey.

   Hospitals that plan to self-administer the survey will want to review these HCAHPS Online training materials.

It should be noted that the requirements for implementing the survey are quite stringent, so most hospitals choose to have their survey process done by a vendor. An updated list of approved vendors can be found at on the HCAHPS Online website. For more information about approved vendors, including those that work specifically with small rural hospitals, see the HCAHPS Vendor Directory from the National Rural Health Resource Center.

2. **Conduct the HCAHPS Survey**
   There are currently four approved methods of conducting the survey:
   - Mail Only
   - Telephone only
   - Mixed (mail followed by telephone)
   - Interactive Voice Response (IVR).

3. **Submit HCAHPS survey data**
   The survey data must be submitted via Hospital Quality Reporting (HQR) in the specified Microsoft Excel XML file format by a registered HQR user. Data may be submitted by the hospital or a vendor representing the hospital.

HCAHPS data is submitted to HQR on a quarterly basis. Refer to the MBQIP Data Submission Deadlines for timeframes.

For more information about the HCAHPS, see HCAHPSOnline.org

National Healthcare Safety Network (NHSN)

MBQIP Measures

Required	Additional
HCP/IMM-3: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) **Antibiotic Stewardship** – NHSN Annual Facility Survey	**Healthcare-Associated Infections (HAI):** **CLABSI**: Central Line-Associated Bloodstream Infection **CAUTI**: Catheter-Associated Urinary Tract Infection **C. diff**: Clostridioides difficile Infection (CDI) **MRSA**: Methicillin-resistant Staphylococcus Aureus Infection

1. **Enroll Hospital in NHSN**
   To report these measures, your hospital must be enrolled in NHSN. If you are unsure of your hospital's status with NHSN, email them at: nhsn@cdc.gov. If your hospital is not already enrolled in NHSN, follow these instructions for enrollment.
2. **Gather Influenza Vaccination Data**
   Hospitals report healthcare personnel (HCP) influenza vaccination coverage in the Healthcare Personnel Safety Component of NHSN. The HCP Influenza Vaccination Summary Protocol is a guide to collecting and reporting influenza vaccination summary data for the HCP Vaccination Module.
3. **Submit HCP Influenza Vaccination Summary Data**
   Hospitals are only required to report HCP Influenza Vaccination Summary Data in NHSN once a year, at the conclusion of the reporting period (October 1 through March 31 A hospital can choose to submit their HCP in NHSN on a monthly basis. Resources and instructions on how hospitals submit HCP influenza data can be found on the Surveillance for Healthcare Personnel Vaccination webpage.

HCP/IMM-3 data is due by May 15 (or the next business day if the 15th falls on a weekend) of the reporting year. HAI data is submitted on a quarterly basis and has the same submission dates as the CMS Inpatient Measures. Refer to the MBQIP Data Submission Deadlines for inpatient measure timeframes.

4. **Complete the NHSN Patient Safety Component Annual Facility Survey**
   This survey will be used to measure implementation of Antibiotic Stewardship. The deadline for submission is March 1 with responses based on information from the previous calendar year. A copy of the survey and instructions for completion of the survey can be found on the NHSN website.

   Accessing the survey in NHSN:
   - If a hospital has only been reporting on the Influenza Vaccination Coverage Among Healthcare Personnel measure, they will need to select the Patient Safety Component to access the survey.
   - Hospitals that submit HAI measures via NHSN do so through the Patient Safety Component, and completion of the annual facility is required for submission of HAI data.

Further information on timeframes and how to report the additional measures in NHSN can be found on the Tracking Infections in Acute Care Hospitals/Facilities webpage.

Emergency Department Transfer Communication (EDTC)

MBQIP Measures

Required

EDTC Data Elements:

- Home Medications
- Allergies and/or Reactions
- Medications Administered in ED
- ED Provider Note
- Mental Status/Orientation Assessment
- Reason for Transfer and/or Plan of Care
- Tests and/or Procedures Performed
- Tests and/or Procedure Results

All-EDTC: Composite of all 8 data elements

1. **Identify Measure Population**
   Hospitals need to identify which emergency department cases fit in the measure population for reporting. Instructions on how to determine the patient population for the measure is found on the Population and Sampling page of the EDTC Data Specifications Manual available on the EDTC Resources webpage.

MBQIP Training Video: EDTC Data Specifications Manual training video. A guided overview of how to abstract the EDTC measure using the Data Specifications Manual. We recommend having the manual open to follow along. (28-minute video)

2. **Abstract the EDTC Measure Data**
   Hospitals must chart abstract the EDTC data elements to determine the numerator and denominator for the MBQIP program submission on a quarterly basis. Data can be collected via a tool from a vendor or by using an Excel-based data collection tool. A free Excel-based Data Collection Tool for EDTC measure, along with instructions for using the tool, can be found on the EDTC Resources webpage.

