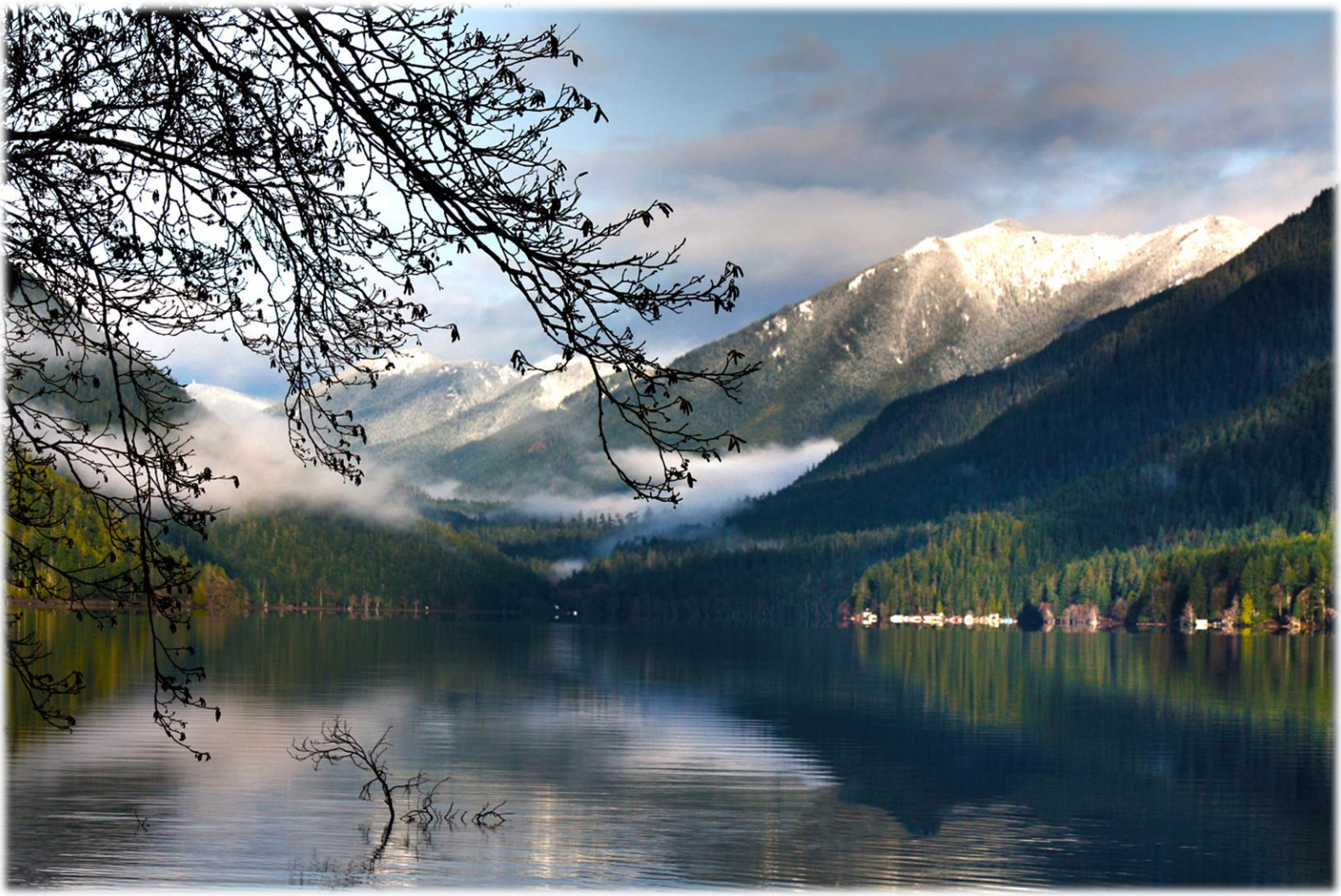
State of Washington

Medicare Rural Hospital Flexibility Program



Medicare Beneficiary Quality Improvement Project (MBQIP)

Desk Manual

(DOH 609-011 May 2020)

For questions or for updates to this manual contact:

Rural Hospital Quality Improvement Manager (RHQIM)

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For an electronic version of this manual please visit
https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/AboutUs/RuralHospitalFlexibilityGrantProgram/MedicareBeneficiaryQualityImprovementProjectMBQIP

Manual contains a number of links and is best utilized electronically. Manual will print front and back manual style if preferred in print.

This manual is an adaptation of manuals, publications, and resource documents provided by the Federal Office of Rural Health Policy, National Rural Health Resource Center, and Stratis Health Rural Quality Improvement Technical Assistance.

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H54RH00002, the Medicare Rural Hospital Flexibility Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Table of Contents:

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Section 1 – Flex Program Background

Program Background:

The Medicare Rural Hospital Flexibility (Flex) program was established by the Balance Budget Act (BBA) of 1997. Any state with rural hospitals may establish a Flex Program and apply for this federal funding. This funding provides resources for the creation of rural networks, promotes regionalization of rural health services, and improves access to hospitals for rural residents. The Federal Office of Rural Health Policy (FORHP) provides this funding to the state programs.

The BBA of 1997 also created the critical access hospital designation (CAH). This designation allows hospitals to be reimbursed on a different cost basis for inpatient and outpatient services provided to Medicare patients and in some states Medicaid patients. This alternative payment model assists rural hospitals that may not get the volumes needed to cover costs in the Perspective Payment System (PPS).

In the State of Washington, the Flex program is housed within the State Office of Rural Health (SORH) which is located in the Rural Section of The Department of Health (DOH).

Washington State Department of Health

Health Systems Quality Assurance

Office of Community Health Systems

Rural Health Section

Executive Director

Administrative Assistant

	Workforce Director
Rural Hospital Program Manager	Primary Care Office Manager
Rural Hospital Quality Improvement Manager	Rural Program Manager
State Office of Rural Health Grant Manager	Workforce Advisor
Oral Health Consultant	Health Care Analyst(s)

Our program encourages and supports the development of cooperative systems of care in rural areas, joining together CAHs, emergency medical service (EMS) providers, clinics and health practitioners to increase efficiencies and quality of care.

The Flex program is required to develop rural health plans and funds efforts to implement community-level outreach. The program includes support for the following five program areas:

- CAH Quality improvement
- CAH Financial and operational improvement
- CAH Population health management
- Rural EMS improvement
- Innovative Model Development

Currently our program supports both hospital networks in the state – The Washington Rural Health Collaborative (WRHC) and The Northwest Rural Health Network (NWRHN).

Our program provides funding for hospitals to participate in or conduct:

- The University of Washington Tele-Antimicrobial Stewardship program (UWTASP)
- Population Health Projects
- Planning and supporting the Annual Northwest Rural Health Conference
- Providing scholarships to attend the Northwest Rural Health Conference
- Chief Financial Officer Annual Summit
- EMS testing vouchers for certification
- The educational program providing funding for CAH staff to earn and maintain their CPHQ, CIC, CDE, CPPS, or CPHRM certifications.
- Charge Master Reviews
- Volunteer Retired Provider Program
- Leadership training
- Quality Improvement Projects
- Billing and Coding Training

The Washington State Flex program collaborates with state and national partners to bring our hospitals and health care facilities an abundance of resources and targeted programs. Some of these groups include:

- Washington State Hospital Association (WSHA)
- Washington Rural Health Association (WRHA)
- Washington Rural Health Collaborative (WRHC)
- Northwest Rural Health Network (NWRHN)
- Qualis Health

To be eligible to participate in Flex funded programs a hospital must meet certain criteria:

1. Be designated as a critical access hospital.
2. Have a signed Memorandum of Understanding (MOU)
3. Be in good standing with the MBQIP program:
    a. Report data on at least one MBQIP Core measure, for at least two quarters, in at least three of the four quality domains, by the second reporting quarter of the previous year.
    b. Complete the Notices of Participation (NOPs) for "Public Reporting" and "Quality Improvement" as well as not opt to suppress their quality data from Hospital Compare.

WASHINGTON

STATE OFFICE OF RURAL HEALTH

Making Health Care Better for Our Rural Communities

MISSION:

The Washington State Office of Rural Health supports health systems planning and development in Washington's rural and underserved communities to improve health and healthcare across the life span.

500+

Direct technical assistance hours per year

In one year, provided regulatory consultation support on federal regulations to 25 Rural Health Clinics

Increased the Northwest Rural Health Conference attendees to over 500

STATE AT A GLANCE:

STATE POPULATION:

7,405,743

PERCENT OF POPULATION CONSIDERED RURAL:

16%

NUMBER OF:

CRITICAL ACCESS HOSPITALS:	39
RURAL HOSPITALS:	6
RURAL HEALTH CLINICS:	115
FQHC ORGANIZATIONS:	27
FREE CLINICS:	101

MAJOR ACCOMPLISHMENTS:

- Trained rural providers on implementing Universal Development Screening for children aged birth to 3
- Currently spearheading a program to advance rural palliative care
- Supported infrastructure development for small rural health organizations
- Increased the Northwest Rural Health Conference to over 500 attendees
- Provided regulatory, operations, and quality support Rural Health Clinics
- Provided education on recruitment and retention to clinics and providers by funding statewide participation in the 3RNET program

SERVICES:

- Provide education to rural health providers on emerging rural health concerns
- Support advancements in telehealth in rural WA
- Support rural and underserved recruitment and retention
- Lead the annual Northwest Rural Health Conference
- Coordinate rural health activities and resources across the state
- Consult with rural health facilities and organizations
- Manage the Medicare Rural Hospital Flexibility Program and the Small Hospital Improvement Program
- Act as the liaison between the Federal Office of Rural Health Policy and rural communities
- Fund the Volunteer and Retired Provider program

Number of organizations that contacted the SORH in the last 6 months for health service development support:

48

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Washington State Department of Health

Medicare Rural Hospital Flexibility Program

Working with Our Rural Communities to Shape Sustainable Solutions

350

Hours Technical Assistance Provided

MISSION:

The Flex Program supports rural healthcare infrastructure by strengthening critical access hospitals (CAH). This support is vital to maintaining access to care for rural residents. By working within the domains of Flex, this program encourages and supports the sustainability of rural health care and fosters growth towards quality care, financial improvement, operational efficiency, and community collaboration.

PROGRAM FOCUS AREAS:

- Quality improvement
- Financial and operational improvement
- Population health management
- EMS improvement
- Critical Access Hospital designation
- Integration of innovative health care models

Funded Advanced Trauma and EMS Training Certifications

EDUCATION PROGRAM

In collaboration with the Washington State Hospital Association

PROGRAM AND NUMBER OF PARTICPANTS:	
CERTIFIED PROFESSIONAL IN HEALTHCARE QUALITY (CPHQ):	57
CERTIFIED INFECTION CONTROL (CIC):	13
RISK MANAGEMENT & PATIENT SAFETY:	18

$30,000

IN SCHOLARSHIPS AWARDED ANNUALLY TO ATTEND THE NORTHWEST RURAL HEALTH CONFERENCE

FUNDED ACTIVITIES:

- 20+ Pop. Health Projects
- Enrollment in UW Tele-Antimicrobial Stewardship
- EMT Testing Vouchers
- Northwest Rural Health Conference
- 20+ Quality Improvement Projects at CAH level
- Billing & Coding Workshops
- Charge Master Reviews
- Leadership Training
- CMS Quality Reporting TA
- Operational Consultants
- EMS Leadership Training
- WA Rural Palliative Care Initiative

MAJOR ACCOMPLISHMENTS:

- Over (20) individual quality improvement projects have been conducted at the hospital level. Project proposals require data support and the use of proven quality improvement tools.
- Over (20) population health projects have been conducted in various communities in the state. These projects require collaboration between community partners, and the critical access hospital.
- Washington State was one of three states to receive the award for most improved in the Medicare Beneficiary Quality Improvement Project (MBQIP).

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36 Critical Access Hospitals Enrolled in an Antimicrobial Stewardship Program

Washington State Department of Health

Section 2 – Medicare Beneficiary Quality Improvement Project (MBQIP)

Medicare Beneficiary Quality Improvement Project (MBQIP) Program:

MBQIP is a quality Improvement activity launched in 2011 under the Flex program. The goal of the program is to improve the quality of care provided in critical access hospitals (CAH) by increasing quality data reporting and then driving quality improvement activities based on the data. MBQIP provides an opportunity for individual hospitals to look at their 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 every patient.

Because CAHs are paid under a cost-based reimbursement model from Medicare, they have historically been excluded from federal quality reporting and incentive programs linked to payment, such as the Inpatient and Outpatient Quality Reporting, Hospital Value-Based Purchasing, and other such pay for reporting and performance programs that impact Medicare reimbursement for prospective payment system (PPS) hospitals. 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.

MBQIP takes a proactive approach to help ensure CAHs are well-prepared to meet future quality requirements. Furthermore, it is clear that some CAHs are not only participating in national quality improvement reporting programs but are excelling across multiple rural relevant topic areas.

MBQIP measures are divided into two categories:

- **Core MBQIP Measures** are those that all state Flex Programs are expected to support, and reporting on these measures contributes towards a CAH's Flex eligibility requirements.
- **Additional MBQIP Measures** are those that state Flex Programs can elect to support in addition to the Core measures, particularly in alignment with other partners or initiatives. While these measures are also rural relevant, they may not be as widely applicable across all CAHs.

MBQIP measures, both Core and Additional, are further divided into four domains:

- Patient Safety
- Patient Engagement
- Care Transitions
- Outpatient

MBQIP CORE Measures Grid

Current Medicare Beneficiary Quality Improvement Project (MBQIP) CORE Measures			
Patient Safety/Inpatient	Patient Engagement	Care Transitions	Outpatient
HCP/IMM-3: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (Facilities report a single rate for inpatient and outpatient settings) **Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass eight key topics:* *Communication with Doctors* *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* *The survey also includes screener questions and demographic items. The survey is 29 questions in length.*	**Emergency Department Transfer Communication (EDTC)** *1 Composite; 8 Elements* **All EDTC Composite:** 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 Test and/or Procedure Results	**Chest Pain/AMI:** **OP-2:** Fibrinolytic Therapy Received within 30 minutes **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention **ED Throughput:** **OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients **OP-22:** Patient Left Without Being Seen

MBQIP OPTIONAL Measures Grid

Current Medicare Beneficiary Quality Improvement Project (MBQIP) OPTIONAL Measures			
Patient Safety/Inpatient	Patient Engagement	Care Transitions	Outpatient
Healthcare Acquired Infections (HAI) CLABSI: Central Line- Associated Bloodstream Infection CAUTI: Catheter-Associated Urinary Tract Infection CDI: Clostridium difficile (C. Diff) Infection MRSA: Methicillin-resistant Staphlococcus aureus SSIs: Surgical Site Infections Colon or Hysterectomy **Perinatal Care** PC-01: Elective Delivery **Falls** Potential measurement around: Falls with Injury Patient Fall Rate Screening for Future Fall Risk **Adverse Drug Events (ADE)** Potential measurement around: Opioids Glycemic Control Anticoagulant Therapy **Patient Safety Culture Survey** **Inpatient Influenza Vaccination**	**Emergency Department Patient Experience Survey**	**Discharge Planning** **Medication Reconciliation** **Swing Bed Care** **Claims-Based Measures** *Measures are automatically calculated for hospitals using Medicare Administrative Claims Data* • **Reducing Readmissions** • **Complications** • **Hospital Return Days**	**Chest Pain/AMI** • **Aspirin at Arrival** (formerly OP-4) • **Median Time to ECG** (formerly OP-5) **ED Throughput** • **Door to Diagnostic Evaluation by a Qualified Medical Professional** (formerly OP-20)

Data Submission Deadlines Chart

Medicare Beneficiary Quality Improvement Project (MBQIP) Data Submission Deadlines*						
Measure ID	Description	Reported To	Q1 / 2020 Jan 1 – Mar 31	Q2 / 2020 Apr 1 – Jun 30	Q3 / 2020 Jul 1 – Sep 30	Q4 / 2020 Oct 1 – Dec 31
Pop. & Sampling	Population & Sampling Submission (Inpatient and Outpatient)	QualityNet via Secure log in	08/01/2020	11/01/2020	02/03/2021	05/01/2021
OP-2	Fibrinolytic therapy received within 30 minutes	QualityNet via Outpatient CART /Vendor	08/01/2020	11/01/2020	02/01/2021	05/01/2021
OP-3	Median time to transfer to another facility for acute coronary intervention	QualityNet via Outpatient CART /Vendor	08/01/2020	11/01/2020	02/01/2021	05/01/2021
OP-18	Median Time from ED arrival to ED departure for discharged ED patients	QualityNet via Outpatient CART /Vendor	08/01/2020	11/01/2020	02/01/2021	05/01/2021
OP-22	Patient left without being seen	QualityNet via Secure log in	May 15, 2021 (Aggregate based on full calendar year 2020) May 15, 2022 (Aggregate based on full calendar year 2021)			
HCP	Influenza Vaccination coverage among healthcare personnel	National Healthcare Safety Network (NHSN)	May 15, 2021 (Aggregate based on Q4 2019 & Q1 2021) May 15, 2022 (Aggregate based on Q4 2020 & Q1 2022)			
EDTC	Emergency Department Transfer Communications	As directed by State Flex Office	04/30/2020	07/31/2020	10/31/2020	01/31/2021
HCAHPS	Hospital Consumer Assessments of Healthcare Providers and Systems	QualityNet via Vendor	07/01/2020	10/07/2020	01/06/2021	04/01/2021
Antibiotic Stewardship	CDC NHSN Annual Facility Survey	National Healthcare Safety Network (NHSN)	Jan 2021 – March 2021 (Full calendar year 2020 data) Jan 2022 – March 2022 (Full calendar year 2021 data)			

* Dates are based off of previous reporting cycles. Some dates have not been officially been published by CMS at this time and are subject to change.

**The encounter period for HCP is limited to Q4 and Q1.

Section 3 – Getting Started with Reporting

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.

When reporting data there are many locations that require data submission. This section discusses only those systems that are required for reporting MBQIP measures. There are also numerous tutorial videos on their specific sites that can be helpful when first starting out.

