



Interpreting MBQIP Hospital Core Measures Reports for Quality Improvement

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Overview

About MBQIP

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

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

Purpose of this Guide

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

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

Measures included in the MBQIP Data Interpretation Guide

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

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

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

Data Exceptions and Labels on MBQIP Hospital Core Measures Reports

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

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

Interpreting Reports to Support Improvement

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

Lack of Consistent Process

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

Process May Need Adjustment

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

Understanding Variation

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

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

Considerations for Timing Measures

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

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

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

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

Organization of the Report

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

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

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

Using Comparison Data for Patient Safety/Inpatient and Outpatient Measures

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

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

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

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

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

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

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

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

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

Using Patient Experience Core Measures/HCAHPS Reports

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

Using Comparison Data for HCAHPS Measures

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

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

- Note: Beginning with data reports reflecting Q1 2019 - Q4 2019 HCAHPS data, state and national rates in the Patient Experience Core Measures/HCAHPS Reports represent just CAHs in the state and nation. CMS Care Compare is the best source for state and national rates that include PPS hospitals as well, but data may be a bit older than what is included in Patient Experience Core Measures/HCAHPS Reports.
- HCAHPS data are presented as a [rolling four quarters](#) (see the sample Patient Experience Core Measures/HCAHPS Report in [Appendix A](#)) and each report represents the most recent rolling four quarters available, so it will take time to see improvements/changes in the data. To look at HCAHPS performance over time, you can compare Patient Experience Core Measures/HCAHPS Reports from different time periods. If quarterly reports are available from the survey vendor (or through the internal processes if a vendor is not used) those reports may be more useful for evaluating changes resulting from specific initiatives or efforts that have been launched. Always use caution when interpreting data from individual quarters, as the number of surveys completed in any individual quarter may be small.
- Not all hospitals will be given an HCAHPS Star Rating. Hospitals must have 100 completed surveys in a rolling four quarter period to have an HCAHPS Star Rating calculated. Hospitals that generally have near 100 completed surveys in such a time period may have no Star Rating for some time periods that dip slightly below 100 completed surveys.
- The data publicly reported on Hospital Compare includes percentage of “Always”, “Yes”, “Yes Definitely” and “9” or “10” ratings depending on the type of question for the most recent rolling four quarters. These are known as the [top box](#) scores.

Interpreting Patient Experience Core Measures/HCAHPS Reports to Support Improvement

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

[Example D](#): Opportunity for Improvement

In this example of the HCAHPS [composite](#) scores for Composites 1 through 3:

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

[Example E](#): Calculating the Number of Patients

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

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

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

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

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

Using Care Transition Core Measures/EDTC Reports

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

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

Using Comparison Data for the EDTC Measure

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

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

Interpreting Care Transition Core Measures/EDTC Reports to Support Improvement

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

Example F: Opportunity for Improvement

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

Example G: Documentation or Process?

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

Additional Resources

[CAHMPAS \(Critical Access Hospital Measurement and Performance Assessment System\)](#)

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

[Emergency Department Transfer Communication Measure Resources](#)

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

[MBQIP Measures Fact Sheets](#)

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

[MBQIP Reporting Guide](#)

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

[Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals](#)

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

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

Appendix A – Sample MBQIP Hospital Data Reports



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

Quarter 4 - 2019

MBQIP Hospital Example

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

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

This report contains the following core MBQIP measures:

Patient Safety/Inpatient Measures

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

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

Outpatient Measures

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

General Report Information

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

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

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

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

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

Percentage Values

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

Time Values

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

Percentiles

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

Binary Responses (Y/N)

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

Reporting Periods for Annual Measures

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

Measure Aggregation

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

Data Exceptions & Labels

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

999999: MBQIP Hospital Example

City, ST, 00000

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report
 Quarter 4 - 2019
 Generated on 10/23/20

Example A

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

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

“N/A” indicates that the CAH did not submit any data for this measure.

“†” This measure may not accurately reflect the true value of the data. Without access to population and sampling data, we cannot determine whether a CAH submitted that they had no eligible patients in the required measure population (indicated as a “0” in earlier reports) or that the CAH did not submit data or data was rejected (indicated as “N/A” in earlier reports).

“#” indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

“D/E” indicates that the data was submitted but excluded because it did not meet the measure criteria.

999999: MBQIP Hospital Example

City, ST, 00000

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

Quarter 4 - 2019

Generated on 10/23/20

Example B

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

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

“N/A” indicates that the CAH did not submit any data for this measure.

“#” indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

999999: MBQIP Hospital Example

City, ST, 00000

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

Quarter 4 - 2019

Generated on 10/23/20

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

Example C

“N/A” indicates that the CAH did not submit any data for this measure.

“#” indicates that the CAH did not have a signed MOU at the time of reporting for this time period.



Hospital-Level Patient Experience Core Measures/HCAHPS Report

Current Reporting Period: Q1 2019 - Q4 2019

MBQIP Hospital Example

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

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

This report contains the following core MBQIP measures:

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

General Report Information

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

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

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

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

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

Measure Adjustment & Aggregation

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

Response Categories

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

Data Exceptions & Labels

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

999999: MBQIP Hospital Example

City, ST, 00000

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

Generated on 10/23/20

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

Example D

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

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

“N/A” indicates that a CAH did not report data for each of the four quarters included in the reporting period.

“N/C” indicates that less than 100 surveys were returned in the reporting period so a Star Rating was not able to be calculated.

“#” indicates that the CAH did not have a signed MOU at the time of reporting for this period.

999999: MBQIP Hospital Example

City, ST, 00000

Hospital-Level Patient Experience Core Measures/HCAHPS Report

Current Reporting Period: Q1 2019 - Q4 2019

Generated on 10/23/20

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

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

HCAHPS Global Items	HCAHPS Star Rating	Your Hospital's Adjusted Score			Your State's CAH Data			National CAH Data		
	Star Rating (0-5)	0-6 rating	7-8 rating	9-10 rating	0-6 rating	7-8 rating	9-10 rating	0-6 rating	7-8 rating	9-10 rating
Q21 Overall Rating of Hospital (0 = worst hospital, 10 = best hospital)	N/C	5%	17%	78%	4%	16%	80%	5%	17%	78%
Q22 Willingness to Recommend This Hospital	N/C	1%	14%	85%	2%	18%	80%	3%	21%	76%

Example E

“N/A” indicates that a CAH did not report data for each of the four quarters included in the reporting period.

“N/C” indicates that less than 100 surveys were returned in the reporting period so a Star Rating was not able to be calculated.

“#” indicates that the CAH did not have a signed MOU at the time of reporting for this period.



Hospital-Level Care Transition Core Measures/EDTC Report

Quarter 2 - 2020

MBQIP Hospital Example

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

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

This report contains the following core MBQIP measures:

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

General Report Information

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

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

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

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

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

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

Percentage Values

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

Percentiles

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

Measure Aggregation

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

Data Exceptions

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

999999: MBQIP Hospital Example

City, ST, 00000

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

Generated on 10/23/20

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

Example F

Example G

* The EDTC measure was revised starting January 1, 2020, so comparable data for previous quarters are not available.

“N/A” indicates that the CAH did not submit any data.

indicates that the CAH did not have a signed MOU at the time of reporting for this period.

Appendix B – Glossary

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

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

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