MBQIP Training Video: EDTC Data Collection Tool training video**.** A step-by-step guide on how to download the Excel-based data collection tool, enter data, and run reports to calculate your measures. (25-minute video)

3. **Submit the EDTC Data**
   Numerator and denominator data are submitted to the State Flex Coordinator or their designee. Contact your Flex Coordinator to determine how the EDTC data should be submitted. To find your State's Flex Coordinator, visit the State Flex Profiles on the Technical Assistance Services Center (TASC) website.

Data submissions must be timely. Refer to the MBQIP Data Submission Deadlines for timeframes.

Record Your Hospital Quality Reporting Contacts

It's important to keep track of who in your organization has roles in the reporting process. If you have staff changes, this list can be a helpful record of which personnel have access to reporting sites, tools, and vendors.

Reporting Tools and Contacts

HQR Security Administrators: (recommend two from each facility)	

NHSN Facility Administrator:	
NHSN Users: (recommend at least one additional user beyond the facility administrator)	

CMS Chart-Abstracted Measures

Who is responsible for collecting the data:	
Who is responsible for submitting the data:	

If using the CMS CART tool:

CART Administrators (recommend at least two from each facility):	

If using a Vendor tool:

Vendor:	
Staff with Access:	
Contact information for vendor tool:	

Emergency Department Transfer Communication

What data collection tool is used:	
Staff with access to the tool:	
Process for submission of EDTC data (note this varies by state):	

HCAHPS

HCAHPS vendor:	
Staff with responsibility for working with HCAHPS vendor:	

Other Hospital Quality Reporting Tools or Contacts:	

For MBQIP Assistance

State Flex or MBQIP Coordinator:	

Data Specifications Manual

Emergency Department Transfer Communication Measure

Revised: October 2019

Prepared by Stratis Health
In collaboration with Dr. Jill Klingner from the
University of Minnesota Rural Health Research Center

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- Centers for Medicare & Medicaid Services, Quality Improvement Organization (QIO) Special Innovation Project
- Federal Office of Rural Health Policy, RQITA (Rural Quality Improvement Technical Assistance) Program

Stratis Health, based in Bloomington, Minnesota, is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

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Table of Contents

Emergency Department Transfer Communication Measure Specifications

ED Transfer Communication Quality Measure

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all the following relevant elements were documented and communicated to the receiving hospital in a timely manner:

- Home Medications
- Allergies and/or Reactions
- Medications Administered in ED
- ED Provider Note
- Mental Status/Orientation Assessment
- Reason for Transfer and/or Plan of Care
- Tests and/or Procedures Performed
- Tests and/or Procedures Results

Denominator Statement: Transfers from an ED to another healthcare facility.

Background of the Measure

In 2003, an expert panel convened by Stratis Health and the University of Minnesota Rural Health Research Center identified Emergency Department care as an important quality assessment measurement category for rural hospitals. Emergency care is particularly critical in rural hospitals where more limited scope of hospital services and geographic realities make organizing triage, stabilization, and transfer of patients an essential aspect of rural hospital care. Communication between hospitals and clinicians promotes continuity of care and may lead to improved patient outcomes. From 2005 to 2014, these measures were piloted by rural hospitals in Hawaii, Iowa, Maine, Minnesota, Missouri, Nebraska, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Utah, Washington, West Virginia, Wisconsin, and Wyoming. Results of the pilot projects indicated room for improvement in ED care and transfer communication. Aggregate project results are available at http://www.flexmonitoring.org/wp-content/uploads/2014/02/ds8.pdf and http://www.flexmonitoring.org/publications/ds3/.

Communication problems are a major contributing factor to adverse events in hospitals, accounting for 65% of sentinel events tracked by The Joint Commission. In addition, research indicates that deficits exist in the transfer of patient information between hospitals and primary care physicians in the community, and between hospitals and long-term facilities. Transferred patients are excluded from the calculation of most national quality measures, such as those used in Hospital Compare. The Hospital Compare Web site was created to display rates of Process of Care measures using data that are voluntarily submitted by hospitals.