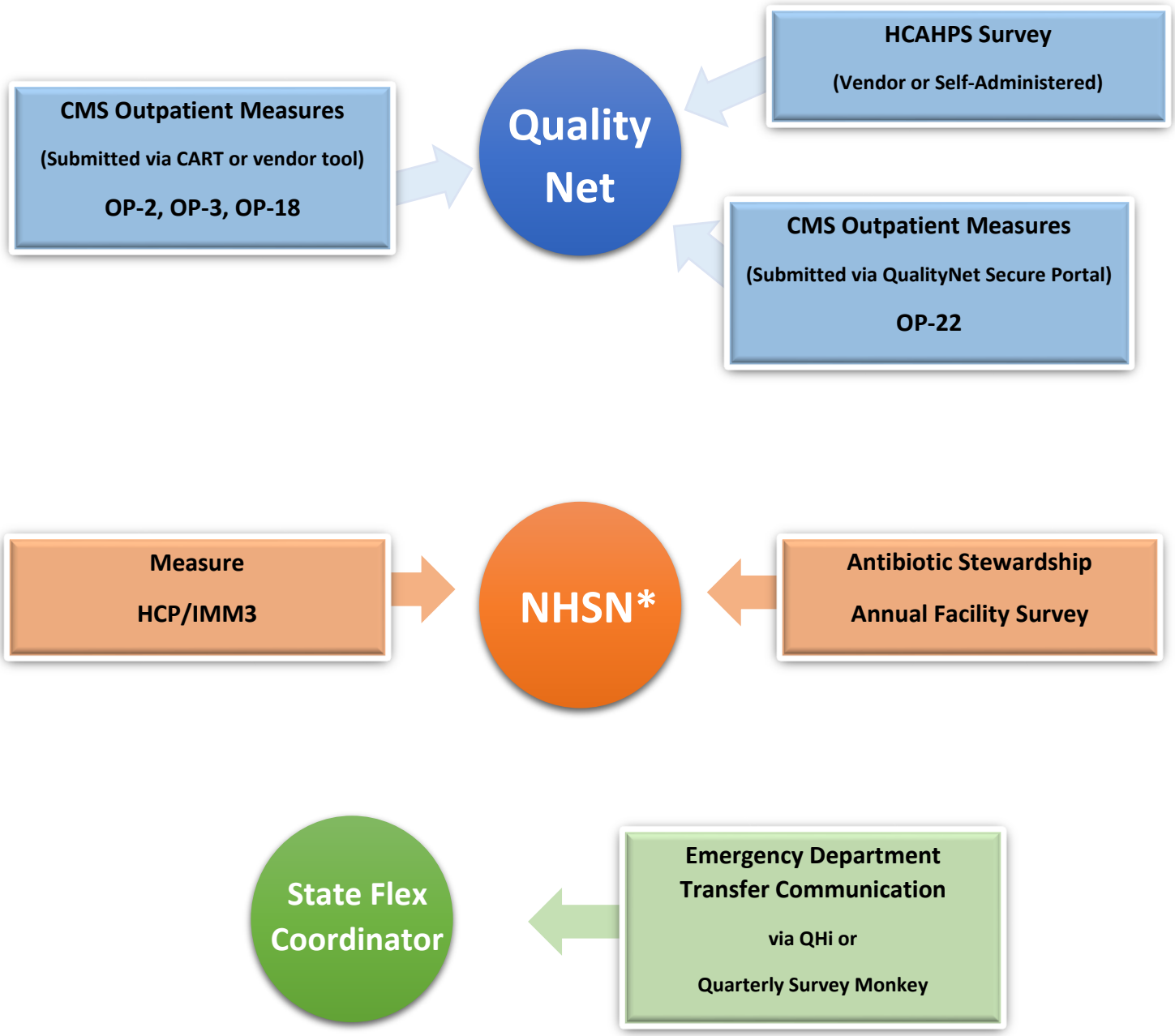
The following page lays out the separate reporting systems and where measures are required to be reported. Keep in mind each system has a series of steps to get set up with an account. Be sure to check with other facility staff to see if accounts are already set up and that you only need to set up a log in for yourself. This will save you a great deal of time.

Each system has a series of steps that do have waiting periods. It's best to start the set up process as soon as possible to avoid missing reporting deadlines due to longer than normal wait periods for gaining access.

If for any reason you are unable to report data due to waiting on the system for access, let the Rural Hospital Quality Improvement Manager (RHQIM) know as soon as possible so it can be documented. We want to keep documentation of inability to report due to system hurdles.

This also is the case if you get locked out and have to wait for the system help desk to respond to your access request. This does happen and you are not alone in this situation.

Quality Data Reporting Channels for MBQIP Required Measures



*National Healthcare Safety Network

Adapted from original diagram created by Stratis Health Rural Quality Improvement Technical Assistance (RQITA)

National Healthcare Safety Network (NHSN) Enrollment and Use:

The National Healthcare Safety Network is a program through the Centers for Disease Control and Prevention (CDC) and is currently the nation's most widely used healthcare-associated infection (HAI) tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections.

Beginning decades ago with 300 hospitals, NHSN now serves over 17,000 medical facilities tracking HAIs. Current participants include acute care hospitals, long-term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and nursing homes, with hospitals and dialysis facilities representing the majority of facilities reporting data. Currently NHSN is the conduit for facilities to comply with Centers for Medicare and Medicaid Services (CMS) infection reporting requirements.

MBQIP measures your hospital will need to submit via NHSN include HCP and the Antibiotic Stewardship Annual Facility Survey. Optional Measures include CLABSI, CAUTI, C.Diff, and MRSA.

Enrollment in NHSN – This can be a lengthy process so be sure to start this as soon as you are starting this work if your facility is not already enrolled.

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, the instructions to enroll can be found here.

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 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). Resources and instructions on how hospitals submit HCP influenza data can be found on the Surveillance for Healthcare Personnel Vaccination webpage.

4. **Complete the NHSN Patient Safety Component Annual Facility Survey.**
   This survey will be used to measure the required Antibiotic Stewardship work. Data is completed during the first quarter of a calendar year based on information from the previous year.

NHSN Training Video: Healthcare Professional Flu Measure. This video provides an overview of the Healthcare Professional Flu measure (HCP), including how to sign up for an account through NHSN, the measure submission process and available quality improvement support.

Getting Registered in QualityNet:

QualityNet is a program established by the Centers for Medicare & Medicaid Services (CMS). This program works to provide not only a reporting portal, but healthcare quality improvement news, resources and data reporting tools to be used by healthcare providers as well as others.

QualityNet is the **only** CMS-approved website for secure communications and healthcare quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end stage renal disease (ESRD) networks and facilities, and data vendors.

"The goal of QualityNet is to help improve the quality of health care for Medicare beneficiaries by providing for the safe, efficient exchange of information regarding their care."

Quality Net New User Instructions:

https://www.qualitynet.org/getting-started#tab2

Note: At the bottom of the webpage linked above is a 20 min video on new user enrollment

1. **Register with QualityNet**
   First, a hospital must register for a QualityNet Account. That is done by going to QualityNet and setting up at least one QualityNet Security Administrator (SA).

   It is highly recommended that hospitals designate **at least two QualityNet SAs** – one to serve as the primary QualityNet SA and the other to serve as backup.

   Download and complete the registration packet and mail to the address indicated in the instructions. You will be notified by e-mail when registration is complete and your QualityNet account has been activated. The e-mail will also contain your User ID. A Temporary Password will be sent in a separate e-mail. You will need both to complete enrollment for access to the QualityNet Secure Portal.

2. **Access the QualityNet Secure Portal**

   For access to the QualityNet Secure Portal, complete the New User Enrollment Process. As part of the process, you'll be asked to change your password and answer a set of security questions.

3. **Maintain an Active QualityNet Security Administrator (SA)**

   Hospitals are required to maintain an active QualityNet SA. To maintain an active account it is recommended that QualityNet SAs log into their account at least once per month. If an account is not logged into for 120 days it will be disabled. Once an account is disabled, the user will need to contact the QualityNet Help Desk to have their account reset.

4. **Complete a Notice of Participation (NoP)**

In order for a hospital to have their data publicly reported a NoP must be completed. A NoP must be completed for both inpatient and outpatient reporting.

To verify if your hospital has completed a NoP, or needs to complete a NoP for the first time:

a. Log into the QualityNet Secure Portal.
b. Under Quality Programs select Hospital Quality Reporting. This will bring up the My Tasks page.
c. In the box titled Manage Notice of Participation click on View/Edit Notice of Participation, Contacts and Campuses.
d. Follow the instructions to see your hospital's status. Once your hospital's NoP is accepted, it remains active unless your hospital changes its pledge status.

QualityNet Help Desk:

7 am – 7 pm CT
Monday – Friday

E-mail: qnetsupport@hcqis.org
For ESRD support, e-mail:
qnetsupport-esrd@hcqis.org

Phone: (866) 288-8912*
TTY: (877) 715-6222
Fax: (888) 329-7377

CART – Downloading and Installing

Background

CART is an application for the collection and analysis of quality improvement data.

The application is available at no charge to hospitals or other organizations seeking to improve the quality of care for hospital measure sets selected by CMS.

CART has been designed to allow hospitals to abstract and edit medical record data, allowing for the answering of all questions or the use of skip-pattern logic (in other words, skip some questions based on specified criteria). Reports are available to preview detailed abstraction information as well as detail and summary measure outcome information for both providers and physicians.

Once data collection is completed, hospitals are able to export their data from the tool and submit it to the QIO Clinical Warehouse via the QualityNet website. QualityNet Data Submission and Feedback/Comparison reports are available for registered QualityNet users via My QualityNet.

The Inpatient and Outpatient CART Users Guide provide detailed information about how to do this setup and navigate through the CART application. These User Guides are located at the very bottom the Inpatient and Outpatients CART Downloads pages, on the QualityNet.org website. Training videos are also available at:

CART TRAINGING VIDEOS

https://www.qualitynet.org/outpatient/data-management/cart/resources

Steps for Downloading CART:

Before downloading the CART software, you must decide if you will be loading it to your local computer or your hospital's network system. The hospital IT department may need to do the download to ensure that CART is in the most optimal location on the hospital's network system.

CART will show up as "QMS30" on your computer after downloading, not "CART".

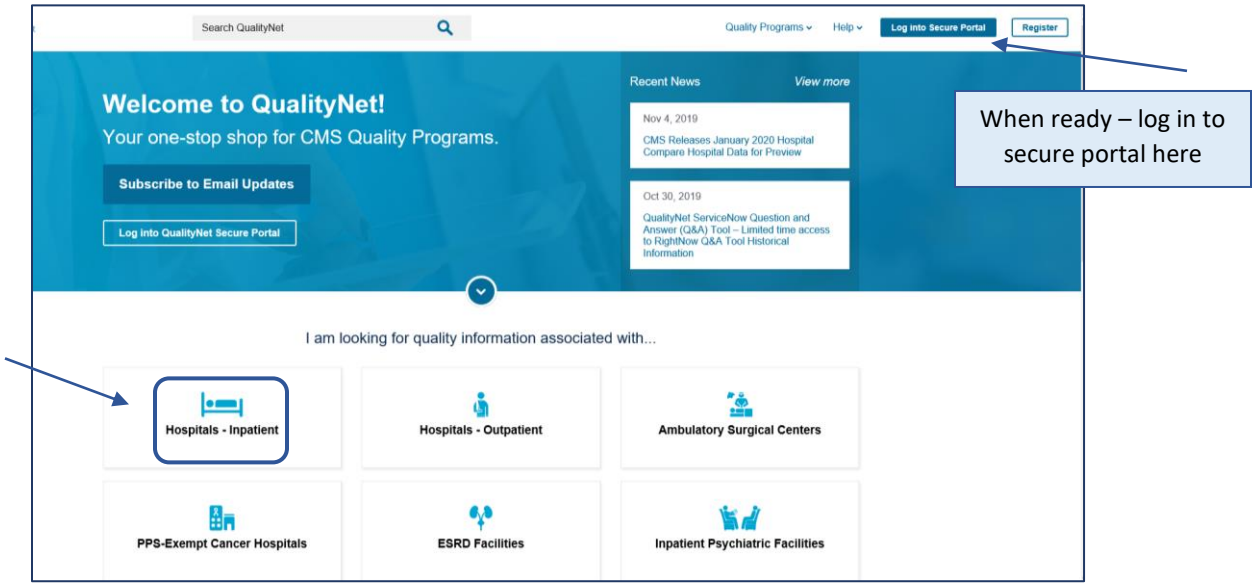
The next pages show instructions for finding and downloading the CART applications. Here are the quick links to the download pages:

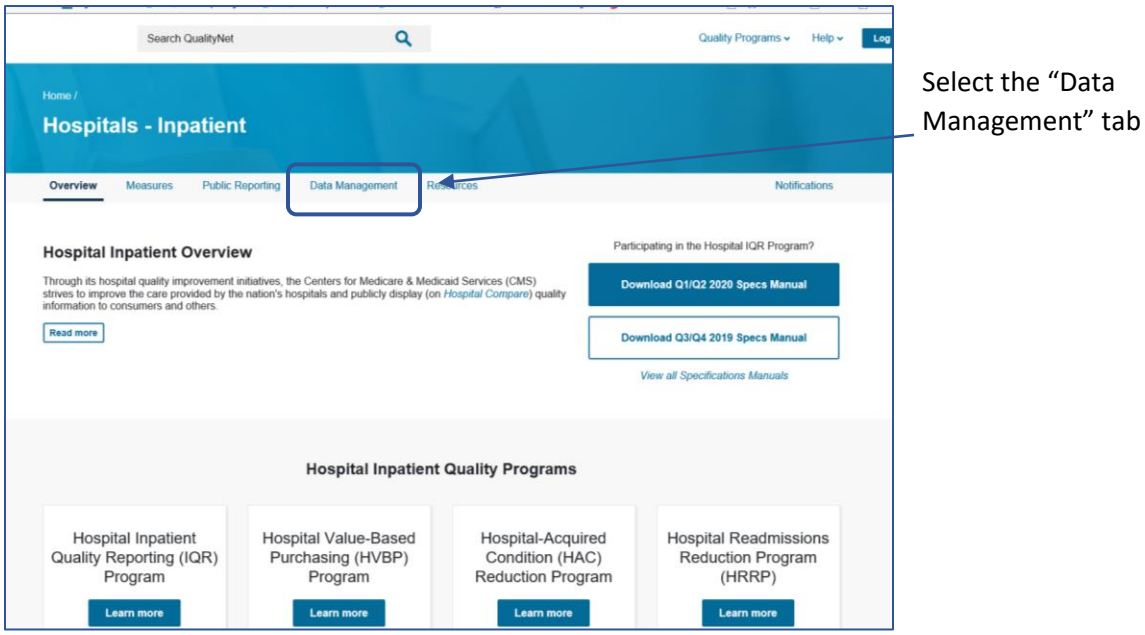
INPATIENT: https://www.qualitynet.org/inpatient/data-management/cart/download

OUTPATIENT: https://www.qualitynet.org/outpatient/data-management/cart/download

Downloading or updating **INPATIENT CART:**

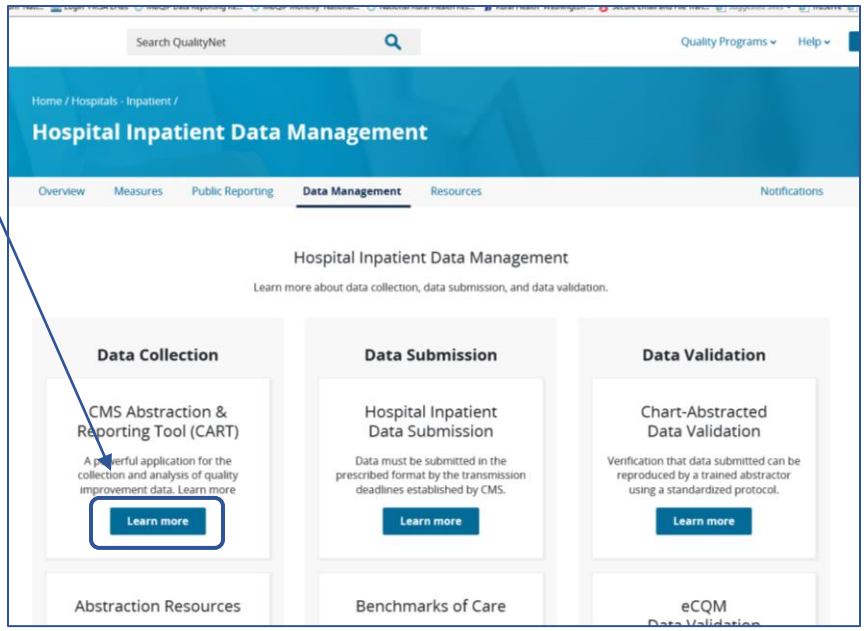
1. Go to www.qualitynet.org
2. Go to the "Hospitals-Inpatient" tile

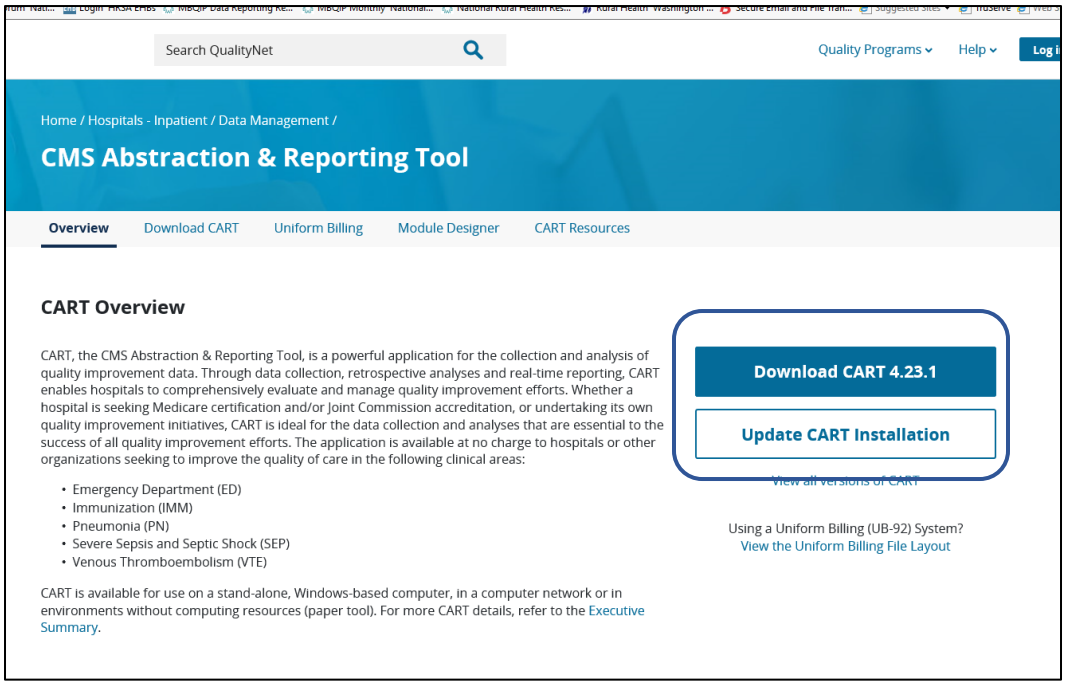




Select “Learn More” button within the “Data Collection” tile.

The Inpatient and Outpatient CART applications are separate modules and require separate downloads, and separate setups for your hospital and users.



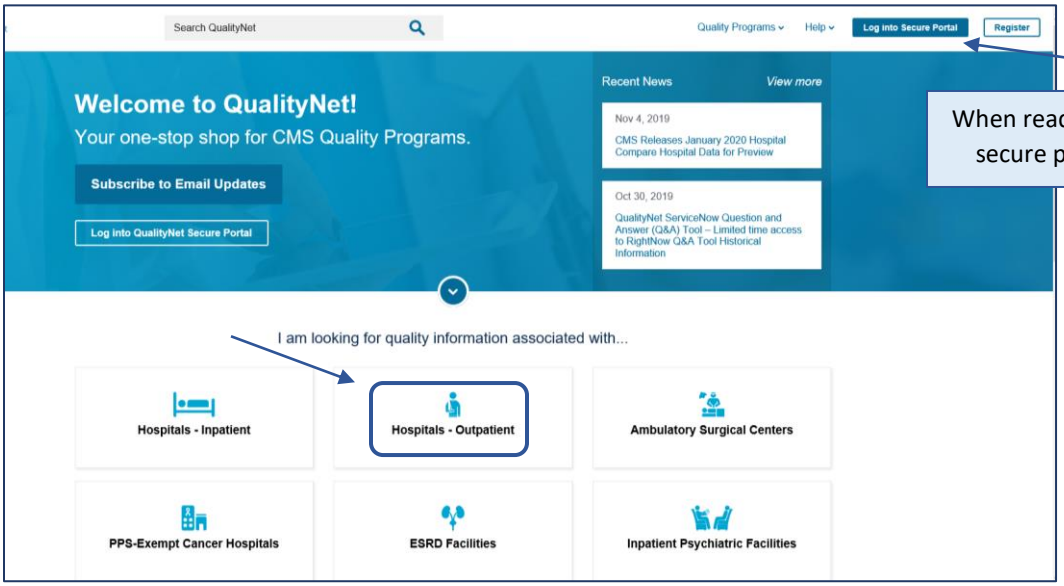


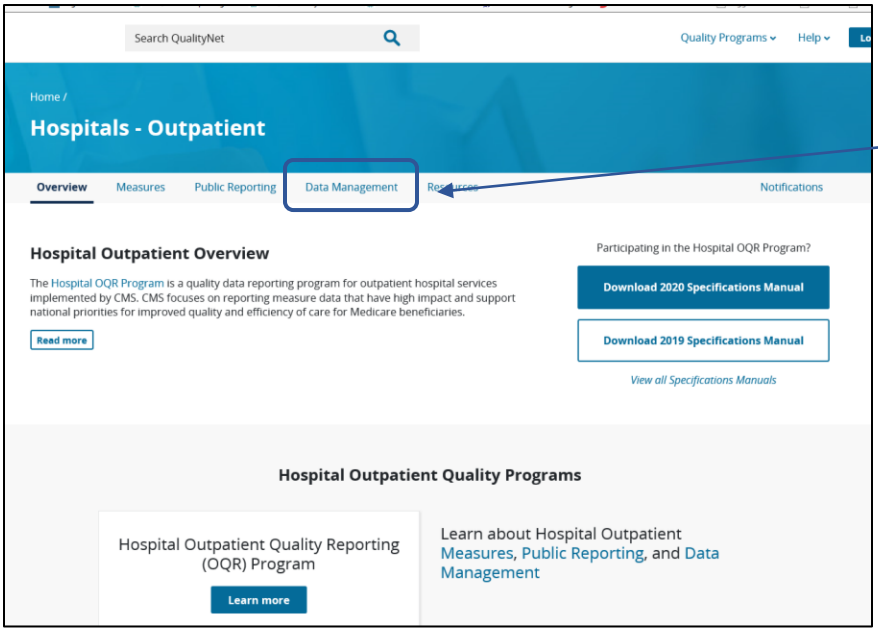
Under the “Download CART” Tab are CART installation instructions as well as different versions of CART.

From this overview page you can select “Download CART” for your initial installation or “Update CART Installation” If you already have CART installed on your computer.

Downloading or updating **OUTPATIENT CART:**

1. Go to www.qualitynet.org
2. Go to the "Hospitals-Outpatient" tile





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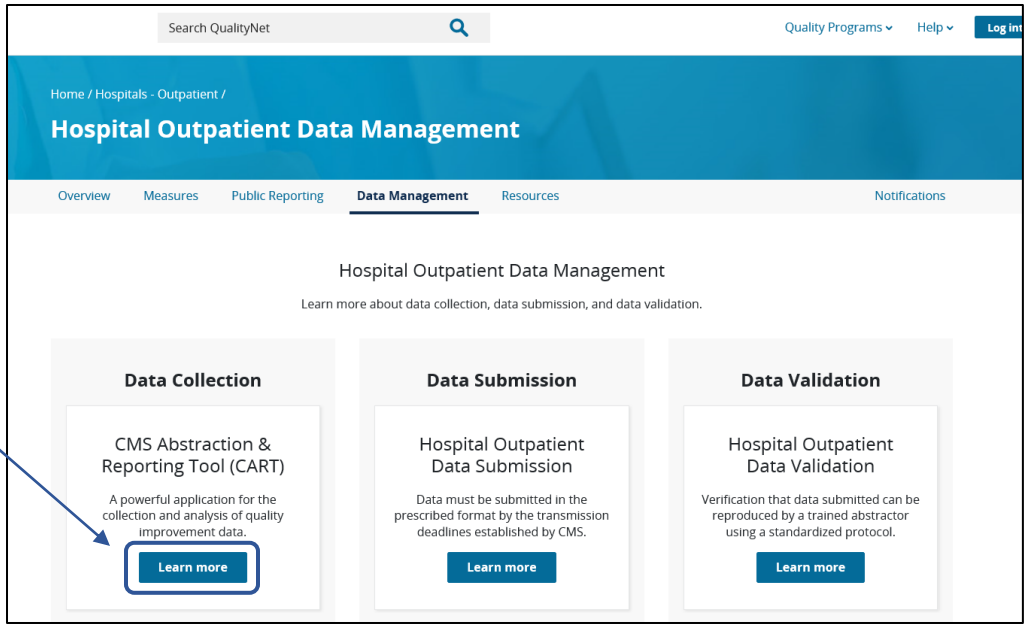

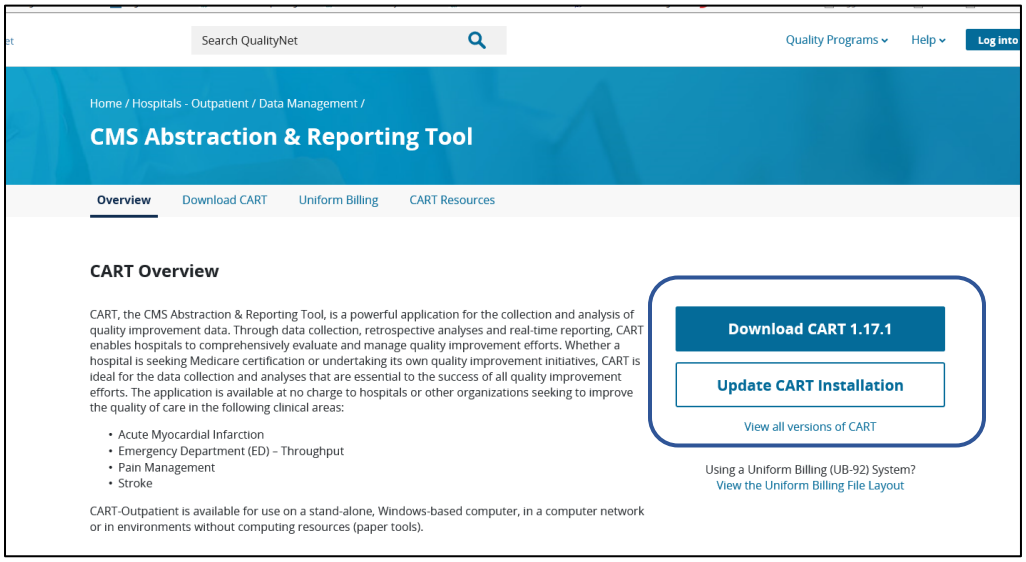

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From this overview page you can select “Download CART” for your initial installation or “Update CART Installation” If you already have CART installed on your computer.

The CART program will be on your computer’s desktop with the icon named “QMS30”.

When it is time to update your version of CART, go to the “CART Downloads and Info” page for either Inpatient or Outpatient as described above. In the drop down list box, choose the date range for the abstractions you are working on. Then choose “Upgrading an Existing CART Installation” and follow the installation instructions.

You will need to update your CART version to match the encounter date range for the records you are abstracting.

CART – Adding Hospital Information and Users

The Inpatient and Outpatient CART Users Guide provide detailed information about how to do this setup and navigate through the CART application. These User Guides are located under the CART resources tab for both inpatient and outpatient. Training videos are also available at:

https://www.qualitynet.org/outpatient/data-management/cart/resources

You will need your hospital's CMS Certification number for the setup process. Usually, this can be obtained from your billing or medical records department.

You can also request this number from the Rural Hospital Quality Improvement Manager (RHQIM).

This number is used as your MBQIP number and is on all of the reports you will receive from us.

After you have installed CART, the initial person signing into the application is required to set up at least one Provider and one System Administrator user. Be sure to document this information in the login tracker in the back of this manual.

It is recommended that you set up more than one System Administrator account as a back-up in the event that one of the System Administrator account becomes locked. Each provider must always have at least one active System Administrator. If there is only one System Administrator and that person terminates his/her position, another System Administrator must be created before entering the Termination Date for the existing System Administrator.

***Note: The Inpatient and Outpatient CART applications are separate modules and require separate downloads, and separate setups for your hospital and users.**

1. When the first **Inpatient login** screen appears, the User ID is *cart* and the password is *p@ssw0rd* (the first **Outpatient login** User ID is *opps* and the password is *p@ssw0rd*).

This initial User ID has very limited access; it is established only for the initial user to setup the Provider and System Administrator user. (You may not use the "*cart*" or "*opps*" User ID user to create abstractions.) Once successfully signed in with this initial User ID, you will be prompted to change the password and answer at least six of the security questions.

Passwords in CART must meet all of these criteria:

- Use a minimum of eight characters and a maximum of nineteen.
- Use at least one upper case, one numeric, and one special character.
- Valid special characters are: % # * + - , : = ?
- Not be your User ID, First Name, or Last Name.
- Not have more than three consecutive like characters.

Once you are logged in with this initial login, go to the Provider screen and set up your hospital as a provider. The Provider screen is found by clicking on the Administration tab at the top of the page.

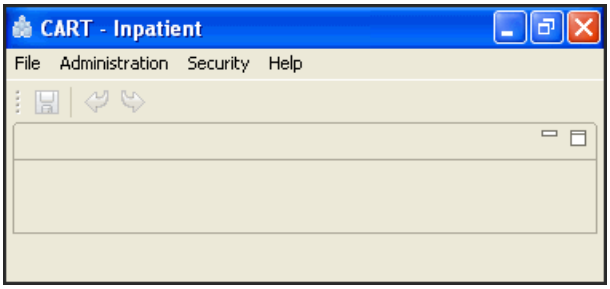
2. Choose Provider. On the following screen enter information about your hospital in the area on the right side of the page. The CMS Cert No is your hospital's Medicare number. It is a six digit number, usually beginning with the number 5. Your billing or medical records department will have this number. This is also your identifier for MBQIP. You can request this number from the RQHIM or look at your Telligen reports for it.

3. When you have entered the information, click on the Save icon at the top left of the page once you have entered the hospital information (or choose File, Save in the menu). You can exit this screen by clicking on the "x" at the Provider Information tab (not the "x" at the top right hand corner – this will exit you out of the program).

4. Next, set up at least one System Administrator. The System Administrator is the highest-level user and are able to:
    - Setup and maintain provider information
    - Setup and maintain user accounts
    - Specify measures and measure sets to be collected
    - Modify archive directory location if necessary

We recommend setting up two administrators.

5. Choose the Administration menu item and then select Users.



6. Enter information about the System Administrator in the area on the right side of the page. The User ID can be any you choose.

When you have entered the information, click on the Save icon at the top left of the page once you have entered the hospital information (or choose File, Save in the menu). You can exit this screen by clicking on the "x" at the Provider Information tab.

Exit out of the program by clicking on the "x" at the top right hand corner of the page. Open up the program again and the following will appear:

The New User ID is the one that you assigned in the previous session, and the password is *p@ssw0rd*. Once successfully signed in, you will be prompted to change the password and answer at least six of the security questions.

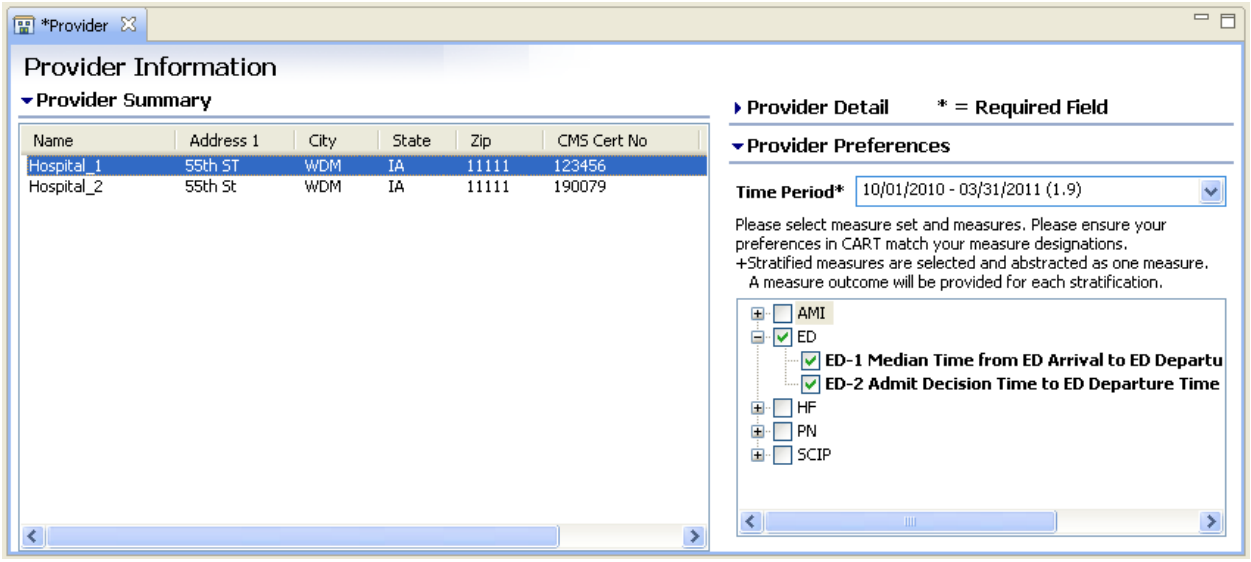
Additional Users can now be added through the User menu item (under the Administration tab). In the User screen, you will need to click "New User +" to enter new user information.

Setting Preferences for your Hospital:

Preferences define the measure sets and measures for which the provider data can be collected. Only the system administrator can set the preferences.

The preferences can be changed at any time but will only affect future abstractions. At least one measure set with corresponding measures has to be selected and saved for a time period. To set preferences:

1. On the Administration menu, click Provider. The Provider Information window is displayed.
2. In the Provider Summary section, select the desired provider.
3. On the right side of the window, click the arrow next to Provider Preferences (in the lower right corner of the window) to expand the Provider Preferences section



4. From the Time Period list, select the desired time period.
5. Sets and their measures are displayed in a tree format preceded by a green checkmark. You may need to use the scroll bars to view all of the measure sets and measures. By default, the system will automatically populate a checkmark in the box next to each measure. To deselect a measure, click the box next to the measure name that will not be collected.
6. Once you have selected the desired measures, click Save .

Be sure to set up OUTPATIENT users and administrators in addition to inpatient.

If you are having issues or have questions, see the CART training videos and user guides for both Inpatient and Outpatient applications. Once you have the initial installs and users set up you will not need to go through the process again. At that point you will only upload updates and add new users as needed.

Note:

If you are not planning on reporting ED-2 for MBQIP until its retirement and do not plan on reporting any other inpatient measures you can opt to just install outpatient CART.

Keep these instructions in case new inpatient measures are added to the MBQIP program.

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Section 4 – Specific Measure Reporting

Introduction:

This section of the manual provides resources and information to assist you in the abstraction and reporting of individual MBQIP Measures. If at any time you have a question regarding the abstraction criteria, submitting data, or issues with the reporting systems used there are many ways to get technical assistance.

In Section 3 we discussed resources to assist in abstractions including how to reach the QualityNet helpline and links to the Data specification manuals that CMS provides to assist with data collection. Section 6 also provides contact information for the Flex program.

For assistance with MBQIP measures and other quality or data related requests you will want to reach out to the Rural Hospital Quality Improvement Manager (RHQIM) for technical Assistance. Keep in mind this person as well as the Flex coordinator can help with a majority of technical assistance requests you may have, even if not quality related, by connecting you with other state and national contacts or resources that could assist you.

NOTE: This is only within the MBQIP program. There are other data systems and reporting requirements for other entities. You can reach out to us for technical assistance on measures outside of MBQIP, but it may take a bit longer to find you an answer or we may need to connect you with an outside responsible entity.

Within the following pages you will find information related to abstracting and reporting:

- Patient Safety
- Patient Engagement
- Care Transitions
- Outpatient Measures

For specific online abstraction tutorials please view the videos here:

https://www.youtube.com/playlist?list=PLrX6m5cvp8hAEJXD3Z1NeP_o1AxyTJw5w

Robyn Carlson with Stratis Health created these as a tool for data abstractors.

This first section is in regards to Patient Safety Measures. This includes:

- HCP
- Antibiotic Stewardship

Influenza Vaccination Coverage among Health Care Personnel (HCP)

HCP (formerly OP-27): *Influenza Vaccination Coverage among Healthcare Personnel (HCP):*

Facilities must report vaccination data for three categories of HCP:

- Employees on payroll
- Licensed independent practitioners (who are physicians, advanced practice nurses, and physician assistants affiliated with the hospital and not on payroll)
- Students, trainees, and volunteers aged 18 or older.

Reporting data on the optional, other contract personnel category is not required at this time. Only HCP physically working in the facility for at least one day or more between October 1 and March 31 should be counted. Data on vaccinations received at the facility, vaccinations received outside of the facility, medical contraindications, and declinations are reported for the three categories of HCP.

This measure is reported May 15th annually for data collected October 1st of the prior year through March 31 of the current year.

This data is submitted via the National Healthcare Safety Network (NHSN) portal. Please reference the NHSN enrollment instructions and video within this manual to complete enrollment for reporting this measure located on page 12 of this manual.

OUTPATIENT Specifications Manual: https://www.qualitynet.org/outpatient

Influenza Vaccination Coverage among Health Care Personnel (HCP)

HCP (formerly OP-27) Influenza Vaccination Coverage Among Health Care Personnel (Single Rate for Inpatient and Outpatient Settings)	
MBQIP Domain	Patient Safety CORE MEASURE
Measure Set	Web-Based (Preventative Care)
Measure Description	Percentage of health care workers given influenza vaccination.
Importance/Significance	1 in 5 people in the US get influenza each season. Combined with 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	Hospital Compare (Note: Listed on Hospital Compare as IMM-3-OP-27-FAC-ADHPCT) 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 between 10/1-3/31: • Employees on payroll • Licensed independent practitioners • Students, trainees and volunteers 18 years and over • A fourth optional category is available for reporting other contract personnel Health care personnel 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 – Submission Deadline ***Dates subject to change by CMS**	Q4 2020 - Q1 2021 (Oct-Mar) – May 15, 2021 Q4 2021 - Q1 2022 (Oct-Mar) – May 15, 2022 Q4 2022 – Q1 2023 (Oct – Mar) – May 15, 2023
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).

National Healthcare Safety Network Annual Facility Survey

Antibiotic Stewardship Measure:

Antibiotics are powerful drugs to treat serious infections. However, decades of overprescribing and misuse have resulted in bacteria that are increasingly resistant to these potent drugs, creating a growing threat of new superbugs that are difficult, and sometimes even impossible, to treat. According to the Centers for Disease Control and Prevention (CDC), drug-resistant bacteria cause two million illnesses and 23,000 deaths annually.

Improving antibiotic use in hospitals is imperative to improving patient outcomes, decreasing antibiotic resistance, and reducing healthcare costs. According to the CDC, 20-50% 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.

A copy of the survey can be found here.

The instructions for completion of the survey can be found here.

Accessing the survey in NHSN:

If the 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 Hospital Acquired Infection 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 here.

Antibiotic Stewardship NHSN Annual Facility Survey is open for submission during the first quarter of a calendar year and is based on the information from the previous year. Example 2019 facility information is used to complete survey sometime between January 1, 2020 and March 1, 2020.

The CDC has provided a checklist for core elements of hospital antibiotic stewardship programs. You can also find a link to the *Antibiotic Stewardship in Acute Care: A Practical Playbook* published by the National Quality Forum here.