The Joint Commission has adopted National Patient Safety Goal 2, “Improve the Effectiveness of Communication Among Caregivers.” This goal required all accredited hospitals to implement a standardized approach to hand- off communications, including nursing and physician handoffs from

the emergency department (ED) to inpatient units, other hospitals, and other types of health care facilities. The process must include a method of communicating up-to-date information regarding the patient's care, treatment, and services; condition, and any recent or anticipated changes. (Note: The National Patient Safety Goals are reviewed and modified periodically. In 2013 a communication goal focused on the communication of test results.) http://www.jointcommission.org/assets/1/6/HAP_NPSG_Chapter_2014.pdf

Limited attention has been paid to the development and implementation of quality measures specifically focused on patient transfers between EDs and other health care facilities. Examples are patients transferred between an ED and a skilled nursing facility with their often vulnerable and fragile populations. These measures are essential for all health care facilities, but especially so for small rural hospitals that transfer a higher proportion of ED patients.

While many aspects of hospital quality are similar for urban and rural hospitals (e.g., providing heart attack patients with aspirin), the urban/rural contextual differences result in differences in emphasis on quality measurement. Because of its role in linking residents to urban referral centers, important aspects of rural hospital quality include triage-and-transfer decision making about when to provide a particular type of care, transporting patients, and coordinating information flow to specialists beyond the community.

Emergency care is important in all hospitals, but it is particularly crucial in rural hospitals. Rural residents often need to travel greater distances than urban residents to get to a hospital initially. Because of their size, rural hospitals are less likely to have specialized staff and services such as cardiac catheterization or trauma surgery found in larger tertiary care centers, so high acuity patients are also more likely to be transferred. These size and geographic realities increase the importance of organizing triage, stabilization, and transfer in rural hospitals, which, in turn, suggest that measurement of these processes is an important issue for rural hospitals.

In 2018, as part of the Rural Quality Improvement Technical Assistance (RQITA) program, Stratis Health, in partnership with the University of Minnesota Rural Health Research Center, convened a Technical Expert Panel (TEP) to review, revise, and update the EDTC measures and the related specifications manual. The Panel members represented national experts in hospital ED physicians and nurses, quality measurement, electronic health records, and data analytics. The TEP met three times via conference call to review the measure specifications, and discussion was framed around three primary issues and challenges, including EDTC in a ""wired" world, appropriate population for transfers, and clinical relevance of specific data elements. The TEP recommended significant changes to help streamline and modernize the measure including reducing the total number of data elements from 27 to 8, updating the definition of 'sent' to better address communication via electronic health record (EHR) or health information exchange HIE, and clarifying specific definitions of individual data elements.

The ED Transfer Communication measure aims to provide a means of assessing how well key patient information is communicated from an ED to any healthcare facility. They apply to patients with a wide range of medical conditions (e.g., acute myocardial infarction, heart failure, pneumonia, respiratory compromise, and trauma) and are relevant for both internal quality improvement purposes and external reporting.

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Population and Sampling

ED Transfer Communication (EDTC) Initial Patient Population

The population of the EDTC measure is defined by identifying those patients admitted to the emergency department who were then **discharged**, **transferred,** or **returned** to these facilities:

Inclusions:

- Acute Care Facility – Cancer Hospital or Children's Hospital – Including emergency department
- Acute Care Facility – Critical Access Hospital – Including emergency department
- Acute Care Facility – Department of Defense or Veteran's Administration – Including emergency department
- Acute Care Facility- General Inpatient Care – Including emergency department
- Hospice – healthcare facility
- **Other health care facility*, including discharge, transfer or return to:**
  - Extended or Intermediate Care Facility (ECF/ICF)
  - Long Term Acute Care Hospital (LTACH)
  - Long Term Care Facility
  - Nursing Home or Facility, including Veteran's Administration Nursing Facility
  - Psychiatric Hospital or Psychiatric Unit of a Hospital
  - Rehabilitation Facility, including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
  - Skilled Nursing Facility (SNF), Sub-Acute Care, or Swing Bed
  - Transitional Care Unit (TCU)

***Other health care facilities MUST be included in the population.**

Exclusions:

- AMA (left against medical advice)
- Expired
- Home, including:
  - Assisted Living Facilities
  - Board and care, foster or residential care, group or personal care homes, and homeless shelters
  - Court/Law Enforcement – includes detention facilities, jails, and prison
  - Home with Home Health Services
  - Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs, and Partial Hospitalization
- Hospice-home
- Not Documented/Unable to determine
- Observation Status

Sample Size Requirements

Hospitals need to submit a **minimum of 45 cases** per quarter from the required population. A hospital may choose to sample and submit **more than** 45 cases. Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. Hospitals whose initial patient population size is **less than** the minimum number of 45 cases per quarter for the measure cannot sample and should submit **all cases** for the quarter.

Hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected.

Measure Calculation

This measure is calculated using an all or none approach.