The **Core Elements of Hospital Antibiotic Stewardship Programs Assessment Tool** is listed below for your reference:

National Healthcare Safety Network Annual Facility Survey

Core Elements of Hospital Antibiotic Stewardship Programs Assessment Tool		
Hospital Leadership Commitment	**Established at Facility?**	
Does facility leadership provide stewardship program leader(s) dedicated time to manage the program and conduct daily stewardship interventions?	Yes	No
Does facility leadership provide stewardship program leader(s) with resources (e.g, IT support, training) to effectively operate the program?	Yes	No
Does your antibiotic stewardship program have a senior executive that serves as a point of contact or "champion" to help ensure the program has resources and support to accomplish its mission?	Yes	No
Do stewardship program leader(s) have regularly scheduled meetings with facility leadership and/or the hospital board to report and discuss stewardship activities, resources and outcomes?	Yes	No
Does your facility leadership ensure that staff from key support departments and groups have sufficient time to contribute to stewardship activities?	Yes	No
Does facility leadership ensure that antibiotic stewardship activities are integrated into other quality improvement and patient safety efforts, such as sepsis management and diagnostic stewardship?	Yes	No
Does facility leadership support enrollment and reporting into the NHSN Antimicrobial Use and Resistance (AUR) Module, including any necessary IT support?	Yes	No
Accountability	**Established at Facility?**	
Does your facility have a leader or co-leaders responsible for program management and outcomes of stewardship activities?	Yes	No
a. If a non-physician is the leader of the program, does the facility have a designated physician who can serve as a point of contact and support for the non-physician leader?	Yes	No
Pharmacy Expertise	**Established at Facility?**	
Does your facility have a pharmacist(s) responsible for leading implementation efforts to improve antibiotic use?	Yes	No
Does your pharmacist(s) leading implementation efforts have specific training and/or experience in antibiotic stewardship?	Yes	No
Action: Implement Interventions to Improve Antibiotic Use	**Established at Facility?**	
Does your facility perform prospective audit/feedback for specific antibiotic agents?	Yes	No
Does your facility perform preauthorization for specific antibiotic agents?	Yes	No
Does your facility have facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilities, to assist with antibiotic selection for common clinical conditions?	Yes	No
Does your facility have specific interventions (e.g., ensuring correct discharge duration of therapy) to ensure optimal use of antibiotics for treating the most common infections in most hospitals?		
a. Community-acquired pneumonia	Yes	No
b. Urinary Tract Infections	Yes	No
c. Skin and soft tissue infections	Yes	No
Does your facility have a policy that requires prescribers to document in the medical record or during order entry a dose, duration, and indication for all antibiotic prescriptions?		

a. Sepsis	Yes	No
b. Staphylococcus Aureus Infection	Yes	No
c. Stopping unnecessary antibiotic(s) in new cases of CDI	Yes	No
d. Culture-proven invasive (e.g., blood stream) infections	Yes	No
e. Review of planned outpatient parenteral antibiotic therapy (OPAT)	Yes	No
Does your facility have a policy that requires prescribers to document in the medical record or during order entry - dose, duration, & indication for all antibiotics?	Yes	No
Does you have a formal procedure for all prescribers to conduct daily reviews of antibiotic selection until a definitive diagnosis & treatment duration are established?	Yes	No
Tracking Antibiotic Use and Outcomes	**Established at Facility?**	
Does your antibiotic stewardship program track antibiotic use by submitting to the National Healthcare Safety Network (NHSN) Antimicrobial Use (AU) Option?	Yes	No
Does your antibiotic stewardship program monitor prospective audit and feedback interventions by tracking the types of interventions and acceptance of recs?	Yes	No
Does your antibiotic stewardship program monitor preauthorization interventions by tracking which agents are being requested for which conditions?	Yes	No
Does your stewardship program monitor adherence to facility-specific treatment recommendations?	Yes	No
Does your stewardship program monitor adherence to a documentation policy (dose, duration and indication)?	Yes	No
Does your antibiotic stewardship program monitor the performance of antibiotic timeouts to see how often these are being done and if opportunities to improve use are being acted on during timeouts?	Yes	No
Does your antibiotic stewardship program routinely perform medication use evaluations to assess courses of therapy for select antibiotics and/or infections to identify opportunities to improve use?	Yes	No
Does your antibiotic stewardship program assess how often patients are discharged on the correct antibiotics for the recommended duration?	Yes	No
Does your antibiotic stewardship program track antibiotic resistance by submitting to the NHSN Antimicrobial Resistance (AR) Option?	Yes	No
Does your antibiotic stewardship program track CDI in context of antibiotic use?	Yes	No
Does your facility produce an antibiogram?	Yes	No
Reporting Antibiotic Use and Outcomes	**Established at Facility?**	
Does your antibiotic stewardship program share facility and/or individual prescriber-specific reports on antibiotic use with prescribers?	Yes	No
Does your antibiotic stewardship program report adherence to treatment recommendations to prescribers (e.g., results from medication use evaluations, etc)?	Yes	No
Has your facility distributed a current antibiogram to prescribers?	Yes	No
Education	**Established at Facility?**	
Does your stewardship program provide education to prescribers and other relevant staff on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance?	Yes	No
Does your stewardship program provide education to prescribers as part of the prospective audit and feedback process (sometimes called “handshake stewardship”)?	Yes	No

National Healthcare Safety Network Annual Facility Survey

Antibiotic Stewardship Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Annual Survey	
MBQIP Domain	Patient Safety/Inpatient CORE MEASURE
Measure Set	Annual Survey
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% 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
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 hospital has successfully implemented the following core elements of antibiotic stewardship: • Leadership • Accountability • Drug Expertise • Action • Tracking • Reporting • Education
Encounter Period – Submission Deadline ***Dates subject to change by CMS**	Calendar Year 2020 Data – January-March 2021 Calendar Year 2021 Data – January-March 2022 Calendar Year 2022 Data – January-March 2023
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

Patient Engagement

Patient Engagement is measured using the Hospital Assessment of Healthcare Providers and Systems Overview (HCAHPS) Survey.

HCAHPS (also known as Hospital CAHPS) stands for Hospital Consumer Assessment of Healthcare Providers and Systems and is a standardized survey of hospital patients that captures patients' unique perspectives on hospital care for the purpose of providing the public with comparable information on hospital quality.

HCAHPS consists of a standardized survey instrument and a set of data collection and reporting procedures. These are used by hospitals (or their survey vendors) to gather information about patients' perspectives on care in the organization. The core set of HCAHPS questions can either be added to a hospitals current patient survey, or used as a stand-alone instrument. This information serves the goal of increasing consumers' knowledge of hospital care. It also provides hospitals with data and benchmarks to gauge their performance relative to others.

Most facilities choose to have an HCAHPS Survey Vendor to conduct the survey and to submit to CMS. If you choose to administer the survey yourself, there is a long list of rules and regulations you must follow or your survey data will not be considered valid and will not be accepted.

There is a current list of HCAHPS Vendors in the resource section of this manual.

HCAHPS serves the public's interest in improving the quality of care in America's hospitals by providing consumers, healthcare professionals and individual hospitals with standardized and comparable information on how patients view their quality of care experience. HCAHPS furnishes valid and reliable information on several critical aspects of the hospital experience on a continuous basis.

In addition to gaining valuable information about their own care processes, participating hospitals are able to compare themselves to other hospitals and the industry as a whole on exactly the same indicators. This information could be fed directly into the hospitals assessment and improvement program. The ongoing and standardized nature of the survey also allows hospitals to track changes in patient perspectives on care over time.

The HCAHPS survey is broadly intended for patients of all payer types that meet the following criteria:

- 18 years or older at the time of admission
- At least one overnight stay in the hospital as an inpatient
- Non-psychiatric MS-DRG/principal diagnosis at discharge
- Alive at the time of discharge

The HCAHPS protocol supports several modes of data collection. There are advantages and disadvantages for each mode:

- Mail Only: An initial survey mailing to the sample followed by a second survey to non-respondents about three weeks later.
- Mixed Mode: Using this approach, an initial survey mailing is distributed and then a phone call is made to non-respondents of the mail survey.
- Phone Only: This protocol uses exclusively telephone to collect the results. Five survey attempts must be made to each selected patient.
- IVR: IVR stands for Interactive Voice Response. Using this mode, patients will be contacted by telephone and then transitioned to an electronic survey they can completed with their touch-tone telephone.

Important facts to note:

For IPPS Hospitals (not CAH) to achieve the desired number of surveys for CMS, the targeted number of completed surveys is at least **300 per 12 month period.**

Therefore, participating IPPS hospitals should have at least 25 completed surveys per month.

For CAHs that often can't meet the PPS hospital minimum, Hospital Compare does show HCAHPS data reported as long as you have 25 surveys for the most recent four quarters. If you have less than 100 surveys for the rolling year there will be a footnote denoting the small survey number.

Your facility will not receive a star rating if you do not have **at least 100 surveys** for the rolling year. Your goal should be 25 surveys per quarter to receive a star rating.

Your vendor may not submit your data to CMS if you do not meet their minimum survey threshold (often 25 per quarter). If this is the case you should request your vendor report even if only a "0".

We fully understand that HCAHPS is not beneficial for some critical access that do not have the inpatient volume to ever meet the minimum threshold to have their data reported. If your vendor is not submitting a "0" on your behalf or submitting the few surveys you have please contact the Rural Hospital Quality Improvement Manager to find out the steps for documenting your participation for the MBQIP reporting requirements.

If you have a vendor not reporting your small survey numbers please submit documentation of this to the Rural Hospital Quality Improvement Manager each quarter.

Since this reporting is not always beneficial we are working towards finding vendors for group rates and vendors will report all surveys no matter how small.

In addition there is also the Small Hospital Improvement Program or the SHIP grant that will provide funding to pay for your HCAHPS vendor even if you do get plenty of surveys per year. For more information on how to tap into this funding source please see the SHIP grant information in the resources section of this manual.

Below are the elements and questions that are included in the HCAHPS Survey:

The HCAHPS Survey contains 29 questions

- Q1 to 22: Core Questions
- Q23 to 29: Demographic Questions

Below are the survey questions:

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
2. During this hospital stay, how often did nurses listen carefully to you?
3. During this hospital stay, how often did nurses explain things in a way you could understand?
4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

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5. During this hospital stay, how often did doctors treat you with courtesy and respect?
6. During this hospital stay, how often did doctors listen carefully to you?
7. During this hospital stay, how often did doctors explain things in a way you could understand?

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8. During this hospital stay, how often were your room and bathroom kept clean?
9. During this hospital stay, how often was the area around your room quiet at night?

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10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
12. During this hospital stay, were you given any medicine that you had not taken before?
13. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
14. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

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15. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?
16. 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?
17. 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?

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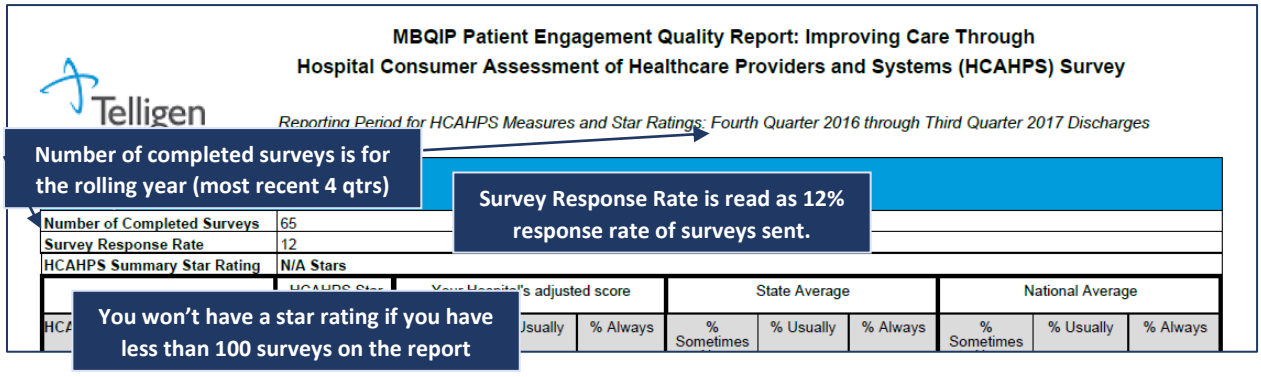
18. Rating of hospital.
19. Would you recommend this hospital to your friends and family?
20. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
21. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
22. When I left the hospital, I clearly understood the purpose for taking each of my medications.

23. During this hospital stay, were you admitted to this hospital through the Emergency Room?
24. In general, how would you rate your overall health?
25. In general, how would you rate your overall mental or emotional health?
26. What is the highest grade or level of school that you have completed?
27. Are you of Spanish, Hispanic, or Latin origin or descent?
28. What is your race?
29. What home language do you mainly speak at home?

Additional customized questions can be added by the facility at the end of the survey.

HCAHPS Telligen Reports

You will receive a report from the Rural Hospital Quality Improvement Manager each quarter and below shows specific information in understanding your HCAHPS Telligen report:



The following pages are "Cheat Sheets" for the various elements of the HCAHPS survey. Although your vendor will do all the data compilation you may want to familiarize yourself with these elements. This information can assist you and your facility in designing and executing quality improvement projects to improve your overall HCAHPS scores.

HCAHPS – Composite 1 Communication with Nurses

HCAHPS Composite 1 Communication with Nurses	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

HCAHPS – Composite 2 Communication with Doctors

HCAHPS Composite 2 Communication with Doctors	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

HCAHPS – Composite 3 Responsiveness of Hospital Staff

HCAHPS Composite 3 Responsiveness of Hospital Staff	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

HCAHPS – Composite 4 Communication about Medicines

HCAHPS Composite 4 Communication about Medicines	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

HCAHPS – Discharge Information

HCAHPS Composite 5 Discharge Information	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

HCAHPS – Question 8 Cleanliness of Hospital Environment

HCAHPS Question 8 Cleanliness of Hospital Environment	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

HCAHPS – Question 9 Quietness of Hospital Environment

HCAHPS Question 9 Quietness of Hospital Environment	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

HCAHPS – Composite 6 Care Transitions

HCAHPS Composite 6 Care Transitions	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

HCAHPS – Question 21 Overall Rating of Hospital

HCAHPS Question 18 Overall Rating of Hospital	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

HCAHPS – Question 22 Willingness to Recommend

HCAHPS Question 19 Willingness to Recommend	
MBQIP Domain	Patient Engagement CORE MEASURE
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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital 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 – Submission Deadline ***Dates subject to change by CMS**	Q1 2021 (Jan 1 – Mar 31) – July 1, 2021 Q2 2021 (Apr 1 – Jun 30) – October 1, 2021 Q3 2021 (Jul 1–Sep 30) – January 4, 2022 Q4 2021 (Oct 1 – Dec 31) – April 1, 2022
Other Notes	None

Care Transitions

Care transitions refers to the Emergency Department Transfer Communications (EDTC) measure. This measure is considered a "bundle" measure meaning you must answer all elements to get credit for reporting the measure.

The EDTC measure is different in that it is not a CMS mandated measure. Instead it was created specifically for critical access hospitals and will be submitted directly to the Rural Hospital Quality Improvement Manager (RHQIM) who will then submit the state data.

We will discuss submission further in this section.

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.

Rationale

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 website was created to display rates of Process of Care measures using data that are voluntarily submitted by hospitals.

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.

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.

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. These changes have been approved by the National Quality Forum (NQF) and are currently being used by critical access hospitals starting with January 1 2020 encounters.

Care Transitions – Abstracting Data

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 VA – 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:

1. AMA
2. Expired
3. 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
4. Hospice-home
5. Not documented/unable to determine
6. Observation Status

Note: ED patients that have been put in observation status and then are transferred to another hospital or health care facility should *NOT* be included.

Sample Size Requirements

Hospitals need to submit a **minimum** of 45 cases.

Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to use a larger sample size than is required. Hospitals whose initial patient population size is less than the minimum number of cases per quarter for the measure set cannot sample.

If you have less than 45 cases for a reporting quarter you must report all cases.

Regardless of the option used, 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.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes.

Hospitals performing quarterly sampling for ED Transfer Communication must ensure that their initial patient population and sample size meet the following conditions:

Population Per Quarter	**45-900**
Quarterly sample size:	45
Monthly size:	15
Population Per Quarter	**Less than or equal to 45**
Quarterly sample size:	Use all cases
Monthly size:	Use all cases

Measure Calculation

This measure is calculated using an all or nothing approach.

The overall EDTC Measure can be calculated as the percent of medical records that met all of the 8 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 of the data elements or have an NA.

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.

To make abstracting data easier, Stratis health has an abstraction tool that allows you to enter all your data and produce a report that will be used to submit your data to the Rural Hospital Quality Improvement Coordinator by the deadline.

To begin abstracting you will want to go to the Stratis site and download the tool:

http://www.stratishealth.org/providers/ED_Transfer_Resources.html

Halfway down the page you will see the Data Collection Tool section. Please do read the "READ FIRST" guide first so you don't make an error that costs you more time or frustration. The second link in this section is the Data Collection Tool and then they do provide a manual.

Below this section is a data collection tool training video that can be super helpful when first learning how to use the tool.

This page has all the resources you need to successfully abstract your EDTC data.

It is important to bookmark this page in case you need to download a new tool or need a refresher on abstracting the elements.

http://www.stratishealth.org/providers/ED_Transfer_Resources.html

For detailed abstraction elements please see the pages that follow or reference the Stratis Health Data Specifications Manual: http://www.stratishealth.org/documents/EDTC-Data-Specs-Manual-2019.pdf

Once you have gone through the abstraction process and created your final report you will submit very specific portions of that data to the Rural Hospital Quality Improvement Manager.

Please remember:

- Never send your Stratis abstraction tool or final report produced from the abstraction tool to anyone. This contains PHI.
- You can do all of your abstractions by hand and do not have to use the abstraction tool (see Stratis website referenced above for how to do that).
- If you ever have data abstraction interpretation questions or are unsure about how to answer the element questions please seek technical assistance from the Rural Hospital Quality Improvement Manager.
- There is no account that you have to create to report this measure. See the Reporting your data portion following the element data after this page.

EDTC Data Elements

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.

Inclusion Guidelines for Abstraction:

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

Exclusion Guidelines for Abstraction: None

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.

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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.

- Current encounter
- Transfer Summary document

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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.

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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.

Inclusion Guidelines for Abstraction:

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

Exclusion Guidelines for Abstraction: None

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.

Inclusion Guidelines for Abstraction:

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

Exclusion Guidelines for Abstraction: None

EDTC – All or None Composite Calculation

Emergency Department Transfer Communication (EDTC) All or None Composite Calculation	
MBQIP Domain	Care Transitions CORE MEASURE
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have all necessary communication with the receiving facility.
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 – Submission Deadline	Q1 2020 (Jan 1 - Mar 31) – April 30, 2020 Q2 2020 (Apr 1 - Jun 30) – July 31, 2020 Q3 2020 (Jul 1 - Sep 30) – October 31, 2020 Q4 2020 (Oct 1 - Dec 31) – January 31, 2021
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.

Care Transitions – Reporting your Data

Now that you have successfully abstracted all of your records and created your final report that contains your final counts it is time to report this information.