The overall EDTC Measure can be calculated as the percent of patients that met all the eight data elements.

Data elements not appropriate for an individual patient are scored as NA (not applicable), are counted in the measure as a positive, or 'yes' response, and the patient will meet that element criteria. The patient will either need to meet the criteria for all the data elements, or have an NA.

For quality improvement purposes, facilities are encouraged to review their information at the data element level to identify improvement opportunities in the transfer communication process.

Definition of *Sent* and Considerations for Electronic Transfer of Information

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE (see definition below)

For purposes of this measure, an EHR is defined as one where data entered into the system is **immediately** available at the receiving site. Facilities using the same EHR vendor or an HIE cannot assume immediate access by the receiving facility to the transferred patient's records.

Emergency Department Transfer Communication: All or None Composite Calculation

Measure Name: Emergency Department Transfer Communication
Measure ID: EDTC-All

Description: Patients who are transferred from an ED to another healthcare facility have all necessary communication made available to the receiving facility in a timely manner.

Rationale: Timely, accurate, and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all the following relevant elements were documented and communicated to the receiving hospital in a timely manner:

1. Home Medications
2. Allergies and/or Reactions
3. Medications Administered in ED
4. ED Provider Note
5. Mental Status/Orientation Assessment
6. Reason for Transfer and/or Plan of Care
7. Tests and/or Procedures Performed
8. Tests and/or Procedures Results

For ALL data elements, the definition of 'sent' includes the following documentation:

- Hard copy sent directly with the patient, or Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Denominator Statement: Transfers from an ED to another healthcare facility
Included Population: All transfers from an ED to another healthcare facility
Excluded Populations: None

Calculation:

$$\frac{\text{\# of patients who have a Yes or NA for all elements}}{\text{All transfers from ED to another healthcare facility}}$$

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Sampling: Yes, please refer to the measure specific sampling requirements (pg. 6)

Emergency Department Transfer Communication Data Elements

1. Home Medications

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's current home medication list was sent to the receiving facility?

Allowable Values:

Y (Yes) Select this option if there is documentation that the patient's current home medication list was sent to the receiving facility.

N (No) Select this option if there is no documentation that the patient's current home medication list was sent to the receiving facility.

Notes for Abstraction:

- If documentation indicates patient is not on any home medications, select yes.
- If documentation is sent that home medications are unknown, select yes
- If patient is unable to respond, select yes.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:

- Complimentary medications
- Over the counter (OTC) medications
- Prescription medications

Exclusion Guidelines for Abstraction: None

2. Allergies and/or Reactions

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's allergy history was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient's allergy information (or "unknown" if allergies not known) was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient's allergy information was sent to the receiving facility.

Notes for Abstraction:

- Allergy information can include:
    - Food allergies/reactions
    - Medication allergies/reactions
    - Other allergies/reactions
- If there is documentation of either an allergy or its reaction, select yes.
- If documentation that allergies are unknown, select yes.
- If documentation of "No Known Allergies", select yes.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

3. Medications Administered in ED

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that the list of medication(s) administered in the ED was sent to the receiving facility?

Allowable Values:

Y (Yes) Select this option if there is documentation that the list of medications administered was sent to the receiving facility.
N (No) Select this option if there is no documentation that the list of medications administered was sent to the receiving facility.
NA (Not Applicable) Select this option if no medications were given.

Notes for Abstraction:

- Medication information documented anywhere in the ED record is acceptable.

Suggested Data Sources:

- Emergency Department record
- Medication Administration Record (MAR) if part of the ED documentation for the current encounter
- Transfer Summary document

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

4. ED Provider Note

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that an ED Provider Note was completed by the physician, advanced practice nurse (APN), or physician assistant (PA) and sent to the receiving facility?

Allowable Values:

Y (Yes) Select this option if there is documentation that an ED Provider Note was completed and sent to the receiving facility.

N (No) Select this option if there is no documentation that an ED Provider Note was completed and sent to the receiving facility.

Notes for Abstraction:

Provider note must include, at a minimum:

- Reason for the current ED encounter (medical complaint or injury)
- History of present illness or condition
- A focused physical exam
- Relevant chronic conditions, though chronic conditions may be excluded if the patient is neurologically impaired/altered

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

5. Mental Status/Orientation Assessment

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that a Mental Status/Orientation Assessment was completed and sent to the receiving facility?

Allowable Values:

Y (Yes) Select this option if there is documentation that a mental status/orientation assessment was completed and sent to the receiving facility.

N (No) Select this option if there is no documentation that a mental status/orientation assessment for the condition was completed and sent to the receiving facility.