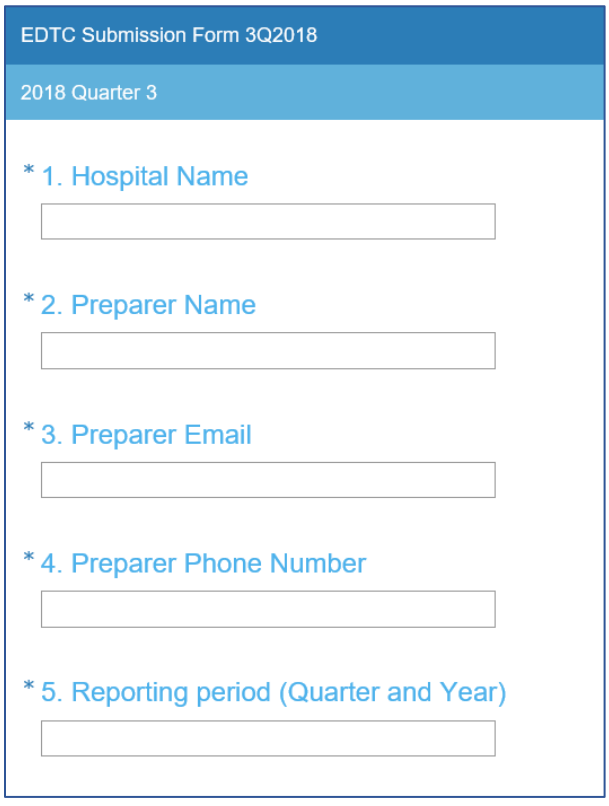
Because this is not a CMS measure you must report your data to the Rural Hospital Quality Improvement Manager. This person will then report the information for all CAHs in the state to HRSA.

There are currently two methods to report this data to the coordinator:

- Survey monkey survey
- Quality Health Indicators

Survey Monkey

You will receive an email at the beginning of the new reporting quarter as well as throughout the quarter that contains a link to submit your EDTC data for the quarter. This email comes from the Rural Hospital Quality Improvement Manager and you are more than welcome to email them at any point during the quarter if you can't find it.



The link will look something like this: surveymonkey.com/r/EDTC3Q2020

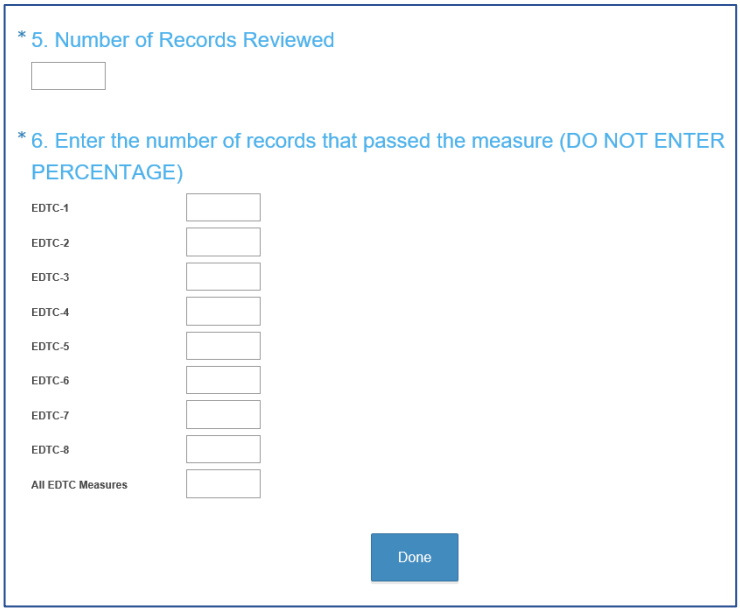
This link changes every quarter in order to keep your submissions separate. The highlighted portion tells you what quarter that specific survey is for so you can make sure you are submitting to the right one. If you get a message stating the survey is closed you are either using the wrong link or you have missed the reporting deadline.

The first portion of the survey collects your information as well as the quarter you are reporting. This is to make sure you are not submitting previous data.

The preparer is who will be contacted if there is an error in the data submitted so if there is someone else who should receive those emails be sure to put their information.

This part of the survey is asking for the data that was produced in your report.

The next portion asks specifically for your data.



First be sure to input your total number of records that you reviewed.

Next you will put the whole number of the number of records that passed the element and then how many records passed all EDTC elements.

DO NOT ENTER A PERCENTAGE. We have to have the whole number of records.

If you have to submit for more than one facility or if you made an error on your submission you can use the link multiple times.

If you submit for the same facility twice, the most recent submission data will be used.

Quality Health Indicators

This is a benchmarking system we provide to CAHs using Flex funding. You will need a log in to submit data through this method.

Please see the resource page in the resources section for instructions on how to gain access and how to use the system. You can use it for so much more than just submitting this measure.

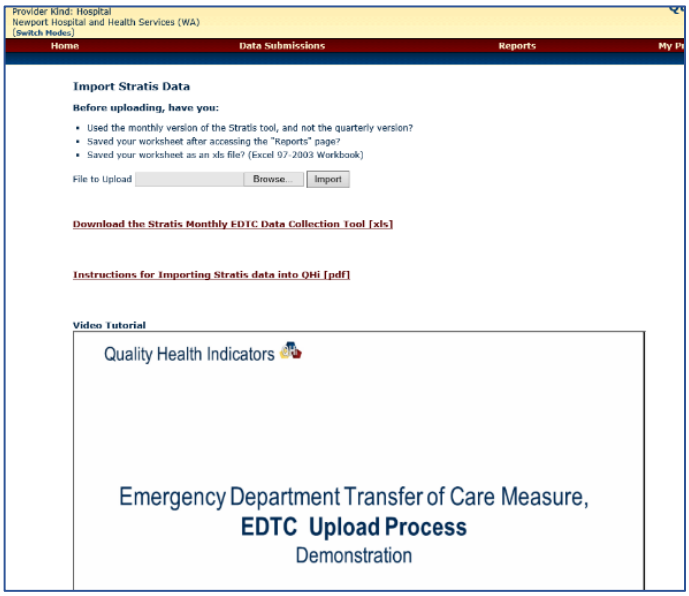
Once you have gained access you can use your Stratis abstraction tool final report to upload your data into the system.

https://www.qualityhealthindicators.org/account/login

This is the log in page (see link above).

Log in.

This is your main page when you log in. You will want to go to the left side menu and select imports.



This will take you to a page that allows you to upload your Stratis abstraction tool final report. What is useful with QHi is you can upload monthly rather than having to wait until the end of the quarter. This page has a video tutorial as well as instructions and a link to download the tool if you haven't already done so from the Stratis site.

You will see on the left menu where you selected New Stratis EDTC Import there is also a place to import your CART data. You are more than welcome to upload your CART data which allows you to do so monthly and create a wide variety of reports and charts with your data as well as benchmark yourself with the other state CAHs and all CAHs in QHi.

Disclaimer:

Uploading CART data to QHi DOES NOT upload your data to QualityNet and CMS will not receive your data. This program is simply a benchmarking system which allows you to do more with your data.

Once you have submitted your data either via Survey Monkey or QHi, your data will be included in the state report that is sent to HRSA each quarter. This measure is a core measure and does count towards your MBQIP minimum reporting requirement.

The Rural Hospital Quality Improvement Manager sends out a confirmation email one week prior to the deadline to those who have already submitted their data. For those that have not yet submitted, you will receive a reminder email of the deadline and the submission methods.

You are more than welcome to reach out once you have submitted to verify the manager has received your data. On the submission deadline date you will receive an email stating that your data has not been received (if it has not been received). If you believe you did submit and received this email in error, respond AS SOON AS POSSIBLE so the manager can find the error. Sometimes it is a matter of human error and overlooking someone's facility when sending the blanket email.

If you are concerned about any part of this process please reach out to us. Our job is to offer as much technical assistance that you need to be successful.

Outpatient Measures

Outpatient measures include:

- OP-2 : Fibrinolytic Therapy
- 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

All measures *except* OP-22 will be submitted via QualityNet using the Cart application or other vendor.

OP-22 is submitted through QualityNet, but it is submitted through the secure portal and is a taken directly from your EHR.

To submit the bulk of these measures you will need to complete your abstractions using the current version of CART for outpatient measures. To download this application use the following link:

https://www.qualitynet.org/outpatient/data-management/cart

Be sure you have downloaded the appropriate CART tool for your encounter period for the quarter you are abstracting. Downloads are in the left hand bar.

Once you have completed your abstractions you will need to log in to QualityNet and upload your CART abstractions.

See Instructions Below

**Note: If you are using QHi for benchmarking now is the time to import your CART abstractions into that application.

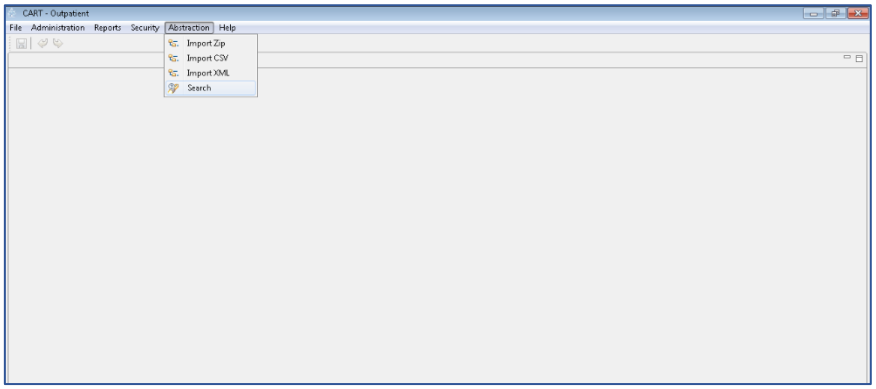
Following the QualityNet submission instructions are “cheat sheets” for each of the outpatient measures listed above.

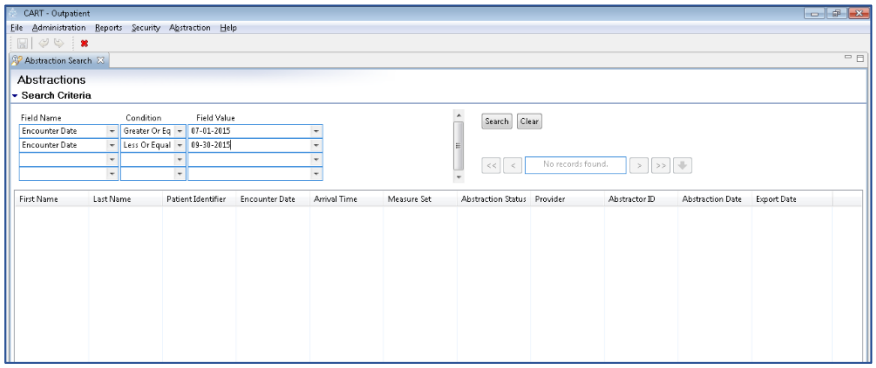
Submitting OP-2,3 and 18 from CART

Submitting CART Abstractions to QualityNet (You will use outpatient CART)
(Written by Pullman IT Department 2016)

The following describes the procedure for preparing abstracted records in CART and submitting them to the QualityNet warehouse. These steps apply to both inpatient and outpatient data:

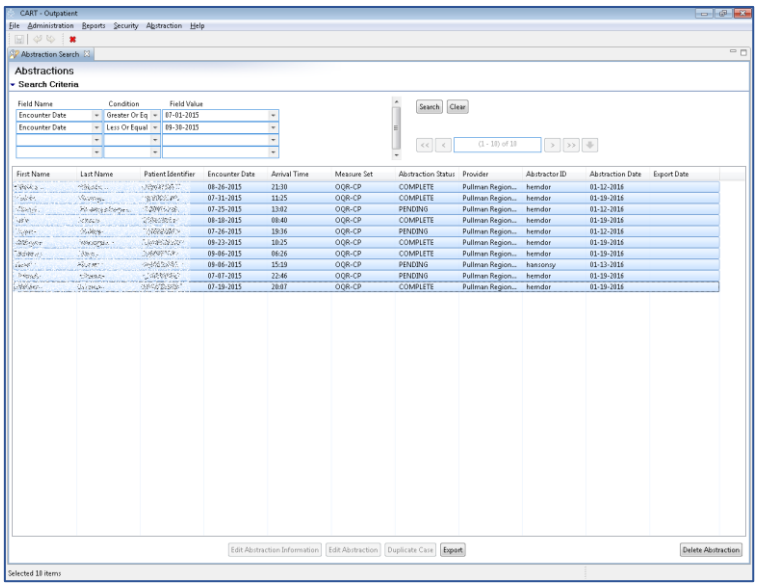
1. Start and log in to the appropriate CART app (inpatient or outpatient).
2. From the Abstraction menu, select Search…





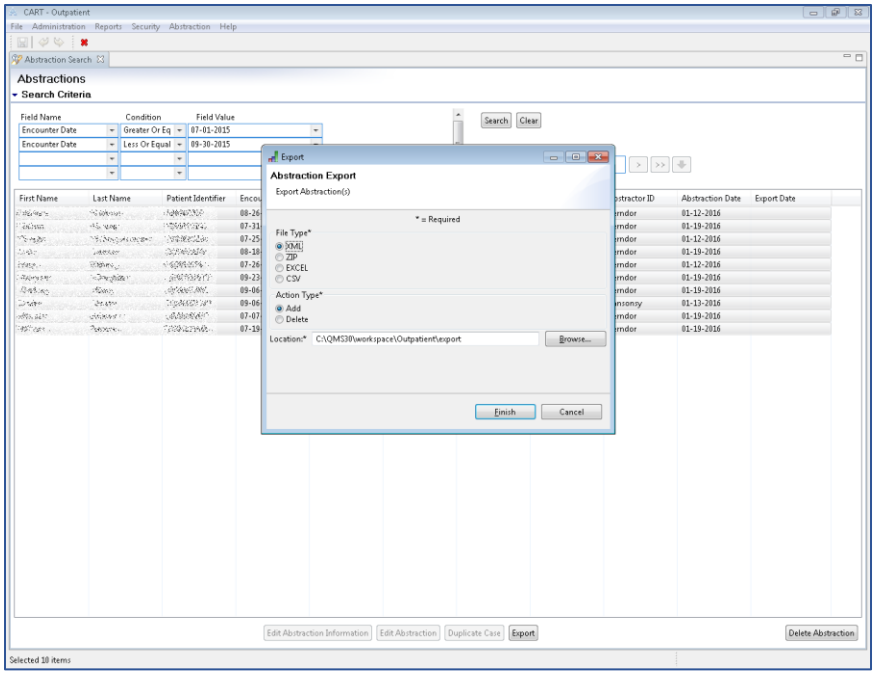
3. In the Search Criteria fields, search by **Encounter Date (outpatient)** or **Admission Date (inpatient)**, where the dates are ≥ the beginning of the quarter and ≤ the end of the quarter.
4. Click on the [Search] button when done.

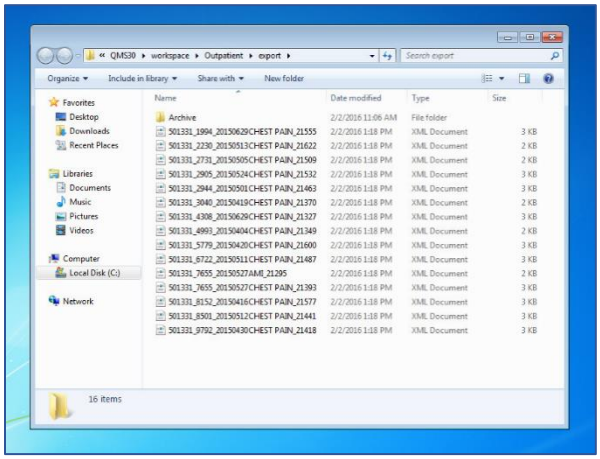
5. To export the results, click on the first item on the list, then scroll to the bottom of the list, hold down the [Shift] key while clicking on the last item on the list. The following screenshot is what all items selected looks like:



6. Click on the [Export] button.

7. Accept the default settings shown and click [Finish]. Close out of CART.

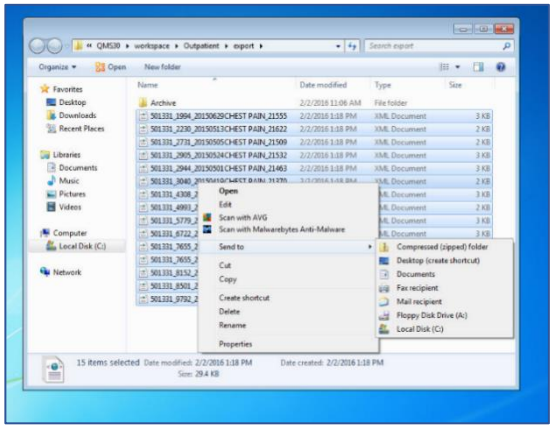




8. The next step is to package the exported records. On the CART desktop, you will see shortcuts for both inpatient and outpatient export files. Double-click on the appropriate shortcut to open it. You will see a list of files…

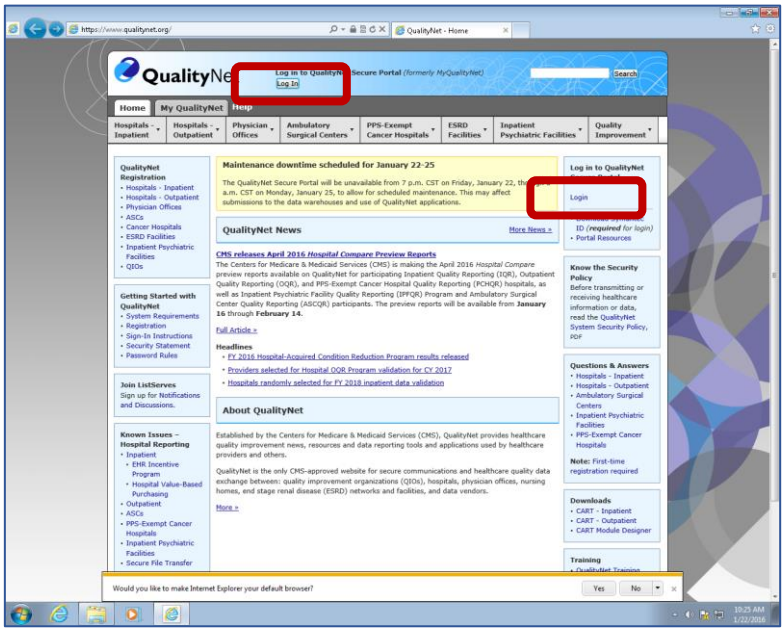
9. Select all the files (similar to how you selected the records to export), then right-click and select Send to > Compressed (zipped) folder.

10. Rename the file created.



11. Start the Symantec VIP access program on your desktop.

12. Launch the QualityNet website from the **CART** desktop link. Click on the [Log In] button at the top of the page.

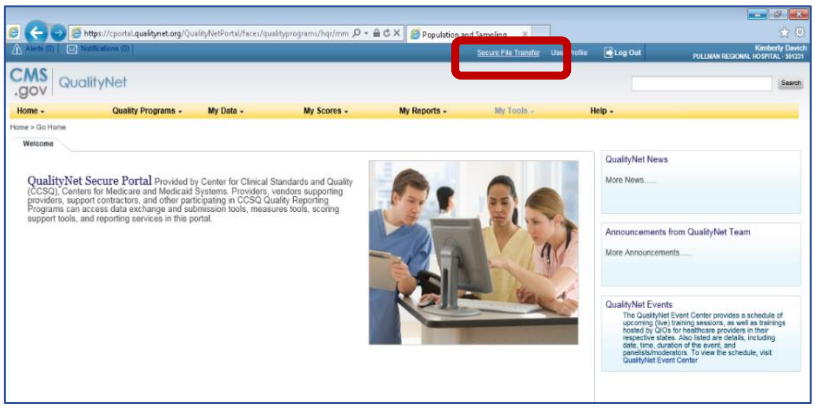


13. On the *Choose your QualityNet Destination* page select the Inpatient or Outpatient Hospital Quality Reporting Program link as appropriate.