Notes for Abstraction:

Acceptable documentation includes but is not limited to:

- Alert
- Oriented
- Comatose
- Confused
- Demented
- Unresponsive
- Any Coma/Stroke Scale (e.g., Glasgow coma scale)
- Any mental status/orientation exam, scale, or assessment

Suggested Data Sources:

- Emergency Department record
- Transfer Summary document
- Glasgow coma scale
- Neuro flow sheets
- Vital Signs flow sheets

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

6. Reason for Transfer and/or Plan of Care

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that a reason for transfer and/or plan of care was identified by the physician, advanced practice nurse, or physician assistant (physician, APN, PA) and sent to the receiving facility?

Allowable Values:

Y (Yes) Select this option if there is documentation that a reason for transfer and/or plan of care was written and sent to the receiving facility.

N (No) Select this option if there is no documentation that a reason for transfer and/or plan of care was written and sent to the receiving facility.

Notes for Abstraction:

- May include suggestions for care to be received at the receiving facility.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary
- EMTALA form

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

7. Tests and/or Procedures Performed

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that information was sent regarding any tests and procedures that were done in the ED?

Allowable Values:

Y (Yes) Select this option if there is documentation that information on all tests and procedures that were done in the ED prior to transfer was sent to the receiving facility.
N (No) Select this option if there is no documentation that information on all tests and procedures that were done in the ED prior to transfer was sent to the receiving facility.
NA (Not Applicable) Select this option if no tests or procedures were done.

Notes for Abstraction:

- If no tests or procedures were done, select NA.

Suggested Data Sources:

- Emergency Department record
- Lab documentation
- Transfer Summary document

Inclusion Guidelines for Abstraction:

- Lab work ordered
- X-rays
- Procedures performed
- EKGs
- Cultures

Exclusion Guidelines for Abstraction: None

8. Tests and/or Procedure Results

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that results were sent from completed tests and procedures done in the ED?

Allowable Values:

Y (Yes) Select this option if there is documentation of results being sent either with the patient or communicated to the receiving facility when available.

N (No) Select this option if there is no documentation of results being sent either with the patient or communicated to the receiving facility when available.

NA (Not Applicable) Select this option if no tests or procedures were done.

Notes for Abstraction:

- If facilities have a shared electronic health record, then tests and procedure results are considered sent, select yes.
- If results are not sent and facilities do not share electronic health records, then documentation must include a plan to communicate results to select yes.
- If no plan to communicate results, select no.

Suggested Data Sources:

- Emergency Department record
- Lab documentation
- Transfer Summary document

Inclusion Guidelines for Abstraction:

- Lab results
- X-ray results
- Procedure results
- EKG
- Cultures

Exclusion Guidelines for Abstraction: None

Appendix A: Emergency Department Transfer Communication Data Collection Tool

CMS Certified Number (CCN): _____

Name of State: _____

Patient Name: _____

Patient Medical Record Number: _____

Select Patient Discharged Disposition: (Select one option)

_____Acute Care Facility – Cancer Hospital or Children's Hospital

_____Acute Care Facility – Critical Access Hospital

_____Acute Care Facility – Department of Defense or Veteran's Administration

_____Acute Care Facility – General Inpatient Care

_____Hospice – healthcare facility

_____Other health care facility –

- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Long Term Care Facility
- Nursing Home or Facility, including Veteran's Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility, including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care, or Swing Bed
- Transitional Care Unit (TCU)

Date of Patient Encounter: _____/_____/_____
(MM-DD-YYYY)

Date of Data Collection: _____/_____/_____
(MM-DD-YYYY)

NOTE: Prior to completing the data collection tool, please reference the Emergency Department Transfer Communication Measures Data Specifications Manual for detailed descriptions of each data element.

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

1. **Home Medications:**

   _____Yes _____No

2. **Allergies and/or Reactions:**

   _____Yes_____No

3. **Medications Administered in ED:**

   _____Yes_____No_____N/A

4. **ED Provider Note:**

   _____Yes_____No

5. **Mental Status/Orientation Assessment**

   _____Yes_____No

6. **Reason for Transfer and/or Plan of Care**

   _____Yes_____No

7. **Tests and/or Procedures Performed:**

   _____Yes_____No_____N/A

8. **Tests and/or Procedure Results:**

   _____Yes_____No_____N/A

Appendix B: EDTC Crosswalk with Promoting Interoperability Requirements

Eligible Hospital and Critical Access Hospital Promoting Interoperability 2019 Objectives and Measures - Health Information Exchange

Objective: The eligible hospital or critical access hospital (CAH) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT).

The summary of care record must include the following elements:

Promoting Interoperability Programs standard	EDTC Aligned Data Element
Patient name	Not included
Procedures	7, 8
Encounter diagnosis	4
Immunizations	Not included
Laboratory test(s)	7
Laboratory test results	7, 8
Vital signs (height, weight, blood pressure, BMI)	Not included
Smoking status	Not included
Functional status, including activities of daily living, cognitive and disability status	5
Demographic information (preferred language, sex, race, ethnicity, date of birth)	Not included
Care plan field, including goals and instructions. Care Plan: The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome)	6
Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider	Not included
Discharge instructions	Not included
Current problem list (At a minimum a list of current and active diagnoses)	4
Current medication list (A list of medications that a given patient is currently taking)	1, 3
Current medication allergy list (A list of medications to which a given patient has known allergies)	2
Unique device identifiers for a patient's implantable device	Not included

Table by Jill M. Klingner. Updated by Stratis Health October 2019

References:

- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2019ProgramRequirementsMedicare.html
- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EH_Medicare_2019.pdf

Patients' Experiences in Arizona CAHs: HCAHPS Results, 2018

Mariah Quick, MPH; Megan Lahr, MPH; Tongtan Chantarat, MPH; Ira Moscovice, PhD

KEY FINDINGS: ARIZONA

- The HCAHPS reporting rate of 73.3% for Arizona CAHs in 2018 was lower than the national reporting rate of 85.7% and ranks #37 among 45 states that participate in the Flex Program.

- Compared with all other CAHs nationally, CAHs in Arizona scored significantly higher on 0 HCAHPS measures, significantly lower on 7 measures, and did not have significantly different performance on the remaining 3 measures.

BACKGROUND

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a national, standardized survey of patients' perspectives of hospital care. It was developed by the Agency for Healthcare Research and Quality and the Centers for Medicare & Medicaid Services (CMS) to complement other hospital tools designed to support quality improvement. The survey is administered to a random sample of adult patients following discharge from the hospital for inpatient medical, surgical, or maternity care.

Ten HCAHPS measures are publicly reported on Hospital Compare. Six are composite measures that address how well doctors and nurses communicate with patients, the responsiveness of hospital staff, communication about medicines, and patient understanding of their care when they left the hospital. The provision of discharge information is reported as "yes/no." The other five composite measures, along with two measures regarding the hospital environment, are reported in response categories of "always," "usually," and "sometimes/never." Additional measures address the overall rating of the hospital on a 1–10 scale ("high" = 9 or 10, "medium" = 7 or 8, "low" ≤ 6) and the patient's willingness to recommend the hospital ("definitely would," "probably would," and "probably/definitely would not"). CMS adjusts the publicly reported HCAHPS results for patient-mix, mode of data collection, and non-response bias.

Critical Access Hospitals (CAHs) may voluntarily report HCAHPS measures to Hospital Compare. HCAHPS data are a core measure in the Medicare Beneficiary Quality Improvement Project (MBQIP).

The Flex Monitoring Team (FMT) also produces a national HCAHPS report.

APPROACH

This study used data publicly reported to Hospital Compare by CAHs for discharges during calendar year 2018 as well as suppressed data from MBQIP. In 2016, CMS began suppressing HCAHPS results from Hospital Compare for hospitals with fewer than 25 completed surveys. The FMT national and state HCAHPS reports include MBQIP HCAHPS data from 187 CAHs that agreed to participate in Hospital Compare,

but whose results were suppressed from Hospital Compare because of having fewer than 25 completed surveys. Although some CAHs had very few surveys, the results are reported in aggregate for all CAHs in each state, and no states had fewer than 25 surveys for all CAHs in the state

The national and state HCAHPS reports exclude results from 19 CAHs that did not agree to publicly report to Hospital Compare, though 14 of these submitted HCAHPS data to MBQIP. The reports include data from two CAHs that reported HCAHPS data to Hospital Compare, but not to MBQIP.

For each HCAHPS measure, the percentages of patients reporting the highest response (e.g., "always") on each measure were summed and averaged across all reporting CAHs within a state and all other states. Two-sample t-tests were used to compare whether the mean scores on each measure are significantly different between CAHs in each state and all other CAHs. Weights were applied to all calculations.