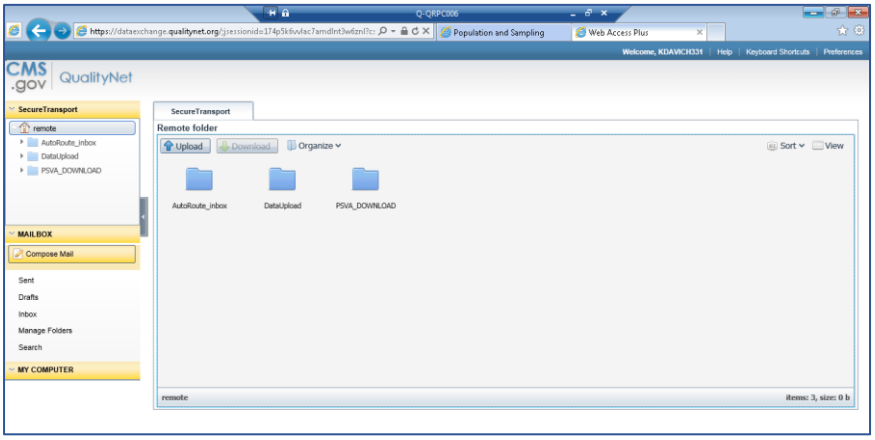
14. Log in to QualityNet using the username, password and security code generated by the VIP tool This code changes every 30 seconds, so be sure to enter the code early in the cycle.

15. Acknowledge the security banner and continue.

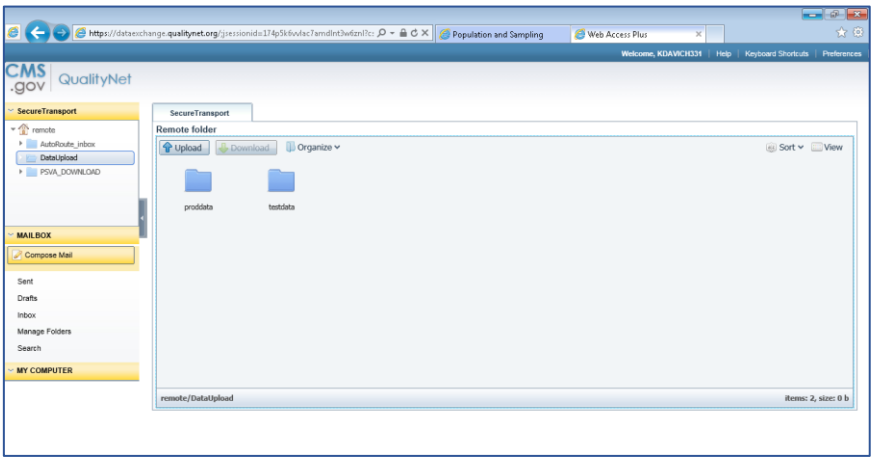
16. You should be at the portal page now. Click on the Secure File Transfer link at the top of the page.



17. In the folder tree view, click on the DataUpload folder.



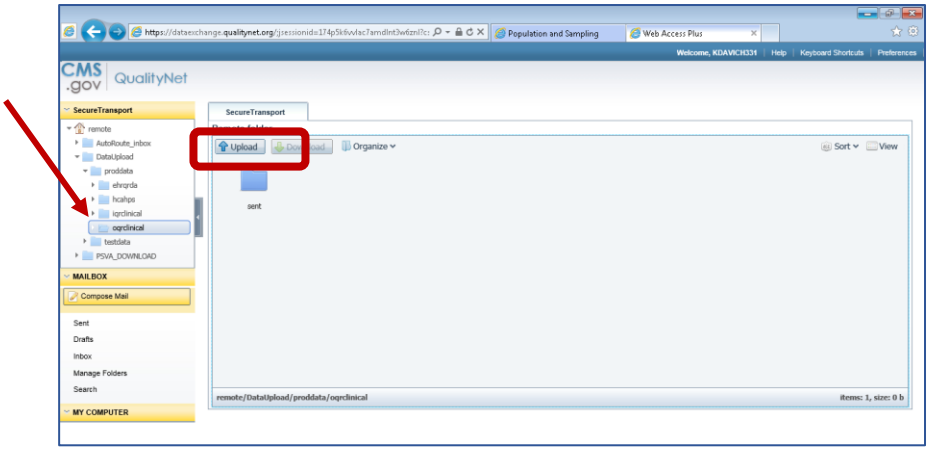
18. Click on the Proddata folder:



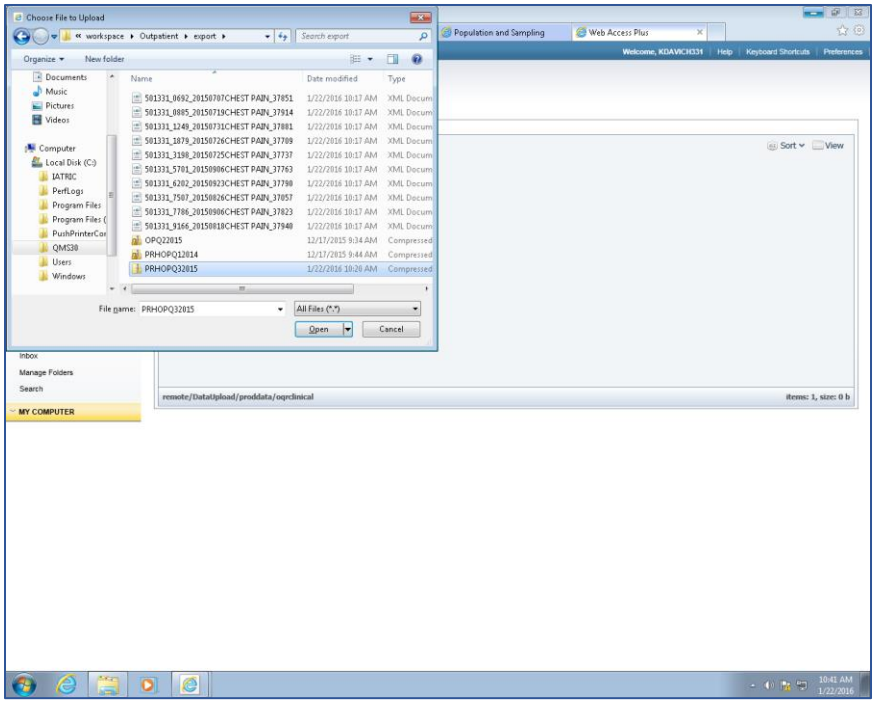
19. Select either the:

iqrclinical (inpatient) or

oqrclinical (outpatient) folder



20. Click the [Upload] button.



21. Select the file you created in step {#} & click [Open]. The file will upload and be scanned.
22. Repeat as needed
23. Close out of QualityNet.

QualityNet Report - Check Submitted Cases

After your data is submitted to the QualityNet warehouse you will get confirmation that data was received. To check and make sure the data was accepted and not rejected, run the Case Status Summary Report out of QualityNet. Reports are located through the QualityNet Secure Portal.

To Run the Case Status Summary Report:

1. Look for My Reports and from the drop-down menu select Run Reports
2. Select Run Reports from the I'd Like To…. list
3. Select IQR from the Report Program drop-down menu
4. Select Hospital Reporting – Feedback Reports from the list in the Report Category drop-down menu
5. Select View Reports to display a list of report names
6. Select Hospital Reporting – Case Status Summary Report under Report Name
7. Select the quarter and measure sets for the data you have just submitted
8. Select Run Reports at the bottom of the screen
9. If the report shows cases have been rejected, run the Submission Detail Report. This report will show you why the case is being rejected. Correct and submit any applicable cases.

Do not wait until right before the due date to submit and check on data. Once the due date has passed, no further data will be accepted for the quarter.

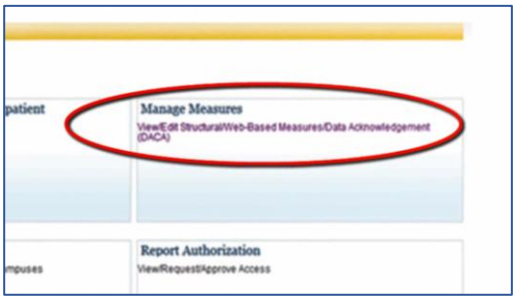
Submitting OP-22

OP-22 is uploaded on an annual basis the same time every year.

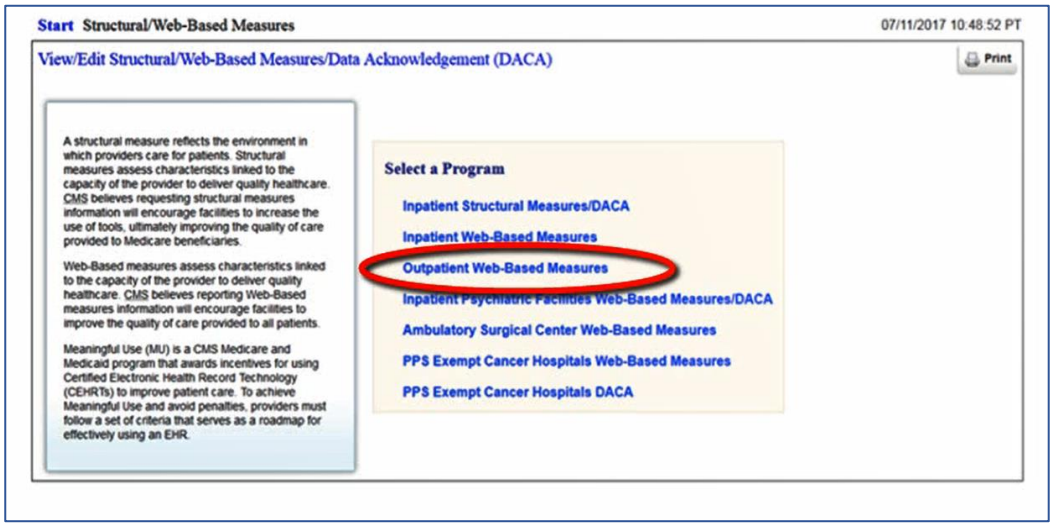
To view a tutorial video on this unique submission process follow the link below:

https://www.qualitynet.org/training-guides

Towards the bottom is “Outpatient Quality Reporting (OQR) Web-Based Measures” this is the video you want. At about 3 minutes it describes how to find the measures within the secure portal so you can enter data. At 10 min it will go into entering the data for OP-22.

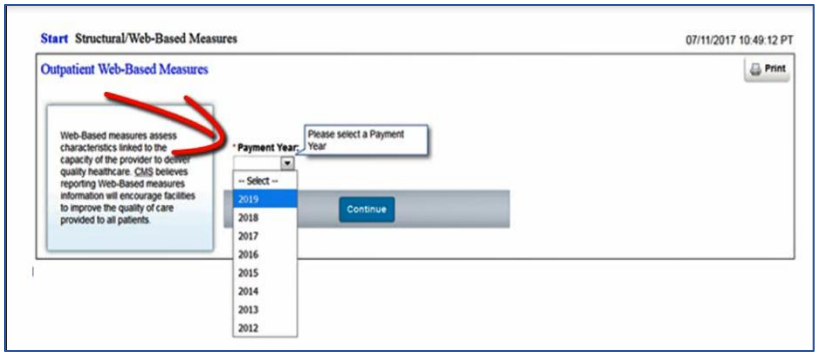


After you log in to QualityNet you will navigate to “My Tasks” page. Then click “View/Edit…” under the Manage Measures section. If you have access to more areas it will bring you to the programs page where you will select Outpatient Web-Based Measures (If you don’t have access to this it will take you directly to the payment year selection).



You will only see this page if you have access. If not you will skip this step.

Select **Outpatient Web-Based Measures**

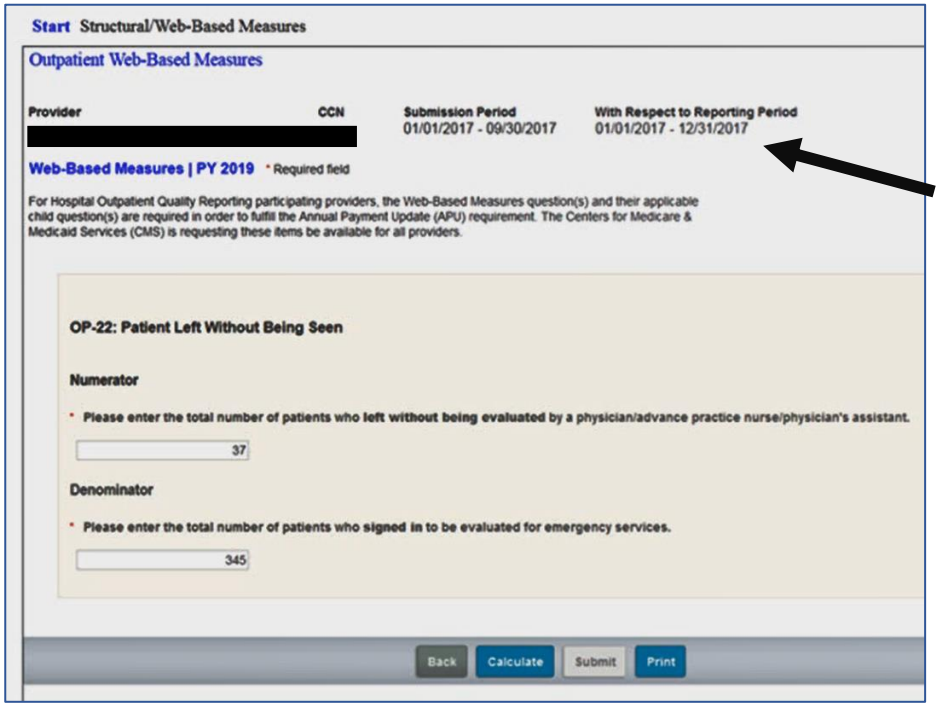


Even if you get to skip the previous step you will be taken to the payment year selection page. This can be confusing.

To report May 15, 2019 for data from the previous year (patients who left without being seen in 2018) you will select Payment Year 2020.

Select your payment year and click continue.

You will then be taken to a page that shows all the web based measures and whether they are completed. You will select OP-22. Again you may skip this step if you don't have access. After this step (if you see that page) you will be taken to submit your data.



This is what your submission page will look like.

You want to make sure your reporting period range matches the year your data is from (again patients left without being seen in 2017 should match this here)

If it does not match change your payment year.

You will enter your numerator and denominator which you can get directly from your EHR or tracking system.

If you are in the wrong payment year your Numerator and Denominator boxes will be grayed out and won't let you submit data. This is another way to see if you have chosen the wrong payment year. It is confusing and doesn't exactly make sense to some, but you are not alone in choosing the wrong year more than once.

Once your data is submitted you are good for another year!

Fibrinolytic Therapy Received within 30 Minutes

OP-2 Fibrinolytic Therapy Received Within 30 Minutes	
MBQIP Domain	Outpatient CORE MEASURE
Measure Set	AMI
Measure Description	Percentage of outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival.
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	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital 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 Initial ECG Interpretation Outpatient Encounter Date Reason for Delay in Fibrinolytic Therapy
Encounter Period – Submission Deadline	Q1 2020 (Jan 1- Mar 30) – August 1, 2020 Q2 2020 (Apr 1 - Jun 30) – November 1, 2020 Q3 2020 (Jul 1 - Sep 30) – February 1, 2021 Q4 2020 (Oct 1- Dec 31) – May 1, 2021
Other Notes	None

Median Time to Transfer to another Facility for Acute Coronary Intervention

OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention	
MBQIP Domain	Outpatient CORE MEASURE
Measure Set	AMI
Measure Description	Median number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital. Note: Hospital Compare described measure as "average number of minutes"
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 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	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital 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 Initial ECG Interpretation Outpatient Encounter Date Reason for Not Administering Fibrinolytic Therapy Transfer for Acute Coronary Intervention
Encounter Period – Submission Deadline	Q1 2020 (Jan 1- Mar 30) – August 1, 2020 Q2 2020 (Apr 1 - Jun 30) – November 1, 2020 Q3 2020 (Jul 1 - Sep 30) – February 1, 2021 Q4 2020 (Oct 1- Dec 31) – May 1, 2021
Other Notes	None

Median Time from ED Arrival to ED Departure for Discharged ED Patients

OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients	
MBQIP Domain	Outpatient CORE MEASURE
Measure Set	ED Throughput
Measure Description	Average time patients spent in the emergency department before being sent home
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	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital 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 2020 (Jan 1- Mar 30) – August 1, 2020 Q2 2020 (Apr 1 - Jun 30) – November 1, 2020 Q3 2020 (Jul 1 - Sep 30) – February 1, 2021 Q4 2020 (Oct 1- Dec 31) – May 1, 2021
Other Notes	None

Median Time from ED Arrival to ED Departure for Discharged ED Patients

OP-22 Patient Left Without Being Seen	
MBQIP Domain	Outpatient CORE MEASURE
Measure Set	ED Throughput
Measure Description	Percentage of patients who left the emergency department before being seen.
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	QualityNet via Secure Portal Log In
Data Available On	Hospital 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 – Submission Deadline	Q1-Q4 2020 (Jan-Dec) – May 15, 2021 Q1-Q4 2021 (Jan-Dec) – May 15, 2022
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

Optional Reporting Measures

Additional MBQIP measures are included after the core measures grid in the MBQIP section. These measures are optional and are included so that Flex Programs can elect to support these in addition to core measures. Although important, they are not applicable across all critical access hospitals so they are not included in the MBQIP core measures.

You may already be reporting these for other programs, organizations, or agencies. Some facilities are reporting some of these optional measures to the Washington State Hospital Association (WSHA) for the Partnerships for Patients programs. For more information see the information page in the resource section of this manual.

We can offer some technical assistance for these measures, but we do not currently receive your data for these measures and will often need to refer you to the responsible organization or agency that is collecting this data.

Additionally, reporting these measures do not count towards the minimum reporting requirements to be eligible for the Flex program. We love to hear that you are reporting these measures, but if you are not meeting the minimum core measure reporting requirement, your facility has the potential to be removed from the MBQIP and Flex program.

The following pages are “Cheat Sheets” for these optional measures. We suggest referencing the Specification Manuals found on the QualityNet website for additional information.

www.qualitynet.org

PC-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 5% 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 results in more cesarean births and longer maternal length of stay.
Improvement Noted As	Decrease in the rate
Data Reported To	QualityNet via an Online Tool
Data Available On	Hospital 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	Retrospective data sources for required data elements include administrative data and medical records
Data Elements	Admission Date, Discharge Date Birthdate, 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 – Submission Deadline	Q1 2020 (Jan 1- Mar 30) – August 15, 2020 Q2 2020 (Apr 1 - Jun 30) – November 15, 2020 Q3 2020 (Jul 1 - Sep 30) – February 15, 2021 Q4 2020 (Oct 1- Dec 31) – May 15, 2021
Other Notes	Inpatient Web-Based Measure

HAI – 1 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	Hospital 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 – Submission Deadline	Q1 2020 (Jan 1- Mar 30) – August 15, 2020 Q2 2020 (Apr 1 - Jun 30) – November 15, 2020 Q3 2020 (Jul 1 - Sep 30) – February 15, 2021 Q4 2020 (Oct 1- Dec 31) – May 15, 2021
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

HAI – 2 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	Hospital 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 – Submission Deadline	Q1 2020 (Jan 1- Mar 30) – August 15, 2020 Q2 2020 (Apr 1 - Jun 30) – November 15, 2020 Q3 2020 (Jul 1 - Sep 30) – February 15, 2021 Q4 2020 (Oct 1- Dec 31) – May 15, 2021
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

HAI – 6 CDI	
MBQIP Domain	Patient Safety/Inpatient, ADDITIONAL MEASURE
Measure Set	Healthcare Acquired Infections (HAI)
Measure Description	Clostridium difficile – Laboratory identified events (Intestinal infections)
Importance/Significance	Clostridium 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 Ratio
Data Reported To	National Healthcare Safety Network (NHSN) Website
Data Available On	Hospital 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 – Submission Deadline	Q1 2020 (Jan 1- Mar 30) – August 15, 2020 Q2 2020 (Apr 1 - Jun 30) – November 15, 2020 Q3 2020 (Jul 1 - Sep 30) – February 15, 2021 Q4 2020 (Oct 1- Dec 31) – May 15, 2021
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

HAI – 5 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	Hospital 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 – Submission Deadline	Q1 2020 (Jan 1- Mar 30) – August 15, 2020 Q2 2020 (Apr 1 - Jun 30) – November 15, 2020 Q3 2020 (Jul 1 - Sep 30) – February 15, 2021 Q4 2020 (Oct 1- Dec 31) – May 15, 2021
Other Notes	Training materials/reporting instructions can be found on the NHSN website.

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Section 5 - Resources

MBQIP Measure Change Summary – Removal of ED-1, ED-2, and IMM2

September 2018

CMS has announced that three chart-abstracted inpatient measures that are currently required for MBQIP will be removed:

Two of the measures will be removed following Q4 2018 data submission:

IMM-2: Influenza Immunization

ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients

One of the measures will be removed following Q4 2019 data submission:

ED-2: Admit Decision Time to ED Departure Time for Admitted Patients

Submission of IMM-2 and ED-1 will be included in the evaluation of CAH participation in MBQIP for FY 2019, but will be removed from MBQIP evaluation criteria and MBQIP reports starting with Q1 2019 discharges (discharges as of January 1, 2019). CAHs should continue to collect these measures through Q4 2018 discharges (due May 15, 2019). Starting with Q1 2019 discharges, the QualityNet warehouse will no longer be accepting submission of data for these measures.
Submission of ED-2 will be included in the evaluation of CAH participation in MBQIP for FY 2019 and FY 2020, but will be removed from MBQIP evaluation criteria and MBQIP reports starting with Q1 2020 discharges (discharges as of January 1, 2020). CAHs should continue to collect these measures through Q4 2019 discharges (due May 15, 2020). Starting with Q1 2020 discharges, the QualityNet warehouse will no longer be accepting submission of data for these measures.

Background:
As part of the annual rule-making process, CMS regularly removes measures from the Inpatient and Outpatient Quality Reporting programs (IQR, OQR). Once CMS has removed a measure from the IQR or OQR program, it is no longer possible to submit data for this measure to the QualityNet Warehouse. When feasible, FORHP works to align MBQIP measures with other Federal reporting programs. Thus, removal of measures from the IQR or OQR programs typically results in removal of those measures from MBQIP.

CMS indicated that the rational for removing all three of these chart-abstracted measures is that the cost to providers associated with submitting data on the measures outweighs the benefits of their continued use in the program. The ED-1 and ED-2 are also currently available as electronic Clinical Quality measures (eCQMs). Although not part of MBQIP, CAHs are required to submit eCQMs as part of the CMS Promoting Interoperability Program requirements. Additional information on eCQMs for CAHs can be found here. The final rule also provided additional information regarding removal on each of the specific measures.

- **IMM-2: Influenza Immunization** – Hospital performance on IMM-2 is statistically "topped-out" such that performance is so high and unvarying that meaningful distinctions in improvement cannot be made. Furthermore, CMS believes that hospitals will continue the practice of administering influenza vaccinations to patients even after the measure is removed, therefore utility in the program is limited.

- **ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients** – CMS recognizes that ED-1 is an important metric for patients, but noted that ED-2 has greater clinical significance for quality improvement because it provides more actionable information as hospitals have somewhat less control to consistently reduce the wait time between ED arrival and decision to admit due to the need to triage and prioritize more complex or urgent patients. Note that as of CY 2020, ED-1 is also being removed as an eCQM.

- **ED-2: Admit Decision Time to ED Departure Time for Admitted Patients** – The timing of the removal of ED-2 as a chart-abstracted measure aligns with the anticipated availability of validated ED-2 eCQM data. CMS is currently implementing a validation pilot to review the accuracy and completeness of eCQM data in anticipation that eCQM data may be utilized for future public reporting.

MBQIP Measure Change Summary – Removal of OP-5 and Changes to HCAHPS and OP-27

December 2018

The Centers for Medicare & Medicaid Services (CMS) has announced that one chart-abstracted inpatient measures currently required for MBQIP will be removed following Q1 2019 data submission:

OP-5: Median Time to ECG

Submission of OP-5 will be included in the evaluation of CAH participation in MBQIP for FY 2019, but will be removed from MBQIP evaluation criteria and MBQIP reports starting with Q2 2019 discharges (discharges as of April 1, 2019). CAHs should continue to collect this measure through Q1 2019 discharges (due August 1, 2019). Starting with Q2 2019 discharges, the QualityNet warehouse will no longer be accepting submission of data for these measures.

Background

As part of the annual rule-making process, CMS regularly removes measures from the Inpatient and Outpatient Quality Reporting programs (IQR, OQR). Once CMS has removed a measure from the IQR or OQR program, it is no longer possible to submit data for this measure to the QualityNet Warehouse. When feasible, FORHP works to align MBQIP measures with other Federal reporting programs. Thus, removal of measures from the IQR or OQR programs typically results in removal of those measures from MBQIP.

The final rule provided additional information regarding removal and changes to these measures.

- **OP-5: Median Time to ECG** – CMS indicated that the rational for removing this measure is that the cost to providers associated with submitting data outweighs the benefits of its continued use in the program. Based on analysis of data submitted by 1,995 hospitals from Quarter 3 in 2016 through Quarter 2 in 2017, the variation in average measure performance between hospitals is minimal, with a median time to ECG of less than two minutes between the 75th and 90th percentile hospitals. Furthermore, the difference between the 25th and 75th percentile, distinguishing between high and low performers, is only 5.5 minutes. Given clinical guidelines recommend that ECG be obtained within 10 minutes of arrival to the emergency department, CMS does not believe this difference is clinically significant and variations are not sufficiently large to inform beneficiary decision-making to justify the cost of collecting the data.

Changes to MBQIP Core Measures

CMS has also announced the changes below to current MBQIP measures. **Please Note!** These changes will not result in changes to MBQIP Core Measures as far as data submission is concerned.

- **OP-27: Influenza Vaccination Coverage Among Healthcare Providers (HCP)** - Will no longer be a part of the Outpatient Quality Reporting Program. However, this measure is included in the Inpatient Quality Reporting Program under the measure name HCP. Therefore, this will

remain an MBQIP Core Measure under the new name HCP. Data for Q4 2018 through Q1 2019 is due May 15, 2019.

- **HCAHPS Composite 4: Pain Management** – The three recently revised pain communication questions will be removed from the Healthcare Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey beginning with October 2019 discharges. This will not change the status of HCAHPS as a

Interpreting MBQIP Hospital Data Reports for Quality Improvement

This guide was put together by Stratis Health Rural Quality Improvement Technical Assistance (RQITA). You can access this guide here:

https://www.ruralcenter.org/resource-library/interpreting-mbqip-hospital-data-reports-for-quality-improvement

This guide is intended to help critical access hospital (CAH) staff use Medicare Beneficiary Quality Improvement Project (MBQIP) Hospital Data Reports to support quality improvement efforts and improve patient care.

You will receive these reports on a quarterly basis. Because these are coming from the Federal Office there is no way to predict exactly when we will receive these reports. Once received we try to get them dispersed to you as quickly as possible.

If you ever have questions about these reports, find errors, or need assistance, please reach out to the Rural Hospital Quality Improvement Manager as soon as possible.

HCAHPS Vendor List

The Rural Center provides a thorough HCAHPS vendor list for CAHs to utilize when trying to establish or change HCAHPS vendors.

We highly encourage using an HCAHPS vendor due to the numerous and intense rules and requirements CMS has in place for those wishing to administer and compile their own surveys.

If you need assistance in the HCAHPS vendor process please do not hesitate to reach out to the Rural Hospital Quality Improvement Manager.

HCAHPS Vendor List:

https://www.ruralcenter.org/resource-library/hcahps-overview-vendor-directory

Small Rural Hospital Improvement Program (SHIP)

The Washington Flex Program also houses the Small Rural Hospital Improvement Grant Program (SHIP). Although a separate funding source from Flex, we work towards maximizing SHIP funding by pairing activities with Flex in as many ways as possible.

This small grant is awarded to hospitals who will then receive a set amount of funding that is the same amount for all awardees in the state. Hospitals choose activities from a purchasing menu to put the funding towards.

If you have additional questions about your hospital's participation or future participation please reach out to the Rural Hospital Program Manager:

Lindy Vincent
Rural Hospital Program Manager
Lindy.Vincent@doh.wa.gov
360-236-2826

Below are further details on the SHIP grant:

The Small Rural Hospital Improvement Grant Program (SHIP) is supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration's Federal Office of Rural Health Policy (FORHP).

Section 1820(g)(3) of the Social Security Act (SSA) authorizes SHIP to assist eligible hospitals in meeting the costs of implementing data system requirements established under the Medicare Program, including using funds to assist hospitals in participating in improvements in value and quality to health care such as:

- **Value-Based Purchasing Programs (VBP**): Improving data collection activities in order to facilitate reporting to Hospital Compare.
- **Accountable Care Organizations (ACOs) or Shared Savings:** Improving quality outcomes. Focus on activities that support QI such as reduction of medical record errors as well as education and training in data collection, reporting, and benchmarking.
- **Payment Bundling (PB):** Building accountability across the continuum of care. Funding could be used to improve care transitions between ambulatory and acute, acute to upstream acute and acute to step-down facility. This could be done in the form of training, clinical care transition protocol development or data collection that documents these processes.
- **Prospective Payment System:** Maintaining accurate PPS billing and coding such as updating charge master or providing training in billing and coding.

Eligibility for the SHIP grant:

Eligible small rural hospitals are located in the United States and its territories and include hospitals with 49 available beds or less. These small rural, non-federal hospitals provide short-term, general acute care to their communities. They may be for-profit, not-for-profit or tribal organizations. Critical access hospitals are eligible for the program.

In addition:

- SHIP funded investments are prioritized based on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) reporting and ICD-10 coding.
- Hospitals must utilize resources to fully implement ICD-10 coding and HCAHPS reporting to Hospital Compare before the facility can select any other investment options without exceptions.
- Hospitals with low HCAHPS patient volume are still required to report HCAHPS to participate in the SHIP Program.
- Hospitals that do not follow the purchase priorities and/or purchase equipment/services that are not listed on the SHIP Purchasing Menu without prior approval may be subject to penalties including exclusion from the next SHIP funding opportunity.
- SHIP funds are to be used during the Fiscal Year in which they are received. If they are not used or requested, then the hospital may be excluded from the next SHIP funding opportunity.
- Hospitals already implemented ICD-10 coding and reporting HCAHPS to Hospital Compare may select other investments and training options. CAHs must continue to participate in MBQIP.
- Hospitals may request approval from the state SHIP Coordinator / SORH for changes to the SHIP investment(s) and activities.
- Hospitals must submit a request for approval before changing investments and activities prior to the mid-year point. No changes can be made to the SHIP investment(s) and activities at or after the mid-year point.
- Hospitals must be able to utilize resources to demonstrate and report outputs/outcomes to the SORH, and show the impact of the SHIP investment through progress reporting, tracking appropriate measures and report progress at the end of the award year.

For more resources and information please visit: https://www.ruralcenter.org/ship

Quality Health Indicators (QHi)

About QHi

Quality Health Indicators (QHi) is an economical, quality benchmarking program specifically designed, developed and driven by small rural hospitals and rural health clinics to compare selected performance measures with other similar hospitals and clinics.

The program was developed through a partnership of the Kansas Rural Health Options Project (KRHOP), Kansas Department of Health and Environment Office of Rural Health (KDHE), Kansas Hospital Association (KHA) and the Kansas Hospital Education and Research Foundation (KHERF).

Participating hospitals and clinics benchmark against self-defined peer groups to learn from the best practices of other organizations to facilitate the adoption of new processes in four categories of measures:

- Clinical Quality
- Employee Contribution
- Financial and Operational
- Patient Satisfaction

QHi allows small rural hospitals and clinics to:

- Collect, track and trend data unique to their specific environment
- Evaluate current performance every month and integrate successful solutions from other benchmark hospitals and clinics
- Participate in a nationally recognized initiative to demonstrate healthcare quality in rural America

Registering and Using Quality Health Indicators

This is a benchmarking system we provide to CAHs using Flex funding. You will need a log in to submit data through this method.

If not a current user, or if wishing to obtain a log in please contact the Rural Hospital Quality Improvement Manager (RHQIM). You will need to complete a point of contact form.

Once you have gained access you can begin to explore uploading your data.

QHi allows you to:

- Directly upload EDTC data using the final report the StratisHealth Abstraction Tool final report.
- Directly upload CART abstractions for inpatient and outpatient data.
- You can also hand enter your financial and employee data for benchmarking.

After gaining access we offer individual walk throughs of the system and frequent refresher webinars. Please request a 1:1 guided session through the RHQIM whenever you are ready.

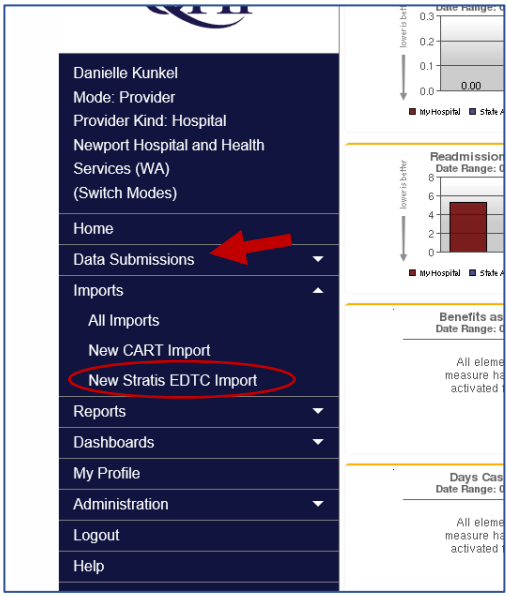
https://www.qualityhealthindicators.org/account/login

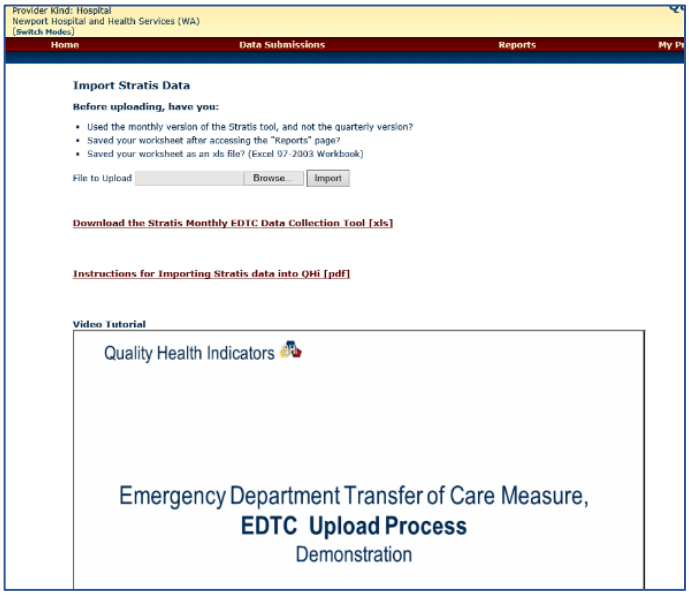
This is the log in page (see link above).

Log in.

Below are the instructions for uploading EDTC data to QHi:

This is your main page when you log in. You will want to go to the left side menu and select imports.





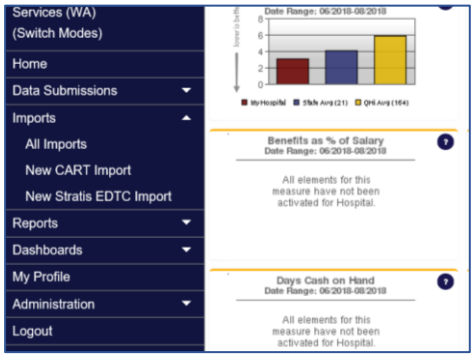
This will take you to a page that allows you to upload your Stratis abstraction tool final report. What is useful with QHi is you can upload monthly rather than having to wait until the end of the quarter. This page has a video tutorial as well as instructions and a link to download the tool if you haven't already done so from the Stratis site.

You will see on the left menu where you selected New Stratis EDTC Import there is also a place to import your CART data. You are more than welcome to upload your CART data which allows you to do so monthly and create a wide variety of reports and charts with your data as well as benchmark yourself with the other state CAHs and all CAHs in QHi.

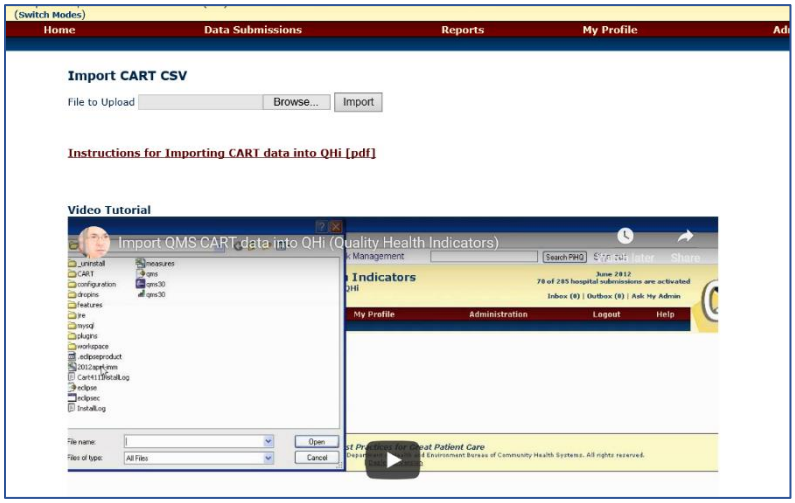
Disclaimer:

Uploading CART data to QHi DOES NOT upload your data to QualityNet and CMS will not receive your data. This program is simply a benchmarking system which allows you to do more with your data.

Below are instructions for finding information on uploading inpatient and outpatient CART abstractions:



You will see just like with uploading EDTC you will log in and select New CART Import from under the Imports Tab on the left side menu bar.



Once selected you will see PDF instructions as well as a video tutorial.

We can also do a 1:1 virtual walk through of this process by request.

Hospital Compare

https://www.medicare.gov/hospitalcompare/search.html?

Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals, including over 130 Veterans Administration (VA) medical centers, across the country. You can use Hospital Compare to find hospitals and compare the quality of their care.

The information on Hospital Compare:

- Helps patients make decisions about where to get their health care
- Encourages hospitals to improve the quality of care they provide

Hospital Compare was created through the efforts of the Centers for Medicare & Medicaid Services (CMS) in collaboration with organizations representing consumers, hospitals, doctors, employers, accrediting organizations, and other federal agencies.

Please contact your State Survey Agency (CASPER/ASPEN Contact) if:

- Your hospital's administrative data (name, address, phone number) is incorrect
  - (Please note: If your hospital's address is listed as a PO Box or by cross streets, we strongly suggest that you list an exact address in the Medicare survey and certification database. This helps ensure that the Google Maps function on Hospital Compare will accurately show your location);
- You are a Medicare or Medicaid certified hospital but aren't listed in this database
- You are a Medicare certified agency but aren't listed in this database.

To find your CASPER/ASPEN contact visit:
https://www.medicare.gov/hospitalcompare/Resources/CASPER.html

For any other data issues on Hospital Compare, please contact your Quality Improvement Organization (QIO):

http://www.qualitynet.org/dcs/ContentServer?cid=1228774346757&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page

Partnership for Patients

Partnership for Patients is a CMS contract that was awarded to 16 Hospital Improvement Innovation Networks (HIIN).