RESULTS

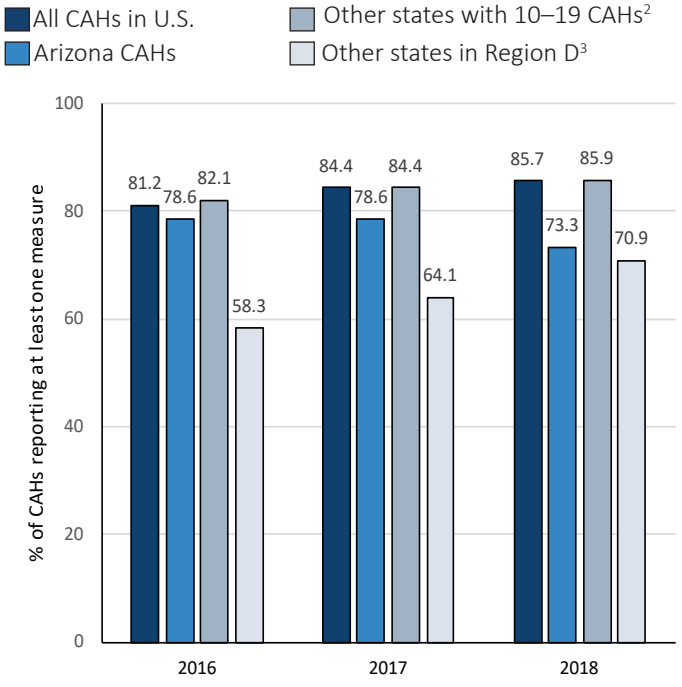
Figure 1 compares participation rates in HCAHPS over time among four groups of CAHs: those in Arizona, all CAHs nationally, those located in other states with a similar number of CAHs, and those located in the same Health Resources and Services Administration (HRSA) geographic region as Arizona. The HCAHPS reporting rate of 73.3% for Arizona CAHs was lower than the national reporting rate of 85.7%.

Table 1 ranks the states by their CAHs' respective HCAHPS reporting rate for 2018. Arizona ranked #37 for reporting rates of the 45 states that participate in the Flex program.

Table 2 shows the number of completed HCAHPS surveys per CAH in Arizona and nationally in the five survey completion and three survey response rate categories reported by CMS. Hospitals with 100 or more completed HCAHPS surveys over a four-quarter period receive HCAHPS Star Ratings from CMS. CMS recommends that each hospital obtain 300 completed HCAHPS surveys annually, in order to be more confident that the survey results are reliable for assessing the hospital's performance. However, some smaller hospitals may sample all of their HCAHPS-eligible discharges and still have fewer than 300 completed surveys. Caution should be exercised in comparing HCAHPS results for states that have few CAHs reporting results and/or CAHs whose results are based on fewer than 100 completed surveys.

Compared to all other CAHs nationally, Arizona's CAHs scored significantly better on 0 of 10 HCAHPS measures, significantly worse on 7 measures, and did not have significantly different performance on the remaining 3 measures (Table 3).

FIGURE 1. CAH Participation in HCAHPS,[1] 2016–18



1. Percentage of CAHs in each state or group of states reporting HCAHPS data.
2. Group includes states with 10–19 CAHs: AK (14), FL (12), ME (16), NH (13), NM (10), NV (13), NY (18), PA (15), TN (16), UT (13), WY (16)
3. HRSA Region D includes: AR (29), CA (34), HI (9), LA (27), NM (10), NV (13), OK (40), TX (85)

TABLE 1. State Rankings of HCAHPS Participation Rates for CAHs, 2018

Rank	State	# of participating CAHs	% of CAHs
	National	**1,158**	**85.7**
1	Illinois	51	100.0
1	Maine	16	100.0
1	Pennsylvania	15	100.0
1	New Hampshire	13	100.0
1	Vermont	8	100.0
1	Virginia	7	100.0
1	Alabama	4	100.0
1	South Carolina	4	100.0
1	Massachusetts	3	100.0
10	Wisconsin	57	98.3
11	Ohio	32	97.0
12	Nebraska	62	96.9
13	Oregon	24	96.0
14	Minnesota	74	94.9
15	Michigan	34	94.4
16	Iowa	77	93.9
17	Wyoming	15	93.8
18	Idaho	25	92.6
19	Utah	12	92.3
20	Montana	44	91.7
21	West Virginia	18	90.0
21	New Mexico	9	90.0
23	Arkansas	26	89.7
24	South Dakota	34	89.5
25	New York	16	88.9
26	Mississippi	27	87.1
27	Georgia	26	86.7
28	North Dakota	31	86.1
29	California	29	85.3
30	Nevada	11	84.6
31	Kansas	71	84.5
32	Colorado	26	81.3
33	Indiana	28	80.0
34	Washington	31	79.5
35	Missouri	27	75.0
35	Tennessee	12	75.0
37	**Arizona**	**11**	**73.3**
38	Kentucky	19	70.4
38	Louisiana	19	70.4
40	North Carolina	14	70.0
41	Texas	55	64.7
42	Florida	7	58.3
43	Oklahoma	23	57.5
44	Alaska	8	57.1
45	Hawaii	3	33.3