The Partnership for Patients is focused on making hospital care safer, more reliable, and less costly through the achievement of two goals:

- **Making Care Safer.** Preventing hospital-acquired conditions.
- **Improving Care Transitions.** Preventing complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced.

Patient Safety Areas of Focus

All 16 HIINs are working on 11 core measures and most are working on additional areas.

To learn more about the areas of focus: https://partnershipforpatients.cms.gov/about-the-partnership/what-is-the-partnership-about/lpwhat-the-partnership-is-about.html

To see the list of HIINs: https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html

The HIINs will continue to evaluate the capacity of large improvement networks to bring about improvement in patient safety. In an effort to bring about improvement in patient safety, the HIINs will continue to evaluate the capacity of large improvement networks by focusing on the following required

11 core areas of harm:

1. Adverse drug events (ADE), including at a minimum, opioid safety, anticoagulation safety, and glycemic management
2. Central line-associated blood stream infections (CLABSI), in all hospital settings, not just Intensive Care Units (ICUs)
3. Catheter-associated urinary tract infections (CAUTI), in all hospital settings, including avoiding placement of catheters, both in the ER, and in the hospital Central line-associated blood stream infections (CLABSI), in all hospital settings, not just Intensive Care Units (ICUs)
4. Clostridium difficile (C. diff) bacterial infection, including Antibiotic Stewardship
5. Injuries from falls and immobility
6. Pressure Ulcers
7. Sepsis and Septic Shock
8. Surgical Site Infections (SSI), to include measurement and improvement of SSI for multiple classes of surgeries
9. Venous thromboembolism (VTE), including, at a minimum, all surgical settings
10. Ventilator-Associated Events (VAE), to include Infection-related Ventilator-Associated Complication (IVAC) and Ventilator-Associated Condition (VAC)
11. Readmissions

In addition to these core eleven topics, HIINs are expected to address all other forms of preventable patient harm in pursuit of safety across the board and additional areas in pursuit of the reduction of all-cause harm for Medicare beneficiaries.

Additionally, the following are some additional harm topics and measurement approaches HIINs may consider:

- Multi-Drug Resistant Organisms (e.g. VRE, CRE, MRSA, etc.)
- Diagnostic Errors
- Addressing Malnutrition in the Inpatient Setting
- Airway Safety
- Iatrogenic Delirium
- Undue Exposure to Radiation
- Hospital Culture of Safety
- Developing a metric to measure and report on all-cause harm within the HIIN network, directly reflecting the metric used to track progress on the national aims

The HIIN for Washington State is the Washington State Hospital Association (WSHA). The WSHA HIIN is comprised of 119 hospitals (22 in Alaska, 9 in Oregon, the remaining in Washington).

While all Washington hospitals are members of WSHA, not all are part of our HIIN – UW Medical Center, UW Harborview, Seattle Children's, and a couple others are part of other HIINs (such as one's that are mainly academic hospitals).

The vast majority of Washington hospitals are, however, part of WSHA's HIIN. The contract requires them to achieve a 20% reduction in harm in each of these areas (except readmissions which is 12%). Hospitals are not technically required to participate but they have very high engagement from hospital leaders and quality leaders. This program benefits all hospitals by having access to WSHA's support and rapid sharing of best practices. WSHA collects data on each measure in various ways and compiles that data to report to CMS each month along with a narrative report about what they have done for each measure to work to achieve target performance.

If you need technical assistance with reporting this data please reach out to your WSHA contacts. If you request TA from DOH we will connect you to WSHA.

Current Contact:

Tianna Fallgatter, MPH
Rural Program Manager
Washington State Hospital Association
Phone: (206) 216-2536
TiannaF@wsha.org

MBQIP Acronyms

AA Aortic aneurysm

ADE Adverse drug events

AFIB Atrial fibrillation

AHA American Hospital Association

AHRQ Agency for Healthcare Research and Quality

AMI Acute myocardial infarction

CAC Children's asthma care

CAH Critical access hospital

CAP Community-acquired pneumonia

CART CMS Abstraction and Reporting Tool

CAUTI Catheter-associated urinary tract infection

CCN CMS certification number

CDC Centers for Disease Control and Prevention

CDE Common duct exploration

C.Diff/CDI Clostridium difficile

Chole Cholecystectomy

CLABSI Central line-associated blood stream infection

CMS Centers for Medicare & Medicaid Services

COPD Chronic obstructive pulmonary disease

CQM Clinical quality measure

CT Computerized tomography

DACA Data Accuracy and Completeness Acknowledgement

DVT Deep vein thrombosis

ECG Electrocardiogram

eCQM Electronic clinical quality measure

ED Emergency department

EDHI Early hearing detection and intervention

EDTC Emergency Department Transfer Communication

EHR Electronic health record

MBQIP and Other Quality Reporting Acronyms

Rural Quality Improvement Technical Assistance, www.stratishealth.org 2

EMS Emergency medical service

ESI Emergency Severity Index

Flex Medicare Rural Hospital Flexibility Program

FORHP Federal Office of Rural Health Policy

FY Fiscal year

GI Gastrointestinal

HAI Healthcare-associated infections

HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems

HCP Healthcare personnel

HIIN Hospital Improvement and Innovation Network

HIQR Hospital Inpatient Quality Reporting Program

HF Heart failure

HIP-KNEE Total hip arthroplasty and/or total knee arthroplasty

HOQR Hospital Outpatient Quality Reporting Program

HRET Health Research & Education Trust

HRSA Health Resource and Services Administration

HTN Hypertension

HWR Hospital-wide all-cause unplanned readmission

ICU Intensive Care Unit

IMM Immunization

IQR Inpatient Quality Reporting

IVAC Infection-related ventilator-associated complications

IVR Interactive Voice Response

MBQIP Medicare Beneficiary Quality Improvement Project

MMA Medicare Prescription Drug Improvement and Modernization Act

MORT Mortality

MOU Memorandum of Understanding

MRI Magnetic Resonance Imaging

MSPB Medicare spending per beneficiary

MRSA Methicillin-resistant Staphylococcus aureus

NHSN National Healthcare Safety Network

NoP Notice of Participation

ONC Office of the National Coordinator for Health Information Technology

MBQIP and Other Quality Reporting Acronyms

Rural Quality Improvement Technical Assistance, www.stratishealth.org 3

OP Outpatient

OQR Outpatient Quality Reporting

P4P Partnership for Patients

PC Perinatal Care

PCI Primary percutaneous coronary intervention

PE Pulmonary embolism

PN Pneumonia

PI Promoting Interoperability

POD Postoperative day

PPS Prospective Payment System

PSI Patient Safety Indicators

QIN-QIO Quality Innovation Network – Quality Improvement Organization

QMP Qualified medical professional

QRDA Quality reporting document architecture

READM Readmission

RN Registered nurse

SA System administrator

SCIP-Inf Surgical care improvement project-infection

Sfusion Spinal fusion

SSI Surgical site infection

STEMI ST-Segment Elevation Myocardial Infarction

THA Total hip arthroplasty

TKA Total knee arthroplasty

UTI Urinary tract infection

VAE Ventilator-associated event

VBP Value-Based Purchasing

VTE Venous thromboembolism

Return to Table of Contents

Log In Tracking

Use this space to keep track of your log ins and when you need to change passwords. It's important to log into systems at least once a month to ensure you don't lose access.						
System	Name	Username	Password	Last Updated	Update Next	Notes
NHSN						
QualityNet						
CART Inpatient						
CART Outpatient						
Quality Health Indicators						
Miscellaneous						

Return to Table of Contents

Resource Links

Flex Eligibility Criteria and Waiver Templates

https://www.ruralcenter.org/resource-library/flex-eligibility-criteria-for-mbqip-participation-and-waiver-templates

MBQIP Acronyms List and Measure Change Summaries

https://www.ruralcenter.org/resource-library/mbqip-fundamentals-guide-for-state-flex-programs

MBQIP Frequently Asked Questions

https://www.ruralcenter.org/tasc/mbqip/faq

MBQIP Key Resource List

https://www.ruralcenter.org/tasc/mbqip/key-resource-list

MBQIP Program

https://www.ruralcenter.org/tasc/mbqip

NHSN Homepage

https://www.cdc.gov/nhsn/index.html

QualityNet Homepage

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetHomepage&cid=1120143435383

Section 6 – Contact Lists

Your Current Rural Hospital Quality Improvement Manager:

(The individual to contact about any information listed in this manual)

Danielle Kunkel MPH CHES CPH
Rural Hospital Quality Improvement Manager
Office of Community Health Systems, Rural Health Section
Washington State Department of Health
Danielle.Kunkel@doh.wa.gov
Office: 360-915-5135
Fax: 360-236-2830

Your Current Rural Hospital Program Manager:

Lindy Vincent
Rural Hospital Program Manager
Office of Community Health Systems, Rural Health Section
Washington State Department of Health
Lindy.Vincent@doh.wa.gov
Office: 360-236-2826
Fax: 360-236-2830

Office of Rural Health Contact List

Below is information for all contacts within the Office of Rural Health at the Washington State Department of Health and their areas of expertise. If you have questions outside of MBQIP and quality data reporting you can reach out to these people directly or contact the Rural Hospital Quality Improvement Manager to find the best fit.

Pat Justis

Executive Director - Rural Health Director, State Office of Rural Health

360-236-2805 | patricia.justis@doh.wa.gov

- Provides oversight of rural and underserved programs that work with rural health clinics, critical access hospitals, federally qualified health centers and free clinics
- Consults on state and national rural health policy
- Leads WA Rural Palliative Care Initiative

Lindy Vincent Rural Hospital Program Manager

360-236-2826 | lindy.vincent@doh.wa.gov

- Rural Hospital Flexibility Grant program manager (Flex)
- Small Hospital Improvement Program (SHIP)
- Assists with resources, regulations, quality, operational, and financial improvement for critical access hospitals

Danielle Kunkel Rural Hospital QI Manager

360-915-5135 | danielle.kunkel@doh.wa.gov

- Provides assistance to CAH staff in quality improvement and change management
- Assists CAHs with Medicare Beneficiary Quality Improvement Project (MBQIP) and other quality work

Sigrid Reinert State Office of Rural Health Grant Manager

360-236-2856 | sigrid.reinert@doh.wa.gov

- Connects rural communities with federal grants, resources and programs
- Provides consultation to rural health clinics

Claudia Shanley Workforce Director

360-236-2814 | claudia.shanley@doh.wa.gov

- Leeds efforts to increase resources for workforce recruitment and develop workforce policy.
- Liaison to Washington State Health Professional Work Corps Program and other statewide workforce activities.

Sam Watson-Alvan Primary Care Office Manager

360-236-2812 | sam.watson-alvan@doh.wa.gov

- Provides assistance to community health clinics, federally qualified health centers, free clinics and tribal health clinics
- Conducts advocacy, policy work and consults on primary care access on behalf of underserved and uninsured populations
- Oversees Volunteer and Retired Provider Program

Amanda Latchaw Rural Health Program Manager

360-236-2862 | amanda.latchaw@doh.wa.gov

- Provides assistance to sites and providers interested in the National Health Service Corps program
- Manages the J-1 Visa Waiver Program for foreign-trained physicians
- Provides project management skills and topic expertise for a changing portfolio of initiatives including the WA Rural Palliative Care Initiative

Faith Johnson Workforce Advisor

360-236-2815 | faith.johnson@doh.wa.gov

- Recruits primary care providers for areas of need
- Assists candidates to define where they want to practice and live
- Helps communities develop recruitment strategies

Claire Horton Oral Health Consultant

360-236-2819 | claire.horton@doh.wa.gov

- Assists Rural Health Clinics to integrate oral health services
- Supports improved dental access in rural communities and contributes to workforce efforts in dental professions

Terri McReynolds Administrative Assistant

360-236-2804 | terri.mcreynolds@doh.wa.gov

- Provides administrative support to staff members

Kassie Clarke Palliative Care Project Manager

kassie.clarke@doh.wa.gov

- Provides support to the Rural Palliative Care Project

Randy Saylor Healthcare Analyst

360-236-2865 | randall.saylor@doh.wa.gov

- Conducts healthcare access surveys and performs Health Professional Shortage Area analysis
- Manages Washington State's Adverse Health Events and Incident Reporting System

Section 7 – FAQ

Does every CAH have to report on these measures?

Participation in MBQIP is voluntary, but FORHP is asking that every hospital that is able, participate in and report on these measures. CAHs wishing to participate in any Flex funded activities must meet the MBQIP participation requirements.

How is MBQIP participation defined?

To be eligible to benefit from Flex grant funds and participate in Flex funded activities, CAHs must meet annual MBQIP participation requirements set out by the Federal Office of Rural Health Policy (FORHP), or have completed the necessary MBQIP Waiver. FORHP is implementing a phased approach when determining the minimum level of reporting requirements in MBQIP for participation in Flex-funded activities, with requirements increasing each year after 2015.

Does MBQIP replace the CMS Hospital Quality Measures?

No. Except for the EDTC and antibiotic stewardship measures, MBQIP core measures are a subset of measures from the CMS Hospital Inpatient and Outpatient Quality Reporting Programs. Hospitals currently reporting additional CMS measures are encouraged to continue that process.

How were the MBQIP measures selected?

FORHP selected the current measures with the input of rural experts who have worked with or within CAHs, including CAH quality administrators, the Flex Monitoring Team (FMT), state Flex Coordinators and rural clinical experts. FORHP adds measures to MBQIP as needed based on alignment with other Federal quality reporting programs, with a strong preference for standardized measures that are supported by a national reporting system. The measures are intended to remain consistent, but updates and adjustments are made regularly to ensure that measures continue to align with national quality priorities and reporting systems. For more information about how measures are added and removed from MBQIP, see the MBQIP Fundamentals Guide for State Flex Programs.

With a small caseload, does it make sense to have CAHs publicly report?

Yes. Public reporting of quality data is not going away and is increasingly being tied to reimbursement from a variety of payers. It is to the advantage of CAHs to participate in public reporting to demonstrate the quality of services they provide and ensure preparedness for future payer requirements.

Hospitals with low volumes should report all of their cases; for MBQIP, there is no minimum required number of cases. While available to hospitals at the individual level, MBQIP data is aggregated at the state and national level, providing FORHP the ability to show a more robust picture of the quality of care being provided in CAHs. The aggregation addresses the small caseload issues faced by individual CAHs, as the small numbers in each CAH add up to many patients receiving care in rural hospitals for each state and the nation as a whole.

What is "Population and Sampling" and is it required for CAHs participating in MBQIP?

Population and Sampling refers to the recording of the number of cases the hospital is submitting to the QualityNet Warehouse. This is done directly through the QualityNet Secure Portal. Entering a "zero" (0) when appropriate in population and sampling data is a mechanism that allows CAHs to report that they had no eligible cases for a measure set in a given quarter. CAHs are strongly encouraged to submit their population and sample size counts each quarter, but reporting of population and sampling data is not required for data to be submitted to CMS.

Who will have access to the data? How are reports produced?

CAHs, state Flex Coordinators, FORHP, and relevant parties such as FMT, Rural Quality Improvement Technical Assistance (RQITA) and TASC have access to hospital-level data submitted through QualityNet, the National Healthcare Safety Network, and state Flex programs for all hospitals participating in MBQIP. MBQIP data reports are provided to FORHP through a contract with Telligen, the CMS data warehouse contractor that has proprietary privileges to collect and store the data.

Will MBQIP data be shared publicly on Hospital Compare?

For inpatient quality data to be shared publicly on Hospital Compare, hospitals must complete the Inpatient Quality Reporting Program Notice of Participation (NOP) and must not opt out of publicly reporting inpatient quality data. If a CAH has completed the NOP and has not opted to suppress their quality data, then inpatient data submitted to QualityNet and/or NHSN is eligible to be posted to Hospital Compare so long as the necessary volume thresholds are met.

In the Fiscal Year (FY) 2019 Outpatient Prospective Payment System (OPPS) Proposed Rule, the Centers for Medicare & Medicaid Services (CMS) propose removing the NOP requirement for the Outpatient Quality Reporting Program. If this proposed change is finalized, all outpatient data reported to QualityNet is eligible to be posted to Hospital Compare so long as the necessary volume thresholds are met.

Please note, as of FY2016, hospitals participating in the Small Rural Hospital Improvement Grant Program (SHIP) are required both to conduct HCAHPS and to opt to publicly report HCAHPS data by completing the Inpatient Quality Reporting Program NOP. By doing so, all inpatient data reported to QualityNet is eligible for publishing on Hospital Compare so long as the necessary volume thresholds are met as determined by CMS.

The CAH says they are participating in HCAHPS, why does their data not show up in the MBQIP Patient Engagement (HCAHPS) reports?

There are several possible reasons:

- HCAHPS data in the MBQIP reports reflect the most recent four quarters. Thus, CAHs must have at least four consecutive quarters of HCAHPS data reported before they are included in the MBQIP Data Reports
- Some HCAHPS vendors have not been submitting CAH HCAHPS data, and/or are using vendor identified volume thresholds for submission (and CAHs may not always meet that threshold). CAHs should check with their HCAHPS vendor to ensure the vendor is submitting HCAHPS data to QualityNet on their behalf (and if not, request that they do so).

- If the CAH recently converted, or had an ownership change that resulted in a change to their CMS Certification Number (CCN number), they must have at least four consecutive quarters of HCAHPS data under their new CCN number before the data will appear in the reports

The MBQIP reports indicate my HCAHPS scores are adjusted – what does that mean?

HCAHPS survey results are adjusted for patient-mix and mode of data collection to help ensure that differences in HCAHPS results reflect differences in hospital quality. Only the adjusted results are publicly reported and are considered the official results. Several questions on the survey, as well as items drawn from hospital administrative data, are used for the patient-mix adjustment. Examples of factors used for adjustment include the mode of survey implementation (mail, phone, mixed, interactive voice response) and patient-mix such as age, education, self-rated health, language, and under which service line they received care (surgery, maternity, medical). Neither patient race nor ethnicity is used to adjust HCAHPS results. The adjustment model also addresses the effects of non-response bias.

What is the difference between "0", "N/A" and "D/E" on the MBQIP Data Reports?

Zero (0) means that the CAH entered a zero into the population and sampling grid on QualityNet, indicating there were no eligible patients in a measure set population for the reporting quarter.

N/A (Not available) can mean two different things:

- Data were not submitted/reported by the CAH
- Data were submitted by the CAH but was rejected/not accepted into the QualityNet Warehouse. The MBQIP Quality Reporting Guide includes instructions on how to run a case status summary report to ensure that data has been accepted to the QualityNet Warehouse

Note: If the CAH had no eligible cases in a quarter to submit, but did not enter a zero (0) into population and sampling (see below), the report will indicate N/A.

D/E (data excluded) means that the CAH submitted eligible cases to QualityNet. Data were considered submitted and accepted to the QualityNet Warehouse; however, case(s) were excluded from a particular measure.

Because of the small volumes in some CAHs, one case can skew performance data significantly. How can hospitals address this issue?

MBQIP is an initiative to encourage all CAHs to report their data, regardless of how many patients they have, and FORHP recognizes the issues variation when reporting small volumes. While it is true that a percentage at the individual hospital level is not significant with such low volumes, it is important to remember that each number is a patient. Whether one out of four patients does not receive the recommended care, or one out of 400, hospitals should be using the data to determine which processes should be improved to ensure that every patient receives the highest quality care.

Note that while MBQIP eligibility requires hospitals to report data publicly, Hospital Compare suppresses data if certain volume thresholds are not met.