TABLE 2. Number of Completed HCAHPS Surveys and Response Rates for CAHs Nationally and in Arizona, 2018

	Total CAHs reporting	Number of completed HCAHPS surveys					HCAHPS survey response rates		
		< 25	25–49	50–99	100–299	≥ 300	< 25%	25–50%	>50%
National	1,158	187	248	291	378	54	330	801	27
Arizona	11	0	3	1	6	1	5	6	0

TABLE 3. HCAHPS Results for CAHs in Arizona and All Other Flex States, 2018

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

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

HCAHPS Measure	Average percentage of patients that gave the highest level of response (e.g., "always")	
	Arizona (n=11)	All Other Flex States (n=1,147)
Nurses always communicated well	79.7	83.7
Doctors always communicated well	77.3	84.6
Patient always received help as soon as wanted	75.2	76.9
Staff always explained medications before giving them to patient	67.4	69.9
Staff always provided information about what to do during recovery at home	86.9	88.6
Patient strongly understood their care when they left the hospital	52.4	56.2
Patient's room and bathroom were always clean	73.7	81.0
Area around patient's room was always quiet at night	59.5	65.6
Patient gave a rating of 9 or 10 [high] on a 1–10 scale	69.2	76.6
Patient would definitely recommend the hospital to friends and family	68.6	75.1

Note: Rates without highlights were not significantly different from comparable rates among all other reporting CAHs nationally.

Medicare Beneficiary Quality Improvement Project (MBQIP)

Data Submission Deadlines [1,2]

Measure ID	Description	MBQIP Domain	Reported To	Encounter Period and Due Date			
				Q1 / 2022 Jan 1 - Mar 31	Q2 / 2022 Apr 1 - Jun 30	Q3 / 2022 Jul 1 - Sep 30	Q4 / 2022 Oct 1 - Dec 31
Population & Sampling	Population & Sampling Submission (CMS inpatient and outpatient measures)	Outpatient	HQR via HARP Log In	August 1, 2022	Anticipated November 1, 2022	Anticipated February 1, 2023	Anticipated May 1, 2023
HCP/IMM-3[3]	Influenza vaccination coverage among health care personnel	Patient Safety/ Inpatient	NHSN	May 16, 2022 (Q4 2021/Q1 2022 aggregate)	N/A	N/A	May 15, 2023 (Q4 2021/Q1 2022 aggregate)
Antibiotic Stewardship	CDC NHSN Annual Facility Survey	Patient Safety/ Inpatient	NHSN	March 1, 2023[4] (Calendar year 2022 data)			
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	Patient Engagement	HQR via Vendor	Early June 2022[6]	October 5, 2022	January 4, 2023	April 4, 2023
EDTC[5]	Emergency Department Transfer Communication	Care Transitions	As directed by state Flex program	April 30, 2022	July 31, 2022	October 31, 2022	January 31, 2023
OP-2	Fibrinolytic therapy received within 30 minutes	Outpatient	HQR via Outpatient CART/Vendor	August 1, 2022	Anticipated November 1, 2022	Anticipated February 1, 2023	Anticipated May 1, 2023
OP-3	Median time to transfer to another facility for acute coronary intervention	Outpatient	HQR via Outpatient CART/Vendor	August 1, 2022	Anticipated November 1, 2022	Anticipated February 1, 2023	Anticipated May 1, 2023
OP-18	Median time from ED arrival to ED departure for discharged ED patients	Outpatient	HQR via Outpatient CART/Vendor	August 1, 2022	Anticipated November 1, 2022	Anticipated February 1, 2023	Anticipated May 1, 2023
OP-22	Patient left without being seen	Outpatient	HQR via HARP Log In	May 15, 2023[6] (Calendar year 2022 aggregate)			

1. Based on currently available information. Submissions dates are subject to change.
2. Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter and are reflected in this document where applicable.
3. The encounter period for HCP/IMM-3 (formerly OP-27) is limited to Q4 and Q1.
4. Hospitals are strongly encouraged to complete the NHSN Annual Facility Survey by March 1 of each year, but may submit or update survey responses throughout the year.
5. State Flex Programs must submit data to FORHP by the 10th day of the month following the hospital deadline (e.g. Q3 2022 data due to FORHP by Nov 10, 2022).
6. Anticipated due date/timeline based on previous years.

For additional information about measure submission see the MBQIP Quality Reporting Guide.